The final, definitive version of this article was first published in French: Annick Anchisi, Laurent Amiotte-Suchet, Kevin Toffel, Social Compass 2016, Vol. 63(1), 3-19, 10.1177/0037768615613892, © The Author(s) 2015
http://journals.sagepub.com/doi/pdf/10.1177/0037768615613892

[nnn] = page numbers in parallel to the original article.
Reference to this translation = "*reference to the first published version as above - page(s)* - translation in English"

[3]

Ageing nuns: congregational strategies and the paradox of secularism

Annick ANCHISI
HESAV-HES-SO - Lausanne, Suisse

Laurent AMIOTTE-SUCHET
FTSR-ISSRC - Univesité de Lausanne, Suisse

Kevin TOFFEL
HESAV-HES-SO - Lausanne, Suisse

Abstract

In Switzerland and in France, religious communities are ageing. With the growing age infirmities, the customary support of the eldest nuns by younger sisters is therefore no longer feasible. This article is based on a sociological study that analyses the transformation of Catholic convents into nursing homes for the elderly in Switzerland and France. The findings highlight the differences in how each country mediates between congregations and the state, as well as inequalities in the treatment of elderly nuns. Given the need for state recognition to benefit from state pensions and a marked preference for spending their last years at home, nuns are innovating in an attempt to re-appropriate their future – for however long it may last.

Keywords
congregations, nuns, nursing home, old age, secularism, welfare state

Corresponding author:
Annick ANCHISI, HESAV, HES-SO – Lausanne, 21 av. de Beaumont, Lausanne, 1011, Suisse
Email: annick.anchisi@hesav.ch

[4]

Introduction

Communities[1] of Catholic nuns[2] are ageing in both Switzerland and France, due to longer life expectancy and fewer people entering religious orders each year). The average age is increasing, making it more difficult for older nuns to receive care from their younger counterparts, as was previously the case. Associated with ageing comes an increased risk of health problems. When faced with situations of age-related dependence prior to the early 2000s, communities often hired (female) professional care staff who came to the convent. Another option was for elderly nuns to leave the convent to live out their lives in an off-site medical facility. Over the past several years, dependent nuns have become a major issue in many communities. They commonly express their desire to *grow old and die at home*. One possible solution to such requests has been to medicalize one part of certain convents, turning them into healthcare facilities that meet current gerontological criteria. While such approaches take a burden off the community, they also require the introduction of lay professionals (administrative and healthcare staff) with whom the community must learn to cooperate.

The primary focus of our three-year research initiative is twofold: to pursue research into the evolution of gerontological culture on the one hand, and into the reshaping of church/state relations on the other hand. The initiative has received funding from the Swiss National Science Foundation (SNF)[3] and is interested in the gradual decline of customary practices within religious communities. Indeed, dependence is now broadly managed by the state, which means that healthcare facilities must meet current norms and have professional care staff. This article addresses the new reality of convents turned into healthcare facilities and focuses its analysis on the relationship between states and congregations.

Ageing and religious communities: strategies to address the inevitable

Managing age-related dependence

New categories related to old age have emerged alongside extended life expectancy (Caradec, 2012), including those related to functional …/..

[5]

and mental health (Ennuyer, 2004). As a category of risk related to old age, dependence is most often defined as a state requiring the assistance of another person to accomplish the activities of daily living[4] and that is evolving towards greater incapacity. With regard

[1] Throughout this article, we use both the terms congregation and community to refer to religious groups. The term congregation refers to the overarching body of communities that unites and coordinates the latter around a specific type of social or spiritual work.

[2] Male members of religious orders are also affected by the ageing phenomenon. We refer mainly to female members here due to the places studied in our research which were female communities.

[3] SNF, division I, project # 149678: http://p3.snf.ch/project-149678

[4] The six activities of daily living (ADL) are bathing, dressing, eating, transferring, use of toilet facilities and continence; in addition to which are instrumental activities such as using the telephone, doing housework and shopping, meal preparation, managing medications and personal finance, and using transportation. These elements are used in scales to measure dependence.

to overall health and despite persistent social disparities, the situation for people under the age of 80 has improved over the past thirty years. For the oldest age groups, the situation has remained relatively stable (Höpflinger et al., 2011). While a long life does not inevitably entail dependence, there is nevertheless a high risk of disability beyond the age of 80 (Lalive d'Epinay and Spini, 2008). The health of elderly nuns deserves more specific examination. A systematic overview of studies conducted in the United States and Europe between 1959 and 2000 points up a lower mortality rate for nuns than among the general population (Flannelly et al., 2002; Höpflinger et al., 2011; Luy, 2011). Let us refer more specifically to the Nun Study which involved 678 Catholic nuns from the same American congregation. The aim was to leverage the regularity of everyday life and the homogeneity of behaviours, thus minimizing exogenous variables, in order to compare the cognitive problems of elderly nuns. The findings showed lower levels of dementia among the highest educated nuns (Tyas et al., 2007). These positive findings do not cancel out the issue of dementia entirely, however, and it is nonetheless a problem, especially for the oldest age groups, and is often compounded with other disabilities. In our fieldwork, cognitive problems were a common cause leading nuns to be transferred to the medicalized wings of the convents studied.

Modern gerontological institutions date back to the 1980s. While, in the past, asylums for the elderly were limited to supervising patients, today's medicalized nursing homes – *Établissements médico-sociaux* (EMS) in Switzerland and *Établissements d'hébergement pour personnes âgées dépendantes* (EHPAD) in France – are much more attentive to patients' human rights. This evolution is part of a move to "humanize" practices and institutions (Cabirol, 1983), an effort to combine specialized gerontological approach and consideration for individual expectations, including when customary practices appear incompatible with such changes[5]. The older people get, the likelier they will die in an EMS or EHPAD (OFS, 2009 ; Prévot, 2009). The approach of professionals as such involves doing everything possible so that patients live out the last phase of life in the best possible conditions, which sometimes means making the issue of death secondary (Anchisi et al., 2014 ; Rimbert, 2011). As written elsewhere (Anchisi et Debons, 2014), the move away from the asylum-like hospices organisation – that of the "total institution" defined by Goffman (1968), of which convents are one type – was is less about removing constraints; rather, it than a reformulation or shifting of such constraints towards an ethos adapted to current values such as autonomy or project-based approach (Cavalli, 2007 ; Gagnon, 1995 ; Levilain, 2000). Our research is indeed interested in this approach to dependence and the institutionalization of the elderly in the context of contemporary gerontological thinking.

A decline in religious vocations

The societal changes that have affected the place of religion within societies of the global north and the western world have in part delegitimized the apostolic action of religious communities …/..

[6]

(e.g., nursing, teaching, assisting the poor). Perceived as irreversible, secularization processes have not only reduced religious affiliation but have also affected the logic underpinning rationalization and differentiation processes in the spheres that regulate and

[5] In his research into the pilgrimage of sick people to Lourdes, Amiotte-Suchet (2010, 2011) has emphasized the centrality of individualization in current pilgrimages and the personalization of the sick. Céline Béraud (2006) has shown that claims related to working conditions, the right to a personal life and the desire to take advantage of retirement are now increasingly common amongst parish priests.

shape all aspects of social life (Wilson, 1966). Ample debate exists over these processes, their origins, their effects and the likeliness of their exportation beyond Europe's borders (Tschannen, 1992 ; Berger, 1999). There is a legitimate need to distinguish between laicization and secularization (Dobbelaere, 2002), to differentiate between institutional religion and diffuse religion (Campiche, 2004), and not to confound faith and affiliation (Davie, 2003). But the so-called traditional churches of the west (Catholic, Protestant and Jewish) have in any case been affected by these transformations in terms of their official membership and have notably seen a drop in the religious ceremonies that mark the different stages of life (birth, marriage, death) and a decrease in priestly vocations (seminarians and noviciates)[6]. The drop in vocations within Roman Catholicism over the past fifty years has actually pushed the institution to reorganize how it manages mass and its presence in different territories. Unable to reverse the trend, the conferences of bishops (of Switzerland and France) have sought solutions to at least limit the damage: the pooling of parishes into Pastoral Units, Sunday Celebrations in the Absence of a Priest (SCAP), a broadening of the scope of responsibilities given to deacons and greater involvement of laypeople in liturgical life. There is a lack of priests in the Church and there is also a lack of novices. Female religious communities are also affected by the decline in vocations. The decreasing number of able-bodied nuns focus mainly on administrative tasks and the spiritual guiding of communities. Most are elderly themselves and are no longer able to care for their dependent sisters.

In France, the number of nuns declined constantly between 2000 and 2010, with an average annual decrease of 3.5%. While there were 51 000 nuns in 2000, there were only 35 000 left in 2010. The situation is similar in Switzerland where, in late 2014, there were 3 200 sisters and nuns, whereas there had been twice that many ten years earlier[7]. The declining numbers within congregations are mainly due to the reduced number of women entering the order and to an increase in deaths. The demographic estimates of the congregations we met in both Fribourg (Switzerland) and Besancon (France)[8] – our fieldwork sites – predict the end of their communities by 2040-2050. Their future appears destined to move out of Europe, towards countries with a missionary past.

Finding ways to adapt

Fully aware of this state of affairs, religious congregations have begun organizing to guarantee their future over the short and medium term. Not all communities are able to adapt to the situation in the same way, however. At the turn of the 21st century, different initiatives were explored. Our research into congregations in the two dioceses[9] studied has allowed us to draw up a non-exclusive typology of the ways communities adapt to the issue of age-related dependence.

---

[6] The regular decline in priestly ordinations in the French Catholic Church began in 1950. The number of ordinations remained stable until the 1980s. Switzerland has experienced the same type of evolution.

[7] Statistics obtained in July 2015 by the nun who was secretary of the Union of Major Superiors of French-speaking Switzerland.

[8] In the canton of Fribourg, there are houses attached to over forty female apostolic congregations and a dozen contemplative convents and monasteries (Mayer, 2012). In the Besancon diocese, there are nineteen active female congregations (data available on the website of the Besancon diocese: http://besancon.mondio16.com/ – consulted on 30 March 2015).

[9] Sources connected to the Church provided a point of view that reflected the entire diocesan territory: the Besancon diocese includes some municipalities in the Doubs and Haute-Saône departments and the LGF diocese includes the cantons of Lausanne, Geneva, Fribourg and Neuchâtel.

- Survival: making partial sanitary changes in order to manage old age internally for as long as possible; this involves hiring lay staff (caregivers/nurses – with a contract based on mutual agreement).
- Pooling: mergers, absorption or the regrouping of communities that are geographically close with the aim of remaining large enough to manage old age internally. Facilities are transformed into healthcare units; lay healthcare staff is hired.

- Alliance: a more or less formal agreement between the congregation and a recognized healthcare facility traditionally managed by another congregation or lay body that welcomes elderly nuns into its care (the latter are given priority for available spots).

- Delegation: an approach aimed at entrusting a Christian association with the responsibility of caring for elderly nuns in a medicalized context (the convent is rented or lent to the association, which then ensures that it meets health standards).

- Evolution: transition to becoming a medical facility managed by the religious congregation with broad support from laypeople or a team entirely composed of laypeople. The convent is renovated to meet state requirements in order to obtain EHPAD or EMS status. This is the approach that we will examine in more detail below.

This typology[10] of the situations encountered in both the territories studied highlights several things. For one, the strategy chosen is in part based on the size of the community. Small communities (roughly ten members) generally have no choice but to delegate the handling of dependence to a third party whereas larger communities may still have sufficient human resources to at least partially manage the situation internally, at least for a few years. Moreover, the strategies adopted are often guided by the apostolic tradition of the congregation. Nursing orders as such often have skills and knowledge that let them more easily address this evolution.

If we consider that pooling and survival are, de facto, temporary strategies, it becomes clear that approaches such as delegation, alliance and evolution all involve dependence being handled by lay professionals within facilities that are recognized and certified by the state. While the situation that interests us here – i.e., when one part of a convent is transformed into a nursing home – is not yet the most widespread, it appears to be a sustainable choice that complies with state health policies.

Besancon and Fribourg: from convent to healthcare facility

The Besancon-Savoie Province of the Sisters of Charity of Saint Jeanne-Antide Thouret began reorganizing its six retirement homes across eastern France (Franche-Comté, Gard,

[10] This typology was elaborated based on our contact with fifteen convents and monasteries that have healthcare facilities. We visited the premises when a visit was possible and we interviewed managers from all locations. To have the broadest overview of approaches, we also conducted interviews with the Superiors of congregations and with representatives from the diocese on issues related to old age. In this context, we also encountered situations of "mutation" (groups of female non-congregationist Catholics who wanted to live in convents), but this form was too marginal to be included in our typology.

Champagne-Ardennes, Paris region) and Switzerland (Givisiez, canton of Fribourg) in the 1990s. …/..

[8]

Tripartite agreements were signed in the early 2000s between the associations that managed these facilities in France, the General Councils and the French departmental health and social security authorities (DDASS[11]) to enable these already medicalized nursing homes to receive EHPAD status and as such benefit from public funding to cover their running costs. The Sisters of Charity congregation as such opted to obtain state recognition (with all that this entailed in terms of complying with health and sanitary norms) but they did not lose control of their nursing homes. In each of the associations that manage these EHPADs, a majority of the board of directors is composed of members of the congregation (the sister superior of the Province is an *ex officio* member with a majority voice) in such a way as to maintain some control over the facility directors and their staff (now exclusively laypeople). From the outset, the EHPADs run by the Sisters of Charity were open to nuns from other congregations, as well as to elderly priests and laypeople. Wings were set up to optimize group life at these facilities. One of the facilities we studied is run by the Sisters of Charity in Saint-Ferjeux (Besancon) and received EHPAD status in 2004. It is home to fifty elderly dependent nuns and almost as many laypeople (in two different buildings[12]). The Sisters of Charity know that they will have to open their EHPADs to even more laypeople in the future so they are working to have their know-how officially recognized in order to maintain control over the handling of end-of-life situations in their homes and ensure that the spirituality they embody remains present.

Excerpts from community reports from the archives of the Besancon congregation show how the decision to shift from a nursing home for elderly runs to an EHPAD was gradually made. The sisters first attempted to use their own internal resources to care for the eldest nuns. Very early on, in the 1980s, the congregation became aware that its population was ageing and of the extent of issues surrounding the management of dependence.

- 1983–1984: “Our sisters are more and more dependent.”
- 1984–1985: “This house is increasingly an infirmary… And yet the health of a good number of sisters calls for a different organization. We are still looking for a solution. Gradually, we are accepting the help of laypeople.”
- 1988–1989: “Some sisters – albeit whose numbers are declining each year – can still provide small services. It is certain that it will be necessary in the coming years to rely more on laypeople to look after the home and care for sisters who are sick.”
- 1991–1992: the report indicates that two laypeople were hired (including one for healthcare needs).
- 1992–1993: “This year we think we can envisage a re-organization of the different services, given the advanced age of our sisters – and in response to their proposals – to provide better living conditions for each of them and for the entire Community.”

[11] This is now handled by the *Agence Régionale de Santé* (ARS – regional health authority).

[12] A certain degree of intermixing has begun since, in 2014, three vacant rooms in the sisters’ pavilion were attributed to laypeople.

[9]

- 1996–1998: the report indicates the hiring of three nurse's aides.
- 1998–1999: the report indicates the hiring of a nurse "to compensate for the decreased number of nurse sisters."
- 1999–2001: "The time has come to think about lay management in order to undertake the reforms required of nursing homes."

The case of the Sisters of Charity of Saint Jeanne-Antide Thouret in Besancon is a good example of the changes experienced by religious congregations over the past twenty years. Their strategy was first based on survival (handling the problem internally). Then, in the very early 2000s, they accepted a merger with the Hospitaller Sisters (2001-2002). This pooling, which brought the congregation of Hospitaller Sisters under the umbrella of the Sisters of Charity, offered the latter rapid demographic and real estate growth which provided sufficient space to open a nursing home in Besancon while also preserving other buildings for fit sisters. While these sisters from Besancon first opted for survival and then adopted a pooling strategy, they gradually acknowledged the need to medicalize their facilities (evolution) to avoid depleting their remaining forces managing dependence.

In the Swiss canton of Fribourg, discussions about the need to redirect the everyday missions of congregations towards a focus on the issue of ageing dates back to the 1990s. At the time, congregations did not benefit from health insurance coverage for healthcare provided to elderly nuns within their confines, by either religious or lay care staff. In 2005, ASCOREF (the association of religious communities of the canton of Fribourg – an association representing 26 congregations) was created and became the main partner in negotiations with the government to address both the issue of ageing nuns and to guarantee their right to health insurance. While dialogue remained open between the two parties, no actual agreement was reached. It was a "real war of attrition" according to one senior ASCOREF figure. The nuns' attempt to have all of their rights to health insurance recognized was contested by the highest legal body in Switzerland, among others. The *Tribunal fédéral* (TF – federal supreme court) ruled against a nun who appealed the decision of the compensation fund of the canton of Fribourg in the context of the calculation of *prestations complémentaires* (PC - top-up benefits), an insurance benefit attributed based on resources, as well as on the recovery of ancillary costs when a person is placed in an EMS (same basis of calculation). When it ruled that the canton was correct in taking into account a life annuity when calculating the nun's revenues, the TF also based its ruling on an article of canon law (#670) that stipulates the obligation for congregations to provide subsidence for their members as a counterpart to the work completed by each of them[13]. This ruling, which confirmed the principles established in a previous ruling[14], still applies across all Switzerland. In 2006, a work group entitled "Dependent Brothers/Sisters" was created to raise awareness among congregations of the scale of assistance provided to the oldest members; this was done to help garner social and political recognition of the problem. The goal was to assess the gestures of everyday

[10]

life provided to nuns and priests and to help educate all communities in the canton, as this excerpt from a document from the "Dependent Sisters/Brothers" work group illustrates (the document was sent to all male and female communities in the canton of Fribourg. Members of the work group could serve as reference people in case of doubt):

---

[13] 2P.271/2006/svc, judgement on 12 January 2007.

[14] P1/66, judgement on 19 January 1967.

> "3.1.4. **Bathing**: make sure you are not too good! No false charity. Simply tell the truth! You know that, starting at a certain age, a person needs help to bathe. They need help washing their back, their feet, etc. Simply state since when you've had to help, say that you need to help them, every day. **Hair combing (or covering)**: what do you do when you see a brother who has not combed his hair? What do you do if you see a sister with a crooked veil (or coif)? You fix it: you comb their hair or cover it! How long have you done so? Simply say that you need to do it daily or help them to do so or check and fix it for them."

In 2008, with the consultancy of an economist and a legal expert, and the help of committed laypeople, religious professionals from the health and social sector calculated – based on gerontological scales – the number of dependent community members and showed that roughly a hundred of them should be in a specialized facility. Presented with facts, the government recognized the need for an EMS for nuns and priests in the canton. The decision was made to use three convents that were sufficiently large and had already been partially transformed into healthcare facilities. Smaller, infirmary-style facilities with only a few beds were side-lined, although their spokespeople remained active in debates with the government.

In 2010, the *Institut de santé des religieuses et religieux Fribourg* (ISRF – Health institute for the nuns and priests of Fribourg) opened, with the obligation to treat men and women from all congregations in the canton. The institution offers sixty-three beds in transformed wings at three convents from different congregations: the Ursulines, the Sisters of Saint Paul and the Ingenbohl Sisters. Non-resident nuns continue to live in these convents and are in contact with residents in certain shared spaces, such as the chapel and meeting rooms, and the refectories on some occasions. This three-site facility is run by a team of lay managers and healthcare professionals. Like at Saint-Ferjeux, however, the Superiors of the three convents have a seat on the ISRF board of directors, which is chaired by a lawyer. Running conditions at ISRF are almost identical to those imposed on other EMSs in the canton, albeit with a few exceptions. While staff allocations must be respected, the sites themselves – often protected heritage buildings – are not always transformable.

The state as such revised certain requirements and gained access to facilities transformed for other needs. This set-up allows congregations to finance the upkeep of their costly real estate assets by renting out the facilities to the EMS. Disagreement remains over funding for these facilities, however. Of the sixty-three beds that were opened, only fifty beds are funded by the state and only partially. Under cover of the initial agreement in place when the facility was opened, ancillary care (beyond what is provided by state health insurance) is still not covered by the government. This detail significantly increases the cost of care for all congregations (including those that transformed their facilities) and makes it difficult for nuns with limited means to enter the ISRF, in some cases forcing them to enter a different cantonal EMS instead. **[11]**

While the two examples here concern only a few congregations, they can without risk serve as a model for others. All the religious communities we met in both France and Switzerland strive to keep their elderly sisters at home until they die. They as such needed an alternative that could be a middle ground between surviving at all cost in the convent or dying in a medicalized healthcare facility outside the convent, something that would satisfy both health norms and the requirements of the congregation. In both France and Switzerland, it was not simply a matter of letting secular logic enter the convent or of securing a place for religious authorities within civil society institutions. Each time, a

hybrid process was created[15]. While laypeople have been allowed in, the congregations have nevertheless kept a certain degree of control over how things are done – they sit on boards, participate in the recruitment of staff, remain present within the convent and draft different strategies so that the "spirit of the community" continues to be felt throughout the facility.

> "We have received and forged values that we offer as beacons, as solid foundations but we also have requirements … In the tradition of the teachings of Saint Jeanne-Antide, we will use her message to express our expectations and demands…regarding the Spirit that will guide you in this mission so that the word Accomplishment takes on full meaning…we must continue the tradition of placing humanity at the core of our work... As a congregation, from chapter to chapter, we have the same goal of 'working with our lay collaborators, of sowing the seeds of a simple, supportive and fraternal humanity'... Strengthened by this spiritual legacy, it is with Joy and Hope that we intend to pursue, with you, the work begun by Saint Jeanne-Antide in her time, to reinvent, develop and adapt it to the present, and also thanks to the wealth of our different perspectives on the World. (Excerpt from the brochure "Making sense of our everyday life" written by the Sisters of Charity of Saint Jeanne-Antide Thouret congregation for the nursing and care staff at their facilities, translated here)

As this excerpt shows, the nuns strive to remind the care staff of the congregational origins of the homes and the nursing tradition that they feel they represent to ensure that the approach to nursing and the relationship with others remain influenced by their legacy. While the nuns have had to become more open to professional practices, the care staff, too, has had to rethink their approaches[16] to make them more compatible with the rhythm of religious life and the history of the communities.

Paradoxical Secularism

The religious communities we studied have renovated their facilities and turned part of their infrastructure into an EMS or EHPAD. To obtain such status, a whole set of norms must be met and the nursing and care staff must work set hours regulated by the labour code. Live-in nurse-nuns who once looked after residents in the nursing home at any time of the day or night have indeed been replaced by professional staff who work specific hours, do not live on-site and take the rest days stipulated by labour laws. Over the course **[12]**
of the 2000s, there was a shift from a community organization based on the devotion of each nun for all, overseen by the sister superior and her council, to a professional organization based on labour law and piloted by a lay management team responsible for scheduling but which does not have absolute authority over its staff. From a strictly financial perspective, this shift had a cost:

---

[15] By hybrid facilities, we mean institutions in which several different schools of thought coexist but in which no single one appears able to impose its authority. While he uses the term to refer to social spaces rather than to institutions specifically, this reminds us of the notion of "mixed specialized spaces" used by Pinell (2012). We are tempted to think that religious logic is more structuring than economic, political or health-related logic; this is notably true for medical institutions housed within convents.

[16] Some forms of religiosity (or spirituality) are present in the secularized sphere of healthcare. Some nursing and support staff indeed employ a spiritualizing discourse aimed at giving meaning to suffering and the end of life; interaction between different registers of belief is inevitable in these hybrid facilities (Hervieu-Léger, 2003 ; Stiefel, 2007).

> "… nearly two employees were needed to replace each sister. Because sisters were available twenty-four hours a day – morning, noon, evening and night. They would get up, do what needed doing and be there for everyone. For us employees, the labour laws are very restrictive, you know [laughs] and so, yes, it was quite problematic at first because the government didn't provide us with as many employees as we would have – as we needed... We don't count our time, we don't look at how much we're paid, that is not the problem. In 2002, laypeople arrived and, unfortunately, well, laypeople have to work seven hours a day, need eleven hours between shifts, and bla, bla, bla… So, historically, it is a nursing home with a very low per diem rate. That is the story. Everything is connected." (Interview with the director of an EHPAD of congregational origin in the Doubs department, 16 June 2014, translated here)

Increasing the amount of staff in facilities to adequately replace the tireless and unflagging nuns was a recurring issue in most of the interviews we conducted. Still today, the phenomenon tends to be offset by valid sisters who continue to take on different tasks in the health units (secretarial duties, transport, helping at mealtime and with chores, watching over dying sisters), to offer, among other things, a family-like presence for the resident nuns.

The licence issued by the state imposes management and organizational conditions (collective labour agreements, staff protection, professional development requirements, standard pay) and standard monitoring and control procedures (quality systems, systematic and computerized inputting of degrees of dependency, analytical accounting). In exchange, healthcare facilities receive funding from the state via the existing healthcare and health insurance systems. The state in turn gains access to pre-existing facilities that avoid the heavy cost of real estate investment and it can rely on communities that are actively involved in the life of each facility. The institutions studied in the context of our research have all embraced this hybrid nature. The internal running of the facilities is the topic of negotiations between congregations, management, staff and nuns, all under the auspices of the state, which ensures a certain degree of uniformity across all of its facilities and guarantees their compliance with health and socio-sanitary norms.

The place of religion in the public sphere is not the same in Switzerland and France and the approaches taken by nuns in the two countries have as such been handled and treated differently. In Fribourg, the ISRF is reserved for nuns and priests or affiliates from the canton[17]. For reasons of proximity, it is the three congregations that initiated the project who benefit most from it. The EHPAD in Saint-Ferjeux, however, has a legal obligation to reserve half its beds for laypeople and is not allowed under any circumstances to base admissions criteria on religious belief (principle of secularism). Moreover, there are also differences in terms of the insurance coverage and assistance available in the two countries. Nuns are eligible for schemes related to dependence (the benefit for disability in Switzerland and the personalized dependence benefit in France). But, while nuns in France can benefit from social assistance (AS) if they meet the limited resource criteria based on their small pensions (like any citizen in a similar situation), nuns in Fribourg, …/..

[13]

in addition to the ancillary costs they must pay on their own, see a life annuity deducted from the calculation of their top-up benefits (PCs). These differences in treatment deserve further examination.

In Switzerland, the regulation of religion in the public sphere falls in part under cantonal remit, given the country's communitarian principle (Campiche, 2003, 2004 ;

[17] The ISRF statutes stipulate that parish housekeepers, lay missionaries and other people close to the religious community are also concerned. This openness towards a group of affiliates is also a means of perpetuating the ISRF.

Ossipow, 2003). The historically Catholic canton of Fribourg grants Catholic and Calvinist churches recognition in public law that gives them superior status over other religious groups in the territory. This requires that the churches meet certain cantonal requirements, however. The creation of the ISRF occurred within this particular context. The canton recognized that the Catholic church and its communities had a certain "public utility" and as such had to consider the request for its support for a project aimed at managing the dependence of elderly nuns. But while the canton has duties towards the Church, it also demands substantial participation from the latter. This is indeed a case of negotiated collaboration: the canton agrees to partially finance the institution – 60% of the cost per patient stay – but the remainder must be paid by the congregations who are also responsible for setting up a lay management team and staff, and the associated costs. Moreover, nuns may be eligible for infirmity benefits (based on health criteria) and to some top-up benefits based on economic criteria. But, given their unique situation (choice of a group life and the support obligation) and based on the ruling of the TF court mentioned above, the canton created a situation that is unique to the ISRF and is deemed unfair by the congregations but equitable by the authorities.

The situation is different in France's Franche-Comté region. The region and the department supported turning the Saint-Ferjeux retirement home into an EHPAD. The Sisters of Charity had already anticipated the situation and began major renovations in the 1990s to convert part of their facilities and take in laypeople. At the time, the region was short on EHPAD beds and needed to invest. The congregation was as such able to benefit from major funding from the department for its renovation work. Further, EHPADs are eligible for social assistance and this became an issue of importance for those in charge of the congregation starting in the 2000s. Given its secular tradition, the French state does not recognize any religion and is as such required to treat nuns as regular citizens above all. Nuns, who tend for the most part to have limited income in retirement, are eligible for social assistance. The state as such covers a large share of the cost of their stay in an EHPAD facility. These payments are allocated based on resources and, in theory, all or part of the amounts attributed may be recovered by the state when a nun dies. It is indeed in the context of their succession that the personal effects of nuns are bequeathed[18]. Most of the time, the congregation is the main legatee. The state is as such not able to recover the amounts granted to compensate its assistance. This amounts to a situation in which the state is forced to pay social assistance (without any hope of recovering the amounts) for nuns who, at times, are part of congregations with a great deal of capital and property assets. All the actors with whom we met in the region – from the General Council (CG) …/..

[14]

and the *Agence régionale de santé* (ARS – regional health authority) – expressed their discomfort over the fact that nuns who, from their perspective, had considerable community assets were eligible for social assistance.

> "It is true that it raised a lot of questions in 2004 when we received the request for accreditation because…in other facilities, when a social assistance recipient has assets, amounts are recovered following their death, based on the expenses of the department…we call it an estate recovery. So it's true that when they asked to be accredited for social assistance, we said to

[18] When they join a congregation, members of a religious order who take a perpetual vow retain bare ownership of their assets until their death, at which time their will attributes their distribution. When they join an order that takes solemn vows, members of the religious community renounce ownership of their assets to the benefit of the order. This distinction can lead to misunderstanding on the part of professionals in charge of the field of social insurance.

> ourselves: but these sisters, who may have had belongings and who gave everything to the community, well the community benefits from them nevertheless! … That's why, they [the nuns] maybe gave their belongings to the community when they were 20 years old, but after ten years a donation can no longer be recovered. … You cannot go back ten years in time…especially since they've acquired a lot of property." (Interview with a senior manager from the pricing department at the General Council of the Doubs department, 16 September 2014, translated here)

As this source pointed out, government departments cannot challenge the logic behind the attribution of assistance without running the risk of having to revise the regulations (which is what the state of Fribourg did with the rules on health institutions[19] modifying some articles aimed at congregations). The only thing the French state can demand is that beds be opened for lay residents and that there be an independent lay managerial team. And yet those in charge of the congregation are not adversely affected by these demands. The facility was already accessible to laypeople before the creation of the EHPAD in any case, since the community had a building that it could not afford to leave empty. And with regard to the lay management, it remains under the discreet but efficient control of a board of directors on which sisters have a majority voice to ensure that the facility evolves in the "right" direction.

In some ways, the nuns in Fribourg benefit from better political recognition from the state than their French counterparts. The EMS is included in health planning as a specifically religious institution. Swiss nuns (and affiliates) have retained the right to religious exclusivity in their facility whereas French nuns must accept to live alongside lay residents. But the latter paradoxically receive better financial support since their social assistance is obtained without counterpart and they have a better chance than ordinary citizens of securing a spot in an EHPAD given that the congregation has partial control over admissions boards. Ultimately, strict and overt secularism is not necessarily the least advantageous situation for a religious congregation.

Conclusion

The history of the twentieth century was marked by the implementation of means to regulate the church/state across the global north and the western world. The authority and spheres of influence of religious institutions were scaled back and limited in the name of citizens' freedom to think and act. As the ability of Catholicism to impact the political evolution of society withered somewhat, it became increasingly restricted to the spiritual realm. From the end of "parish civilization", noted by Gabriel Le Bras …/..

[15]

in 1955–1956, to the observation by Danièle Hervieu-Léger of "crumbling religion" (2001), the place and legitimacy of religious institutions in society has changed. In national contexts such as in Switzerland and France, and despite the differences in their respective secular models, members of the Roman Catholic Church feel they are increasingly part of a minority that is disconnected and resistant; some researchers even talk of a sectification process within Catholicism (Béraud, 2006).

---

[19] Regulation of 4 December 2001 on medical-social facilities for elderly people (REM), Art. 4 . 1 let. h and . 1bis – Art. 11 . 1 and . 2 in which it is stipulated that, for members of religious communities, an agreement with a municipality is not required, such an agreement is mandatory for EMSs in the canton for reasons of financial insurance – Art. 19a on the beneficiaries of public contributions to ancillary costs.

The history of religious congregations – particularly in France following the law on the separation of church and state (1905) – is marked by their increased autonomy and distancing from the state. And yet our findings show another facet of this reality since states and congregations have managed to work together to address new societal needs. Until now, religious communities have been financially independent and quite reticent about the intrusion of civil society into their affairs; recently, they have begun to revalue their contribution to the wealth of states (education, health, social work, etc.) and have convinced themselves that they have a legitimate right to old age security schemes. Within this transformation of practices and institutions, congregations are actively working to formalize the specificity of their establishments in order to conserve a primarily religious or allied population for as long as possible. Alongside this, states are rediscovering the resources of these congregations and are working with them in the public sphere in the field of old age and dependence.

In any case, both in Switzerland and France, dioceses appear to be sufficiently concerned about the future of their elderly priests to not mobilize more around the outcome of religious communities. The latter, primarily female, have been invited to find their own solutions internally. Transforming convents into EMSs and EHPADs is indeed one strategy adopted by different congregations in both countries to ensure a smooth transition from customary tradition towards the professionalization of old age care. It is one way of offsetting the declining community, notably by attempting to formalize know-how that can influence nursing practices. Such changes make it necessary for two different universes to learn to work together – and that requires arrangements and negotiations whose conditions and effects still need to be examined further.

Funding

Research funding provided by the Swiss National Science Foundation. The authors declare they have no conflicting interests.

[17]

References

Amiotte-Suchet L (2010) Les hospitaliers de Lourdes: une communauté événementielle? In: Sainsaulieu I, Salzbrunn M, Amiotte-Suchet L (eds) *Faire communauté en société. La dynamique des appartenances collectives*. Rennes: Presses Universitaires de Rennes, 75–88.

Amiotte-Suchet L (2011) Énoncés de croyance en situation. Réflexion à partir des « croyances » d'un pèlerin de Lourdes. In: Gisel P, Margel S (eds) *Le croire au cœur des sociétés et des cultures. Différences et déplacements*. Turnhout: Brepols, 147–161.

Anchisi A, Debons J (2014) Travailler auprès de personnes âgées dépendantes à domicile et en institution. In:Hummel C, Mallon I, Caradec V (eds) *Vieillesses et vieillissements. Regards sociologiques*. Rennes: Presses Universitaires de Rennes, 373–383.

Anchisi A, Hummel C, Dallera C (2014) Finir sa vie en établissement médico-social: mourir dans un lieu de vie. *Soins Infirmiers* 8: 66–69.

Béraud C (2006) *Le métier de prêtre, approche sociologique*. Paris: Éditions de l'Atelier.

Berger PL (ed.) (1999) *The desecularization of the world. Resurgent religion and world politics*. Michigan: Eerdmans.

Cabirol C (1983) *Vivre : la fin des hospices ?* Toulouse: Privat.

Campiche RJ (2003) La régulation de la religion par l'État et la production du lien social. *Archives de Sciences Sociales des Religions* 121: 5–18.

Campiche RJ (2004) *Les deux visages de la religion. Fascination et désenchantement*. Genève: Labor et Fides.

Caradec V (2012) *Sociologie de la vieillesse et du vieillissement. Domaines et approches*. Paris: Armand Collin.

Cavalli S (2007) Modèle de parcours de vie et individualisation. Un état du débat. *Gérontologie et Société* 123: 55–69.

Davie G (2003). *Europe: The exceptional case. Parameters of faith in the modern world*. Londres: Darton, Longmann & Todd.

Dobbelaere K (2002) *Secularization: An analysis at three levels*. Bruxelles: Peter Lang.

Ennuyer B (2004) *Les malentendus de la dépendance, de l'incapacité au lien social*. Paris: Dunod.

Flannelly KJ, Weaver JW, Larons DB, . (2002) A review of mortality research on clergy and other religious professionals. *Journal of Religion and Health* 41(1): 57–68.

Gagnon E (1995) Autonomie, normes de santé et individualité. In: Côté JF (ed.) *Individualisme et individualité*. Québec: Les Éditions du Septentrion, 165–176.

Goffman E (1968) *Asiles*. Paris: Minuit.

[18]

Hervieu-Léger D (2001) *La religion en miette ou la question des sectes*. Paris: Calmann-Lévy.

Hervieu-Léger D (2003) La religion, mode de croire. *Revue du Mauss* 22(2): 144–158.

Höpflinger F, Bayer-Oglesby L, Zumbrunn A (2011) *La dépendance des personnes âgées et les soins de longue durée. Scénarios actualisés pour la Suisse*. Berne: Hans Huber.

Lalive d'Epinay C, Spini D (2008) *Les années fragiles, la vie au-delà de quatre-vingts ans*. Laval: Presses Universitaires de Laval.

Le Bras G (1955–1956) *Études de sociologique religieuse. Tome I: Sociologie de la pratique religieuse dans les campagnes françaises. Tome II: De la morphologie à la typologie*. Paris: Presses Universitaires de France.

Levilain H (2000) De l'hospice à la prestation spécifique dépendance. *Informations sociales* 82: 96–107.

Luy M (2011) Causes de la différence d'espérance de vie entre les sexes, résultats de l'étude des cloîtres. *Forum Médical Suisse* 11(35): 580–583.

Mayer JF (2012) *Les communautés religieuses dans le canton de Fribourg. Aperçu, évolution, relations et perspectives*. Rapport établi par l'Institut Religioscope sur mandat du Conseil d'État du canton de Fribourg. Disponible sur: www.fr.ch/diaf/files/pdf46/Rapport_Religioscope_F.pdf (consulté le 30 mars 2015).

Office fédéral de la statistique (OFS) (2009) *Parcours de fin de vie en institution. Analyse de la statistique médicale des hôpitaux et de la statistique des institutions médico-sociales*. Neuchâtel: Office fédéral de la statistique.

Ossipow L (2003) La double logique des relations Église/État en Suisse. *Archives de Sciences Sociales des Religions* 121:41–56.

Pinell P (2012) À propos du champ médical : quelques réflexions sur les usages sociologiques du concept de champ. In : Lebaron F, Mauger G (eds) *Lectures de Bourdieu*. Paris : Ellipses, 305–318.

Prévot J (2009) Les résidants des établissements d'hébergement pour personnes âgées en 2007. *Études et résultats*. Numéro 699. Disponible sur : www.drees.sante.gouv.fr/IMG/pdf/er699.pdf (consulté le 30 mars 2015).

Rimbert G (2011) *Vieillards sous bonne garde. Réparer l'irréparable en maison de retraite*. Bellecombe-en-Bauges : Éditions du Croquant.

Stiefel F (2007) *Soins palliatifs : une pratique aux confins de la médecine*. Paris: L'Harmattan.

Tschannen O (1992) *Les théories de la sécularisation*. Genève/Paris: Droz.

Tyas SL, Snowdon DA, Desrosiers MF, . (2007) Healthy ageing in the Nun Study: Definition and neuropathologic correlates. *Age and Ageing* 36(6) : 650–655.

Wilson B (1966) *Religion in secular society: A sociological comment*. Londres : C.A. Watts.