UNIVERSITÉ EUROPÉENNE DU TRAVAIL

Sous la conduite de
Rachel Beaujolin-Bellet
et de Claude Emmanuel Triomphe

Takeover of a private clinic by a public hospital in a medium-sized town Restructuring and improvement of job quality

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Summary

The acquisition of the private clinic by the public hospital of this medium-sized town has not only allowed jobs to be preserved but also to improve quality. The 'transferred' workers were taken on as public servants and have been able to benefit from improved working conditions and quality of life.

The operation, which was completed in three months, has made it possible to structure a network of local care which links the public sector hospital and private practice. It could be accomplished successfully thanks to the quality of the dialogue between management and workers which has long been encouraged within the hospital, and due to the mutual respect and confidence which distinguish the relationship between the different partners, but also thanks to the choice of a methodology of change built on participation, transparency and anticipation.

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Monitoring Innovative Restructuring in Europe

THE RESUMPTION OF THE ACTIVITIES OF A PRIVATE CLINIC BY A PUBLIC HOSPITAL IN AN AVERAGE TOWN

Study carried out on behalf of the UET

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This report was drawn up on the basis of information provided by the management of the public hospital centre (HC) and the interviews were held with several role players, internal and external (complete list in Appendix 2). We wish to thank each person involved for their availability when holding these interviews.

To ensure anonymity, the names of the health institutions and those of the role players have been replaced by codes. More exactly, we have replaced by X the name of the average town where the public hospital has resumed the activities of a private clinic owned by the SG health group.

Once the context has been explained, we shall be presenting the overhaul process and then analyse the reasons for the "success" of this operation and its likelihood of transferability. Finally we shall appraise the overhaul in the sense on a social level, economic level, work conditions and on the level of the territory itself.

1- The context

We should remember the specific features of the French health system prior to studying how things are developing in Town X.

1-1 The specific features of the French health system

A liberal and totally socialised system

The French health system is based on a major principle: the free choice of doctor and care establishment for each patient. Application of this principle translates into a public-private duality: general practitioners work in the freelance sector, specialists and surgeons are perhaps working in hospitals, as civil servants or freelance practitioners whose earnings come from fees received from the patients. The system is therefore completely socialised: financial soundness is ensured by the Social Security (social contributions and budgetary allowances) and by the mutual insurance companies which reimburse totally or partially the expenses incurred by the patients (fees, hospitalisation expenses, pharmaceutical expenses, etc.).

Constant budgetary difficulties

Where health is concerned, France is undergoing an almost constant financial crisis which can only get worse due to the ageing of the population. *"People over the age of eighty consume six times as many days of hospitalisation than a person under the age of fifty. Six times more. Upon being aware of the growing population of people over eighty, it is clear that these needs are going to increase" (DRHA).*

Overhauls over the last twenty years

In the framework of the Regional Plans of Health Organisation (*Schémas Regionaux d'Organisation Sanitaire - SROS*), the regional hospitalisation agencies (RHA) motivate health establishments (public hospitals, private clinics, mutual insurance clinics, etc.) to undergo an overhaul in order to rationalise the offer of health care on a regional basis (and in the outlying suburbs) thus avoiding doubling, using to their best effect the technical support centres and expensive equipment, and closing down those structures which fail to reach the level deemed critical, of all that improving the quality of the services offered to the patients. In this respect, the health system is undergoing a complete overhaul. The question of the side effects of this hospital re-organisation is raised in terms of employment, work conditions and quality of care given to the patients.

Regulated professions

The health care world is characterised by ancient professions (doctors, midwives) with strong identities. The professional corps are anchored in occupations which have remained more or less stable over centuries but which have evolved very forcefully over the last twenty years due to the introduction of new technologies but also, more recently, to "management" technologies. The evolution in terms of the organisation of the public hospital clearly embodies this process. During the fifties, freelance doctors spent time at the hospitals to provide care to the poor, a traditional charitable gesture inherited over many centuries. They became hospital doctors, teachers and researchers at some and managers at many. We would add that these professions (doctors, midwives, nurses, health care aides) are highly regulated: "*Any drift of tasks always exceeds the regulated expectations" (DRHCH).*

A complex hierarchical system

Hospitals are run on a complex hierarchical system. The executive team is formed by "experts", trained by the ENSP[1], but this team has little power over the medical corps which has great autonomy and its own enquiry board, the Establishment' elected Medical Committee

[1] See glossary in Appendix 2

(*Commission Médicale d'Etablissement – EMC*). The latter is formed by doctors and is presided over by a doctor, closely linked to decision-making in the hospital. Similarly, at a private clinic, the doctors are not employees but subscribe to a contract whereby they hire the means of work and their earnings come from the fees paid by their patients but reimbursed by the Social Security and by the mutual insurance companies.

1-2 The hospital organisation at X and its environment

Private clinic - public hospital: an ancient rivalry

The hospital as such exists since the 12th century and has developed a long tradition of welcoming the poor. At the end of the eighties, the hospital was still receiving the most deprived patients, whereas the private clinic was chosen by the wealthier. "*The town doctors are no longer voluntarily sending their patients to the clinic unless they are very old, very seriously ill, or those in the most precarious of situations" (CAB*). The hospital had a "*bad reputation … It has the lowest daily fees in the region … It has become very depleted, with the passing of time" (DGCH).* In the nineties, it was facing serious financial difficulties: "*A deficit of six million francs. It is no longer possible to pay the suppliers" (DGCH).* The management drew up a restructuring plan in 1995 which envisaged reducing the number of employees by 9 per cent. The objective was reached without any layoffs, re-organising the services (a significant reduction in the number of beds used for after-care or convalescence), in delayed discharges, by moving over to part-time work: "*the executive team even put itself on part-time, at least on paper!" (DGCH).* That was a "*great battle" (DGCH).* The majority trade union representatives (CFDT, the only one represented in the case) accepted this plan which was deemed indispensable. The financial situation improved after 1996 as a result of this re-organisation and thanks to the financial grants agreed to by the DDASS and by the RHA. The hospital then began slow but regular development marked by the improvement in the accommodation of patients (maternity, the elderly), development of the radiology sector, the installation of a scanner.

Th Saint J clinic was significantly active throughout the eighties. It employed prestigious surgeons to whom the general practitioners were happy to send their patients there. The first SROS (1990) mentioned the necessary amalgamation of the two Technical Support Centres (that of the clinic and that of the hospital) without specifying which would be the beneficiary thereof. The comparable situation of the two establishments posed a threat to the hospital management and its trade unionists and agents about the closure of its Technical Support Centre. *"I believe that the clinic really wanted to take orthopaedic and visceral surgery over from us, to take over a profitable business. Strong on the basis of its reputation and also of a certain belief of the inhabitants of the country where X is located, where it has always been said that one was taken care of better at the clinic than in hospital. That people did not die at a clinic, whereas it was easier to die in hospital!" (CAT).* The reactions were rife. Demonstrations were organised. One of them was attended by 3,000 people. The warden then gave the hospital a change to re-organise itself in co-operation with hospital Y (in an average town 30 km away). Certain technical-administrative bridges were set up between the two hospitals but, on the health level, the issue did not advance. Meanwhile, the meetings between the hospital management and those in charge of the clinic took place to no avail. The situation of the clinic justified its "*superb isolation" (DRHCH).* Nevertheless, at the end of the nineties, it underwent serious financial difficulties and the congregation of sisters of R, the owner, sold the business to the SG Group on 1st January 2001.

The hospital: an essential employer in a depleted industrial setting

The town of X had a lengthy industrial tradition (footwear, glass, etc.) but these sectors were declining heavily and the installation of new industries (telephony, optics) did not compensate the loss of industrial jobs. In X's country (58 districts, 76,517 inhabitants, an area of 1,026 square km), the distribution of jobs by activity sector was still marked by this industrial background. In 1999, the secondary sector represented 37.7% of the jobs (compared to 24.5% for the region of Brittany and 24% for all France), the primary sector represented 12.5% (compared to 8% for the region of Brittany and 4.7% for all France), and the tertiary sector 49.8% (compared to 67.5% for the region of Brittany and 71.3% for all France). The main employer in X (more than 800 employees) was S… which manufactured mobile telephones there. Business emigration was not excluded. The hospital, with 483 permanent jobs in 2000, 628 in January 2004 and 651 in January 2005, was the second employer in the town of X.

The stages of the upturn of business and integration of personnel

End 2002	February 2003	March 2003	May 2003	11 July 2003
Crisis meeting at the RHA, at the initiative of SG: a sole Technical Support Centre at X ?	Audit done at the request of the RHA. Conclusion: the clinic's activity is not profitable	HC proposes resuming the clinic's activity in the form of an "open clinic"	Awareness of the clinic's HR by DRH HC (with the clinic's collaboration) and proposal to develop after-care	Decision of the RHA: the HC should resume the clinic's activity as an open clinic, and all the personnel

Mid July 2003	25 September 2003	October 2003	November 2003	December 2003
SG announces its intention to recruit two surgeons	SG announces the closure of the clinic on 31st December 2003	Creation of a steering committee by the HC	Individual interviews carried out by the DRH of the HC with each employee of the clinic	Decision of the Scénarii hospital AB to reorganise both institutions and to assign the personnel

tttttttttttttttttttttttttttttttttttttttttttttttttt	**October to December 2003**
	Steering committee meeting once a week
	Negotiations between RHA, DDASS, CRAM, HC and the clinic (the latter providing information and / or negotiating): HC budget, material organisation, re-admission of staff
	Negotiations between the management of the HC, chairman of the EMC, Mayor, with freelance surgeons
	Negotiations between the freelance surgeons and SG
	Negotiations between SG and employees of the clinic not re-admitted by the HC
	Meetings organised by the HC and the Mayor for the staff of the HC and of the clinic together
	Initiatives taken by the trade unions (HC and/or clinic): demonstrations, meetings, demands for information, leaflets, etc.

1st January 2004 **recruitment of 76 of the clinic's employees by the HC and assignment in the services**

2- The stages of the overhaul: a very tight schedule but prior planning and consensus

In 2002, the SG Group, of national dimensions, owner of the clinic since 1st January 2001, thought it was losing money and called a crisis meeting at the RHA, to accelerate a decision on the amalgamation of the two Technical Support Centres (that of the clinic and that of the HC). The management of the HC also considered that *"to recruit surgeons and anaesthetists, a sole Technical Support Centre was unavoidable" (MP).*

The RHA ordered an audit to be carried out on the clinic's activity during the first quarter of 2003. This audit concluded the non-viability of the clinic (unless its fees were raised from 16 to 25%). In March 2003, the HC proposed taking over the business in the form of an "open clinic". This legal format (created in 1943) allows surgeons to practice as freelance doctors within a public hospital and thus receive direct the fees paid by the Social Security on the patients' accounts, by way of the disbursement of a flat rate to the hospital placing at their disposal a Technical Support Centre, premises and personnel.

The notification of the RHA's decision was the starting point of the overhaul operation. In a letter dated 11th July 2003, the RHA announced to the two establishments that the Saint J limited company should accept the resumption of its activities (in the form on an open clinic), of its personnel and of its tangible assets by the hospital centre. But nothing was resolved. "*This is a policy proposal adopted by the RHA but it has to absolute power of authority. The hospital's administration board and the clinic's surveillance council are those who should decide and can support, or otherwise, the RHA's position" (DRHCH).*

Thus began a period of great uncertainty and negotiations between the RHA, the HC and the clinic and also between the HC and the freelance surgeons (2-1). The HC meanwhile set up a steering committee and its management held a private interview with each one of the clinic's employees liable to be integrated in the hospital structure (2-2). The overhaul project created internal tensions in the hospital and caused concern among the clinic's staff (2-3). The vote of the hospital's administration board (1st December 2003) settled the question of the resumed activities (2-4), leaving two problems to be resolved: setting the budget of the HC for 2004 and integration of the clinic's staff in the hospital framework on 1st January 2004 (2-5).

2-1 Uncertainties about the resumed activities and negotiations undertaken

In mid-July 2003, the clinic's management turned a blind eye to the notification from the RHA and said in the press that it intended to recruit two surgeons. Yet on 25th September, during a board meeting, the regional director of the Group announced the clinic's activities would cease on 31st December 2003. *"The hospital's governing body meets and says it is ready to go ahead. The question that arises now is one of time-scale. We are worried because it takes at least six months from making a decision to transfer the activities to putting it into practice" (DRHCH).* The resumption of the activities, and taking on the personnel able to secure it, is linked to the two main surgeons agreeing to adhere to the open clinic project. In conflict with the Group regarding the ways of rescinding their contracts, the surgeons said they could not give a reply until the end of November. *"The clinic had two surgeons who were very active. The issue is knowing whether they would accept to come and work in an open clinic regime. We had to stick to a schedule and we needed to know their reply. They took a long time to do so, arguing reasons about their severance pay terms" (MP). "Based on the replies from all sides, the general balance of the operation could be deeply upset. It is*

enough for one or two of the major stakeholders not to go along and everything falls apart" (DRHCH).

Nevertheless, the HC set up a steering committee formed by members of its personnel sitting on the administration board, three members of the clinic set-up committee, chairmen of medical committees at the hospital and at the clinic, doctors from both institutions and members of the hospital management. If the discussions of a collective nature took place within the committee, individual ones were held with each one of the freelance doctors who had had a contract with the clinic but who were not employees (which meant a multitude of speakers for the HC). The chairman of the EMC of the hospital played an important role in these discussions with the freelance practitioners, as did the town's Mayor, chairman of the hospital's administration board. The management of the hospital and of the clinic were however meeting very frequently.

October and November 2003 represented a phase of absolute uncertainty. *"We were at the end of November, one month away from the resumption, and still nobody knew if the surgeons were going to accept or not" (DRHA).*

Negotiations took place between the management of the clinic and that of the hospital, under the auspices of the RHA and DDASS (which was also carrying out a mission of re-organising the provision of care under the tutelage of the RHA). *"The RHA is a decision-making institution but its institutional position also allows it to intervene to get the role players together, to try to remove tensions, in such a way that results can be achieved" (DRHA).*

"It was a dossier that had to be dealt with in the sense of ceding authorisations, the budgetary management of the transfer of packages, and the management of jobs. Hence there is a three-fold approach: a juridical one regarding the cession of authorisations, a financial one concerning the transfers of packages as, financially, it was an important operation, and the third in the sense of human resources, employment, the staff treaties" (DRHA).

The main point of litigation between the SG Group and the HC concerned the application of Article 122-12 of the code of labour. *"Should one consider this operation as a breach of work contract with the clinic's employees, a lay-off? The clinic's management considered that the transfer of the business entailed the hospital's taking over all the work contracts" (DRHA).*

"In the end, the non-application of Article L122-12 was pleaded, even though it was applied, to prevent any subsequent opposition being filed"(DGCH).

"For the five people that the HC could not incorporate, we have laid our cards on the table to seek a solution. Three of them have accepted a proposal to join SG as newcomers and it is known that the other two left without any proposal being made" (DRHCH).

"Two or three discussions were held with the people who did not want to go to work at the hospital and the hospital did not need them" (DGSG).

Discussions probably took place between the RHA and the SG Group, which would have required the transfer of beds to the clinic in W. *"There were rumours about negotiations being held regarding beds attributed to this or that clinic" (AM).*

Negotiations also took place between the HC, the RHA, the DDASS and the CRAM, and finally between the RHA and the Ministry of Health, regarding the matter of the budget granted to the HC. Indeed, public establishments are subject to a specific budgetary line and it was necessary to carry out a transfer between the budgetary package destined to the private establishments and this line. The evaluation of the amount of this transfer have rise to an "*important debate" (DRHA). "The RHA has justified things with the CRAM, which concerned most particularly the clinic's operating budget. The Ministry was then asked about an amount on which there was more or less an agreement. … One should renounce building up a dossier if the costs, once the transfer has taken place, are higher than the previous operating costs" (DRHA).* (see below, 2-5).

2-2 The steering committee and the individual interviews

The overhaul process was monitored by a steering committee. The DRH at the hospital held individual interviews with the clinic's staff from November 2003 onward.

A steering committee

A steering committee was created by the management of the HC, in September 2003, "*within 48 hours of the SG's announcement that it would cease managing the clinic on 31st December 2003" (DRHCH).* It was formed by representatives of the personnel at the HC (members of its administration board) and of the clinic (members of the set-up committee), chairmen of the medical committees of the hospital and of the clinic, and members of the HC's management.

This steering committee would meet every week to try to find solutions to all the problems raised by the activity transfer operation.

"The object was to take stock of the entire operation, regarding the personnel, the technical issues, the doctors, the organisation. It was fine to discuss financial matters, technical ones, buying back material… The steering committee was the step-by step follow-up" (ACT).

The individual interview.

During the month of November 2003, the human resources manager at the hospital and the patient care manager individually interviewed the 85 people employed by the private clinic to listen to their wishes about assignment. They organised ten or so meetings in the clinic with the employees to be transferred.

"All 85 people were seen, not just to get to know them but to become aware of their wishes, imagining what was possible" (DRHCH).

"The hospital management called in each person individually to know their experience, from where they had come, what they had done, what they wanted. … These interviews were not accepted too well. It was something they had never done before. Finding themselves face to face, almost in a professional interview after all, was very stressful for them" (IDEB).

2-3 Internal tensions at the hospital and signs of concern among the clinic's personnel

There were evident signs of tension inside the hospital as those hired by set-length contracts (CDD) thought that the commitment to take over all the staff at the clinic could lead the hospital into not renewing that CDD if the resumed activities proved to be less important than was envisaged.

"*Some fifteen civil servant posts had been filled by contract workers since mid 2003 to secure support for integrating the staff from the clinic but that was only socially acceptable if the situation was sorted out quickly. The fact is that not renewing a 3-month set-length contract (CDD) is all right but after being there for six months, the feeling in the hospital is that the employment relationship has kicked in and that the post becomes a stable one even if, legally, the contract is precarious (set-length CDD). A permanent position normally arises after a presence of three or four years when a permanent post is vacated. This situation obeys the fact that around 30 per cent of the fixed personnel works part time and complementary activities can only be carried out by a contract worker to enable the fixed employee to take up full time employment again when he or she wishes to do so" (DRHCH).* In addition, most of the care personnel at the clinic, recruited by the HC, could be directly given fixed posts when these became vacant, obtaining them without passing any test and without undergoing any training period (by virtue of article 102 of the public hospital service code). The contract workers of the HC therefore envisaged a longer wait to obtain permanent posts. The situation only became known through the trusting relationships established between the management and the trade unions - trade unions which still had in mind the overhaul of 1995 and the loss of 9% of the jobs. *"The priority was to maintain a provision of care at X, with the problem of employment and the matter of permanent posts coming a close second" (CAT).*

The clinic's employees were also feeling bad about their situation. The sale of the clinic to the SG Group was a painful issue, still recent in their minds.

"The sisters had said, some years before, that they would never let go of the establishment and then they sold it to SG. That brought about a completely different kind of working regime and some of the employees left. The teams thought they were being harassed. They felt that the management was proceeding so that the older ones would feel weary and leave… It was like a cold shower every day for the these employees. They no longer trusted anyone" (IDEB).

The management of the private clinic developed a secretive strategy, namely the system of "*disinformation" (CAT)* which made the employees' doubts even stronger.

"There were people in the clinic who maliciously enjoyed telling silly stories" (CAT).

"There was a lack of dialogue and communication between the management and the teams. The teams were worried as they felt things were happening and that they were being kept in the dark" (IDET).

"One got the impression that they took us for idiots… At the committee meeting in July, everything was fine .. and in September we were told everything was falling apart, that we'd been bought out by the hospital. Under what terms? Nobody knew anything then" (IDEM).

"The transfer of the business was seen by the vast majority of the employees as the private group's abandoning the establishment just three years after taking it over" (IDEB).

"In the private sector they were on permanent contracts, or 'CDI', whereas to undergo a training period at the hospital was the same as going back to a basic set-length contract or 'CDD'" (DESG).

The representatives of the clinic's staff, present at the steering committee meeting, were silenced by their principles who did not believe in a total take-over without jobs being lost.

"At the committee meeting, there was a time when we felt so unheard … we were positive and optimistic yet we found ourselves rather in confrontation with many of our colleagues"(ATC).

"After all that time we were being lied to! It's true that we were very unwilling. We heard things and the next day we heard the opposite. We had had some hard experiences. We were on guard" (IDET).

"And we were apprehensive at times: even if the Mayor (and the hospital) did want to take on the employees, would the budget allow for it and then what is going to be done?" (IDEB).

"The clinic's employees were always very insecure as they came to see us without knowing much about how the take-over was going to be done. They were suffering" (DRHCH).

The clinic's employees organised themselves to try to obtain information and commitments from the Mayor's office and from the hospital management.

"I have resumed my mandate (as trade union delegate). … A colleague has set up a trade union CGT" (IDET).

"There was only one demonstration but there were several distributions of leaflets in public places, in the markets, in the shops. We went to the Municipal Council. We were received by the deputy warden … " (IDEB).

"We went to the Municipal Council. They were none too happy about it. They did not understand why we were worried. In December, no meeting was held. Just a poster was put up, with a list of people integrated in the hospital" (IDET).

To reassure the personnel at both places, two large meetings of the clinic's staff and hospital workers were held in a hall at the cultural centre. At these meetings, the hospital management and the town's Mayor informed us about what was going on and answered our questions. *"To do away with rumours, we organised these meetings open to the public involved" (MP).*

2-4 The vote of the hospital's administration board

Resumption of the clinic's activities in the juridical regime of an "open clinic" was not unanimously approved of within the HC. Indeed, the two freelance surgeons who had delayed their reply published an article in the local press that the HC deemed "*defamatory"*. *"The fact is that those two had made a very negative article about the hospital appear in the press. They were not too keen about working with is. They had disregard for the public service" (CAB).*

The EMC declared against their integration in the "open clinic". The representatives of the personnel on the administration board were embarrassed.

"We were split between defending the public service, because, aware of how the public hospital was considered, there could be doubts about their investment in the establishment, and then in defence of employment because, in any case, the RHA was imposing that eighty people from the clinic should be taken on. It was hard to adopt a position in view of that decision. Finally, our personnel delegates had done all they could to get those two private surgeons to work for the public hospital" (CAB).

"A meeting of the HC's administration board was held, during which a decision had to be made as to whether we would accept the two freelance surgeons. The EMC declared itself against this. The meeting started at 8 PM and ended at midnight. I did not ask them to make a decision that day. I said to them: 'we give the private surgeons another chance. We meet up with them'. One of them came. The other refused to reply as he deemed it belittling for a grand expert such as himself to do so" (MP).

"Some days later, having met up with these surgeons again, a healthier attitude brought the EMC to come to a new meeting in order to achieve a new somewhat more open Medical Committee before the Administration board" (PCME).

On 1st December 2003, the hospital's administration board voted in favour of the resumption of the activities in full (after integration of freelance surgeons, except one) on 1st January 2004. That meant a transfer of administrative permits regarding operation (ruled by the RHA), buying back the materials and equipment, taking over the lease on the building occupied by the clinic, revising the budgetary allowance granted to the hospital to allow it to ensure this increase in business, the financing of the investment in the framework of the "hospital 2007" operation, envisaging an overhaul of the sites of the health establishments at X (regrouping).

2-5 Cessions of permits, fixing the hospital's budget and integration of the staff

"Up to the end of 2005, all planning of the care offer was organised on the basis of a health card defining certain indices: so many medical beds, surgical beds, obstetrics beds for such and such a population" (DDASS).

Each public and private establishment was authorised to run a number of beds determined in the health card of its activity sector (corresponding to half a department in the case in hand). Thus it was a question of transferring the clinic's permits to the HC.

"There is a great procedure to be followed for making these cessions of permits. The cession of 60 beds from the clinic to the HC was achieved for 40 surgical ones (of which 20 beds in the open clinic) and 20 after-care beds (convalescence)" (DRHA).

It was also necessary to ensure that the budget granted to the hospital allowed it to absorb this additional business. As replenishing the budget coming to the hospital which should create jobs and pay its fixed staff (the 76 workers coming from the clinic, a hospital anaesthetist as the one who had been employed by the clinic was working freelance and therefore paid by way of fees) should also cope with an increase in activity and therefore cover higher costs (for example, purchasing more prostheses), then the rules of financing these costs differ depending on whether it is a public structure or a private one. The management of the clinic was asked to provide information. The CRAM expressed its misgivings.

"We had to supply all our external providers, all our external quotations… so that on the level of the CRAM, and also on that of the Director of the HC, they could have a global view of the package they should request in order to be able to carry on with the activity" (DESG).

"The CRAM was very much against this, not in terms of the fact of integration but in terms of the means that had been transferred. It estimated that, in this matter, the hospital was onto a good thing, financially, by collecting the re-directed means, because the transferred business would not be as important as that of the clinic" (DDASS).

"There was also an underlying argument in the sense that those in charge of health insurance consider that the more hospitals there are, the higher the number of ill people needing them. Hence, if a doctor anaesthetist was recruited, additional expenses would be incurred. We replied 'that is not right because a doctor anaesthetist is dependant. His activity is dependant on that of the surgeon'" (DGCH).

"The budgetary discussions were difficult, particularly regarding after-care as we were doubling the capacity of accommodating these cases. The Ministry dealt with this by saying 'that comes to so much' but it was a long way off the estimates" (DGCH).

One could only determine the possibilities of the HC taking on the personnel (and the matter of their salaries) on the basis of the budget granted. However, the response from the Ministry was given some months after the process of integrating the staff. *"We did in fact take the safeguarding of employment for granted, irrespective of the final response from the Ministry which would come at a later date" (DRHA).*

Thereby, the HC became the direct employer of the clinic's employees. Of the 81 people employed by the clinic on 31st December 2003, 76 were integrated within the hospital (three were cross-posted into another establishment of the private health sector and two 'took advantage' of an arrangement with SG). Of these 76 people, 22 were State-registered nurses (SRN), 18 were health care aides (HCA) and 19 were hospital service agents (HSA). The assignment of 'care' personnel did not give rise to many problems to the degree where the resumed activity was not considerably inferior to that of the clinic and because the functions of these 'professionals' are clearly defined. See 'regulated professions' (above, p.2).

A different matter was that of the technical staff (8 maintenance agents and professional workers) and administrative staff (5 executive assistants and 3 administrative agents) who doubled up with the HC's own staff and had to take on the functional modes of the public sector (accounting standards, contracting, coding medical procedures …). *"They didn't know what to do with me. I was sent to two departments before I myself asked to come here" (ACT).*

The hospital management decided to 'blend' the teams in order to eliminate quickly any differentiation between the clinic's staff and the hospital's staff. The newcomers were placed under the charge of a colleague at first.

Hired under contract, all the staff (with 6 exceptions due to departures upon retirement or insufficient seniority) would obtain a permanent contract in the public hospital service, retroactively from 1st January 2004, with no loss of salary.

3- Analysis

As we have already mentioned, the French hospital system is undergoing a total overhaul. It is therefore appropriate to query the factors that facilitated the success of this operation of absorption and to assess transferability. We immediately notice that advancement within the professional markets (see above, 1-1) ***facilitates mobility***. Passing from a private clinic to a public hospital has required only a short period of adaptation for the transferred staff. Some of the clinic's employees, faced with the evident crisis situation since the year 2000, had chosen another form of mobility: that of adopting freelance status. Mobility among the health personnel is also favoured by an on-going increase in the demand for care, due in part to the ageing of the French population.

Three further elements can be transposed to other hospital re-organisation procedures. These are ***politically very sensitive dossiers*** whereby numerous role players are mobilised and whose aim is to accomplish without any job losses. The ***status of the public hospital service*** offers attractive opportunities for the personnel coming from the private sector. The ***"hospital 2007 plan"*** helps provide financing for the investments incurred in such overhauls. A final favourable element concerns the size of the re-organised institutions: a ***"humane-size hospital"*** which absorbs a small clinic with just 60 beds (see 3-1).

Despite these favourable factors, specific difficulties should be stressed: the importance of the private protagonist (the SG Group), the need to negotiate with each freelance surgeon (which is not the case when the re-organisation involved a public HC and a mutual insurance company clinic, for example), uncertainty about the matter of a process held up until one month before it comes in force, the game of rumour-spreading and disinformation. None of these problems could have been overcome without the role players' good will (3-2).

3-1 The factors facilitating the setting (structural and circumstantial) transposable to another territory (in the same activity)

3-1-1 A politically sensitive dossier

The question of the provision of care in any territory is politically very sensitive. The proximity of that care for an ageing population and its quality and safety are priority concerns for the local authorities. The economic and social issues are also of great importance. The hospital is a provider of employment. The local elected politicians are worried about job losses that could raise the unemployment rate in the territory and bring about mobility outside the employment area. The displeasure of the voters and social troubles can be particularly annoying and affect them directly.

"The clinic staff are very worried about losing their jobs. The same occurs for the auxiliary staff at the hospital. This was a risky operation, socially speaking" (MP).

3-1-2 The treaties of the Public Hospital Service

Article 102 of the PHS allows permanent contracts for employees who had acquired a service seniority in the private sector in very favourable conditions (no loss of salary, no training period).

"Article 102 of the by-laws is well known but the problem arose regarding the take-over with the benefits acquired arose. There was an overlap of two texts (this one and article L122-12 of the code of labour)" (DGCH).

3-1-3 The "hospital 2007 plan", a powerful tool in re-organisation

"The "hospital 2007 plan" represents five hundred million euros of investments in works carried out in the region in five years, and this opportunity has allowed us to imagine the construction of a new building on the site of the hospital. It is evident that when an investment of twenty or twenty-five millions can be made, that gives margins for working in terms of co-operation. The "hospital 2007 Plan" has been a real lever" (DRHA).

3-1-4 A hospital of humane dimensions integrating freelance surgeons (in "open clinic")

The HC is of good size to enable the co-existence of several services and so that mobility of the personnel is possible, for the stand-bys to be shared among the hospital practitioners and allowing correct living conditions with a balance between professional and private life. The size is nevertheless not too big and permits a certain user-friendliness. The proximity of a large town nearby (40 km) is to be noted. There could be a "local payment office".

"*There is a connection which, in the thirty years of my career I have never seen before, something I have never seen elsewhere" (DDASS).*

"The first condition of the "open clinic" system's success is that the number of public practitioners should be greater than the number of freelance ones" (DGCH).

3-2 The factors that affect the role players

Individual and institutional positionings generate collective synergies.

"I believe that the personalities of the different role players have a lot to do with it. The first and foremost condition for success is, of course, to share common goals, to know exactly what one really wants" (CAB).

3-2-1 The role players and institutions present and their objectives

The Mayor, management of the HC and the doctors

"The hospital is governed by a trinity formed by the chairman of the administration board, who is the Mayor, the director of the establishment and the chairman of the Establishment's elected Medical Committee (EMC) which is the medical representative" (PCME).

The *Mayor* of this average town is very concerned about the issue of access to care and about employment. He is also the chairman of the recently set-up health conference of Sector X. He is also on the administration board of the University Hospital Centre of the nearby large town. Likewise, he is chairman of the Conference of Towns of the Region and, in this regard, he has allowed the director of the Regional Hospitalisation Agency to come to present the third-generation SROS to the group of Mayors - Chairmen.

"The Chairman of the Administration board has always adopted a soft but firm position, a medium one, meaning that he does not adopt radical orientations and listens at all stages, about all the options, showing great patience toward the lack of consistency of the SG Group, so that little by little, everyone comes to the most rational solution" (DDASS).

The *director* of the HC was able to advance, taking *"a turning well before the others" (DDASS)* with the re-structuring plan in 1995. He was also able to present solid dossiers (an important role among his collaborators as a whole), to dialogue with the staff (in the steering committee, ETC, administration board and more informally, too), to discuss …

"This success is fruit of the productive work done by Monsieur … and his team … He is among a rare set of directors who are still able to find the medical and surgical competence they want given the establishment's good reputation and means of operation" (DDASS).

"Here before us is a role player who has been extremely efficient, highly motivated, extremely conscientious, the hospital's director. He and his team have spent their evenings and weekends from September to December dedicated to this project" (DGSG).

The *chairman of the EMC* knew how to convince his colleagues of the opportunities entailed in taking over the business in the form of an "open clinic" even though, in the early stages, the EMC had expressed itself negatively regarding this operation.

"This is someone who truly seeks high quality services and who has procrastinated much more than the other doctors who disapproved of surgeons coming from the private sector to work in the public hospital, people from the private sector for whom materials and offices were purchases, who had secretaries, when some public sector surgeons had neither a secretary or nurse assigned to them. Doctor M really has done a lot to overcome the small day-to-day rivalries for the sake of a prime general interest, to return to the foreground the need to maintain a provision of care in X" (CAB).

The agents and trade unions of the HC

A division of tasks was set up. Discussions with the freelance surgeons were carried out by the hospital director, the Mayor - Chairman of the hospital's Administration Board and the chairman of the EMC. The trade unions at the hospital (essentially the CFDT section) worked on the Establishment's Technical Committee, the ETC, and discussed the new organisation of the work: how to distribute the activities between the two sites, for example. They upheld the project of "bridging the gap" proposed by the management of the HC despite the worries of those hired by the HC about a possible non-renewal of their set-length contract or 'CDD'.

"We had been assured by the RHA regarding the taking up of staff. They would not commit themselves lightly" (CAT).

The Regional Hospitalisation Agency, RHA

"The RHA has four missions: to organise the provision of care, to allocate the resources, to co-ordinate the activities of the role players of the establishments and to control" (DRHA).

To carry out these tasks well, the RHA in this region respects certain basic principles:

- *"Optimising resources": "In this health world there were double staff (above all in surgery) and also shortcomings (in after-care, for example)" (DRHA);*
- To avoid loss of employment: *"None of the re-structuring operations we have carried out in the region has led to lay-off" (DRHA) ;*

- To provide high quality care *"improved, and an undeniable safety care" (DRHA) as the patients' expectations are ever higher;*
- To uphold freedom of choice for the users: *"How to uphold this freedom of choice, one of the foundations of our health organisation in France, with this mixed public-private system?" (DRHA).*

The option of maintaining the Technical Support Centre within the hospital and allowing freelance practitioners to operate in an "open clinic" regime, within the public structure, is not a clear option.

"This is a fair and just decision. I am not sure that, when the committee met to make a decision, the director of the RHA opted in favour of the hospital. At a given moment, she must have thought that the best thing for X would be for the Technical Support Centre to go to the private sector which would be able to recruit surgeons, anaesthetists, etc. more easily" (MP).

The DDASS

"Our role, we DDASS, either under the wardenship before 1996 or under the RHA later on, is to ensure that the population is provided with the best possible care with a minimum of resources, without these being lost and without the beds, for example in surgery, being shared with the large neighbouring town, as this would have affected the people in a negative way. Hence, the object is to keep in this place a well-performing Technical Support Centre" (DDASS).

The SG Group

Several interpretations have been made of the SG Group's strategy:

- That of the people in charge: *"The object of SG buying back the clinic was to form a synergy between the clinic at W and the clinic Saint J at X, with all heavy operations taking place at W and less serious ones on the level of Saint-J » (DESG);*
- That of the Mayor of X*: "We at once thought that the fact of the SG Group coming to X was not because its inhabitants were pretty. There was obviously a strategy for re-grouping the beds on the site of W. Of course, those in charge at SG defended themselves" (MP);*
- Shared by the DDASS: *"Until 2005, the owner of the beds (as the beds are bought in the private sector, not in the public one, for sure) could transfer them to another clinic in the same sector with no problem. That was our worry in this specific case" (DDASS);*
- That of the staff at the clinic: *"It was clear from the attitude of the management of SG, when they arrived, that they would not be giving the establishment any chance at all to try to go ahead. There was no investment made in the establishment, the rooms were very old, and from the time SG arrived and until it left, we were working with very little material and deliveries not being respected. The establishment had been taken over but there were no longer any means for it to operate" (IDEB).*

The freelance surgeons

The freelance surgeons were worried about the loss of freedom they enjoyed in the private sector. However, their age did prevent their mobility.

"In fact, the absorption would never have happened, mainly because the medical team at the clinic was against it. But at a given moment, it was said that it was not up to the medical team to decide, but the shareholders of SG, if things were going to change or not" (DGSG).

"They held sway over the establishment for 20-25 years without anything being imposed on them. They did as they liked, they operated when they wanted to, even Sunday afternoons if that was convenient for them" (IDEB).

"The surgeons have accepted moving into the open clinic regime as they were fairly old and did not want to have to start again from zero" (DESG).

The staff at the clinic

Some of the clinic's employees were cynical. *"We knew nothing at all about how we were going to be taken over, we were told it was not our concern" (IDEM). "It is true I once said 'We're going to let a social plan slip by and we'll have to sort it out for ourselves to find work'. But the real worry was that there was not enough perspective in time and there were all sorts of people who were in service, people with houses to be paid for, children… » (IDEM).* Others got mobilised (see above, 2-3).

In short, a transposition seems possible in this activity, based on its characteristics, (very weighty political, economic and social issues, regulated professional markets, resolutions of the code of the PHS, the "hospital 2007 plan") with the condition that the size of the hospital benefiting from the resumption of the activities is suitably adapted (a humanised dimension allowing for user-friendly relations, allowing for a balanced sharing of stand-by duty. However, without the good will and mutual respect of the role players, without mutual trust, these necessary facilitating factors would be insufficient. Hence, there must be a will to use the resolutions in the code of the PHS to provide a solution of integration which is interesting for the staff. People must be convinced that a legal status which has fallen into disuse (that of the open clinic) can be adapted to propose a business take-over which is acceptable for the freelance surgeons. The complex alchemy of the relations binding the role players is difficult to decipher and, in part, remains unexplained.

3-2-2 The collective synergies

Good will, mutual respect, consideration, trust: these are the essential ingredients present. They are the gauges of the quality of the social atmosphere within the hospital and explain why a methodology of changed was chosen based on participation, transparency and anticipation, a choice of methodology that would guarantee the success of the change.

The essential role of mutual respect and the good will of the role players

The notion of mutual respect is expressed in a number of witness statements.

"There is a lot of respect among all the partners, among all the role players in the town. The town of … is just the right size, with a good balance, of respect between all parties. It is thanks to this that it all worked out … The town … represents a set of factors which are quite exceptional and which have allowed a rare project to be mightily successful" (DDASS).

One sees that same respect in the relations between the management of the HC and its employees, between the agents and trade unionists at the HC and the integrated employees from the clinic …

The main role players were able to find "half-way ground" in most cases: the freelance surgeons kept their secretaries and their instrumentalists but agreed to share stand-by duties; they accepted using the hospital's Technical Support Centre for serious operations; the anaesthetists re-organised their teams so they could work at the site of the clinic whose activities will be upheld until the end of the construction works allowing re-groupment on a single site …

"For the surgeons in the open clinic regime, the management of the programme may present a problem in the sense that they are also bound by the decisions of the anaesthetists, who are exclusively anaesthetists of the public sector as the private ones were not integrated in the open clinic" (DESG).

A serene social atmosphere and shared confidence

The "confidence" was created long-standing on the base of routines or implicit rules (to be on a set-length contract -CDD- more than six months meant stabilisation, with the contractual workers at the hospital being put on a permanent contract after three to four years …).

"The test" undergone ten years earlier (reduction of personnel and re-organisation) probably contributed to forging or strengthening common values (maintaining a provision of high quality care for the inhabitants of X).

"The success of this kind of operation is linked to the people involved in the events. There is great confidence between the Chairman of the AB, the Executive team and the staff's representatives. There is a similarity of opinion, based on common values" (CAB).

We would add that the respect of the staff's representatives of the trade unions enables holding a lively social dialogue (trade unionists can knock on the director's door or that of the DRH and obtain easily the information they are requesting).

"It is true that things have gone very well. I was well monitored. My dealings with the management, as a trade unionist, were always correct. I get the information I want" (IDEB).

"There were role players involved in the dialogue … Dialogue has been included in the establishment project for 2005-2009" (CAT).

"The DRH receives us regularly, as soon as he is asked to look at the problems" (IDET).

The choice of a methodology of change based on participation, transparency and anticipation

The desire for ***transparency*** and ***dialogue*** (the creation of a steering committee meeting once a week, the general assemblies of the staff from the hospital and from the clinic, the agents of the clinic received one by one, see above) characterise the process observed.

"Rumours were flying in all directions. We managed to avoid that by setting up a strategy of great transparency. Three days after SG announced that the activity at the Saint-J clinic

would cease, we had already held one meeting of a steering committee with representatives of the clinic's non-medical staff, and these meetings went on regularly every week" (DGCH).

"We organised two meetings open to the staff at the clinic and at the hospital. During the first of them, we explained where we were and, in the second, how things were going to be done. I think that is how we were able to create an atmosphere of trust" (MP).

"The trade unions could have seen this operation as dangerous for them if they had been narrow minded. They were able to understand the usefulness explained to them by the administration board and all the establishment's technical committees where social dialogue took place … I had never seen the trade unions support a director so strongly on a subject like that one" (DDASS).

This will for concert is found against in the functions of the Establishment's elected Medical Committee. Indeed, it runs according to the logic of a group of pairs, with the participation of all the doctors in its debates and discussions. The approach of accreditation taken up in 2005-2006 is likewise "participatory": *"The medical and care staff was deeply involved in the entire approach of accreditation. As to the self-assessment subject groups, these were recruited broadly and exhaustively from the range of services and range of colleagues" (PCME).*

The issue of ***anticipation*** is another essential feature. Indeed, despite the situation of absolute uncertainty in which the management team at the HC found itself, while awaiting the decision from the RHA, plus that of the freelance surgeons, It tried to anticipate the resumption of the clinic's activities and taking on its.

"Since May 2003, we have been collaborating with the management of the clinic to find out the situation of its human resources, to see if there was a match between them and the staff the hospital would need in order to take over the business. On the level of the D.R.H. I received fairly complete details about the 90 agents working at the clinic, at the time, their status, their salaries, their functions… and 'grosso modo' the current organisation. There were a few mis-matches. There was no place in this operation for some 14 people: double-ups, for example in the kitchens, an excess of care personnel. To avoid a social plan, the hospital proposed not only resuming the clinic's surgical activities but to develop the aftercare (convalescence) activities which were strongly lacking in the sector of X. The proposal was well backed by local politicians and that made it possible to lower the number of people who could have found themselves without a job in this operation" (DRGCH).

"The Personnel Manager was striving to integrate the clinic's staff, having to re-create careers to know on which level of the PHS index they could be included so as not to lose out in their wages. The financial departments were working on acquiring the material" (CAB).

"The month of December was spent drawing up all kinds of hypotheses on overhauling the business and, behind each one of those hypotheses, there were 4 or 5 solutions regarding the assignment of the personnel" (DRHCH).

Given the importance of the role players and their inter-actions, the transferability of such an operation was not at all assured.

4- Evaluation

The balance seemed positive for the agents of the HC, for the hospital activity and for the population. New co-operation projects could be envisaged to create a genuine health network (4-1). But there was still a fair number of problems and doubts about the future. The social balance reached was fragile (4-2).

4-1 A positive balance

4-1-1 Satisfied personnel

All the staff were taken on at their previous salary levels. These levels were a bit different for the nursing staff, due to their being group conventions in place covering them in the private sector. However, these levels were well below those of the public sector for the other staff areas such as administrative and technical staff. These were integrated in the public service with a given number of years of seniority more or less divided by two, whereas as the care staff were integrated with all their years of seniority.

The wishes regarding assignment were respected for a good majority of the employees (including that to remain on the site of the ex-clinic). There were some disappointments: young nurses integrated in the stand-in pool would have preferred being assigned to a service or department.

However it was helpful that the diversity of services within the hospital allowed mobility when the first assignment was not satisfactory for the agent. Hence a third of the HSA and HCA coming from the clinic changed the service to which they were first assigned within two years of their integration in the hospital (compared to a quarter of administrative staff). The 22 integrated nurses remained in their first assigned post (with just a couple of exceptions).

The interviews held also reveal:

- More respect for the employees' right to express their opinion at the public hospital:
"There was just one word back there. Nobody had the right to speak., Here we have the right to speak" (CAT).

- A more generous training policy:
"Training plans are set up at the hospital and we are in favour of them each year. In the private sector the training plans were more or less respected, mainly not at all" (CAT).

- Greater respect of the safety regulations:
"In the private sector, you work with an anaesthetist doctor, There are not 36 anaesthetist nurses around. Here we work with parachutes and safety nets" (IDEM).

"I arrived in 1999 and fifteen days later the steriliser unit at the clinic had to be closed down, after the inspection of the pharmacy took place, sub-contracting it to the hospital. Everything had to be brought up to standard to e able to reopen the sterilisation unit at the clinic" (IDEB)

- Better conditions of work and life:

"When we said we had a lot of work, the management told us that either we didn't know how to work or that we spent too much time cheering up the patients. When the people came out of the theatres, we were told that it wasn't worth taking their blood pressure. So maybe it wasn0t necessary to take everyone's temperature either. I preferred to recover the time but to do my work like I had always done it. I had my conscience to deal with – and I wasn0t the only one to react in this way" (IDET).

"I would say that we were no longer working with any kind of safety in place" (IDEM).

"We did not protect our private lives and were made to feel guilty. If we took a day off to look after our sick child, that was a catastrophe. … I never saw my kids grow up. I started to see them grow when I started to work here. Family life? I didn0t know what it was!" (IDEM).

4-1-2 Improved hospital activity

For the freelance surgeons, the situation is satisfactory. They work in better conditions. It is true they have other new restrictions (like guard duty) but they have no logistics problems (personnel charges, renting premises). They kept their "teams" (secretary, instrumentalist). One of the two most important of them (in terms of activity) did not join the HC which had to hire a hospital practitioner to replace him, and there was a momentary loss of activity (some of the patients "followed" the surgeon in his new assignment, a private clinic located 40 km from the site under study). The hospital overcame this problem and shows increasing activity which complements its attractiveness.

The establishment's activity, measured in number of patients admitted at the two sites, has risen by 3% between 2004 and 2005. This average, calculated on all the activities as a whole, conceals significant differences: a fairly important reduction of entries in the day hospital, a very strong increase of entries in after-care and convalescence (66%).

4-1-3 Quality and safety in improved care: towards the construction of a health network ?

In the health world, the emergencies are dealt with better: a double surgical stand-by (a visceral surgeon and an orthopaedic surgeon) is assured seven days a week. Coverage of care is better (30 beds for after-care and palliative care). A critical level is attained for the HC.

The re-grouping of activities on the main site (which should be finished in 2008) will resolve some of the current functional problems (two technical service centres, never-ending runs between the two sites…) and will enable forming new co-operation deals, strengthening the health network already in place.

"Advanced consultations" are organised in the specialities not present at X (urology, for example). Urologists from the UHC take visits at the HC once a week and thus confirm the diagnosis and follow up on a certain number of patients. If they require surgery, this takes place at the UHC. Meanwhile, the premises of the HC (the emergency department) will soon be placed at the disposal of an association of general practitioners to ensure the permanence of the care: this is the guard-duty medical house.

"Thereby, and in accordance with the protocols still to be defined, the emergency department will be able to send patients who do not require emergency treatment to the general practitioners. Of course, the general practitioners will also be able to send to the emergency

department those patients whose problems are beyond their own circle of competence. The second concern is to make the system secure in the sense that the general practitioner on duty is no longer isolated. That will allow taking better charge of the emergency patients and those coming from a general practitioner, providing a genuine Technical Support Centre right on hand" (DGCH).

4-2 A fragile social balance

The global situation of the "health" sector is alarming. Public hospitals have serious financial problems. The new activity tariffs (T2A) are probably more favourable to small and medium size hospitals to the detriment of large ones. The hospital at X seems to have been able to benefit on a financial level. However, there are risks of coming up against new difficulties in the management of hired staff, difficulties that could deteriorate the atmosphere of trust that was built up over the last decade. Incidentally, the important overhaul of the social system at the HC could affect the social cohesion that characterises it today, in as much as the fusion between the staff of the HC and of the clinic (who remained on the site) does not appears to be finished as yet. More globally, the social system formed by the personnel will be transformed deeply, following massive retirements. Yet the demography of the medical system and that of the care personnel will generate difficulties of recruitment, sensitively improved by the demand of new skills, managerial and in terms of relations, for the hospital practitioners (in the framework of the overhaul underway in care systems).

4-2-1 Activity tariffs and the maintenance of a gloat of precarious staff

For now, the new financing method has benefited the hospital at X and has enabled it to absorb the strong increase of its expenses. However, it introduces many uncertainties about financing in the future and hence risks to break the social pact in force (difficulties from now on to integrate the people hired on set-length contracts –CDD-, the need to operate continuously with a float of CDD people to absorb the fluctuations of business). The activity tariffs have introduced a management mode *"which directly buffers the management from the public service" (DRHCH)* as it requires the constant maintenance of a sufficient volume of personnel with a precarious status. *"For all those who arrive, no hiring. We were told: 'if the business goes well, we'll hire and if it doesn't then we'll fire'. We have entered a commercial system. Indeed, even in the documents of the highest health authority, the 'Haute Autorité Sanitaire', they no longer speak of patients but of clients" (CAT).*

4-2-2 A renewal of the possibly destabilising social system

More than a third of the agents working at the hospital in 2004 were not present in the year 2000 (31 jobs created in 3 years due to the reduction in working hours, 76 jobs created for integrating the staff of the Saint J clinic). 40% of the doctors and 50% of the officials present in the establishment in 2004 were recruited or appointed in their position since 2000. The social cohesion of the establishment is at risk of suffering from this important modification of its social system. A loss of agreements and values is possible (establishment project 2005-2009, p.68) as well as forgetting about what went before (the overhaul in 1995, for example).

4-2-3 An unfinished fusion of personnel

A heterogeneity can be seen in the modes in which the two sites are run. The "old habits" return to the site of the clinic. The routines inherited from the times of the religious

congregation are creeping back and the “re-organisation” imposed by SG (in the framework of an accreditation process) will be abandoned progressively. The problems of integration of less “mobile” and less “adaptable” staff will be delayed until coming together on a sole site. We note that only one service, that of the open clinic, is concerned by the phenomenon and that when the services are regrouped on a single site, retirements will be taking place, thus reducing the number of “badly integrated” agents.

4-2-4 Departures due to retirement and the demography of the health professions

The hospital centre at X, like other French hospitals, took on many employees during the seventies. Over the next five years, a good number of doctors and hospital staff will leave due to retirement and the demography of the health staff (particularly medical demography) is such that it will be very hard to replace them. We add that the ageing of the staff in such a physically demanding profession, allows us to foresee difficulties at the end of their careers. Finally, we note that the "open clinic” system will probably be done away with when the main freelance surgeon there retires.

“Now, it seems to me that some people are beginning to think there is nothing to worry about any more, that the hospital has been ‘saved’. But, like many other hospitals, we are in a relatively fragile situation, bearing in mind the departures due to retirement of the medical staff over the next five years and the matter of the medical demography” (DGCH).

4-2-5 The new skills demanded of hospital establishments

The “hospital 2007 plan” sets up a new governance: the hospital is organised in care poles directed by a doctor assisted by a health official and a responsible administrative agent. These poles have a delegation of management and decision. Contracts on objectives and means pass between the head of the pole and the director. An executive council formed by doctors and responsible administrative people is created. This new organisation requires that the doctors heads of poles have financial skills, are capable of organising team work, planning, handling conflicts … a range of skills foreign to a large section of practitioners. Hence the set-up of training in certain hospitals. (Le Monde Economie, 10th January 2006, p. VIII).

Besides these “managerial skills”, relation skills now seem to be required of hospital practitioners: knowing how to talk to the patients, *“communicating with the town’s doctors” (MP).* A lack of said skills, the transformation of public hospitals into “trauma-centres” (establishments receiving all the emergencies, as programmed surgical operations would take place in the private clinics), already taking place in certain towns, could spread. The demand for triple skills (medical, managerial and in terms of relations) is liable to make recruitment particularly difficult.

APPENDIX 1: GLOSSARY

HCA: Health-Care Aide
HSA: Hospital Service Agent
RHA: Regional Hospitalisation Agency
AB: Administration Board
HC: Hospital Centre
UHC: University Hospital Centre
EMC: Establishment's Medical Committee (commission médicale d'establissement)
CRAM: Caisse Regionale d'Assurance Maladie (Social Security's Regional Savings Bank)
CDD: set length contract
CDI: permanent contract
ETC: Establishment's Technical Committee (comité technique d'etablissement)
DDASS: Departmental Direction of Health and Social Action
ENSP: Ecole Nationale de la Health Publique (National School of Public Health)
PHS: Public Hospital Service
SRN: State-registered nurses (m & f)
SROS: Schéma Regional d'Organisation des Soins (Regional Schema of Care Organisation)

APPENDIX 2: List of people interviewed between August 2005 and January 2006 (*and reference codes)*

The Mayor of town X, chairman of the hospital's administration board *(MP)*
Assistant Director of the RHA *(DRHA)*
Regional director of the group of "private clinics" *(DSG)*
The director of the establishment of X of the group of "private clinics" (*DESG)*
The director of the DDASS (telephone interview due to transfer to another region) *(DDASS)*
The director of the hospital *(DGCH)*
The human resources manager *(DRHCH)*
The doctor chairman of the EMC (*PCME)*
A freelance surgeon (in the "open clinic" convention with the hospital) *(CL)*
A representative of the CFDT, member of the hospital's administration board, secretary of the CHSCT, technical personnel *(CAT)*
A health official, member of the hospital's administration board, a CFDT politician, member of the steering committee *(CAB)*
A delegate of CGT, nurse in the surgical block (agent of the integrated clinic) *(IDEB)*
A delegate of CFTC, nurse (agent of the integrated clinic) *(IDET)*
A nurse from the surgical block (agent of the integrated clinic, member of the CE), member of the steering committee *(IDEM)*
An administrative assistant (agent of the integrated clinic, member of the CE), member of the steering committee *(ACT*)
A health-care aide, (agent of the integrated clinic, member of the CE), member of the steering committee *(AM)*

With some of the people on this list, two or even three interviews were held.