Since the 1980s in France, like in most European countries, governments have had sustained interest in modernising State. The reforms implemented have resulted in huge changes in the management of public employment relations. The transformations are based on three simultaneous processes: the introduction of a more business-like approach, the so-called New Public Management (NPM), the decentralisation of management and the implementation of collective bargaining settlement (Transfer 2008; Keune, Leschke, Watt, 2009).

Obviously, the specific forms of public sector employment relations in each country (civil services, state-owned companies with separate statutes of employment, public corporations…) and the scope and direction of national reforms (deregulation processes, modernisation of human resource management…) are strongly linked to distinctive national state traditions. Nevertheless, all these transformations have common and important effects in terms of employment relations involving the introduction of human resource management methods coming from the private sector. These have important consequences concerning personnel management and the role of union organisations (Rehfeldt, Vincent, 2004; Vincent, Rehfeldt, Tallard, 2005). The speed at which the reforms were introduced and their more or less radical characters vary from one country to another. The predominant model in Europe is closer to a contractual form of regulation of labour relations than to the statutory form which prevailed in Italy and France. The recent evolution of the Italian public services shows that rapid and radical changes are possible, even in strongly unionised work environments. Italy has achieved a negotiated contractualisation of its public services thus bringing its regulation of public sector labour relations into line with those of the private sector (Bordogna, 1998; Carrieri, 2002).

This paper presents some results of recent researches on the role and strategies of the French trade unions facing transformations in public administration employment. The aim was to analyse the industrial relations changes in this sector. Our fieldwork focused on two sectors, the Ministry of Finance and public hospitals (Tallard, Vincent, 2007, 2009 and forthcoming). We will concentrate here on developments concerning the public hospitals only. A certain convergence of the private and public industrial relations systems is under way which alter the strength of the public sector unions.

Hospitals in France, as in the other European Union countries, are facing major changes. An ageing population, the emergence of new diseases and new techniques of care, along with poverty, are all already combining to change significantly both the requirements of the population and the resources needed to deal with them. In addition, those who in the past were mere “patients” are increasingly behaving as consumers. While there is widespread
agreement on the need to reform the hospital sector, debate is focusing on the speed of the implementation of these changes and the resources to be allocated to the process.

Regarding staff management, beside the implementation of individualized procedures, new tools for managing jobs and competencies (Gestion prévisionnelle des emplois et des compétences, GPEC) have been established in the public hospital. Our paper describes this implementation of a model coming out the private sector in public services structured by the statute and by the medical profession on the one hand, during its development, on the other hand. At the hospital, the bringing together of the public and private models of industrial relations is carried out at the same time by the creation of new institutional bodies between management and staff but also through the bargaining of statutory central elements. This “hybridization” of private and public setup of industrial relations shows a common tension to both sectors: that of the articulation between individual guarantees and collective management of the employment relations. The implementation of more individualised forms of human resource management is bound to destabilize trade unions. How do they adjust to the changes in the rules of the industrial relations game in the public sector, and particularly in public hospitals?

1. THE MAKING OF A STATUTORY PUBLIC SERVICE

The share of public employment in the labour force is quite significant in France: 6 million employees who represent a quarter of the total labour force. Public administrations are divided into three components: the central government and ministries (4 million employees), the local authorities (1.5 million) and the state-owned hospital sector (800,000, including nearly 100,000 physicians)\(^1\). But the most specific characteristic of the French public sector is the special employment statute which was granted to those employed as civil servants or working in public utilities.

Industrial relations are usually analysed as a system produced by the interaction of the collective actors in the field of labour. In the private sector, the distribution of the actors into three groups -- workers, employers and the state -- poses no particular problem (Dunlop, 1958). When the analysis is applied to the public sector, a question immediately arises, that of the double role of the state both as employer and as regulator. Given the particular position of the state in France, its labour relations are quite different from those of the private sector.

According to the legal and administrative culture prevailing in France, public sector employment is characterised by a statute whereas private sector employment is characterised by a contract. The protective statute, however, was only enacted in 1946. Before that date, the public sector union organisations demanded collective labour agreements achieved through collective bargaining, which was for them a way of integrating state agents into the workers’ struggle.

The evolution of the civil servants’ union organisations from the demand of collective agreements to that of a statute started under the Popular Front and developed with the

\(^1\) A major private hospital sector exists (with over 300,000 employees) in parallel with the state-run sector. Therefore, the government is keen to coordinate both state-run and private hospital care capacity. The private sector has traditionally specialised in the more profitable areas of healthcare, leaving the state-run hospitals to pick up the more major and costly care. Doctors working in the private sector often maintain their "liberal profession" status and earn higher salaries than their counterparts in the state-run sector. Traditionally, there has been strong rivalry between the private and state-run sectors. Policies designed to coordinate private hospitals with their poorer state-run counterparts are widely perceived as an assault on the state-run sector.
centralisation of union structures. In October 1946, after long discussions between the political and union forces, the statute was definitely adopted. It defines the rules and obligations of the public servants, particularly:

1. Permanent jobs filled by permanent civil servants (titulaires);
2. Competitive entry examination (concours) and the right to a career with defined procedures for minimum advancement through seniority.

Regarding collective rights, the right of association and the right to strike are fully recognised. Collective bargaining rights, however, are not. In fact, the characterisation of public employment by a statute is accompanied by a system of specific industrial relations rules. Finally, two models can be identified in the French industrial relations: the first one, which tends to be contractual and in which the relations between the actors are ruled by collective bargaining, is that of the private economy; the second one is specific to the public sphere, in which the state decides unilaterally after having consulted with the representatives of the employees to enlighten its decisions (Saglio, 2001). With no collective bargaining, the only possibility for the unions to question the decision of a director is to use the right to strike. Conflict is thus an inherent factor of the public sector social rules system.

The main original features of the statute are the participation of employee representatives in the management of individual careers through joint administrative commissions and in the organisation of the services through consultative committees. Thus we have, on the one hand, institutionalised dialogue bodies dealing with the organisation of the services, the CTP (Comités techniques paritaires, Joint Technical Committees), which play only a rather formal role, and on the other hand, the joint management of the internal labour market through the CAP (Commissions administratives paritaires, Joint Administrative Commissions).

The industrial relations system is quite different in the public hospitals. As for other parts of the civil services, each health establishment has a local CAP (CAPL) and each of France’s départements has a CAPD. Since 1991, the CTP were replaced by Establishment Technical Committees (Comité Technique d’Établissement, CTE) which look more or less like work councils of the private sector. Elected by hospital staff with civil service statute, they comprise staff representatives, who are elected on union lists, and are chaired by the director. The CTE also have competences broader than the CTP since they examine all collective issues concerning staff and the establishment, including future prospects for the establishment, budget and staffing levels, working conditions and organisation, arrangement and distribution of work schedules, criteria for distributing bonuses, general policy on staff training and the establishment’s social plan. Collective bargaining is also indeed quite present in the state-owned hospitals. Trade-union organisations hold a central place through negotiation activities which they carry out with the direction of the hospital. This process of negotiation was strongly instigated, in the last decade, by two national collective agreements: the agreement of March 2000 which sets the hospitals to bargain a social plan; the agreement of March 2001, followed by another one in October 2006, which improves paths career of a certain number of hospital professional.

Union organisations are associated to decision making at all levels but the final decisions are the exclusive prerogative of the administrative power. By actively taking part in the CAP, however, the public sector unions built their action upon the individual defence of the employees while keeping a collective control over the mobility and promotion criteria in order to guarantee an equal treatment to all the staff. It is upon this relationship with their ranks that the public sector unions have built their strength and their capacity to mobilise the ranks.

2. A POWERFUL BUT FRAGMENTED UNIONISM

The département being the administrative unit between the local and regional levels; in total, France has 95 départements, excluding its overseas départements.
French unionism is characterised by the importance and the influence of trade unionists coming from the public sector, and the weakness of the trade unions in the private sector. The role of trade unions in the public sector as well as in the private sector is to defend the interests of the employees. Public sector unionism has always oscillated between the corporate defence of the professions, the defence of the rights and advantages of the civil servants, on the one hand, and the global defence of public services and of their place and role in society, on the other hand.

The unions which represent civil servants function in a limited context of less autonomy as compared to that of the private sector unions which aim at representing both the professional interests of their members and the interests of all wage earners. The unionism of civil servants in France is quite different from that of the private sector. It is rather recent since union rights were granted to civil servants only in 1946, even though unions existed well before that date. It is also rather powerful since the unionisation rate is much higher in the public than in the private sector. Union fortresses, as they are sometimes called, organised around a profession (teachers, police officers, postmen…), emerged in the public sector. Whether related to the confederate union movement or gathered in autonomous federations, the unionism of civil servants is also today a unionism undergoing different transformations and evolutions, with some organisations arising and others disappearing.

Historically, there are two main civil servants unions. The Civil Servants Federation as such joined the CGT only in 1920. During the same period, in 1934, a French federation of the professional unions of civil servants, composed mostly of women, was created within the CFTC. It demanded union rights but refused to join the strike movements considering strikes as contrary to the duty of service continuation. It benefited, as the CGT, from an affluence of members in 1936, particularly among the auxiliaries, again mostly women.

After World War II, the CGT General federation of civil servants (Fédération Générale des fonctionnaires) benefited, as did all the unions, of a new massive influx of members. Even though several political tendencies coexisted in the federation, the communist influence was growing. The unification of the labour relations of the civil servants through the statute did not prevent the growing fragmentation of the public sector unionism. After the 1948 split within the CGT, certain federations joined the CGT-FO (Force Ouvrière). With the transformation of the CFTC into the CFDT in 1964, when the confederation abandoned its Christian dimension, the majority of the civil servants followed the new leadership; only a small number of unions and members joined the remaining CFTC. Civil servants now represent at least 38% of the active members of the CGT within which the Public service Federation is the largest federation. Civil servants are even more important within FO which is less well implanted than the CGT in the private sector, and also within the CFDT, within which the public sector represents at least 40% of the members.

In the 1990s, there was a new wave of fragmentation of the public sector union representation with the emergence of new autonomous unions and a recombinating of the existing ones. The autonomous unionism tended to become polarised between a reformist tendency and a radical one. In the reformist tendency there was a new grouping, the UNSA (Union nationale des syndicats autonomes). The UNSA was founded in 1993 by the FEN (Fédération de l’Education Nationale, national education federation), together with a certain number of autonomous unions and it has declared its intention to organise also in the private

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3 The CGT (Confédération Générale du travail) was created in 1895 and, in 1902, was joined by the Fédération nationale des Bourses du travail (Federation of local unions) created in 1892, to become the main French national union federation or rather confederation.

4 The CFTC (Confédération française des travailleurs chrétiens) was created in 1919 and was of Christian obedience.
sector and to become, in the long run, a full fledged inter-sectorial confederation. It was joined by certain parts of the FO reformist minority constituted by certain activists of the rail, mail and income tax federations.

In the radical tendency there is the FSU (Fédération syndicale unitaire) which came out of the 1993 split in the FEN. The second component is the Union Syndicale Solidaires which now brings together a large number of autonomous unions. The Union Syndicale Solidaires has its origin in a certain number of radical organisations from SUD (Solidaires, unitaires, démocratiques), which came out of a series of splits within the left wing of the CFDT, particularly in the health sector.

Trade unions in the health sector are as divided as the public sector trade unions: their membership domain depends on the workers' status (private or public sector), whether they are physicians or non-physicians, and whether they are administrative or technical staff, executives or agents at baseline. Trade unions in health also depend on the major trade unions that dominate the national scene. Furthermore, the health sector is also characterised by corporatist clashes between hospital managers and hospital doctors, involving power struggles.

Regarding election results, the three most popular unions are CGT, CFDT and CGT-FO. Despite a small reduction in its share of votes, CGT remains the leading trade union confederation among hospital staff with 31.5% representation, ahead of CFDT with 24.4% and CGT-FO with 22.1%. Compared with the 2003 election results, CGT and CGT-FO have lost 1.5 and 0.2 percentage points, respectively, while CFDT has gained 0.3 percentage points.

The three were followed by the other trade union bodies representing public sector hospital staff, namely: SUD with 9.1% representation (up nearly 1 percentage points), the UNSA with 4.6% (down a half percentage points), the CFTC with 3.9% (up 0.5 percentage points), the National Nurses Coordination (Coordination nationale infirmière,CNI) with 0.9% (down 0.2 percentage points), the National Hospital Management Staff Union (Syndicat national des cadres hospitaliers,SNCH) with 0.9% (down 0.1 percentage points) and the French Confederation of Professional and Managerial Staff – General Confederation of Professional and Managerial Staff (Confédération française de l’encadrement – Confédération générale des cadres,CFE-CGC) with 0.5% (up 0.1 percentage points) (see Table 1).

### Workplace election results for main trade unions in public service hospitals

<table>
<thead>
<tr>
<th>Trade union organisation</th>
<th>2007 results(%)</th>
<th>Change 2003/2007(percentage points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGT</td>
<td>31.48</td>
<td>- 1.48</td>
</tr>
<tr>
<td>CFDT</td>
<td>24.37</td>
<td>0.32</td>
</tr>
<tr>
<td>CGT-FO</td>
<td>22.12</td>
<td>- 0.22%</td>
</tr>
<tr>
<td>SUD</td>
<td>9.14</td>
<td>0.99</td>
</tr>
<tr>
<td>UNSA</td>
<td>4.63</td>
<td>- 0.55</td>
</tr>
<tr>
<td>CFTC</td>
<td>3.89</td>
<td>0.49</td>
</tr>
<tr>
<td>CNI</td>
<td>0.95</td>
<td>- 0.24</td>
</tr>
<tr>
<td>SNCH</td>
<td>0.92</td>
<td>- 0.14</td>
</tr>
</tbody>
</table>

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5 Hospitals doctors have their own autonomous trade unions. Hospital doctors' trade unions are, principally, the National Hospital Practitioners' Inter-Union Organisation (Intersyndicale nationale des praticiens hospitaliers, INHP) and the Confederation of General Hospitals (Confédération des hôpitaux généraux, CHG), which represent 75% of medical staff.
The unionism of the public sector in France is characterised both by the strength of the number of its members and by the plurality of its union organisations. Thus, it is a fragmented unionism, often divided, which is to face the reform of health policies and the parallel renewal of social dialogue in the public sector. The current reforms, however, alter the strength of the public sector unions. How do they adjust to the changes in the rules of the industrial relations game in the public sector, and particularly in the state-owned hospital sector?

3. THE MODERNISATION OF THE PUBLIC HOSPITALS AND THE RENEWAL OF INDUSTRIAL RELATIONS

By the end of the 1960s, the public sector underwent an important evolution related to the extension and complexification of the domains of state action and intervention. In order to respond to that extension, the public administrations considerably increased their staff, and hired a significant proportion of women at a quicker pace than other sectors of the economy. Furthermore, a higher osmosis was reached between politics and higher civil service. After the strikes of May 68, particularly powerful in the public sector, a policy of bargaining emerged in the public sector at the national level. Annual wage bargaining became a regular practice since then. The government also started to negotiate with union organisations over a series of topics such as training, the reduction of precarious employment or job classifications… More recently, the development of collective bargaining has been hampered both concerning wages, with annual agreements being now seldom reached, and concerning the reduction of working time, with the failure to reach an agreement about the details of the application of the legislation that would cover all three components of public administrations (Rehfeldt, Vincent, 2004).

Since the beginning of the 1980s, the goal of modernising public services and reforming the state has been consistently reaffirmed by successive governments either with the intention of controlling public spending or of increasing the quality and efficiency of the services. In this respect, there were two important moments: the 1983 law homogenising the statutes of the three components of public administrations (central government, local authorities and hospitals) and the Rocard decree of application which defines two main axis for the renewal of public service: the improvement of the relationship with the citizens by making the administration more accessible to the users, and the involvement of the civil servants in those changes by making them actors in the evolutions. We witness a double movement. On the one hand, a modification of the rules of social dialogue (introduction of collective bargaining, decentralisation of the joint committees). On the other hand, the importation of methods of human resource management coming out of private enterprise forms of management.

The introduction of human resource management methods coming from the private sector has important consequences concerning personnel management and the role of union organisations. Public firms (such as EDF or La Poste…) became experimentation laboratories for such methods. Having formally entered the collective bargaining arena, they were the first organisations to experience the consequences of the rapprochement between the public and private models of industrial relations (Maggi-Germain, Garbar, 1996). This rapprochement was also established by bargaining over traditionally central components of collective bargaining agreements such as job classifications, often accompanied by the introduction of “competence” measures according to which the job ladder progression of the individuals tends to be based upon a method of evaluation of acquired individual qualifications.
The hospital civil services are different in more than one way from that of the central administration. A certain number of characteristics suitable for the hospital system explain why the introduction of NPM was easier. First of all, the implementation of a managerial logic is made conspicuous by a financial regulation which gives larger room to manoeuvre to the directions of hospital. Started in 1991 with the law Evin, reinforced in 1996 with the ordinances adopted within the framework of the Juppé plan, and prolonged in the last law on the governorship in 2009, the modernisation of the hospital system is concerning at the same time the construction of care offering and the circuits of financement (Vincent, Volovitch, 2003) (see box below). The regulation of the hospital system leaves the place, more than in the central administration, with a sheer-range of interested local actors, to influence regional medical planning: directors of hospital and ARS, hospital doctors, staff, trade-union organisations, local authorities…. In particular, the figure of the employer, incarnated by the director of hospital, approaches that of the private employer because of his relative autonomy. The director of the hospital has a financial autonomy for the distribution of the budgets which are allocated to him by the ARS. The hospital staff depends on him concerning their condition of employment (recruitment, career, mobility, premiums…).

### Reforms of the public hospital system in the last two decades

Since the nineties, public hospitals are under huge and continuous reform process. The resolve to cut public hospitalisation spending is continuous since the nineties. From 1994 to 1998, the state-owned hospitals have lost 17,000 hospital beds, and, between 1999 and 2004, 24,000 beds were cut out of a total of 275,000. The “downsizing” of hospitals has, to date, mainly been an exercise in adjusting the number of beds officially allowed and the actual number of beds. The fact that this area of leeway has been eliminated means that hospitals will now have to get down to genuine restructuring. In recent years, in order to constraint hospital sector budget, budget formula moved away from a funding system calculated in terms of an “overall budget,” which did not reflect the reality of the services provided by the hospitals. The government has set up the “medical information systems programme” (Programme Médicalisé de Systèmes d'Information, PMSI), which will use the “homogeneous patient group” (Groupes homogènes de malades, GHM) technique to attempt to identify the reality of hospital services. Hospital funding already depends to some extent on this type of scheme, and will increasingly do so in the future. Hospital staff criticise this formula for not taking into consideration: the “social dimension” of the services provided by hospitals (eg before discharging a patient from their care, should hospital staff pay attention to his or her housing conditions?); those expenses related to public services provided by hospitals (emergency care, training); and the specific nature of “cutting-edge” activities. Up to the beginning of 2006, public and non profit-making private hospitals, which together account for 80% of all hospital beds in France, were funded on the basis of an ‘overall budget’. In contrast, profit-making private clinics (representing 20% of all hospital beds) were funded on a ‘price per day’ basis. However, since January 2006, profit-making private clinics have been 100% funded on the basis of ‘rates per activity’ (Tarification à l’activité, T2A). In addition, the proportion of this type of funding is to be increased for public and non profit-making private establishments (T2A currently accounts for 25% of their resources). By 2012, both of these types of establishments are due to have the same kind of funding.

In November 2002, a plan - dubbed the 'Hospital 2007' (hôpital 2007) project - shakes up the state-run hospital sector. The plan has split the representative trade unions representing both doctors and other hospital staff. One of the targets for reform is the internal organisation of hospitals. Within hospitals, the existing departments are to be brought together into ‘poles of activity’, which are also to serve as the framework for management. Hospital departments, having escaped abolition thanks to pressure from the doctors’ unions,
are to remain the point of reference in clinical matters. In individual hospitals, in addition to a board of governors and a hospital medical commission (Commission médicale d’établissement, CME), an executive council made up of equal numbers of representatives of managers and doctors is to be responsible for the administration of the hospital’s general policy.

The latest law on reforming the regional healthcare system and hospital organisation came into effect in July 2009. Despite the law seeks to address the issues of universal access to quality healthcare and prevention, the trade unions have not uniformly welcomed it and have denounced unfair competition between public hospitals and the private sector. The 2009 law is divided into four sections: hospitals; improving access to healthcare; prevention; regional organisation of the healthcare system. As far as the modernisation of healthcare facilities are concerned, the law regulates hospitals and contains new provisions covering:

- hospital doctors – the new law changes their conditions of practice. These changes apply to doctors who are already permanently employed in hospitals (known as ‘hospital practitioners’) and to doctors in private practice who wish to work in hospitals some of their time and on an interim basis;
- hospital managers – the law increases their powers considerably, while the powers of co-management bodies are proportionally reduced, with the ‘executive committee’ becoming the ‘board of management’ and the 'board of governors' becoming a ‘supervisory committee’. Doctors’ committees, such as the hospital medical committee (Commission Médicale d’Établissement), will also have less power under the new legislation;
- hospitals – the law strongly encourages hospitals to organise themselves on a regional basis in conjunction with other healthcare facilities and the healthcare staff working in these facilities. Hospitals are being offered new tools: such as regional hospital communities (Communauté hospitalière de territoire, CHT) and health cooperation groupings (Groupement de Coopération Sanitaire, GCS). Mergers are encouraged between hospitals that are considered to be too similar if they have the same legal status or public-private partnerships if they have a different legal status.

The geographic organisation of the healthcare system is covered at regional level by Section 4 of the law, focusing on the newly established regional health agencies (Agences Régionales de Santé, ARS). These agencies aim to go beyond the remit of the current regional hospital care agencies (Agences régionales d’hospitalisation, ARH) in order to manage all regional healthcare work, including medical care, medical and social welfare, as well as prevention. The ARS will also absorb other regional healthcare, social services and medical insurance bodies, which were previously responsible for regulation or monitoring in the sector. The ARS will operate at subregional level in the départements regarding medical and social welfare services or in ‘healthcare areas’.

Following the example of the new hospital managers, the future ARS managers will gain increased powers, meaning that they will sometimes be known as ‘health prefects’. Consultative bodies working alongside the ARS will see their power significantly reduced, just like in hospitals. Examples in this regard include the regional health committees, the Conférence régionale de santé and Conférences de territoire de santé.

The sheer range of interested parties and interests at stake has not enabled constructive critical analysis or the issuing of alternative proposals to the law. Such activities are considered necessary in order to counter what is often perceived as a continuation of the ‘dismantling’ of the public healthcare system to the benefit of profit-motivated private sector players.
4. THE DEVELOPMENT OF A MANAGING JOBS AND COMPETENCIES TOOL

At the end of the eighties, NPM policies begin to be implemented in France. On the side of Human resources, they take their model in private sector management methods. Studies on these last policies show that if some are strictly based on evaluation of individual performance, others try to catch the collective dimension of performance and competencies. They also establish that in big firms and in the public sector, policies based on individual performance can be limited through bargaining compromise in which path dependency processes drive to combine traditional employment relation and more individual practices. In public hospital, the aim is more specifically to move from an HR policy based on statute to one more based on professional skills and competencies, mainly for promotion and mobility in a context dominated by an acute demographic constraint, the consequence of which resulting in the retirement of almost half the staff by 2015. To deal with this situation, and to promote new HR policies several ways have been explored by governments.

First, commissions under the authority of recognized medical personalities gathering training bodies, delegates from health professions (but not trade unions) were settled down. The result of these commissions’ work could this way appear as neutral, because coming from a double authority public and professional. And these group’s reports could give a common scientific and professional analyze on how to face the demographic constraint. One made proposals on widening the skill’s contents of nurses in order for them to assume by delegation some specialized medical acts. Although these changes would be seriously framed, the experimentations encounter many oppositions as these new skill’s contents appear as a danger for existing identities linked to a definite curriculum leading to a highly recognized diploma. Another one had to think over professional skills’ assessments: following European commission recommendations for defining quality patterns in order to facilitate mobility, this group worked with a definition of competence as combining knowledge, capacity and behaviour, very closed to the HR one. But, during its auditions, this conception moved to a more knowledge-oriented one, requested by workplace situations, professionalism and career paths recognition. Finally, competence in health professions appeared to have to be guaranteed by a diploma continued training curricula and periodical verification by professional experts. This approach is closed to a renewed and comprehensive conception of professionalism in general as giving the opportunity to move in a professional mobility space.

Secondly, based on this conception of professionalism, new tools for managing jobs and competencies (Gestion prévisionnelle des emplois et des compétences, GPEC) have been implemented in public administration and more specifically in public hospitals at the beginning of the 2000 years. These tools have been developed under the control of a new body (National employment, skills and competencies observatory in public service hospitals) which mission was to make studies in order to follow employment level and to identify the evolution of skill’s contents and new professions emerging. This kind of bodies already exists since the 1990’s in private sectorial activities, and they were taken as a model by the government when they wanted to promote it in public services. For hospital public sector, this institution was acted in a collective agreement on training and career paths concluding a rough strike of hospital nurses. Its governance is under equal representation of trade unions and administration. At the beginning, trade unions found quite positive to have that way the opportunity, to get a reliable view of workforce evolutions. This structure’s first program was to draw a list of existing skills’ contains at disposal in hospitals. Trade unions hoped this tool could help elaborating a big negotiation on renewing the statute and facilitating career paths. Each occupation task sheet was elaborate by groups of professionals and validate in many hospitals. The whole process involved 60.000 thousand people. Trade unions could only make their comments at the end of the process when the project was presented at the
Observatory. Although administration find it was a “democratic process” and that this tool was “made by professionals for professionals”, trade unions are quite critical as they think their recommendations arrived too late to be taken into account and that, during the process, priority was given to professional associations. Furthermore, as this tool had no legal foundation, it could not prepare the negotiation of an agreement renewing the statute.

Finally, the choice has been made to prefer a professional legitimacy to a social one and then professional internal expertise to trade union collective one. This tool appears to be more technocratic than useful for bargaining as trade unions hoped it could be.

The way this tool has been implemented in hospital establishments confirms this judgment. After a first period when it was used, with the implication of local trade unions, as a way to facilitate reorganisations in big hospitals (like the consequence on employment of subcontracting hostelry functions or regrouping biology laboratories) or to promote, in smaller hospitals, innovative procedures of evaluation in case of mobility and promotion, more recently, it appears as a mere HR tool used mainly in hiring and evaluation before promotion. Nevertheless, in these last cases, it helps in building a mapping of existing competencies in order to anticipate training needs resulting from retirement anticipations and to put “adequate competencies at the adequate place at the adequate moment”\(^6\). But, in spite of the HR directions will, this tool fails to expend in the heart of medical professions where professional identities and legal regulations draw obstacles. Trade unions take no further interest in this tool and leave it at its technocratic use as they are more involved in the nurse curricula reform or in resisting to new laws on hospital reorganisations.

CONCLUSION

New forms of social dialogue emerge in the public hospitals such as the support during negotiations over the expertise tools the public powers put at the disposal of the actors. Despite these trends, the specific forms of each of the public industrial relations system seem to resist. That resistance is based on the obligation to maintain a certain number of advantages included in the statute as well as upon the strength of the statute in the practices and representations of the actors. More generally, our research tends to confirm that the public system of industrial relations re-appropriates the movements which affect society in general (individualisation, decentralisation) but does so according to its own particular manner and in its own particular way.

Finally, we can draw three logics going through actors’ system facing such innovative process; a statutory logic of collective defence of existing employment relation, a professional one which purpose is mainly to preserve the access to the profession, and a managerial one aimed at prevailing rationalisation and performances criterions. Apparently, each type of logic goes with one specific actor: trade unions for the first one, professional associations for the second, head-managers for the third. Nevertheless, there are contradictions in each actor and successive reforms drive to reshaping the actors’ system.

References


\(^6\) Managerial staff interview (january 2009)


