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Global Public Health

An International Journal for Research, Policy and Practice

ISSN: (Print) (Online) Journal homepage: https://www.tandfonline.com/loi/rgph20

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To cite this article: Fanny Chabrol & Pierre-Marie David (2023) How resilience affected public health research during COVID-19 and why we should abandon it, Global Public Health, 18:1, 2212750, DOI: 10.1080/17441692.2023.2212750

To link to this article: https://doi.org/10.1080/17441692.2023.2212750

Published online: 17 May 2023.

GLOBAL PUBLIC HEALTH
2023, VOL. 18, NO. 1, 2212750
https://doi.org/10.1080/17441692.2023.2212750

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COMMENT

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How resilience affected public health research during COVID-19 and why we should abandon it

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ABSTRACT

Resilience has accompanied the COVID-19 pandemic as a rallying motto, with calls by governments for a resilient society, resilient families and schools, and, of course, resilient healthcare systems in the face of this unprecedented pandemic shock. Resilience had already gained traction as an analytical concept in public health research for approximately a decade. It became a key concept despite the recognition of its lack of conceptual consistency. The COVID-19 pandemic presented itself as a perfect test-case and encouraged a multiplicity of studies on resilience and health care systems. In this commentary, we add to the existing critiques of resilience in the social sciences by reflecting on the effects of resilience when used to frame empirical inquiries and to draw lessons from the crisis. Resilience as a concept is unable to address crucial structural issues that health systems already faced throughout the world, and it remains a non-neutral political notion. We argue that we need to resist a generalised view of resilience and work with alternative imaginaries.

ARTICLE HISTORY
Received 8 March 2023
Accepted 7 May 2023

KEYWORDS
Resilience; public health; social sciences; COVID-19; adaptation

Introduction

Like a shadow, resilience has accompanied the COVID-19 pandemic and has become a catchphrase for many governments. From armed conflicts to climate and industrial disasters, like Fukushima and Hurricane Katrina, resilience follows in the wake of catastrophe. Resilience is a term that refers to the idea of absorbing a shock or crisis and bouncing back to a normal situation or even to a better one, while being prepared for future crisis. Since March 2020, many political, media, and other observers have called for the resilience of public health and hospital systems to face the severity and hostility of the situation. Research groups in several countries were also encouraged to build empirical surveys based on resilience as a multidimensional concept (Bryce et al., 2020; Haldane et al., 2021; Ridde et al., 2021). Our aim is to challenge the adoption of a seemingly operational and useful concept for researchers in public health and global health. We argue that resilience is fundamentally a political concept, and research pretending to use it neutrally should be questioned.

This concept relies on the disempowerment of the state, as numerous analyses in various social science fields have shown, for instance, after September 11 or Hurricane Katrina (Klein, 2007). Research on disaster for instance, portends that resilience diverts attention from the underlying causes of vulnerability (Achour & Price, 2010; Blanchet et al., 2017; Rushton et al., 2022). In urban studies, the concept has been criticised for celebrating the social status quo and naturalising

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the dynamics to which one must be resilient (Derickson, 2016; Esser, 2022). It has also been found to be a 'dispositif' of government that prevents oppositional politics (Braun, 2014). This political concept has nonetheless been endorsed in health systems research in recent years, and COVID-19 seemed to be a final test case for its generalised adoption.

At the very onset of the pandemic, we were invited to join a multi-country, multidisciplinary project led by public health and epidemiology specialists who were interested in investigating the resilience of hospitals in a comparative manner. They gathered experienced teams in Canada, France, Brazil, Mali, and Japan to contribute to the debates on resilience in the health system and policy research.[1] We used our participation in a project documenting hospitals' resilience in several countries and our field experiences as anthropologists working with health professionals and in hospitals in France and Quebec to identify the challenges and aporias in applying this approach. We first recall the success of the concept before using our reflexive stance to assess its empirical effects and political implications.

Endorsement of resilience in health systems research

The interest in resilience in health systems research started to grow with the 2014–2015 Ebola epidemic in West Africa. The term was picked up in publications by the World Health Organization (WHO) and academic institutions in Europe and North America that highlighted the weakness of West African health systems and the need to strengthen their capacity to deal with such health crises (Kieny et al., 2014). Resilience has been defined as 'the capacity of health actors, institutions, and populations to prepare for and effectively respond to crises; maintain core functions when a crisis hits; and, informed by lessons learned during the crisis, reorganise if conditions require it' (Kruk et al., 2015). Several prescriptive proposals followed at that time, aiming at measuring this ability to cope, restore, or even seize the crisis as an opportunity to improve the performance of health systems as part of a 'resilience dividend' (Kruk et al., 2015). The variations of the concept of resilience multiplied: 'everyday resilience' (Gilson et al., 2017) when crises turn into a permanent disruption of routines that push staff to the limit with chronic stress, or 'planned and adaptive resilience,' a characteristic of 'complex adaptive systems' (Barasa et al., 2018). Several authors choose to focus on the governance of health systems, and their capacity and legitimacy to manage uncertainty (Blanchet et al., 2017). Yet others insist there is a need to reinforce this 'capacity to adapt' (Abimbola & Topp, 2018) or to ensure that resilience is considered a capacity, not an outcome, and that it does not neglect power mechanisms in health system governance (Topp, 2020).

However, resilience as a concept has gained ground in health systems research without a consensual and operational definition, as confirmed by a scoping review of 45 publications (Pailliard-Turenne et al., 2019) and with no significant empirical basis (Biddle et al., 2020). Surprisingly, this endorsement of the concept of resilience in health systems research has continued to hold appeal despite (or because of) its multifaceted nature, which speaks to both research and public policy (Rushton et al., 2022). The COVID-19 pandemic became a test case for a concept. Our group defined resilience as: 'the capacities of a health system faced with shocks, challenges/stress, or destabilising chronic tensions (unexpected or expected, sudden or subtle, internal or external to the system), to absorb, adapt, and/or transform in order to maintain and/or improve universal access to comprehensive, relevant, and quality health care and services without pushing patients into poverty' (Ridde et al., 2021). The project aimed to document resilience strategies or configurations, in relation to perturbations affecting specific dimensions of hospitals (human resources, equipment, finances, information system, …). The objective was to identify which innovations or strategies were specifically implemented to tackle the effects of the pandemic and with what impact, be it positive or negative. We ourselves conducted the research in Quebec and in France (including on-site inquiries in Paris). We conducted observations and a great number of interviews (more than 90 interviews with professionals in Paris, completed by several focus group sessions and lessons learned workshops and 27 interviews in Quebec, along with three

group sessions gathering employees and managers). Collected in a deductive fashion, the empirical data answered most of the framework questions and were analysed comparatively. Data were also discussed with researchers and health professionals and compiled to serve as lessons learned, particularly in dealing with service reorganisation strategies, information and communication challenges, etc. It was also possible within the project to conduct more inductive, ethnographic fieldwork, for example in the Mortuary Room of a Parisian referral hospital (Chotard et al., 2022). This anthropological posture certainly helped sharpen the criticism of the concept.

We argue that resilience is not adequate to ask or tackle important questions related to the political economy of health that are key to understanding hospital care. It is too distant from the context that remains truly crucial to investigate. Published COVID-19 studies have investigated management mechanisms rather than social vulnerability or socio-economic status in health service provision, which played a large role during the crisis itself. This is also noticeable in other studies on the level of hospitals during COVID-19, that have mostly discussed leadership (Beilstein et al., 2021; Forster et al., 2020) or hospital organisational resilience and management (Atkinson et al., 2021; Harkouk et al., 2022; Lot & De La Garza, 2022) rather than structural stakes involving power dynamics, epistemic inclusion, and the political economy of health. In fact, COVID-19 may help to revisit resilience with new insights to help refine the concept, its definition, key stages, or implementation stakes (Paschoalotto et al., 2023) or better locate it as an explanatory rather than an evaluation framework (Topp, 2023). But we argue that resilience is unsuited to shed light on the extent to which health systems during COVID-19 increased inequalities in access to healthcare, as we have seen with access to the vaccine (Bayati et al., 2022). The empirical insights we gained during this research help understand its direct and indirect practical effects at the closest level of research.

Practical effects of resilience on research

When resilience opens doors and promises 'lessons learned'

Resilience has been a key to getting funding. Many calls for proposals have specified the notion of resilience as a selection criterion. This notion, combined with a focus on 'lessons learned' and valuing 'good deeds', facilitated our negotiations to obtain access to the field (i.e. being allowed to do on-site inquiries within hospitals) to conduct research in a rather uncertain context when death rates in intensive care units were high and infection control was a high priority. In our experience, resilience appealed as much to managers as to department heads, and it motivated them to join an integrated research project that placed value on adaptation and promised in-depth feedback on their experience and the formulation of lessons learned based on a comparative analysis of experiences of management of hospital services during the pandemic, including success stories. By accepting to take part in this research, on the grounds of lessons learned, hospital managers put themselves in the position of negotiating and transposing resilience locally. Critical literature usually presents resilience as a top-down discourse favouring injunctions from international governance (Rushton et al., 2022). While this top-down discourse was exemplified by political declarations like 'Opération Resilience' for French President Macron and recommendations by international health authorities (WHO, 2022) during the pandemic, our experience revealed how the topic of resilience also generated local expectations. The appeal of resilience is thus the product of both a global perspective that translates into grant opportunities and local management perspectives interested in lessons learned.

Resilience affects and emotions

Since the concept pre-exists empirical investigation, the assumptions around resilience guided our research, particularly when it came to documenting the coping strategies of professionals, hospital

services, and innovations adopted during the pandemic. This stance led to healthcare workers' relatively uniform discourse focused on psychological challenges. The intensification of workload was initially experienced collectively as an unprecedented and euphoric phase that was then followed by absolute discouragement. Disenchantment was widespread among healthcare workers, who were exhausted and who criticised their hospital management. Response to this was either psychological, emphasising team peer solidarity and mental health management, or focused on vocation-based recognition (applause at set times and a flood of donations in France, or calling health professionals 'our guardian angels' in Quebec by Prime Minister Legault). Yet our inquiry shows that staff members had expected structural reforms over the long run. Studies on resilience in health systems have hardly touched upon these questions of overwork, exhaustion, despair, contestation, and anger about the crisis state of public hospitals.

Talking about resilience encourages the overvaluing of certain emotions, to the detriment of others (van de Pas et al., 2017). It fosters the optimism, creativity, and innovation of some (often department heads) who propose innovative ideas to reorganise the flow of patients or services. At the same time, other emotions that may be more pessimistic or resigned, are less visible in resilience narratives and reports. Indeed, the loss of meaning in hospital work is recurrent and was amplified by the pandemic. The 'fed-upness' of the staff has led to a wave of resignations and revolts, precisely against what has become the 'R' word! (Wasty, 2022). Making the misfortune caused by the pandemic and its management cause for adaptation, flexibility, and agility is, in a way, the premise of future health systems based on resilience. Resilience operates as a moral judgment between the optimism of some (often the management/executive staff, even if they are equally disillusioned) and the resignation of others, often the less visible hospital staff. Resilience tends to ignore experiences that are deeply embedded in power dynamics of gender, race, and social inequality. Affects can hinder more structural dimensions, as shown in situations of trauma (Fassin & Rechtman, 2009; Jabr & Berger, 2021). This explains the political effectiveness of resilience: valuing attitudes with moral qualities and normalising effects masks the massive reorganisation of hospitals that is underway globally, which should be the ground for political demands. In other words, the celebration of agility hides the forced flexibility that workers have long denounced, particularly regarding labour standards.

Agile and degraded hospitals

An overly specific focus on the organisation of hospital workflows might neglect the large-scale non-respect of labour standards to *adapt* and absorb cases. Closing services and redeploying healthcare providers made it possible to deal with COVID-19 cases during the successive waves of the pandemic. Yet, it is the underlying nature of these exceptional reorganisations that should be questioned. In Quebec, an initial phase of 'deployment' (i.e. reassignment of personnel) was done on a 'voluntary' basis, but it was not long before the ministerial decrees issued in April 2020 allowed hospital management and authorities to reassign their staff members on a mandatory basis (David et al., 2023). Reassignment meant a suspension of vacation time. Also seen in France, this hiatus lasted long after the absorption of the first wave and infringed previously established workplace regulations. Instead of prompting dialogue between managers and workers, the suspension has generally resulted in authoritarian and uncoordinated decisions, the effectiveness of which can be widely questioned, both in terms of health efficiency (e.g. protected hospitals to the detriment of other peripheral health resources such as retirement homes) and of labour laws in hospital settings, which have been largely undermined (David et al., 2023; Gabet et al., 2023). As a result, many workers in Quebec, France, and other countries have chosen to leave the healthcare system altogether. The use of private employment agencies has become commonplace in these countries, such as interim or 'pool' nurses in France, fostering a fundamental transformation of a generally public service by indirectly privatising human resources management and, in the mid-term, making

work more flexible, a regular leitmotiv in both French and Quebec hospital policies before the pandemic.

Resisting the neoliberal injunction for adaptation

Our criticism of resilience is in line with other critical works on notions of the same register: adaptation, reliability, or assets (Friedli, 2013). Adaptation during the pandemic paved the way for widespread acceptance of 'degraded' hospitals whose practice of medicine was characterised as 'sub-optimal' by some of our participants. This changeover to a 'degraded mode' went hand-in-hand with resilience and the acceptance of a new type of triage that is unquestionably adapted to the new material and work conditions (Chabrol et al., 2023). From this point of view, resilience leads to an analytical dead end, which, in turn, contributes to normalising the degradation of work standards and the quality of care as well as the new forms of 'infrastructural triage' that it produces (Gaudillière et al., 2021). As a result, aiming for resilience has an impact that goes well beyond the initial crisis, as it allows for the continuation of structural reforms already underway and the improvement of new forms of governance that are organised around adaptation.

Most resilience frameworks view health systems as complex adaptive systems in which local interactions can be controlled and regulated (Lansing, 2003). These studies conceive of resilience as a property common to many complex systems, defined as the ability of the system to respond to disturbances, internal failures, and environmental events by absorbing the disturbance to maintain its functions. But through this definition, a double movement takes place: firstly of maintaining the status quo on the conditions of the occurrence of disturbances, which are not questioned (Derickson, 2016) and secondly, submitting the so-called complex system to an adaptation imperative. As a major component of resilience, 'adaptive resilience' becomes a political imperative. This imperative can be traced back to the development of neoliberal thinking and public programmes in the United States in the 1930s, following the Great Depression (Stiegler, 2019). As a mode of governance, resilience encourages individuals to adapt to these conditions rather than resist them or be actors of change. The government has become not only the regulator, but also the creator of the market, thus encouraging the adaptation of individuals and communities. The imperatives of adaptation are foundational to neoliberal politics, and resilience may constitute a 'neoliberal mode of subjectification' (Bracke, 2016). In other worlds, a resilience agenda promotes a neoliberal acquiescent citizenship that should be resisted (Neocleous, 2013).

In a time of growing critique and urgent calls to decolonise global health as a field of knowledge and practice (Büyüm et al., 2020; Fofana, 2021) we should recognise the non-neutrality of resilience, and the epistemic violence associated with its insistent use and top-down imposition. Instead of celebrating this western concept, we should consider that the pandemic in fact exposed European vulnerability in its reliance on the medical infrastructure (Macamo, 2020). Resilience qualifies as one of the vocabularies of this epistemic violence that researchers need to resist and engage with decolonial and feminist epistemologies that target global inequalities and work primarily for social justice. In urban studies, this critique has already led to emphasise the need for situated knowledges centreing justice and transgression, reflexive and historical thinking in connection to social struggles (Wijsman & Feagan, 2019). An 'interim politics of resourcefulness' has been proposed as an alternative to resilience (Derickson & MacKinnon, 2015), promoting social relations and knowledge to strengthen the capacity of subaltern or marginalised populations. There are many ways out, from many different fields and epistemologies. Such critical alternatives exist in public health and hospital institutions and should be supported. Many professionals in the health field reflect on and warn against the dangers and pitfalls of resilience. Rita Giacaman, a physician and public health specialist in Palestine, questioned the approach by which the victims of Israeli occupation have been so repeatedly urged to be resilient and showed that resilience itself has justified individualising humanitarian interventions that did not address

the crude question of injustice (Giacaman, 2020). For psychiatrist Samah Jabr, *sumud* – a Palestinian Arabic term that has a strong connotation of resistance – would be an alternative concept to define the violence being endured and to orient action, resistance, and moral and social solidarity (Helbich & Jabr, 2022).

Conclusion

Health system resilience appears as an intellectual trap that overlooks pressing issues of social vulnerability, structural inequalities, and the political economy of health. In 2017, van de Pas and colleagues warned of its risks, and, in light of the COVID-19 pandemic, we argue that we should simply abandon it. Longing for a conceptual maturity that would not be limited to their adaptation but would emphasise the 'robustness' of health systems (Abimbola & Topp, 2018) or the act of calling for a better conceptualisation of resilience through empirical studies and applied research to fill the gaps of the nascent concept (Saulnier et al., 2021) all together miss the real stakes. Resilience is first and foremost a non-neutral political concept and an institutional aspiration that cannot be turned into an analytical framework. We therefore prefer discarding the concept of resilience to critically re-politicize research in public health. Public health and the social sciences have a long history of productive collaboration and public health research has greatly benefited from incorporating key questioning from the social sciences to better reveal underlying systemic racism, gender power relations, and all structural inequalities that are aggravated in the context of the finitude of the planet. COVID-19 showed the extent to which global dynamics of inequality play out, as well as the lack of global solidarity. Maintaining a narrow view of the resilience of national or local health systems tends to overlook them. After COVID-19, we need to resist a generalised view of resilience and work with alternative imaginaries and their translation in the field of health services to promote more just and equitable health systems.

Note

1. The project received Ethical approval Hospital review board MP-21-2020-2879, and Université de Montréal IRB, certificate CERSES 20–061 D. The study received ethical approval from the Institutional Review Board (IRB 00006477) for Northern Parisian Hospitals, Paris 7 University, AP– HP, on April 15, 2020.

Acknowledgments

This study was funded by grants from the Canadian Institutes of Health Research [DC0190GP] and the French Agence Nationale de la Recherche [ANR-20-COVI-0001-01]. We thank all the participants of the project. We are grateful for the support of our colleagues who allowed for the critical and reflexive stance. The views expressed are solely the responsibility of the authors.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by Agence Nationale de la Recherche: [Grant Number ANR-20-COVI-0001-01]; Canadian Institutes of Health Research: [Grant Number DC0190GP].

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