

P55 - The making of target publics for welfare policies. A multilevel approach.

Implementing policies: targets, actors and critics. The case of users's rights in health and social care institutions.

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Abstract : This paper addresses the issue of the differing interpretation of public policies by social actors who are or feel affected by them. We focus on a law that was voted in 2002 in France, which aimed at renewing health and social care to the destitute. We postulate that without actually naming any social group in particular, this law tends to target all individuals evolving within the field of health and social care. Relying on a multi-sited ethnography of French health and social care sector, we show that social actors interpret differently this law which reconfigures the field they belong to, accordingly with their position within this field. This position justifies them taking position, either in favor or against the dispositions of the law.

Keywords : Health and social care; users; field theory; homelessness; social work

Introduction

This paper addresses the issue of the differing interpretation of public policies by social actors who are or feel affected by them. Most of the time, the effects of such policies are anticipated: those are implemented in order to solve a problem that was formerly identified and formulated as such by social groups who have an interest in doing so (Lindesmith et Strauss 1969; Gusfield 1981). However, unintended, collateral and even contradictory impacts may appear, shedding light both on the unpredicted complexity of the initial problem, or on the inefficiency of the chosen solutions: the “wars” on terror, on poverty and on drugs (GCDP, 2011; Ferreira 2015), are typical examples of such public policy failures. Without evacuating the issues of public policy efficiency, efficacy or their results, we focus on social actors who are – and are not –, or feel – and feel not – affected by public policies. Social actors might *be* concerned, when policies explicitly target them, for example when a social category is identified, thus institutionalized, and even sometimes created by such policies (Lenoir 1992). They might as well *feel* concerned, when a policy ends up modifying their daily lives, public or private, even though they are not formally identified as beneficiaries of it. On the other hand, individuals might be identified as the main recipients of welfare policies without them actually feeling any effect when those are implemented. In order to analyze how social actors are or are not affected by public policies, we follow Pierre Bourdieu's field theory (Bourdieu 1980; Bourdieu et Wacquant 2014), which helps understanding how social actors can maneuver in order to influence the effects and juridical dispositions of public policies (Bourdieu 1990; Bourhis et Lascoumes 1996).

We focus on a law which was voted in 2002 in France and aimed at “renewing health and social care”¹. Significantly in France, health and social concerns for precarious populations have been tightly intertwined for decades. This historical combination can currently be observed through the peculiar policies and apparatus (Foucault 1994; Agamben 2007) that ought to take care of the poor. Health and social care (HSC) thus refers to a sector of activities that organizes assistance to precarious populations, i.e. the poor and the destitute (handicapped and old individuals) both on health and social matters. As a result of such an organization, actors of various social and professional status interact on a daily basis: health practitioners, from nurses to doctors and psychiatrists; social workers who are responsible for different individuals, different populations and who manage different tasks depending on their status; the homeless, who are merely visible out of the frames of specialized institutions; and bureaucrats from various administrative levels, though most of them work for the region (Nord-Pas-de-Calais) and department (Nord) which are in charge of health and social administration. All these actors are somehow influenced by welfare policies organizing assistance to the poor; in return, they as well influence these policies, from their elaborating to their implementing. Our hypothesis is that these individuals are unequal when confronted to policy maneuvering and implementation, and that targeting of specific publics should not be isolated from the relations that exist between social actors belonging to the same field.

Methodology

This study relies on an ongoing, multi-sited ethnography taking place in various specialized health and social care institutions dedicated to the homeless. This fieldwork is part of a thesis in which we analyze the medicalization of the poor’s regulation in both historical and empirical perspectives. All the investigated institutions are located in and around Lille, which various social actors frequently describe both as a city where many homeless people live, and as a strongly equipped territory when considered health and social care apparatus. The mobilized results come from three sections of the fieldwork: the first one is composed of two daytime and nighttime shelters which belong to the same association; the second one consists in following social fieldworkers, whose role is to reach out to homeless persons who do not frequent specialized institutions²; the third section of fieldwork is a collective of former homeless persons, who managed to get out of specialized institutions or the streets on their own, and who have been defending homeless people’s rights since then³. Our materials are made of observations and interviews of the various actors we meet during fieldwork.

To begin with, we rapidly present the HSC organization and the 2002 law which we focus on; then we reconstitute the differing interpretations of this law by the social actors we met during fieldwork; eventually we analyze these various interpretations in regard to the occupied

¹ « LOI n° 2002-2 du 2 janvier 2002 rénovant l'action sociale et médico-sociale ».

² This kind of social work, commonly called *maraude* in French, was institutionalized in 1992, through the creation of the Samusocial in Paris (Cefaï et Gardella 2011). Since then, other French cities have implemented it. Our observations were not realized with the Samusocial of Lille, but with another association which implemented the “*maraudes*” in 2008.

³ This collective was born in 2011. Even though it gained the status of association one year later, its members still refer to it as the collective, and we will do so too through this paper.

position of the actors who enounce them within the field and show that the notion of targeting is not adequate to understand the unequal appropriation of policies by social actors.

The origins of a field.

Central to our analysis is law 2002-2, entitled “of renovation of health and social care”. Before we show how social actors interpret it, we present it rapidly. In order to limit the bias of presenting our own interpretation of the law, we refer to writings by Jean-François Bauduret, who redacted the law in 2002.

Brief history of the health and social care sector in France.

The contemporary configuration of French public assistance to the poor is the result of a long history of mixed and combined health and social policy implementation. For a long time, hospitals have been in charge of social and medical regulation of the poorest and the destitute. The creation of the Hôpital General in 1656 strengthened a security-related purpose, which already existed within classical institutions (Foucault 1975; de Swaan 1990). As a result, regulation of the poor was then structured in and around the medical system, within which hospitals gradually became central. This lasted until a law passed in 1893, creating free health assistance for the persons lacking resources (Faure 1994). Significantly, such a disposition was administrated by a bureau of social assistance, thus denying the exclusive management of healthcare by medical institutions. However, in 1941⁴, hospitals stopped being dedicated to people lacking resources, and were opened to the entire population. Later on, in 1970⁵, a law was voted which organized hospital as a public service and as a whole sector of intervention: through this law, hospitals ceased to be the center of poverty administration.

Authors have written that the 1941 and 1970 laws were the signs of the actual medicalization of hospitals (Imbault-Huart, in Lebas et Chauvin 1998; Parizot 2003). Indeed, while those had remained central to the structure of assistance to the poorest until then, these 2 laws contributed to make hospitals the main medical structures within the French health sector. After centuries of hospital-centered poverty administration, a law was voted in 1975, creating health and social care⁶ as a relatively autonomous sector. By designing an autonomous hospital public service on one hand, and a whole new field of intervention dedicated to the poor and the destitute on the other hand, the state and legislators expressed their will to solve poverty through dedicated devices and policies, and to distinguish between common health concerns and the peculiar health and social problems that precarious populations may face.

⁴ « Loi du 21 décembre 1941 de réorganisation des hôpitaux et des hospices civils ».

⁵ « Loi n°70-1318 du 31 décembre 1970 portant réforme hospitalière ».

⁶ « Loi n° 75-535 du 30 juin 1975 relative aux institutions sociales et médico-sociales ».

Law 2002-2.

Genesis.

Law 2002-2 can be identified as the result of a process starting a short time after the 1975 law. Indeed, many juridical dispositions affected the HSC sector right after it was created: according to Jean-François Bauduret, the initial version of the 1975 law was obsolete when law 2002-2 was voted, for many articles had been either modified or created to specify new dispositions (Bauduret et Jaeger 2005). This process was amplified by the publication of a report from the Inspection Générale des Affaires Sociales (IGAS) in 1995, which was an assessment of the HSC sector since its creation in 1975. This report underlined many structural limits that could prevent assistance from being effective: lack of complementarities and continuity between the various existing institutions, strong territorial disparities, blurred status of the State, lack of representation and participation of the persons receiving the provided care (IGAS 1995). This last concern became emblematic and was identified as a priority by legislators (Bauduret et Jaeger 2005; 2012). According to Bauduret, the renovation of the HSC sector immediately benefitted of strong support and consensus from all parties involved, from social workers to political parties (Bauduret et Gauthier 2013). In 1996, the French minister of Work and Social Affairs, Jacques Barrot, launched the process that permitted the renovation of the HSC sector. Within those 6 years, exploratory studies were conducted on various territories, before a law project was finally submitted to the chambers, leading to the vote of law 2002-2.

Both the history of the French social administration of poverty and the evolutions of health and social care from 1975 help understanding the ambition of the law. More than a renovation, law 2002-2 proceeded with an actual definition of what health and social care should refer to, what it should aim at, and how it should do it: as a result, the field was deeply reshaped, and so were the relations between social actors evolving within it.

Contents.

The law is divided into two chapters. The first one enounces the fundamental principles upon which health and social care is organized, whilst the second one details this organization through 74 articles. Chapter 1 is divided into two sections: section one defines health and social care and the main actions it is supposed to implement in order to help the beneficiaries: HSC aims at “promoting autonomy and protection for people, as well as social cohesion and citizenship, to prevent exclusions and to fix their effects⁷”. Significantly, the law enounces that HSC relies upon “a continued evaluation of needs and wills of all social groups, and in particular of the eldest and the handicapped, of vulnerable individuals and populations, of the poor and the destitute⁸”. In other words, the entire population is theoretically concerned with health and social care dispositions, but the many faces of destitution are specifically identified as potential beneficiaries, reflecting concerns about how these populations should be taken care of. Through this disposition, the law theoretically specifies that the problems of specific individuals should not be disconnected from the whole society.

⁷ Article 2 of law 2002-2 (Art. L. 116-1 of the Code de l'Action Sociale et des Familles).

⁸ *Idem.*

The law further details specific measures corresponding to specific populations (articles 15, 35, 37), but all these figures of poverty and destitution are merged into one, in section two of the first chapter which creates and simultaneously defines health and social care users' rights, thus directly responding to one of the main critics that had been formulated towards the previous juridical frame. Among these rights are the right to privacy, the right to be fully informed about the various services that the users are entitled to, and the right to take part to the structures' operations. This last concern implies for the social workers to implement participatory devices, which can turn out to be problematic as we will demonstrate further. Section 2 is a turning point for the organization of HSC because it theoretically frames and legitimates the role and status of HSC beneficiaries as new actors through the entity of "the user".

Chapter 2 enumerates many dispositions which structure the whole HSC sector. Beyond the creation of the users and their rights and other fundamental principles, 4 sets of orientations can be identified throughout the reading of the articles, which influence the way the HSC sector operates:

Health and social care planning: as for users' rights, planning of the actions that actors of the health and social care field undertake was a big concern in the IGAS report of 1995. In the law, planning refers to the identification of objectives and of the ways to reach these efficiently.

Matching the results and the financial means: the law strongly insists on the necessity for HSC institutions to rationalize their actions and projects in regard to their financial possibilities. More and more, HSC relies on call for project grants, which reduces social workers' capacity of action.

A new regime of authorization: article 15 enumerates the types of institutions that are formally part of the HSC sector. Concerning the creation of new structures, the law modifies the regime of authorization for social entities who wish to be defined as HSC institutions. Since a law was voted in 2009 which renovated health administration, authorizations are growingly delivered by the Agences Régionales de Santé⁹.

Evaluation of the accomplished work: matching the will of a greater appreciation of the financial means and a detailed planning of the actions the structures should undertake, the law enounces the necessity for evaluating the accomplished work, both in intern and from the exterior. This second type of evaluation is to be made jointly by an IGAS inspector, and a doctor (article 58).

Relying on the various critics that had been addressed to the HSC sector and the 1975 law, the 2002 law was seen as an opportunity to comply with growing concerns about the users' rights. Above all, planning, economical efficiency and evaluation are part of the same process of rationalization of a sector which is mostly non-for-profit. Seizing the argument of the blurriness of the HSC sector's frame of action, the law contributed to implement control mechanisms, from the start of HSC action through the authorization process, to the end of it through the evaluation devices. Such modifications have important effects on the way care is

⁹ « LOI n° 2009-879 du 21 juillet 2009 portant réforme de l'hôpital et relative aux patients, à la santé et aux territoires ».

conducted, and on the relations between actors of the field. We now analyze how these actors interpret law 2002-2, and try to show that the differences appearing in the testimonies can be related to the status of the persons enouncing those. By doing so, we interrogate the actual “targeting of publics” and show that social actors are unequally affected by law 2002-2.

The various interpretations of the law.

As written earlier, law 2002-2 was ambitious, simultaneously creating a new category of actor within the field, defining what health and social care should aim at, and how it should operate. By doing so, the law reshaped the field of health and social care and the way actors who evolve within it perceive it. Relying on interviews with these actors, we present and analyze how they were – or were not – affected by the law.

A controversial new frame of work.

Among social workers, opinions vary about the law. In fact, when interviewed, very few of them addressed the issue on their own. When they did, their interpretation of it was not unified, and sometimes even contradictory. Significantly, the section of the law they chose to refer to varies, as their appreciation of it does.

One of them, a social assistant, explains that through the last decade, her work has evolved towards more paperwork, and less face to face interaction with the persons she is supposed to assist. She links this evolution to what she identifies as an increasing demand for measurable results: *“we are asked to quantify more and more things... you know, to prove you are important. You have to prove it, by producing numbers. And I find it difficult with our work”* (Samantha). Another social worker, a caseworker, also expresses concerns about this quantification process, and links it more directly to the law: *“Lastly, there have been budget cuts, that’s for sure. Since... I would say, it started with law 2002-2... when evaluation was implemented. Which is a good thing, I mean, internal/external evaluation is a good thing, for it allows us to get a look at our work. But it has downsides: if we go further on evaluation, we see it tends to quantify our work. And then, the State uses it to limit financing, arguing that they have looked at the evaluation and concluded that our financing ought to be diminished. And the problem is that it [quantified results] does not necessarily match reality”* (Elodie). When asked about the other dispositions of the law, she first opposes the users’ rights section to the evaluation process before criticizing the implementation of such rights: *“because the users’ rights, that is great. It’s a good thing, and it’s not always easy to implement. For instance, here, it’s hard to implement a CVS¹⁰. Well...it’s complicated: it’s an open space, people come and go, they don’t live here. It’s interesting to have suggestions for implementation, but it’s complicated. It has been tried, and it has failed. So, there’s a welcoming booklet explaining how we operate, which we deliver when we first meet the persons. Well that is fine, we respect the law, but does it really mean anything? We see few differences depending on whether we deliver it or don’t”* (Elodie).

¹⁰ « Conseil de vie Sociale », a participatory device the law promotes.

Formally, these structures comply with the basic dispositions implemented by law 2002-2, i.e. the obligation to communicate about HSC beneficiaries' rights: internal regulations and listing of the users' rights are publicized and posted on the walls. During first interviews, which take place every time a newcomer asks for social support or even just to register for an address, social workers are supposed to inform them about their rights and does, and to provide them with the structure's regulations and charter. Most of the time, information is passed without being thought as a peculiar ritual. To be more precise, information about the structure is part of the ritualized initial interview, which institutionalizes the transformation of newcomers into actual users (Bourdieu 2014). However, observations have made it appear that information is unequally passed to the beneficiaries. Social workers tend to manage the degree of information they will pass on depending on newcomers' profile, thus displaying a classical discretionary feature of street-level bureaucrats (Lipsky 1980; Evans et Harris 2004). Foreigners or people labeled as lunatics are often deprived with the possibility of obtaining full information. When they retain information they are supposed to deliver, social workers argue that "*it would have been too much information*" (Diane), or that "*it would have confused them*" (*idem*): in the end, discretionary behaviors are presented as good for the beneficiaries. Discretionary management of information has been widely documented, relying on Lipsky's theory of street-level bureaucracy. In various contexts, from the administration of immigration and fiscal matters (Spire 2005; 2008; 2012), to the right to public housing (Weill 2013; 2014) or social assistance (Dubois 1999; 2009), the influence of individuals working face to face on a daily basis with those who deal with social administration or services has been demonstrated. Within the HSC sector, despite the so-called consensus about the 2002-2 law, its application remains problematic. For instance, the two open places we investigate have not implemented the participatory devices that should allow the structure's users to take part to the daily organization. Their directors then argue that their low-level admission status prevents them from implementing such devices, for it would not have any effect on the peculiar organization of the structures.

The myth of law.

The opinions of three other social workers, whose work is to reach out to the homeless who do not use the institutions, reveal their skeptical interpretation of it: "*I call it 2002-Dieu!*" He develops: "*this law governs us all, but you can't feel it*" (Franck). A colleague of his gives his own interpretation of the law: "*I think that this law, as it was passed, is useless. We ask persons who are helped, who are in demand, who are sometimes even begging, to judge our actions. It is as if I invited you to my mother's restaurant and asked you to tell me what you thought of it. It's bullshit. You can't ask people, who are fucked up and who received assistance for that, to evaluate those who helped: it's absurd! They have as much power as the high school student representative during the councils*" (Johnny). Another street caseworker explains the attitude of her colleagues regarding the law: "*they mock it because we're systematically reminded of it, but it doesn't mean anything. Our chief of staff always refers to it: "according to law 2002-2, we should do this and that..." So we call it 2002-Dieu because we're all governed by it, but nobody knows what it's supposed to do. It's kind of a myth, threatening us from above... We laugh at it. Still, I guess this law is common sense: taking care of the person, listening to her. It's basic common sense*" (Violette). These testimonies denote a rather skeptical interpretation of the law, its effects and the ways it is supposed to work. This is partly related to the fact that most of the daily work of these caseworkers takes place out of the concrete frames of the structures they are attached to: on

the streets, the dispositions of law 2002-2 can hardly be effective. It is likely that they, of all social workers, are least affected by the process of rationalization initiated by the law: since 1992 and the creation of the Samusocial in Paris, getting health and social care outside of its classical frame is commonly thought as obvious and of first necessity for homeless who do not ask for help on their own (Rullac 2006; Cefai et Gardella 2011). Thus, fieldwork is highly valued among health and social care workers, even though the working schedules could make it appear like dirty work (Hughes 1962). Instead, these schedules strengthen the prestige of these fieldworkers, who do not hesitate to criticize their colleagues, and especially those who mainly do paperwork and “have lost *it*”, “*it*” being actual concern for the homeless.

Is law 2002-2 favorable to the homeless?

The observations and interviews we conducted on another fieldwork give us different views and interpretations of the 2002 law. The investigated fieldwork is a collective of former homeless individuals, who gathered in order to defend institutional abuses towards HSC beneficiaries. When interviewed, Gerard, the current president who is also one of the collective’s founders explains that he was sheltered when he first heard about law 2002-2: *“one day, a guy tells be about defending users’ rights. Man! The shock. So there are laws, they actually exist, but no one cares, no one gives a shit about it... and it’s true that when I’m there, in 2010/2011, the structures rule everything: ‘users, you shut up. And if you’re unhappy about it, you get out”* (Gerard). He explains that law 2002-2 was the reason why he and other homeless persons decided to create the collective. Since then, they struggle for the defense of HSC users and the right to housing for all, relying on juridical dispositions¹¹. Still, he underlines that *“this law was voted in 2002. But it wasn’t yet applied in 2010... and it’s just partly applied in 2015!”* The collective’s vice-president insists as well on the importance of the law. Within the association he is in charge of visiting the HSC structures in order to implement participatory devices. However, he does so only when structures call upon the collective. Significantly, he is an elected member of various representative authorities, which work both on the regional and national scales, all of which were created after the 2002 law passed. In other words, the collective, and the roles and status of the individuals who constitute it, are largely determined by law 2002-2, to which they always refer as *“the users’ rights law”* while its official title is *“of renovation of health and social care”*.

As for social workers though, reading and interpretation of the law are neither unified nor homogenous. While they formally defend this law and its dispositions, the collective’s members, mostly through its president, claim not to be fools about its efficiency. During the writing of the collective’s official associative statement, a debate emerged about the necessity to refer to the participatory devices that the law promotes. As for social workers, critics were addressed to the fallacy of such devices, for they *“only serve to have chicken at lunch”*. In other words, these devices are mostly superficial and tend to avoid political issues such as rulings, punishment or organization within the structures (Eliasoph 1998). The collective also criticizes the fact that the law does not create any juridical resort that could allow the users to have their opinions heard against the institutions. Its members’ interpretation of juridical dispositions that are supposed to be favorable to homeless persons

¹¹ Mainly law 2002-2, and law 2007-290, which creates an enforceable right to housing for all: « LOI n° 2007-290 du 5 mars 2007 instituant le droit au logement opposable et portant diverses mesures en faveur de la cohésion sociale ».

is paradoxical, but fundamental to the elaboration of a militant capital (Matonti et Poupeau 2004), which they try to pass on to the persons who ask for their help. This militant capital relies both on the knowledge and practical tools that the law implements for homeless people, as well as on a critical reading of the law: by systematically denouncing its limits and defects, the collective's members remain attached to their position of "big mouths", which is valued by other social actors within the field of health and social care.

These interviews and observations tend to shed into pieces what the author of law 2002-2 identified as a broad consensus from all parties involved concerning the necessity to reform health and social care. Having drawn the differing interpretations of the law that the social actors of the HSC sector express, we now address the issue of the actual public targeting this law implies.

Power balance within the field of health and social care.

As evoked earlier, the 1975 law formally created health and social care as a relatively autonomous field, but it was the 2002 law that actually organized it, through the definition and rationalization of what social actors evolving within the field should do. By aiming at renewing the whole sector, this law was quite ambitious and did not target any public in particular, but rather the entire field of health and social care. To be more precise, the law created new configurations and new contexts for social actors interacting and competing within the field.

A flawed law.

Among the several evolutions that law 2002-2 implies, the listing and acknowledgement of institutional rights for the persons using specialized institutions appears as the most emblematic measure. These rights only exist within the field of health and social care: a new category of actor is created, whose social existence is defined by its belonging to the field. Being identified within the fundamental principles of the HSC sector, users' rights are considered by social workers at times as a "good thing", or as "absurd" and useless, and sometimes simply as "basic common sense". On the other hand, among the collective's members, debates underline both the necessity for such rights to exist, as well as their lack of ambition. These two sets of critics – the collective's and the social worker's – reveal the limits of the devices that the law created, as they are very representative of how the social actors who formulated them perceive the field. Whilst the collective's members insist on the limited power such devices allow, thus expressing *political* claims, social workers underline the fact that in the end, the devices can never overpass the structural asymmetries implied by the relation of assistance, then expressing more *sociological* concerns. In fact, these critics can be articulated: the political power that the collective demands is a result of the structural asymmetries that exist within the HSC field. When it was voted, the 2002 law failed to take into account the social mechanisms that underlie the exercise of rights: feeble awareness of such rights, lack of information about those, structural obstacles to the implementation of participatory devices...

Even when these devices are implemented, sociological and political science analysis have shed light on the difficulty to speak and to be heard for those who are not used to it, or feel illegitimate in doing so (Hirschman 1970; Piven et Cloward 1971; Bourdieu 2014). The

efficiency of participatory devices thus reveals a three-level problematic. First, they are not systematically implemented by social actors who are in charge of doing so: by implementing such devices, social workers and directors within health and social care institutions might have their authorities challenged by people whose legitimacy was strengthened, or just created, by law 2002-2, which theoretically gives HSC beneficiaries the possibility to challenge some decisions that concern them. In other words, while homeless people, turned into “users” of the HSC sector, are targeted as a public that law 2002-2 should reach out to, their actual benefitting of it depends on the will of social workers. Second, when they are implemented, those who might benefit from it do not always fully appropriate it, not willing or not being able to do so because they lack information or cultural resources. As we showed, interviews with social workers let it appear that they do not systematically comply with their obligation to inform each and every beneficiary about their rights. The law ends up being formally obeyed, but it is not enforced. Third, even when such devices are invested by homeless persons using HSC institutions, their claims more often regard punctual arrangements than structural problems on the way it is organized, annihilating the political potential of such participatory devices. The critics from the collective of former homeless express well this limit, as they regret that law 2002-2 did not actually modify the role and status of the persons frequenting specialized institutions.

Reshaping the HSC field.

In the end, law 2002-2 reshaped the boundaries and the rules of the health and social care field, and created an opportunity for the mobilization of HSC users. To be more precise, the law created – purposely or no – an opportunity for collective action, by homogenizing various individual trajectories into one figure, that of the *user*. However the creation of a new frame for participation did not permit to overpass the obstacles that both chaotic individual trajectories and the inherited structure of the field constituted for collective action (Mathieu 2011). On the other hand, the collective of former homeless did benefit from the law, claiming to represent the homeless within the field of health and social care: quite paradoxically, its members were able to do so by gathering outside, or at the margins, of the field. Little by little, social actors of different status have come to acknowledge them as legitimate actors of the field. Such legitimacy to evolve and interact with other social actors within the field is based on a very symbolic self-presentation which always puts forward their situation of formerly homeless. This rhetoric is fundamental to the elaboration of a militant capital which they confront to social workers, psychiatrists and doctors’ cultural capital. Also, the new regime of authorization and the evaluation policy that started to be implemented in 2002 modified the way actors of the field could interact and work. The domination of doctors and psychiatrists was thus strengthened by the rationalization that law 2002-2 implied for social workers, and by a 2009 law which put health and social care under the economic and administrative supervision of the medical field.

Conclusion.

Having detailed what law 2002-2 is and does, and how various social actors interpret it, we tried to show that no social actor in particular was targeted by it. Instead, referring to the theory of field, it is possible to say that according to their position within the health and social care field, social actors are unequally influenced by such law. As we tried to demonstrate,

this law created various devices, and reshaped the whole field. Most notably, it modified the boundaries of the field through the creation of a new category of actor, the user. It modified as well the way social actors interact and evolve within the field: the law increased competition between actors, mostly through the devices of objectives planning and evaluation it implemented. While they are never named within the law, social workers that ought to take care of the destitute are the most affected by it, mostly through the rationalization of assistance devices it promotes. One could ask who eventually benefitted from the passing of law 2002-2, if neither the social workers, nor the users did. If we have not interrogated many medical workers yet, observations allow thinking that they were the least affected by the newly created devices. Without anticipating on future research leads, we formulate the hypothesis that medical workers dominate the field of health and social care, which allows them to maneuver potential effects of laws affecting the field.

References.

- Agamben, G. 2007. *Qu'est-ce qu'un dispositif?*. Paris: Éd. Payot & Rivages.
- Bauduret, J.-F., and Gauthier, P. 2013. *Institutions sociales et médico-sociales: de l'esprit des lois à la transformation des pratiques*. Paris: Dunod.
- Bauduret, J.-F., and Jaeger, M. 2005. *Rénover l'action sociale et médico-sociale: histoires d'une refondation*. Paris: Dunod.
- Bourdieu, P. 1980. *Le sens pratique*. Paris: Minuit.
- . 1990. « Droit et passe-droit [Le champ des pouvoirs territoriaux et la mise en oeuvre des règlements] ». *Actes de la recherche en sciences sociales* 81 (1): 86-96.
- . 2014. *Langage et pouvoir symbolique*. Paris: Points.
- Bourdieu, P., and Wacquant, L. 2014. *Invitation à la sociologie réflexive*. Paris: Seuil.
- Bourhis, J.-P., and Lascoumes, P. 1996. « Des « passe-droits » aux passes du droit. La mise en œuvre socio-juridique de l'action publique ». *Droit et société* 32 (1): 51-73.
- Cefai, D. et Gardella, E. 2011. *L'urgence sociale en action: ethnographie du Samusocial de Paris*. Paris: La Découverte.
- Dubois, V. 1999. *La vie au guichet: relation administrative et traitement de la misère*. Paris: Economica.
- . 2009. « Le paradoxe du contrôleur: Incertitude et contrainte institutionnelle dans le contrôle des assistés sociaux ». *Actes de la recherche en sciences sociales* 178 (3): 28.
- Eliasoph, N. 1998. *Avoiding politics: how Americans produce apathy in everyday life*. Cambridge: Cambridge University Press.
- Evans, T., and Harris, J. 2004. « Street-Level Bureaucracy, Social Work and the (Exaggerated) Death of Discretion ». *British Journal of Social Work* 34 (6): 871-895.
- Faure, O. 1994. *Histoire sociale de la médecine*. Paris: Anthropos.
- Ferreira, R. 2015. « The war on drugs addiction ». *Revue européenne des sciences sociales* 53-1 (1): 265-91.
- Foucault, M. 1975. *Surveiller et punir: naissance de la prison*. Paris: Gallimard.
- . 1994. *Dits et écrits, 1954-1988*. Paris: Gallimard.

- Gusfield, J. 1981. *The culture of public problems: drinking-driving and the symbolic order*. Chicago: University of Chicago Press.
- Hirschman, A. 1970. *Exit, voice, and loyalty: responses to decline in firms, organizations and states*. Cambridge: Cambridge University Press.
- Hughes, E. 1962. « Good People and Dirty Work ». *Social Problems* 10 (1): 3-11.
- IGAS. 1995. « Bilan d'application de la loi du 30 juin 1975 sur les institutions sociales et médico-sociales ». 95155. Paris: Inspection Générale des Affaires Sociales.
- Jaeger, M., and Bauduret, J.-F.. 2012. *L'articulation du sanitaire et du social*. Paris: Dunod.
- Lebas, J., and Chauvin, P. 1998. *Précarité et santé*. Paris: Flammarion.
- Lenoir, R. 1992. « L'Etat et la construction de la famille ». *Actes de la recherche en sciences sociales* 91 (1): 20-37.
- Lindesmith, A., and Strauss, A. 1969. *Readings in social psychology*. New York: Holt, Rinehart and Winston.
- Lipsky, M. 1980. *Street-level bureaucracy: dilemmas of the individual in public services*. New-York: Russell Sage Foundation.
- Mathieu, L. 2011. *L'espace des mouvements sociaux*. Bellecombe-en-Bauges: Éd. du Croquant.
- Matonti, F., and Poupeau, F. 2004. « Le capital militant. Essai de définition ». *Actes de la recherche en sciences sociales* 155 (5): 4.
- Parizot, I. 2003. *Soigner les exclus: identités et rapports sociaux dans les centres de soins gratuits*. Paris: PUF.
- Piven, F., and Cloward, R. 1971. *Regulating the poor: the functions of public welfare*. New York: Pantheon books.
- Rullac, S. 2006. *Critique de l'urgence sociale: et si les SDF n'étaient pas des exclus?* Paris: Vuibert.
- Spire, A. 2005. *Étrangers à la carte: l'administration de l'immigration en France*. Paris: B. Grasset.
- . 2008. *Accueillir ou reconduire: enquête sur les guichets de l'immigration*. Paris: Raisons d'agir.
- . 2012. *Faibles et puissants face à l'impôt*. Paris: Raisons d'Agir.
- Swaan, A. 1990. *In care of the state: health care, education and welfare in Europe and the USA in the modern era*. Cambridge: Polity Press.
- Weill, P.-E. 2013. « Sans toit ni loi?: le droit au logement opposable ». Thèse de doctorat, France: Université de Strasbourg.
- Weill, P.-É. 2014. « Quand les associations font office de street-level bureaucracy. Le travail quotidien en faveur de l'accès au droit au logement opposable ». *Sociologie du Travail* 56 (3): 298-319.