

Remuneration system and effort convention in public hospitals in Algeria: a conventionalist analysis applied to the CHU of Tizi-Ouzou

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Abstract:

Based on the theory of conventions, our article proposes to analyse the discrepancy between formal remuneration systems marked by statutory rigidity and uncertainty about bonuses and the efforts actually made by health professionals. Our approach uses the concepts of qualification convention and effort convention. In order to achieve our objectives, we based our research work on an interpretativist epistemological paradigm, using a qualitative study conducted at the Tizi-Ouzou University Hospital. It highlights the tensions and compromises that structure the regulation of hospital work. The results show that the management of human resources is largely based on informal coordination mechanisms, inviting us to rethink remuneration policies beyond their strictly statutory dimension.

Keywords: convention theory; effort convention; human resource management; remuneration system; Algerian healthcare system.

JEL Classification: B52; J24; I11.

Introduction

Algerian public hospitals face a growing tension between, on the one hand, a remuneration system inherited from the civil service—which is rigid and offers few incentives and, on the other hand, high expectations regarding the quality of care, against a backdrop of demographic pressure and resource constraints (Arhab, 2015). This tension is particularly acute in University Teaching Hospitals (UTHs), where the dual mission of care, training and research increases the workload of medical staff.

The issue of remuneration is a key lever in human resources management. In public hospital organisations, it is of particular importance as it is situated both within a public service framework and against a backdrop of increasing budgetary constraints (Bouadi, 2015). In Algeria, as in many administrative systems, the remuneration of healthcare professionals is largely governed by statutory provisions designed to ensure fairness and career stability.

However, these provisions come up against an organisational reality characterised by complexity, urgency and uncertainty. Hospital work cannot be entirely prescribed or measured. It relies on forms of commitment that often go beyond formal requirements and are difficult for remuneration systems to take into account.

The central question guiding this research is as follows: how do doctors at the Tizi-Ouzou University Hospital interpret and adjust their efforts in the face of the characteristics of a hybrid remuneration system? To answer this, we draw on a theoretical framework that has so far been little used in the analysis of developing health systems: the theory of conventions, developed in France from the 1980s onwards within the field of heterodox economics, by (Dupuy & All, 1989), (Favereau, 1989), (Batifoulier & Larquier, 2001), (Orléan, 2004), and (Boltanski & Thevenot, 1991). The distinctive feature of this approach lies in the fact that it integrates, within an economic framework, contributions from other disciplines such as sociology, psychology and law, whilst challenging theories based solely on contracts (Chaudey, 2014). Contract theory has been of interest to management science since the writings of (Gomez, 1994) and (Gomez, 1996).

The originality of this approach lies in moving beyond a purely contractual view of work – where pay is the direct counterpart of a measurable effort – to focus on effort conventions (Leibenstein, 1987); (Gomez, 1994) – which refer to the reciprocal, implicit and locally constructed expectations between doctors and their superiors regarding what constitutes ‘normal effort’. These conventions are formed within a context of uncertainty where formal rules are incomplete and where actors must interpret signals to coordinate their behaviour.

In line with the work of (Gomez, 1996), this analysis is based on the distinction between **qualification conventions**, which structure remuneration systems, and **effort conventions**, which regulate actual work practices. Drawing on a case study conducted with a sample of doctors from the Tizi-Ouzou University Hospital, the article highlights the tensions between these two registers and the resulting forms of compromise.

The decision to focus this research on doctor's stems from their unique position within the University Hospital. As holders of considerable professional autonomy, they are the actors most likely to develop implicit effort conventions and to adjust them in response to remuneration signals. Their dual clinical and teaching role and even managerial role for department heads, exposes them directly to the tensions generated by the decoupling of effort and remuneration.

In order to define our research problem and focus, we put forward three research propositions:

- the first involves identifying the stakeholders' perceptions of the remuneration system (P1);
- the second aims to identify the effort convention governing the stakeholders' behaviour(P2);
- finally, the third will enable us to deduce the effects of the remuneration system on the formation and stabilisation of the effort convention (P3).

To objectify our research propositions and address our research question, we frame our research within an interpretative epistemological paradigm, whilst adopting a qualitative approach. The article is structured in three parts. The first sets out the theoretical framework of the economics of conventions, distinguishing between the qualification convention and the effort convention. The second describes the remuneration system in Algerian public hospitals based on regulatory texts and existing literature. The third part links the first two through an analysis applied to the Tizi-Ouzou University Hospital and proposes a methodology for data collection via interviews.

1- The theory of conventions: qualification convention and effort convention

1-1- Foundations of convention economics

Convention economics (CE) emerged in France at the end of the 1980s as a critique of neoclassical and contractualist approaches (Dupuy & All, 1989); (Orléan, 2004). Its central premise is that coordination between economic agents cannot be based solely on explicit contracts or individual calculations, as these are always incomplete and subject to radical uncertainty (Favereau, 1989); (Simon, 1947 [1997]) points out that employment contracts, for example, never specify all the tasks to be performed or the precise level of effort expected. There is therefore a zone of indeterminacy that the players have to fill in by other means.

A convention is defined as a collective cognitive device, a set of shared implicit rules, which enables players to resolve situations of uncertainty without having to recalculate everything each time (Favereau, 1989). It fulfils three main functions: it reduces uncertainty by providing a common framework for interpretation; it guides behaviour by designating what is "normal" to do; and it is reproduced by the shared conviction that it will be adopted across the board. In other words, a convention exists because everyone believes that others will conform to it, and this belief is self-fulfilling (Orléan, 2004).

1-2- The qualification convention

The qualification convention, developed by (Eymard-Duvernay, 1989), concerns the collective convention on the quality of a good or service. Eymard-Duvernay distinguishes between several models of quality, which he calls "worlds". The merchant world evaluates quality through price and the comparison of offers on the market. The industrial world defines quality in terms of technical norms, standards and verifiable procedures. The domestic world bases quality on trust, reputation, seniority and personal relationships. (Boltanski & Thevenot, 1991) have extended this typology by adding the civic, inspired and opinion worlds.

The qualification convention refers to the socially established criteria used to assess an individual's value in the workplace. It is based on objective factors such as qualifications, status, seniority or membership of a professional body.

In the hospital civil service, this convention is highly institutionalised. It structures careers, organises hierarchies and serves as the basis for remuneration systems. It is based on a logic of formal equity: equal

qualifications mean equal pay. This approach has advantages in terms of transparency and stability. It limits discrimination and guarantees a degree of consistency in human resources management.

1-3- The effort convention

The effort convention, a concept introduced by (Leibenstein, 1987) and taken up in management sciences by (Gomez, 1994); (Gomez, 1996), is at the heart of the analysis of the employment relationship. (Leibenstein, 1987, p. 103) defines the effort convention as "a set of reciprocal expectations between employer and employee concerning the level of effort to be made, expectations which are neither contractualised nor directly observable". For (Gomez, 1994), an effort convention can be modelled as an information system which sends signals to the actors involved.

The structure of an effort convention comprises two main components. Firstly, the statement, which includes the overarching principle (the value justifying the effort, for example 'putting the patient first'), the distinction (the implicit hierarchy of efforts according to departments, ranks or situations), and the sanction (what happens when the norm is not respected: social censure, exclusion, loss of trust). Secondly, the material framework, which includes contacts (the frequency and nature of interactions between doctors, with the hierarchy, and with the administration), technology (management tools, attendance records, information systems), and the scope for negotiation (individual leeway to discuss one's workload, on-call duties, and bonuses).

An effort convention is all the more robust when it is consistent – that is, when its various signals do not contradict one another – and when it is shared by a sufficient number of parties to the convention. When contradictory signals emerge (for example, management claims to want to reward effort but bonuses are paid months late), the convention enters a crisis and may be replaced by another, sometimes less virtuous one.

The coexistence of these two conventions creates a structural tension. On the one hand, remuneration is based on stabilised and formalised criteria; on the other, real effort depends on dynamics that are situated and often invisible. This tension lies at the heart of the issues of motivation, recognition and organisational justice. It is particularly marked in public services, where there is little room for manoeuvre in terms of remuneration.

To conclude this first part, the conventional framework offers tools for analysing how doctors interpret their remuneration and adjust their efforts, not in a contractual vacuum, but in a universe of implicit expectations, local

standards and informal arrangements. This enables us to move away from a binary logic of "salary, effort" and towards a logic of interpretation and local coordination.

2- The remuneration system in Algerian public hospitals

2-1- The status of the hospital civil service

Medical staff in Algerian public hospitals are subject to the general civil service regulations, supplemented by specific provisions for healthcare staff (Executive Decree No. 07-304 of 25 September 2007). These regulations were designed in the 1970s and 1980s to stabilise a skilled workforce and guarantee equal treatment for all civil servants. Remuneration is dominated by a fixed component: an indexed salary calculated on the basis of grade (hospital practitioner, hospital lecturer, professor, etc.), step and seniority. This vertical career system provides doctors with a degree of security, but there is no direct link with individual or collective performance, or with actual workload.

2-2- Bonuses and allowances

In addition to the fixed portion, there are bonuses and allowances, which vary depending on the department and the situation. (Melbouci, Chemoukha, Saifa, Souki, & Boughanem, 2015) and (Ayyad, 2010) propose a typology. The special hardship allowance is paid to "hard" departments (emergency, intensive care, operating theatres) to compensate for time constraints and arduous work. The medical responsibility bonus is paid to heads of department and heads of unit. On-call allowances (for nights, weekends and public holidays) are the main source of variation in monthly pay. Finally, there are various technical bonuses for imaging, laboratories and training activities.

Despite precise regulations, many studies point to discrepancies between the texts and reality. (Boughenem & Souki, 2016) show that there are frequent delays in bonus payments, that some payments are simply omitted for several months, and that there is considerable heterogeneity between establishments and departments. This uncertainty about actual remuneration - we never really know whether the announced bonus will be paid, or when - is a key factor in understanding the formation of local effort conventions.

2-3- Perceived effects on medical behaviour

The few available studies suggest several effects of this system on medical behaviour. (Malek, Ghomari, & Bouzida, 2019), found that the variable portion had little incentive power, being considered too modest or too random to change behaviour. There is a widespread feeling of inequity between departments (for example, emergency physicians feel that they are paid less than radiologists or

anaesthetists, even though they have a heavier workload). In response to these tensions, informal arrangements are being developed: unofficial sharing of on-call bonuses between colleagues in the same department, multiple self-employment (authorised under certain conditions, but which diverts some of doctors' energy), and on-call duty 'arranged' between friends to share out difficult nights.

(Ayyad, 2010) highlights a constant tension between statutory logic (equal treatment for all, regardless of department) and managerial logic (recognition of performance and the arduous nature of the work). This tension is never resolved; it is simply managed locally, department by department, or even team by team. It is precisely within this sphere of local management that conventions on effort are forged.

In conclusion to this second part, the Algerian hospital remuneration system is rigid, offers little differentiation and is a source of uncertainty regarding the link between perceived effort and remuneration received. This context is particularly conducive to the emergence of local, implicit effort conventions that vary according to department. The Tizi-Ouzou University Hospital, with its specific characteristics, provides a prime field of observation.

3- Methodological framework of the research

In order to address our research question and successfully carry out this research project, the methodological framework is grounded in an interpretivist epistemological paradigm, which posits that knowledge arises from lived experience and implies that the construction of knowledge regarding a given situation aims first and foremost to understand the interpretation that the actors give to it (Gavard-Perret & All, 2008). We will apply this paradigm to the case study of the Tizi-Ouzou University Hospital.

3-1- Research strategy: a single case study

The choice of a single-case study research strategy to analyse the relationship between the remuneration system and the 'effort convention' at the Tizi-Ouzou University Hospital is not insignificant. It stems from an in-depth epistemological and methodological reflection that falls within an interpretative paradigm (Gavard-Perret & All, 2008). This choice is justified by the very nature of our subject: the 'effort convention' is a social, local and implicit construct that cannot be reduced to quantitative measures or objective indicators. Convention theory (Gomez, 1994); (Boltanski & Thevenot, 1991); (Favereau, 1989) invites us to understand how individuals coordinate their actions on the basis of shared implicit rules. The interpretative approach is therefore best suited to account for this process of meaning-making.

In our research, we chose to focus on the Neddir Mohamed University Hospital (CHU) in Tizi Ouzou (Algeria), which is regarded as a leading institution.

This choice is justified by its regional importance within the healthcare system and the diversity of its departments (A&E, surgery, medicine, paediatrics, obstetrics, cardiology), which allows for internal comparisons. We can thus examine how the convention on workload varies according to technical and organisational constraints. The Tizi-Ouzou University Hospital experiences recurring tensions related to the remuneration of on-call duties and bonuses (Arhab & Tessa , 2025).

3-2- The semi-structured interview: a data collection tool

Our work is based on a qualitative study using semi-structured interviews with a purposive sample (Thiétart, 2014) of doctors at the University Hospital. We developed an interview guide structured around three main themes. The aim is to understand how doctors perceive their remuneration, what they define as a normal workload, and how these two factors interplay in their daily practice.

The first section of our interview guide focused on perceptions of the remuneration policy. This part of the guide aims to capture doctors' perceptions of their pay system, its rules, its fairness and its effects. This section aims to understand how doctors perceive their remuneration, what its actual components are (beyond the written rules), and what feelings of fairness or unfairness arise from this.

The second focus seeks to reveal the implicit content of the effort convention: what is expected, what is valued, and what is penalised. The aim is to identify the implicit rule, shared amongst peers, which defines what constitutes a 'normal', 'sufficient' or 'excessive' level of effort within the department.

Finally, the third strand examines the relationship between remuneration and the effort convention; the aim is to understand how doctors link (or do not link) their level of effort to their remuneration, and how other factors come into play.

3-3- Composition of the sample

In constructing our sample, we chose to interview a specific category of hospital staff: the medical profession. We used purposive sampling (or selective sampling). The inclusion criteria were: being a practising doctor at the University Hospital, having at least two years' seniority at the institution, and belonging to one of the three target departments (internal medicine, A&E, cardiology). Three strata were formed:

Table number (01): composition of the sample

Code	Grade / position	Department	Seniority	Type
E1a	Specialist practitioner, assistant professor	Internal medicine	11 years	M
E1b	Specialist practitioner, assistant	Internal medicine	10 years	W
E2a	General practitioner	Emergency	6 years	W
E2b	General practitioner	Emergency	5 years	M
E3a	Associate Professor, Head of Department	Cardiology	24 years	M
E3b	Associate Professor, Head of Department	Anaesthesia/intensive care	19 years	M

Source : Own production

In total, six doctors were interviewed (two per stratum). This modest sample size is consistent with the concept of theoretical saturation in interpretative qualitative analysis: the interviews revealed a rapid recurrence of the main themes. First names and any directly identifying information have been altered.

4- Analysis and discussion of the results

After conducting our interviews with the doctors in question, we proceeded to transcribe the speeches rigorously. In order to analyse the data collected, we devised an analysis grid based on the three axes of our interview guide and our research proposals. The data collected was analysed using the thematic content analysis method via simple coding.

The table below presents the results of the thematic analysis based on the semi-structured interviews conducted with doctors at TIZI OUZOU University Hospital. The data are organised.

Table number (02): Cross-sectional thematic analysis of interviews

Proposal	Central theme	Key result	Illustrative verbatim
P1: Perception of the remuneration system	Inadequacy quantitative	Perceived pay is lower than the effort put in. Public/private differential of 1 to 3	"Doing a shift from 16h for 3 400 DA... ". (E2a, E2b)
	Structural unfairness	Seniority = only criterion. Difficulty, speciality, role not differentiated	"The word 'performance' in its title is an administrative lie." (E3a, E3b)
	Institutional incoherence	Chronic delays. Covid bonuses not paid Institutional distrust	"When you're told 'your dedication will be rewarded' and it doesn't

			translate into action...". (E2a, E2b)
P2: Effort convention	Implicit minimum standard	Unwritten, transmitted by socialisation. Varies: emergency flow vs. presence	"Nobody sets you a target figure. It's an unwritten social norm". (E1a, E1b)
	Invisible work outside the job description	4 categories: management, logistics, family mediation, conflict management	"I play an asset management role that I wasn't trained to do" (E3a, E3b). (E3a, E3b)
	Regulation by peers	Reputation, social ostracism. Independent of the formal remuneration system	"Leaving at 8.01am when the relief team hasn't been briefed: that's a moral fault. (E2a, E2b)
P3: Effects on the convention	Strategic withdrawal	Reduction on margins (committees, supervision, publications), never on direct care	"People who used to give 120% have come to give 80%: the bare minimum. (E3a, E3b)
	Compensatory moral economy (informal arrangements)	Exchanges of on-call duty, flexible working hours, discreet resources head of department	"You don't say it, but everyone knows it. It's a parallel moral economy." (E1a, E1b)
	Structural fragility	Medical exodus. Loss of skills. Reproduction crisis of the convention	"It's a question of institutional survival, not just individual equity". (E3a, E3b)

Source: Own calculations based on analysis of results

4-1 Perception of the remuneration system

The first research proposal aims to document how stakeholders perceive and interpret the current remuneration system. The thematic analysis reveals three distinct but converging areas of perception: quantitative inadequacy, structural unfairness and institutional incoherence.

4-1-1- Remuneration perceived as quantitatively inadequate

All the interviewees, regardless of grade or seniority, expressed a shared feeling of inadequacy between the amount of remuneration received and the volume, intensity and responsibility of the work performed. Specialist practitioners (E1a/E1b) see this inadequacy in comparison with the local private sector, where the same skills are paid two to three times more. The heads of department (E3a/E3b) qualified their personal observation by

referring to the public-private combination, but confirmed that public remuneration alone does not reflect the value contributed to the institution.

4-1-2- A pay structure perceived as structurally unfair

Beyond the absolute level of remuneration, the players are developing a structural criticism of the principles of differentiation that govern the pay scale. The unanimity is striking: the seniority criterion, the only effective determinant of salary progression, is seen as fundamentally unsuited to the reality of medical work. This criticism is particularly strong among those working in emergency departments, who experience the anomaly of being paid the same as colleagues working in scheduled services. The performance-related bonus, although described as a performance incentive, is universally perceived as having no link whatsoever with actual performance. E3a/E3b produce a particularly striking formulation of this: *"It's not a motivational lever; it's become a sort of tacit salary top-up that nobody links to performance. The word 'performance' in its title is an administrative lie"*. (Interviews E3a/E3b).

4-1-3- Perceived inconsistency between legislation and payment practices

A third area of perception, systematically present in all six interviews, concerns the discrepancies between the institution's formal commitments and their concrete translation into payment practices. This gives rise to a feeling of institutional mistrust which, in conventional terms, can be described as a crisis in the legitimacy of the wage convention. The Covid-19 crisis is a particularly revealing example of this fracture: *"There had been official announcements of exceptional bonuses for front-line healthcare staff. In reality, these bonuses arrived very partially, very late, and not for everyone. [...] When you're told 'your dedication will be rewarded' and that doesn't translate into action, confidence in the system is seriously eroded"*. (Interviews E3a/E2b).

4-2- Identifying the effort convention

The second research proposal aims to identify the convention of effort that governs the behaviour of doctors at the CHU, i.e. the set of shared, implicit and historically constructed representations that define what it means to "work well" in this context. The analysis reveals a convention that is robust in its moral foundations, differentiated in its practical applications depending on the department, and regulated by an informal system of sanctions and recognition.

4-2-1- The content of the effort convention: an implicit and plural norm

The effort convention at the CHU is entirely implicit: no regulatory text defines it. Its substance is transmitted through professional socialisation and regulated by the judgement of peers. It comprises a minimum level (what you have to do to avoid being looked down upon) and a level of excellence that is recognised but not formally required. In scheduled services, the minimum standard revolves around presence, availability and the assurance of on-call duty: *"A doctor who 'does enough' is one who is present on time, who does not miss consultations, who does not refuse on-call duty when it is assigned to him or her, and who provides the minimum follow-up for hospitalised patients. But it's all implicit. Nobody sets you a target figure in terms of patient numbers"*. (Interviews E1a/E1b).

In emergency departments, the convention is reactive and collective rather than individual and programmed. The norm is one of flow and team solidarity: *"A doctor 'does enough' when no patient is left waiting for too long without being seen, when critical cases are dealt with immediately. It's a collective result standard, not an individual one"*. (Interviews E2a/E2b).

At department head level, the convention includes a scientific and educational dimension, the absence of which constitutes a moral failing in the eyes of peers, even if it is never formally sanctioned.

4-2-2- Invisible work: the gap between prescribed convention and actual convention

A central contribution of the analysis is the evidence of a systematic gap between the prescribed tasks and the tasks actually performed. All of the interviewees abundantly described tasks not included in their job description, which can be grouped into four categories: informal supervision of residents, management of logistical malfunctions, mediation with families, and regulation of internal conflicts. *"Managing medication stock-outs - I sometimes have to call colleagues in other departments to borrow products, bypassing the official channels. And then relations with families [...] All this is invisible in my job description"*. (Interviews E1a/E1b).

"When an echocardiograph breaks down, I'm the one who calls the suppliers again, who contacts the technical department and finds workarounds. I play the role of asset manager, which I wasn't trained to do". (Interviews E3a/E3b).

This invisible work forms the unrecognised basis of the effort convention: it reveals that the players make a massive commitment that goes beyond their formal obligations, and that this excess commitment is the condition for the institution to really function.

4-2-3- Regulatory mechanisms: professional reputation and peer judgement

The effort convention is regulated not by formal administrative mechanisms but by a system of informal sanctions and rewards based on the judgement of peers. The figure of the doctor who fails to pass on information correctly at the end of a shift is the most clearly identified moral failing in emergency medicine. Conversely, the register of positive rewards is dominated by relational and clinical qualities, availability, handling of difficult cases, solidarity, and by scientific reputation for higher hierarchical levels. This dual system of sanctions and recognition constitutes the internal mechanics of the effort convention, which is structurally independent of the formal remuneration system.

4-2-4- The motivational hierarchy: transversal convergence

When asked about the drivers of daily effort, the six interviewees produced a convergent motivational hierarchy. In first place: vocation and moral duty towards the patient, common to all grades. Second: peer recognition and professional reputation. Third: fear of legal sanctions (medical legal liability). Salary systematically comes last.

4-3- The effects of the remuneration system on the effort convention

The third research proposal aims to analyse how the hybrid remuneration system affects the formation and stabilisation of the effort convention. The analysis reveals four main effects: the decoupling of effort and remuneration, the strategic withdrawal from margins, the emergence of a compensatory moral economy, and the structural weakening caused by the threat of exodus.

4-3-1- The decoupling of effort and remuneration: a structurally absent link

None of the interviewees reported modulating their immediate clinical effort according to their remuneration. On the other hand, all of them reported significant indirect effects: financial anxiety affecting mental availability, multiple activities reducing effective presence at the CHU, and calculations of retraining or emigration. The decoupling is thus indirect but real: *"The combination of activities, which is in reality a response to low salaries, ends up affecting the quality of presence at the university hospital. It's an indirect consequence that the system doesn't measure"*. (Interviews E2a/E2b).

This decoupling produces a paradoxical situation: the system does not reduce clinical effort (protected by vocation), but contributes to the gradual

erosion of institutional effort; participation in committees, scientific activity, voluntary supervision.

4-3-2- Strategic withdrawal: a rational response to the breach of the implicit contract

The analysis highlights a behavioural response mechanism known as strategic withdrawal, consisting of a selective reduction in effort, focusing not on clinical activities but on peripheral, institutional and educational tasks. This withdrawal is triggered by perceived breakdowns in reciprocity: *"I said to myself: if the system doesn't respect the commitments it makes, why should I commit myself beyond what is strictly necessary? It's a question of reciprocity. When one of the parties to the exchange doesn't meet its end, the other party adjusts"*. (Interviews E2a/E2b).

This mechanism is directly in line with the theory of conventions: when the wage convention no longer satisfies the condition of legitimacy, the effort convention contracts in response, without this contraction being formally visible or sanctionable.

4-3-3- The compensatory moral economy: informal arrangements as endogenous regulation

Faced with the inadequacies of formal remuneration, the players develop a system of informal arrangements that constitute a genuine substitute moral economy. On a horizontal level, the arrangements concern exchanges of shifts and moral support. At a vertical level, the head of department consciously mobilises discretionary resources as compensation mechanisms, *"There are exchanges of shifts [...] And then there are tolerances: a head of department who turns a blind eye if a practitioner arrives 20 minutes late on certain days because he knows that the practitioner stayed until 10pm the day before. You don't say it, but everyone knows it. It's a parallel moral economy"*. (Interviews E1a/E1b).

"I favour practitioners who invest themselves - I recommend them for training courses abroad, I cite them as co-authors on publications, I give them a certain amount of flexibility with regard to working hours when their investment merits it. These are small discretionary powers on the part of the head of department, which play a crucial role in the balance of the team". (Interviews E3a/E3b).

This compensatory moral economy fulfils a major functional role: it enables the effort convention to be maintained despite the inadequacies of the formal pay convention. It constitutes a robustness mechanism for the convention, an endogenous regulation that absorbs the tensions that the formal system cannot resolve.

4-3-4- The threat of the exodus: structurally weakening the convention

The fourth effect is the most systemically worrying: the remuneration system generates migratory pressure that threatens the reproduction of the effort convention itself. The desire to emigrate is explicit in E2a/E2b; the loss of younger generations is documented by E3a/E3b: *"I took the French equivalence exam two years ago. I'm still waiting to hear back from the university hospital in France. If my salary tripled here tomorrow, I'd withdraw my application. It's not a betrayal, it's a rational calculation"*. (Interviews E2a/E2b).

This dynamic reveals a critical property of the system: the effort convention is based on players who have chosen to stay, motivated by their vocation and territorial attachment. These non-economic motivations function as positive externalities from which the institution benefits without remunerating them. The risk is that these key players, the bearers of the convention, will gradually disappear, taking the effort convention itself with them.

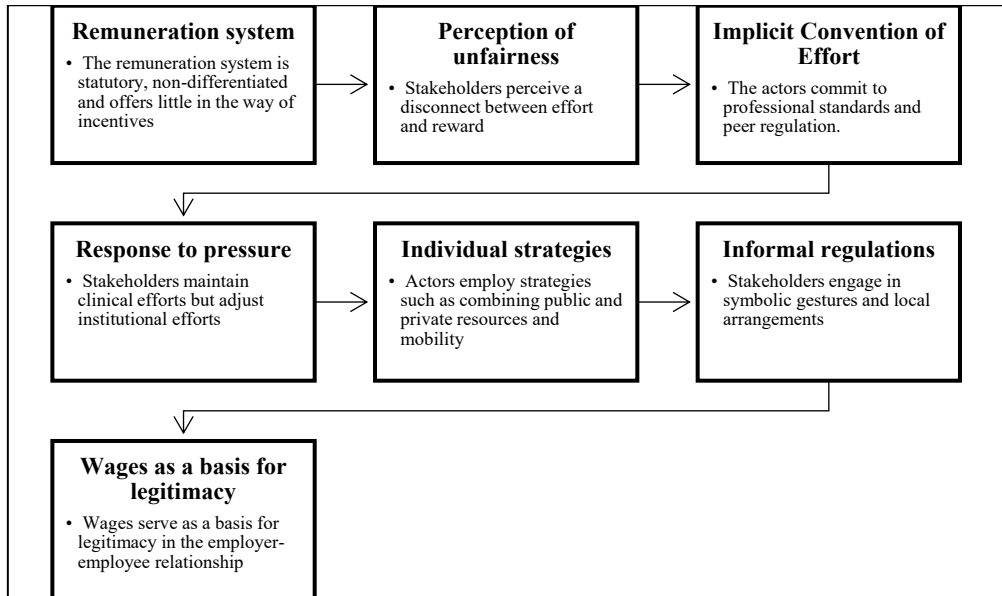
4-4- Analytical summary: the effort convention as an area of institutional resistance

The empirical analysis allows us to formulate a summary proposal: in a context where the formal wage convention is perceived as illegitimate by the players, the effort convention functions as an area of institutional resistance, a mechanism by which the players maintain the operation of the hospital beyond what the formal incentives would rationally justify.

This resistance is based on three pillars: the medical vocation (normative commitment), the judgement of peers (horizontal regulation), and the compensatory moral economy (informal vertical regulation). Together, these three pillars constitute what we propose to call the residual effort convention, a convention that persists despite the deterioration of the wage convention, but whose robustness is conditional and declining.

This result enriches the framework of the economics of conventions by showing that the effort convention can function largely independently of the wage convention, provided that alternative forms of recognition - symbolic, peer, institutional - fill in the gaps. It confirms and extends the work of Favereau (1993) on the plurality of forms of coordination in the organisation. Figure 01 summarises our results.

Figure number (01): Remuneration system and effort convention within the Tizi-Ouzou University Hospital



Source: Author's own work based on the analysis of the survey results

Conclusion

This empirical study, based on a thematic analysis of six semi-structured interviews with doctors at the Nedir Mohamed University Hospital in Tizi-Ouzou, provides a substantial response to the central research question: how do doctors interpret and adjust their work effort in the light of the characteristics of a hybrid remuneration system? The results of our survey have enabled us to objectify our three research proposals.

The results show that doctors perceive this system as quantitatively insufficient, structurally unfair and institutionally incoherent. Faced with this perception, they do not reduce their clinical effort, their vocation constituting a strong protection against disengagement from patients, but they gradually reduce their institutional effort, resorting to multiple activities as a compensatory strategy, and, for some, envisage emigration as a rational outcome.

The convention of effort that governs their behaviour is implicit, differentiated according to department, regulated by the judgement of peers, and maintained by an informal moral economy of which the head of department is the principal architect. It functions as a space for institutional resistance, enabling the hospital to function beyond what formal incentives

would justify, but at the cost of increasing fragility among the players who are its guarantors.

The challenge for the Algerian public hospital system is twofold: to reform the wage convention so that it regains legitimacy in the eyes of the players, and to give institutional recognition to the informal effort convention so as to ensure its durability. Without this two-pronged reform, the risk is of a slow but irreversible erosion in the quality of care, not through the ill will of doctors, but through the gradual exhaustion of an effort convention that the formal system no longer supports.

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