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In the patient queue

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Though they are presented as egalitarian, public health policies make extensive use of patient selection. As Maud Gelly demonstrates in an illuminating new book, this practice contributes significantly to health-related social inequality.

Reviewed: Maud Gelly, *Les Politiques du tri. D'une épidémie à l'autre (SIDA, COVID)* (The Politics of Selection: From One Epidemic to Anotherr [AIDS, Covid]). Le Croquant, 2024, 256 p., 20 €.

In the middle of the Covid-19 epidemic, the prospect of triaging patients, due to a shortage of hospital resources, raised a considerable stir in public opinion. It justified several confinements.[1] Yet selection practices are part of the healthcare system's normal operating procedures, both at the level of care delivery and prevention. The sociologist Maud Gelly seeks to remind us of this fact in a book that examines a blind spot in the increasingly abundant literature on health-related social inequalities: the perspective of public policy.[2]

Gelly seeks to show how and by what criteria public policies contribute to "deprivation processes that result in an unequal distribution of health resources" (p.

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[1] See Emeline Cazi and Alexandre Lemarié, "Covid-19: à l'hôpital, l'épineuse question du 'tri' des patient·es," *Le Monde.fr*, December 7, 2020.

[2] If one is to be precise, it would be more appropriate to speak of public action to emphasize, as Gelly does, the fact that effects are not a mechanical consequence of government decisions, but are mediated by an array of relationships, practices, and representations. See Vincent Dubois, "L'action publique," in Antonin Cohen, Bernard Lacroix, Philippe Riutort, eds., *Nouveau manuel de science politique*, Paris, La Découverte, 2024 [3rd edition], p. 330-343.

19). Yet she does not simply shows that actors located at different levels of the public healthcare system--from the commanding heights of the state to actors in direct contact with the healthcare system's users--deliberately prioritize relations with healthcare users by employing allegedly rational and impartial criteria,[3] but also and especially that these actor, through their choices and actions, indirectly promote other selection processes based on largely unconscious social criteria.

To highlight logic of normal patient "selection," Gelly blends the data from her sociology dissertation, completed in the early 2010s and which examines HIV testing practices at various private and association-run clinics in the Paris region, with information from a study conducted with Alexis Spire between June 2020 and September 2021 that explores how a hospital group in eastern France handled the covid pandemic. Gelly's analysis seeks to gradually narrow the spatial-temporal focus over the course of three sections, in which she alternates, from chapter to chapter, between the two studies.

Social factors as a blind spot

Gelly first examines the construction of public health policies that involve state actors, as well as non-state actors to whom certain tasks are delegated. Starting from the postulate that "every public policy presupposes the prior construction of categories that identify its targets and [that] every nomenclature is shaped by a project that [seeks] to 'describe and act upon the world'" (p. 32) (in the words of the great sociologist of quantification Alain Desrosières[4]), Gelly tracks down the actors who identify the target populations of the two health policies she is examining, as well as the operations they undertake along the way. In the case of HIV and AIDS testing, she shows, through an examination of the archives of AIDES (an AIDS support association) and analyses of recommendations by health authorities, how the commercialization of antiretroviral therapy in 1996 marked a turning point for virus testing. New therapies facilitated the expansion of testing and the targeting of "at risk" groups--gay men and immigrants--to prevent further contamination. Whereas in the late 1980s vigorous resistance ultimately prevailed over the vague hope of mandatory testing (at a time when HIV-positive populations were heavily stigmatized), thus

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[3] Voir par ex. Guillaume Lachenal, Céline Lefèvre, Vinh-Kim Nguyen (dir.), « La médecine du tri. Histoire, éthique, anthropologie », *Les Cahiers du Centre Georges Canguilhem*, n°6, Paris, PUF, 2014.

[4] Alain Desrosières, *La Politique des grands nombres. Histoire de la statistique*, Paris, La Découverte, 1993.

securing the principle of voluntary HIV-testing, organizations like AIDES rallied behind policies favoring the promotion and incentivization of HIV-testing by health authorities as soon as treatments became available. The point was to "occupy our place in the community before others occupy it with a more coercive mindset," as the organization's national council put it in March 1997 (p. 41). In the early 2010s, government authorities sought to emphasize universalism while targeting the most exposed populations by encouraging general practitioners to offer tests. But they were mostly unsuccessful, compared to the two approaches used up to this point: free and anonymous testing centers (*centres de dépistage anonyme et gratuit*, or CDAG), created in 1988, and "peer testing," which was delegated to associations, for populations with the highest infection rates.

Even so, this division of public health labor, which relies heavily on "peer testing" because it is rooted in the collective common sense of the affected parties, which holds that it is better to focus on populations that are the most infected, obscures the inequalities relating to the risk of dying early from HIV contamination. These inequalities are made apparent by a logistic regression model using available data and could have inspired a different testing policy. Whereas for women, nationality is the decisive factor, for men, it is of little significance, unlike socio-professional status, with middle managers, administrators, and skilled laborers being over-represented.

As for the covid crisis, which, as other sociologists have shown, laid bare the muddled state of the French health decision system,[5] Gelly notes President Emmanuel Macron's initial decision to bypass official networks by creating an ad hoc workgroup and a scientific council dominated by doctors, particularly infectious disease specialists familiar with HIV, but in which basic science and representatives of health care patients and users had not representation. Yet the council's recommendation that confinements be limited to people over the age of 70 was rejected by the government, which placed the entire population in confinement. At the same time, the government also rejected the advice of the High Council on Public Health (*Haut conseil de la santé publique*, or HCSP), which noted the lack of clinical data on the effects of hydroxychloroquine while allowing it to be prescribed without first subjecting it to clinical trials. This decision significantly disrupted a clinical trial that had already been launched throughout Europe, DisCoVeRy, which ironically had been spearheaded by France. The hospital officials whom the researchers met unanimously described the local regional health agency (*Agence régionale de santé* or ARS) as an obstacle rather than

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[5] Henri Bergeron, Olivier Borraz, Patrick Castel, and François Dedieu, *Covid-19: une crise organisationnelle*, Paris, Presses de Sciences-po, 2020.

a facilitator due to its failure to issue clear instructions and its injunctions to rationalize (by merging facilities, reducing bed numbers, and outsourcing certain activities). Indeed, hospital officials had to find their own solutions to handling an influx of patients with serious conditions, which they dealt with by mobilizing their personnel to the maximum. Ultimately, beyond the lack of organization, the deeper issue was, in the covid cases, the lack of targeted preventative action and care, which had unequal effects in a period when health-care goods were in short supply, and blindness to the class dimensions of exposure to the disease and its complications.

The mechanics of selection

Going one step down the healthcare system's chain of command, Gelly next examines intermediate actors, who ensure a balance between "the supply and demand of health-care goods" by heeding targets set by public authorities. In the case of HIV testing, Gelly first examines the different factors that led public and nonprofit CDAG employees to become involved in testing, analyzing their biographical trajectories. Whereas nurses sought primarily to escape the hard slog of hospital work, doctors, for whom testing represents a minimal share of their worktime, chose this activity primarily to satisfy their unfulfilled activist inclinations and to embrace a "holistic" conception of medicine that was not limited to healing. Finally, for non-medical employees and volunteers working for nonprofit organizations, who, since November 2010, are authorized to administer tests, this commitment is often tied to experiences of stigmatization that give rise to feelings of solidarity with affected populations and which make up for poor employment and work conditions. The counseling techniques in which they are trained require them to conduct open-ended interviews with the individuals in question which, in a limited amount of time, prove discriminating for users with meager cultural and linguistic skills. Employees' reticence to objectify in quantitative terms these users' social traits makes it harder to render them visible.

In the case of covid, Gelly begins by considering changes made to routine hospital regulations. These consisted first of the discontinuation of forms of care deemed less important than admitting covid patients and, second, of the formalization of criteria for access to resuscitation services. In the first case, the measure's effects were unequal, since more disadvantaged patients were less likely to consult urban doctors or use teleconsultations, in addition to being less inclined to make follow-up appointments once the epidemic peak had passed. They were also overexposed to chronic pathologies that can result in dangerous complications when care is interrupted. At a practical level, this resulted, following the first confinement, in an increased number of lower limb amputations for diabetes patients. In the second case, recommendations from regional health agencies and learned societies recommended considering not only age, but degree of dependence and the number and seriousness of comorbidities when determining priority of access to resuscitation, which again penalized the lower classes. This was also the result of the decision to prioritize the private platform Doctolib for making appointments at vaccination centers, which, thanks to their better grasp of technology, allowed members of the middle and upper classes to be seen ahead of the rest, notably by traveling beyond their home territory, as seen in the municipal health centers of Seine-Saint-Denis.

The practice and denial of selection

Gelly devotes the book's final part to selection practices that occur near patients. In HIV testing centers, she shows how testing agents, while often being aware that attitudes to speech are socially determined, act differently with those who approximate (using categories from the sociology of work) their idea of the "good customer" than they do with those they see as "bad customers." In these situations, "bad customers" are those who do not speak, speak little, or "resist" pedagogical explanations in some way. In practice, this results in interactions that are briefer, more standardized, more top-down, and with fewer explanations, even though most involve recent immigrants of working-class origin. As can be observed with other counter agents, discretionary power "does not affect the delivery of a service so much as its completeness" (p. 189). In this instance, power is justified by a desire to avoid wasting the valuable resource that is the interview time. In the case of a hospital grappling with covid, Gelly observes what she calls (referencing Pierre Bourdieu[6]) "institutional bad faith" and which can be located in the discrepancy between the self-congratulatory discourse of leaders about avoiding recourse to patient selection and its practical implementation by caregivers, in a context in which public hospitals are being dismantled. Forced to make do with bed shortages and poor guidance from health authorities, caregivers were required to make choices that, disregarding contextual variations, resulted, according to Gelly, in the abandonment of stable

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6 Pierre Bourdieu, "La mauvaise foi de l'institution," in Bourdieu, ed., *La Misère du monde*, Paris, Seuil, 1993, p. 377-381.

objective criteria in favor of more subjective criteria relying on caregivers' judgment, such as the extent of the patient's autonomy. Adopting the military metaphor used by Macron at the crisis' outset, many caregivers allowed their professional norms to be bypassed on the grounds that they were engaged in a form of wartime medicine, without challenging the relentless cuts in hospital capacity resulting from health policies pursued for the last two decades. Even so, Gelly shows how caregivers' views of the importance of prioritizing and selecting patients vary as a function of their closeness to hospital administrators, their distance from the dying, seniority, and their proximity to services like resuscitation (which are accustomed to triage)--all factors that increase the likelihood that one considers such practices acceptable.

Even so, moral dilemmas and disagreements about such choices abound. Indeed, the covid crisis lays bare the more pervasive problem of a hospital system subject to budget rationalization. Actors were regularly forced to arbitrate between demands for healthcare that exceeded hospitals' capacities. In this way, Gelly observes, institutions created "mechanisms making it possible to adjust not resources to needs but patient 'flows' to hospital resources" (p. 216), that is, beds and available caregivers. In the hospital she studied, these mechanisms consisted of a "committee for complex trajectories" and a "patient flow management workgroup" comprised of "bed managers" whose primary task was to reduce the average length of hospital stays (*durée moyenne de séjour*, or DMS) to keep hospitalization costs below the lump-sums granted by health authorities. This notably means getting rid of patients regularly characterized as "bed blockers" by billing their costs to their loved ones. Once again, such measures mostly impact working classes.

There are many differences between the two examples Gelly studies. The HIV case is characterized by an abundance of resources, little competition, and sensitivity on the part of actors to health-related social inequality (at least as it affects contamination, and not death). The example of covid-related hospital care was, for its part, characterized by resource shortages, intense competition, and little consideration of health-related social inequalities. Even so, the two situations compared by the book complement one another much more than they contradict one another and bring to light the production of health-related social inequalities by omission[7] that occurs in the public system at various levels. This perspective can be transposed onto other realms, such as education, as Gelly notes. She directly questions the redeployment of the state

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[7] In the case of covid, one also sees the production of "secondary non-recourse," as Gelly shows, following the deauthorization or non-authorization of certain forms of care due to the appropriation of resources during the epidemic.

undertaken by the "new public management," which consists in doing "more with less" by borrowing managerial tools and insights from the lucrative private sector. From a scholarly perspective, Gelly's dual research project enriches existing socioeconomic literature on the mechanisms of resources allocation in contemporary society by blending market mechanisms (such as prices), redistribution, donations, and increasingly matching fund systems.[8] Her work also contributes to studies on the failure to claim rights or use social services.[9]

At a political level, the book is a call not only for greater human and material resources, but also for giving public servants greater latitude, to free them from the constraints in which they find themselves.[10] At a more fundamental level, the book is also an appeal to carefully consider the various social mechanisms that produce social inequalities, so as to adjust public action to the public's differentiated needs, consistent with the principle that Michael Marmot calls "proportionate universalism."[11] This is, of course, an ambitious agenda, which makes it necessary not only to undertake sociological studies of this kind in different sectors, but also to take on comprehensively and simultaneously different forms of socioeconomic inequality. Put differently, Gelly shows that existing public policies should be subject to rigorous triage.

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8 See Philippe Steiner and Melchior Simioni, *La Société du matching*, Paris, Presses de Sciences-po, 2024.

9 See notably the work of the Observatoire du non-recours aux droits et services (Odenore) : https://odenore.msh-alpes.fr/

10 See notably Nadège Vezinat, *Le service public empêché*, Paris, PUF, 2024 and Romain Pudal and Jérémy Sinigaglia, eds., *Le Nouvel esprit du service public*, Broissieux, Le Croquant, 2024.

11 Michael Marmot, Peter Goldblatt, Jessica Allen et al., *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post-2010*, London, Institute for Health Equity, 2010.