Leadership style and motivation of care workers: the case of health networks in France

Aline Courie-Lemeur, Delphine Philip de Saint Julien

To cite this version:

Aline Courie-Lemeur, Delphine Philip de Saint Julien. Leadership style and motivation of care workers: the case of health networks in France. Conference on Global Social and Technological Development and Sustainability, Eummas, 2023, Dubai, United Arab Emirates. hal-04353171

HAL Id: hal-04353171
https://hal.uvsq.fr/hal-04353171

Submitted on 19 Dec 2023

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Leadership style and motivation of care workers: the case of health networks in France

Aline Courie Lemeur & Delphine François-Philip de Saint Julien

Colloque Eummas "Conference on Global Social and Technological Development and Sustainability" - février 2023 - Dubaï, Emirats Arabes Unis,

A obtenu le 2ème prix de la meilleure communication

Abstract

The Covid19 pandemic has shown that the ingenuity of care workers has been pivotal in helping keep the health organizations afloat in France. This is not new and we have seen it many times in previous health or social crises, where the ingenuity of care workers has contributed to ensure rapid care. The Covid19 pandemic has merely confirmed it once again. In this paper, we seek to understand what motivates care workers in their jobs to come up with ingenious solutions and get around problems encountered and the factors that smash their motivation and inventiveness to deal with problems. In particular, we seek to understand whether their involvement in strategic decision-making in healthcare organizations could affect their motivation. The aim is to understand how the leadership style of executives in health authorities and healthcare networks can affect the motivation of health workers.

To explore this question, we examine the case of health networks in France that have undergone successive restructurings initiated by the health authorities and we are particularly interested in the motivation of care workers working within health networks during these restructurings. We develop a theoretical framework around the leadership style and its impact on the motivation of actors in organizations. We seek to provide recommendations regarding the leadership style that would be most conducive to improving the motivation of care workers in French healthcare organizations.

Keywords: Motivation, healthcare, network, care workers, leadership.

Introduction

The field of health care in France, and in particular hospitals, has undergone numerous reforms over the last few decades with a view to modernizing the public service. The chronic shortage of financial and human resources, the need for comprehensive and multidisciplinary management for complex medical cases, combined with an increasing diversity of management protocols, make it necessary to carry out profound transformations in healthcare

field. The health crisis linked to Covid-19 has further demonstrated, amplified and highlighted this.

Faced with these multiple challenges, the public authorities regularly carry out restructuring movements aimed at rationalizing health expenditure and the supply of care. These are a source of profound organizational changes. Admittedly, whether they result in success or failure, changes are inherent to the evolution of an organization and remain 'varied, numerous, increasingly complex, leading to multidimensional effects' (Bareil, 2008); giving rise to numerous psychological states and reactions from the actors (Philip de Saint Julien, 2018). Indeed, public authorities rely on rigid regulatory and normative frameworks and adopt a top-down approach, while taking into consideration the constraints of economic performance, and while dealing with professional and institutional silos specific to health organizations. This makes it difficult to adopt changes designed unilaterally by health authorities and imposed on health organizations and care workers.

A number of studies and writings have been published over the past thirty years, denouncing the negative impact of the so-called "top-down" approach adopted historically by the institutional authorities in France. But despite decades of scientific production advocating collective action to reshape the field of healthcare, and despite attempts to do so by decision-making authorities, these same issues remain relevant. The field of healthcare is facing a "disenchantment" of the different actors, on both patients and care workers part, characterized by a deterioration in working conditions, a continuous reduction in the supply of care, and a constant tension in the hospital system. Also characterized by a strong and specific identity dimension (Sainsaulieu, 1977, 2019), the actors in the healthcare field, particularly the nursing staff, are experiencing greater uncertainty and professional stress; they are subject to injunctions that are 'increasingly paradoxical between the imperatives of management and the imperatives of care, in an increasingly reticular organization that results in multiple bricolages' (Bourret, 2008); they encounter role ambiguities and role conflicts (Kahn et al., 1964). The care worker is thus the 'secant marginal' (Crozier & Friedberg, 1977), the actor involved in several systems of action, interacting with each other.

In this article, we question the design of change projects initiated by public authorities in the French healthcare field, the leadership style that accompanies their deployment, as well as the motivation of care workers to adopt it in healthcare organizations. We are particularly interested in health networks in France. We focus on the behavior of care workers in health networks during the deployment of restructurings initiated by the health authorities. We try to understand what motivates them in their work to find ingenious solutions and work around the problems encountered and the factors that break down their motivation and inventiveness. In particular, we seek to understand whether their involvement in the design of the organizational changes they will be required to adopt might affect their motivation. The aim is to understand how the leadership style that accompanies the design and deployment of organizational change in the health field could improve the motivation of care workers and the action of health organizations?

To explore this issue, we begin by presenting the context of health networks in France, giving a brief overview of the multiple restructuring movements initiated by the public authorities and addressing the perceptions of health workers in health networks of these change projects. In the second part, we propose a theoretical framework on the interaction between leadership style and the motivation of actors.

1. The context of health networks in France

The origins of health networks in France go back to the beginning of the 20th century, when they were set up to treat tuberculosis patients. However, it was in the 1970s that we witnessed the birth of the first network organization between field workers and hospitals, as part of the reform of psychiatry which established sector psychiatric teams. At the beginning of the 1970s, gerontological networks aimed at keeping elderly people at home also appeared. Subsequently, the concept was extended to other pathologies such as AIDS, drug addiction, palliative care, oncology, perinatal care, diabetes, etc., hence the general term "health network". The health network has an associative legal status (Law 1901). It is headed by a director and relies on a multidisciplinary team, including doctors, nurses, psychologists, and sometimes a social worker, etc., to ensure the coordination of care around the patient maintained at home. It supports the attending physician and constitutes a bridge between town medicine and hospital medicine. The health network thus makes up for a weakness in the French health system: the hospital-city link.

However, despite its proven usefulness, the health network has been at the heart of several successive restructuring projects since the 1990s aimed at modernizing the French health system, which is faced, on the one hand, with a shortage of public financial resources and, on the other hand, with the growing complexity of medical treatment and the shortage of specialized human resources. An official report published in 2012 recommended the pooling of single-theme health networks (particularly cancer, gerontology and palliative care) into a single multi-theme network. In 2016, the law n° 2016-41 of 26 January dedicated to the modernization of the French health system then created the complex pathway coordination mechanism known as the Territorial Support Platforms (“*Plateforme Territoriale d'Appui*”, PTA). This system is supposed to absorb all the territorial medical and medico-social coordination structures, including the health networks. Then the Coordination Support Facilities (“*Dispositif d’Appui à la Coordination*”, DAC) were created, with a view to absorbing the PTAs and all the structures linked to the coordination of care. This research focuses on the perceptions of field actors and care workers when the above-mentioned projects were initiated.

When the health authorities introduced the various restructuring projects mentioned above, a feeling of injunction was very frequently reported by care workers and attributed to several factors. While some care workers justified it by the concentration of financial resources for health structures in the hands of the Regional Health Agency, others explained it by the constant reduction of budgets allocated to health networks despite the increase in the number of patients being treated. Some others attributed it to the obligation to extend their territorial coverage and to move towards other themes, which was perceived as a devaluation

of the specificities of the territories and themes. Some care workers consider that the health network reflects the needs of its territory and any institutional injunction at this level is perceived as inappropriate (Courie-Lemeur, 2016).

Furthermore, some care workers attribute the feeling of injunction to the obligation to carry out the change project within a specific timeframe; others explain it by the posture of the health authorities and their way of steering the change project. The health authority's poor support for the change, its lack of transparency and its attitude suggesting favouritism according to the territories and personalities of the network actors were also generally denounced. Also, some care workers justified the feeling of injunction by the inconstancy of the health authorities' projects. The succession of restructuring projects (some of which are not completed even before new ones arrive) is perceived as a sign of instability in the public authorities' project. Some even consider that the health authorities are trying to make the health networks shoulder its failure as a regulatory body and its posture towards the health networks is presented as a discouraging factor. Others described its posture as lenient in the past, even lax and rather police-like today. They justified this change in posture by the current shortage of public financial resources and its lack of understanding of the reality on the field (Courie Lemeur, 2018).

In an attempt to understand the interaction between the leadership style of health authorities and the motivation of care workers in health organizations, such as health networks, we develop a theoretical framework around the levers of motivation and their interactions with the leadership style. We will thus answer our problematic.

2. Theoretical framework: the leadership of health authorities and the motivation of healthcare workers in France

Leadership refers to the notions of influence and power, where it is presented as a process through which an individual will influence the action of a group to better achieve its objectives (Plane, 2015). A leader's authority and power can have different sources of legitimacy: charismatic, traditional or rational-legal (Weber, 1922 in Le Flanchec & Rojot, 2022). These are accepted because of the power of roles, gradual and routine commitment and/or psychological and situational factors. They are based on formal resources but also on informal resources such as the control of one or more areas of uncertainty: relations with the environment, control of information, a degree of competence and/or the use of institutional or organizational rules (Crozier & Friedberg, 1977). The leader ultimately works to influence and motivate others to contribute to the success of an organization of which they are members, or even of a project or mission (House et al., 2004; Boucher & Lescure, 2007; Cristol et al., 2011; Garcia, 2013).

The leader develops power over others, but according to Crozier (Boucher & Lescure, 2007), this power can be multiform and can act on the motivation of the actors subject to his leadership. Thus the leader can be 'authoritarian' by adopting a directive approach. He can be 'democratic' by being concerned with the interaction between actors and by soliciting their participation and involvement in decision-making. It can be 'lax' by not giving directives.

They can be 'exploitative authoritarian' by not trusting, remaining distant and inspiring fear. They can be 'paternalistic authoritarian' by being benevolent, even if they do not trust and inspire fear. He can be 'consultative' by building on the relationship of trust and having a developed relationship with his subordinates. They can be 'participative' by building a real team spirit and strong trusting relationships. They can be 'compromise-seeking' by maneuvering to reconcile the needs of individuals with the challenges of productivity. They can be 'social' by prioritizing the human aspect and being concerned with social relations, creating a good atmosphere and reducing conflict. It can be 'integrative' by working to build trust, by seeking to improve motivation and involvement of the actors, while defining a common objective, with a view to increasing productivity. He can be 'autocratic' by adopting an authoritarian style, focusing on productivity and marginalizing the needs of individuals. They can be 'laissez-faire' by remaining in the background and disinterested in both individuals and production (Plane, 2015; Boucher & Lescure, 2007; Dejoux, 2017).

Several currents have followed one another since the beginning of the 20th century to analyze the notion of leadership, such as the theory of personality traits, which focuses on the qualities and traits linked to the personality of the leader (Plane, 2015; Kirkpatrick & Locke, 1991; Golberg, 1993); or behavioral theory, which seeks to understand the link between the leader's behavior and his or her leadership style (Plane, 2015; Boucher & Lescure, 2007; Dejoux, 2017); or even contingency and situational theory, which addresses the link between the context in which the leader operates and his or her leadership (Hersey & Blanchard, 1982; Garcia, 2013; Kets de Vries, 2006). This leads to several leadership styles, which may impact differently on the motivation of the actors involved in the action.

2.1. Leadership style in healthcare field in France

In the healthcare field in France, as in the whole public sector, the leadership of institutional decision-makers is mainly a top-down leadership linked to a formal authority generating a subordination link, and not a leadership emanating exclusively from the qualities of the leader and the recognition by others of his or her characteristics pushing them to follow him or her voluntarily (Dejoux, 2017; Garcia, 2013; Cristol et al. 2011; Plane, 2015).

For the top-down leadership, legitimacy and power are derived mainly from institutional sources (Ghadiri, Flora & Pomey, 2017; Gravereaux, 2018) and hierarchical power. This is accompanied by pyramidal, centralized and top-down norms and organizational forms, with classic management typologies systematizing action and hierarchizing the relationship between actors (Ghadiri, Flora & Pomey, 2017; Gravereaux, 2018). As in armies, according to a principle of 'command and control', it is the leaders who decide and the troops have no choice but to obey. Certainly, there has been some alleviation with the emergence of the school of human relations and the generalization of the concept of management, which advocates that 'it is better to give desire than to impose'. However, inspiration and impetus continue to come from above (Riveline, 2012). By defending this way of working, decision-makers are reproducing entrenched organizational routines, but they are also defending their power, even if this is at the expense of agility.

But when innovation takes place at the interfaces of highly institutionalized contexts such as healthcare, the creation of innovative spaces should respond to three key processes (Dougherty & Dunne, 2011). First, the knowledge capacities of all stakeholders should be combined. This requires joint regulation that articulates formal and informal knowledge combining the experiences and practices of all necessary institutional and field actors.

On the other hand, the innovations developed should be articulated within the framework of a long-term strategy, while taking into consideration the logic of action (Amblard, 1996) of all the actors (institutional and field), as well as the challenges of territorialities (De Maillard, 2000; Grenier & Rimbert-Pirot, 2014). The construction of an articulated set of autonomous rules and joint rules by the actors, in declination of institutional regulations and public policies, will allow them to better appropriate them and avoid the loss of meaning (Joffre, 2014).

Finally, action should be taken to renovate public policies by involving a variety of actors throughout the process. This will lead to a renovation of public action to better deal with the fragmentation of the health field, the emergence of new demands, and the need for personalized care (Duran & Thoenig, 1996).

In fact, it is a question of renewing the way in which we govern, by modifying the articulation between the power of decisions and the knowledge of the different actors and by challenging the duality between the 'everything regulated by the policies' and the 'let us do it' claimed by certain professionals (Moore & Hartley, 2008; Grenier, 2006, 2014).

To succeed in initiating such transformations, a 'de facto leadership' seems better suited than a 'de jure leadership'. The evolution towards a 'de facto leadership' is more favorable to the development of the strategic skills of the actors and organizations involved in innovations in the health field. It can better contribute to the sustainability of such innovations and to the sustainable transformation of this field.

When leadership is emanating exclusively from the qualities of the leader and the recognition by others, it becomes a “down-top-down” leadership. It becomes above all a skill held by a particular person within a group of individuals, enabling him or her to unite around him or her and to promote the adaptation of action to a given situation (Hersey & Blanchard, 1982). It is the leader's ability to adopt an evolving leadership style, enabling him or her to adapt to a given situation, which will condition the achievement of an organization's objectives and results (Garcia, 2013). Leadership thus becomes situational (Hersey & Blanchard, 1982).

Leadership is then the result of an interaction between the leader, the follower and the situation (Kets de Vries, 2006). A good decision is therefore not always a rational decision: 'Action must be rapid and therefore irrational so that reflection does not suffocate the motivation necessary for taking action' (Geoffroy, 2012). Beyond the qualities and personality traits that enable a person to stand out from the others and to govern, it is his or her behavior

with regard to the actors around him or her that will enable him or her to impose himself or herself as central.

For example, a crisis situation requires the leader to manage delicate, sudden and often rapid kinetic issues. They must prepare their staff to think about the unthinkable, to get directly involved and to instill the necessary dynamics to deal with an unprecedented or unforeseen situation. His action must not be content with being technical, anchored in traditional management methods. To prevent the loss of cohesion and to preserve the stability of the organization, the leader must embody a vision, maintain the confidence of the employees and consolidate the identity of the organization. His action is therefore essential to the survival of the organization for which he is the guarantor (Lagadec, 2012). Leadership then becomes transformational and focuses on the motivation and development of employees to improve their performance (Bass, 1985).

Leadership become then situational and transformational, which is at once 'consultative', 'participative' and 'integrative'. The leader then becomes a conductor, whose prowess lies in his or her ability to synchronize and harmonize the interventions of the various musicians, whose expertise is complementary because of their similarities and/or differences. He is required to give meaning, inspire, federate in a sustainable way and make actions converge to achieve the predefined objective. It feeds and is fed by collective intelligence, defined as the capacity to unite intelligence and knowledge to achieve an objective and as the capacity of a group to ask questions and seek solutions together (Zara, 2008).

Thanks to collective intelligence, it stimulates creativity and innovation (Cristol et al., 2011), motivates and retains employees (Boudrias & Morin, 2011), and changes their behavior while giving real meaning to their work (Boucher & Lescure, 2007).

Forms of collective intelligence appear as soon as, within an organization, the collective use of scattered information held by different individuals is observed. Collective intelligence will then consist of increasing a group's capacity for understanding and action (Autissier & Guillard, 2019). This approach aims to create a consensus around the collective action to be taken through both individual and collective cognitive processes. A macro-competence is thus formed, an assembly of the organization's collective competences and quite strategic for ensuring its growth and survival.

Depending on the richness of the connections between the neurons, between the actors of an organization (Lenhardt, 2018), the constitution of a collective will, in fact, determine a level of collective intelligence. A zero level corresponds to a perfectly homogeneous collective where the individuals are functionally identical. The level of collective intelligence will be all the higher as the variety of the collective increases, linked to a diversity of statuses, knowledge, skills and professions (Bonabeau & Theraulaz, 1994; Géniaux & Mira-Bonnardel, 2003); all the more so as the effectiveness of the group, of the collective, is focused on the overall contribution of the group rather than on individual effort (Gunasekaran et al., 2016).

Improving collective intelligence will result in knowledge management, which implies the need to identify, preserve, value and protect it. The leadership style then becomes a determining factor for the motivation of the actors involved in the action.

2.2. Motivation in health organizations

Within an organization, the leadership and management style can be represented as a continuum, between an authoritarian style on the one hand, and a non-directive style on the other: the former seeks to structure its will, to give each person his or her attributions; the latter seeks to establish more interpersonal relations, relations based on trust, by delegating responsibility for activities to the group and/or to individuals. Between these two poles, multiple forms of leadership exist, more or less directive or collaborative (Tannebaum & Schmidt, 1973).

The question of the relevance of the style of leadership, according to the 'maturity' of the actors, in the sense of Hersey and Blanchard (1982) is, in fact, primordial. The notion of 'maturity' has a particular meaning. Not being defined as a state of equilibrium reached by the individual, as a full physical, intellectual and emotional development, the "maturity" of an actor is a function of two elements: his level of competences, of his knowledge, know-how and interpersonal skills; and his level of motivation, of energy that he is ready to put into his work (Hersey & Blanchard, 1982). Four levels of maturity are possible. Level M1 corresponds to individuals with little maturity, little competence, little motivation: they have a low level of competence for the position held, they know little or nothing about the requirements of their position and are little motivated. Level M2 corresponds to individuals with medium/low maturity, low competence but motivated: they have a slightly better grasp of the requirements of their job, their skills are low but they are motivated. Level M3 corresponds to individuals with a medium/high maturity, low motivation but competent: they master their job, know the expected requirements but have a low level of motivation. Level M4 corresponds to individuals with high maturity, who are both competent and motivated in their work (Hersey & Blanchard, 1982).

Depending on the level of 'maturity', in a dynamic approach, leadership must be situational (Hersey & Blanchard, 1982) and the art of the leader is to diagnose which mode of leadership the individual, the team needs (Le Flanchec & Rojot, 2022).

The effectiveness of a situational leader depends on the development of the people in his or her team, with this development ensuring the success of the group in the long term; it consists of adopting, at a given moment, the style according to the context encountered; it consists of constantly evaluating the 'maturity' of the players, i.e. identifying their degree of competence and motivation; and finally, it consists of creating the conditions that allow the maturity of the players to develop (Hersey & Blanchard, 1982).

Table 1 summarizes the motivational levers with regard to the leadership style that we apply to the case of health network actors.

Table 1. - Leadership vs. Motivation of health network actors

Leadership	Leadership vs Motivation	Leadership vs. Motivation of health network actors
"Top-down Leadership" = "Authoritarian leadership": the leader adopts a single leadership style	**Authoritarian style: hierarchical operation and unilateralism in decision-making power** - Formal authority with subordination; hierarchical power - Mobilization of "quasi-injunction" / "negotiated injunction"	The health authorities adopt an authoritarian leadership style with the health network. Restructuring projects for the health network are constructed in a unilateral way by the health authorities. They are imposed on the health network in a top-down manner, given the organization of the French health scheme, which attaches all financial resources dedicated to health networks to the Regional Health Agency (ARS). It is the ARS that decides on their allocation and defines the criteria and conditions to be met in order to benefit from them. This generates a feeling of injunction among health network actors *"With the ARS, it's like in the army, they are the ones who decide and we have to obey without flinching (...) it's an injunction, or at least within the network we see it that way"*[1]
"Down-top-down leadership" = "Situational leadership": the leader adopts, in an evolutionary manner, a leadership style adapted to the maturity of the actors	**Authoritarian style - maturity level M1**: the leader is very task-oriented and not very relationship-oriented; the actors are not very motivated or competent. The leader prescribes precise directives and instructions, makes decisions; controls the execution of tasks and the results obtained; does not allow room for manoeuvre, autonomy	**The leadership style of the health network leader: between authoritarian & persuasive style. Occasionally participative.** The leadership style is defined by the nature of the task. For issues related to the governance of the health network, as well as strategic decisions within the network or in relation to health authorities and other organizations in the territory, the health network manager adopts a directive style. He or she makes decisions, prescribes precise instructions, and informs team members of the decisions taken. *"It is clear that decisions about the direction of the network and its strategic choices depend on me and the network presidents. The team, I inform them of our choices, that's all. "*[2] Concerning the issues related to patient care, when the health network director is trained as a doctor, he or she participates in decision-making concerning the patient. He appears to be very relationship-oriented when it comes to developing collaborations with other health organizations in the area to improve patient care, or when he seeks to develop alliances to improve his bargaining power with the supervisory authorities in order to access additional financial resources for his health network. His leadership style is therefore persuasive. *"I managed to negotiate with the Regional Health Agency (ARS) and convince them*
	Persuasive style - maturity level M2: the leader is very task and relationship oriented; actors are low skilled but motivated. He provides support, fosters good interpersonal relationships; provides extensive explanations of the reasons and consequences of the goals he has set; encourages the individual and the team	
	Participative style - maturity level M3: the leader is not task-oriented and is very relationship-oriented; the actors are competent but not very motivated. He encourages exchanges between a competent but unmotivated team; listens to and takes into account opinions,	

[1] Courie Lemeur (2018)
[2] Courie Lemeir (2016)

	seeks to create a friendly atmosphere **Delegative style - maturity level M4**: the leader is not very task and relationship oriented; the actors are motivated and competent. There is no need to explain objectives and tasks to a competent and motivated team; they are allowed to work autonomously, without having to control and supervise	*to fund us a new doctor's post (...). We are the only network in the territory that has a social worker post, because I was able to convince the big bosses at the ARS."*[3] He can also be participative at times, when it comes to decisions related to the functioning of the team or also when collaborating with other health structures. The director seeks to create a friendly atmosphere and encourages interpersonal relations within the team. *"We can only be participative if we want to work together (...) We have created a joint working group, with people from their homes and ours, to build common tools"*[4]. **Level of maturity of staff in health networks: between levels M3 & M4:** the multidisciplinary composition of the health network team and the specialization of its members mean that competence in patient care is strong. The employee has the necessary knowledge, skills and attitudes. They know how to use their basic knowledge or previous experience to ensure the coordination of care around the patient. His/her motivation is generally strong, because of the meaning he/she gives to his/her work (service to the patient and to society). Their motivation may be hampered by the lack of resources available to them to carry out their work. However, when it comes to regulatory changes, restructuring projects or experiments initiated by the health authorities, the employee expects information to come from the outside, particularly from the manager. They need to be told what to do. His motivation may be weakened by a feeling of incomprehension about his work, by a conflict with the director of the health network, or by the continuous change projects imposed on him by the health authorities. He thinks that the health authorities do not realize the reality of the needs on the ground and that all the attempts to explain them to them for several years have never been successful. *"I don't know much about the ARS projects, it's xxxx (director) who deals with that (...). When there is something new and important, he explains it to us."*[5] *"There is nothing we can do about it (...) anyway it won't change anything"*[6].

[3] Courie-Lemeur (2016)
[4] Ibid
[5] Courie-Lemeur (2018)
[6] ibid

Conclusion

The health and medico-social sectors in France are constantly being restructured in order to improve patient care while optimizing the use of increasingly scarce specialized financial and human resources. And each time, the restructuring attempts fail to achieve the targeted objectives. Although defensible, these projects are not always unanimously supported by the care workers, and this is generally reflected in the poor success of the projects. The Covid-19 pandemic crisis has shown the flaws in these restructurings and that the reality is still far from the desired Grail.

We have used the case of health networks and the different waves of restructuring they have undergone to explore the impact of the leadership style of the leaders of health authorities and health networks on the motivation of care workers working in these networks. We have attempted to show that a de facto leadership style that is transformational would have a better impact on the motivation of care workers in health networks than a de jure leadership that is exclusively directive.

Such leadership at the level of the health authorities would favor the motivation and involvement of the actors in the field in the formulation of objectives and the deployment of public actions. This would enable the players to understand the meaning of the changes planned by the public authorities and their involvement in such a reflection and in the decision-making process can have a positive effect on their motivation and their support for such projects. And the mobilization of such leadership would be all the more vital as the change desired by the public authorities is of a radical nature.

At the level of health networks, our research has enabled us to observe that the leadership style of managers is de facto and transformational, with a level of maturity of the staff between the M3 and M4 levels. Health professionals in these organizations are generally competent due to their training. However, their motivation may fluctuate: sometimes it is strong because of the meaning given to their work and sometimes it is weak because of the lack of resources available to them to carry out their work or because of the perception of injunction in the change projects imposed on them, or even because of conflicts with the approach of the network director. The leaders of the health networks seem to mobilize persuasive and participative leadership, but particularly when collaborating with other health organizations in the area, or when building alliances to develop negotiating power with the health authorities. However, with regard to the members of their teams, their leadership remains mainly directive and is only participative when making decisions related to the internal functioning of the team. The construction of strategic decisions remains exclusively in his hands, where he makes decisions, prescribes precise instructions, and subsequently informs the team members of the decisions taken. This seems to have a negative effect on the sustainability of their motivation.

Thus, the changes imposed on health organizations seem to impact on the motivation and commitment of health professionals. But if their organizational commitment seems to be diminishing, their commitment at work has been maintained until now because of the presence of 'commitment anchors' (actions, people, ideas, values, etc.) (Kouadio & Emery, 2017).). Public service allows for the ideals of equity and social justice to be lived out, for a job to be meaningful and of concrete use in and for society. The meaning and concrete usefulness that they perceive in their job for society reinforces this commitment. But the weight of these anchors seems to be weakening, and the leadership style of health authorities and health network leaders seems to accentuate this.

Bibliography

Amblard H., Bernoux PH., Herrerors G. & Livian Y. F. (1996), *Les nouvelles approches sociologiques des organisations*, Seuil, Paris.

Autissier D. & Guillard A. (2019), « Désir de participation et intelligence collective : le cas de l'entreprise Covéa » *Question(s) de management*, n°25, p. 89-97.

Bareil C. (2008), "Démystifier la résistance au changement : questions, constats et implications sur l'expérience du changement" *Télescope,* p. 89-105.

Bass B. (1985), *Leadership and Performance Beyond Expectations*, The Free Press, London.

Bonabeau E. & Theraulaz G. (1994), *Intelligence Collective*, Paris, Hermès.

Boucher P. & Lescure S. (2007), Vous avez dit leadership !, Afnor, Paris.

Boudrias J-S. & Morin D. (2011), « Démystifier les inventaires de personnalité », HEC Montreal Revue International de Gestion, Vol. 36, 61-73.

Bourret P. (2008), « Encadrer dans la fonction publique hospitalière : un travail de lien invisible », *Revue française d'administration publique*, n° 128, p. 729-740.

Courie-Lemeur A. (2016), La gouvernance d'une fédération de réseaux : le cas de la Fédération des Réseaux de Santé Gérontologiques d'Ile-de-France, Thèse de doctorat sciences de gestion et du management, Laboratoire Larequoi, Université Paris Saclay.

Courie-Lemeur A. (2018), *Les réseaux de santé – les enjeux de la pérennité,* Editions ISTE.

Cristol D., Laize C. & Radu Lefebvre M. (2011). *Leadership et management être leader, ça s'apprend !*, De Boeck, Paris.

Crozier M. & Friedberg E. (1977), *L'acteur et le système*, Edition du Seuil, Paris.

De Maillard J. (2000), « Le partenariat en représentations : contribution à l'analyse des nouvelles politiques sociales territorialisées », *Politiques et management public*, Vol. 18, n°3, p. 21-41.

Dejoux C. (2017), *Du manager agile au leader designer*, 3ème édition, Dunod, Paris.

Duran, P. & Thoenig J-C. (1996), « L'Etat et la gestion publique territoriale », *Revue française de science politique*, n°4, p. 580-623.

Dougherty, D. & Dunne, D. (2011), "Organizing ecologies of complex innovation", *Organization Science*, Vol. 22, pp. 1214-1223.

Garcia, E-J. (2013), *Le génie du leadership*, Dunod, Paris.

Geniaux I. & Mira-Bonnardel S. (2003), « Configurations organisationnelles et innovations RH » *Actes de colloque, AGRH*, p. 1239-1259.

Geoffroy F. (2012), « Quand l'hypocrisie managériale protège l'organisation », *Revue internationale de psychosociologie et de gestion des comportements organisationnels*, Vol. 18, n°46, 301-315.

Ghadhiri, S-D, Flora, L. & Pomey, M-P. (2017), « Le virage patient partenaire de soins au Québec. Reconfiguration de l'exercice du pouvoir médical et lutte pour de nouvelles subjectivités », *Project: Le partenariat de soin ou partenariat patient*.

Golberg L-R. (1993), "The Structure of Phenotypic Personality Traits", *American Psychologist*. Vol. 48, 26-34.

Gravereaux, C. (2018), « L'innovation, une (re)structuration de formes organisationnelles hospitalières ? Le cas de deux projets « innovants » au sein d'un groupe de santé privé », *Communication & Organisation*, Vol. 2, n° 54, p. 207-225.

Grenier C. (2006), « Apprentissage de la coordination entre acteurs professionnels – le cas d'un réseau de santé », *Revue Gérer et Comprendre*, mars, n° 83, p. 25-35.

Grenier, C. (2014), « Proposition D'un Modèle D'espaces Favorables Aux Habiletés Stratégiques », *Journal De Gestion Et D'économie Médicales, Vol.* 32.1, pp. 3-10.

Grenier C. & Rimbert-Pirot AG. (2014), « Outil de territorialisation de l'action publique et co-construction du territoire - Cas de mise en place d'une CHT (Communauté Hospitalière de Territoire) », in Alam U. & Gurruchaga M. (dir.), *Collectivités, territoires et santé. Regards croisés sur les frontières de la santé*, Paris, L'Harmattan, coll. du GRALE.

Gunasekaran S., Ahmad M., Tang A. & Mostafa S. (2016), "The collective intelligence concept: a literature review from the behavorial and cognitive perspective", 2d International Symposium on Agent, Multi-Agents Systems and Robotics, Maleysia.

Hersey P. & Blanchard K. (1982), *Management and Organizational Behavior, Utilizing Human Resources*, 4th edition, Englewood Cliffs, NJ.

House R. et al. (2004), *Culture, Leadership and Organizations*, Sage Publication, NY.

Joffre C. (2014), « Une organisation d'action sociale et médico-sociale face aux injonctions des pouvoirs publics : le cas de l'ACSEA de 1982 à 2010 – Une approche par l'étude des règles », *Journal De Gestion Et D'économie Médicales*, Vol. 32.1, p.46-62.

Kahn R.L., Wolfe D.M., Quinn R.P. & Snoeck J.D. (1964), *Organizational stress: studies in role conflict and ambiguity*, New York, J. Wiley & Sons.

Kets De Vries M. (2006), *La face cachée du leadership,* Pearson Education France, Paris.

Kirkpatrick S. & Locke E. (1991), "Leadership: do traits matter?", *Academy of Management Perspectives*, Vol. 5, n° 2, 48-60.

Kouadio, A. & Emery, Y. (2017), Employés publics dans les environnements hybrides : quelles ancres d'engagement et quelles pratiques de GRH ?. *Gestion et management public*, 6(2), 9-35.

Lagadec P. (2012), « Gestion de crise : nouvelle donne », *Sécurité et stratégie*, Vol.10, n°3, 50-52.

Le Flanchec A. & Rojot J. (2022), *Théorie des organizations*, Eska, Paris.

Lenhardt V. (2018), *Le management hybride – Mettre le leadership au service de l'intelligence collective*, InterEditions, Dunod, Paris.

*M*oore M & *H*artley *J*. (*2008*), Innovations in governance, *Public Management Review*, Vol. 10 n°1, pp.3-20

Philip de Saint Julien D. (2018), « Réponse des « survivants » à un plan de sauvegarde de l'emploi - Une grille de lecture » *Revue Française de Gestion*, Vol. 44, n°272, p. 11-31.

Plane J-M. (2015), *Théories du leadership Modèles classiques et contemporains,* Dunod, Paris.

Riveline, C. (2012), « Le management la tête en bas » *Le journal de l'école de Paris du management*, 6(6), 7-7.

Sainsaulieu R. (1977, 3ème édition 2019), *L'identité au travail*, Presses de Sciences Po, Paris.

Tannnebaum R. & Schmidt W. (1973), "How to choose a leadership pattern", *Harvard Business Review.*

Zara O. (2008), *Le management de l'intelligence collective* M21 Editions, Paris.

Weber M. (1922), *Economie et Société*, 1ère édition, Plon, Paris.