

AN ECONOMIC ANALYSE OF THE HEALTH AND SOCIAL SECTOR RECASTING IN FRANCE AND ROMANIA

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Abstract

Many reforms are based on the recasting of health and social sector in France and Romania. The two countries do not have the same needs but what they have in common is the need to transform the role of the state. The economic analyse of law allows us to offer an interpretation of these transformations. First of all, this article shows that the two states seek the regulation mode best adapted to their health and welfare system but they rather turn to a subsidised and territorialized regulation. It then shows that in order to ensure public services of general interest in the field, they are interested in using arranged lump sum contracts.

Keywords: Health and social system, Economics of law, Lump sum contract.

1. INTRODUCTION

The economic and institutional conditions are based on a recast of the numerous reforms of the health and social sector in France and in Romania even though the needs are not the same. Many people in difficulty are left out by the Romanian welfare system and poverty traps are more numerous. Despite significant progresses in the last years, health expenditures increased from 90 to 200 Euros per capita.

With health expenditures which are situated around 3 or 4% of the GDP, Romania is located in back of the pack of European countries and far behind France with 12.1% of GDP. On the contrary, the two countries are actually subject to the same injunctions for reform from Europe in terms of social cohesion and risk reduction. They especially have in common the need for changing the role of the state.

Romania, as a country in transition, discovers the freedom, but is no longer able to guarantee the principle of equal access to treatment and certain social benefits as the case has been before. After more than 20 years of revolution, now it must pose itself the question of health and social system. The health system which is regulated by the Law of 2006 is much more advanced than the sector of social assistance. But in the two sectors, several reforms are provided given that the country is still in the phase of problems analysis and research of best practices. As for France, the many reforms are intended to accompany the reform of the welfare state.

Both countries must increasingly deal with an administration and democratisation imperative (P. Duez 2008). In the current context of financial sustainability the administration imperative is translated by the obsession for maintaining the budgetary balance. It places on the second plan the problem of social sustainability of a society that excludes more and more elderly or unemployed people. As for the democratization imperative, this is translated by the obsession of public services quality and of risk reduction. These two constraints will apply to both countries within public-private partnerships in favour of social economy development.

On the contrary, France is much more advanced in legal matters. The regulation in the health and social sector has significantly evolved since the early 2000s even though the process of reform of this sector is older (J. F Bauduret et M. Jaeger 2005). The law of June 30, 1975 on social and medical-social institutions is an important step in the reform of the sector. It allows raising questions that are important for the two countries and which are still current. They are especially the following: the budget issue of the opposability of financial allocations, the issue of decentralization, the issue of evaluation. The law of 2002 renewing social and medical-social action, the law of 2005 on equal opportunities, as well as the law of 2009 on hospital will return following the meticulous work initiated by the Law of 1975. Subsequently, we will leave the French case, referring to the similarities existent in the directions taken by Romania. We especially want to propose a normative analysis of different solutions that are offered to the two countries in terms of sector recasting.

The economic analysis of law allows us to offer an interpretation of this radical recasting (T. Kirat, F. Marty 2007). We can first use the economics of regulation to show that both countries want to evolve towards an increasingly subsidised and territorialized regulation (1st part). The state is withdrawing but

this does not mean it renounced to manifesting certain tutelary desires to guarantee the mission of the public service. Therefore, reference must be made to the economics of administrative contracts for understanding the nature of desires and the interest and desirability for both countries to use these lump sum contracts developed in the health and social sector (2nd part).

2. TOWARDS A SUBSIDISED AND TERRITORIALIZED REGULATION

The regulation policies developed by the state in the health and social sector have as a starting point the improvement of the control of public action in a context of financial crisis and of company transfers crisis (D. Olivennes 1992). The state initially hesitated between different types of regulation before choosing a territorialised conventional regulation.

2.1. The Problem of Public Action Control

The agency theory allows presenting the problem in a simple manner (H. Gintis 1992). The regulation of a property or a public service connects three agents in the health and social sector.

The following diagram (Fig. 1) summarizes the argument:

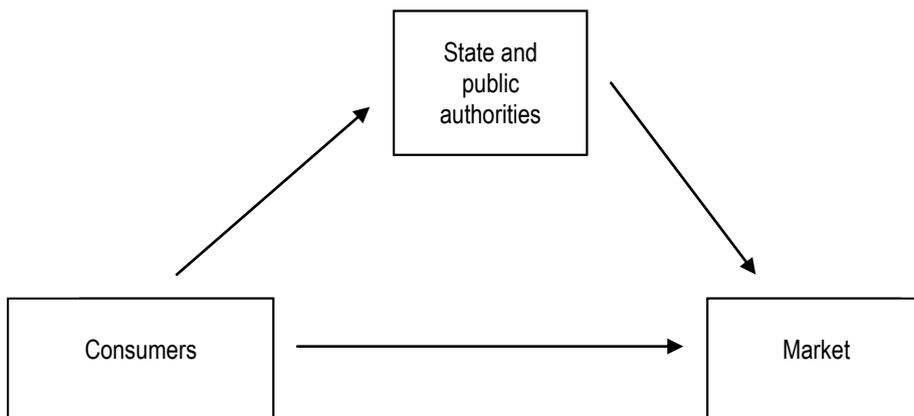


FIGURE1 - THE RELATION OF AGENTS IN THE HEALTH AND SOCIAL SECTOR

In a market economy, the state does not intervene in a relation between consumers and the market except for the case in which it is faulty. Consumers or users for public services of the health and social system are therefore the principals and the state is the representative acting on their behalf. In the health and social sector the market is faulty because it is in the presence of externalities and information asymmetries.

Facilities such as hospitals or foster homes for young or elderly people are club goods (J. Buchanan 1965). This means that there are negative externalities since the service quality offered decreases as club's size increases and that club's size is necessarily limited. The services offered are relational (Uhlener C 1989, Gui B 1996). Above all, people with difficulties require that we take care of them and that we create the link and possibly to establish an emotional relationship. This relationship is often a service that joins a technical intervention as a treatment. This implies the presence of a heterogeneous demand on which it is difficult to make scale economies. This implies the existence of many situations of asymmetric information. Here are two examples. Hospitals may encourage a patient to occupy a bed for one more day for health reasons while the aimed objective is purely budgetary. This is to rationalise the administration of bed occupancy. We are speaking about adverse selection. A facility for dependent elderly people may announce a canteen service at a reduced price and may increase its tariffs as soon as the person is installed. We are speaking about moral hazard.

Overall, the intervention of a private structure maximizing its profit is not possible either because the service is not rentable or because the characteristics of the demand are incompatible with this objective. Therefore, this justifies the intervention of the state but the state will not manage the service by itself because it is also faulty. In other words, it is a good guarantee but a bad manager (G. Sorman 1984).

It has a real tendency to maximize its political support. It is therefore able to implement the measures preferred by its electorate or to be under its pressure. If it moves away from the general interest, then it must wait for the end of the mandate to highlight its discontent by voting. He is wasteful to the extent that taxpayers are victims of fiscal illusion. That is, they do not perceive that the increase of public expenses must be financed by borrowing. This encourages more the state to please its electors and empty the Houses for reporting the burden of debt on the next mandate. If economic agents are less and less victims of this illusion or if management imperative was adopted because there is a refusal to finance the social effort, it will be more and more difficult to ensure access public services of general interest for the entire territory. It is bureaucratic and its time response to consumers' demand is long because of its organization. Moreover, in the health and social sector the anonymous nature of solidarity which the state implements can be evoked. We are in an external social sector compared to the internal sector. (M. Serva 1999). In the social and medical-social sector, we speak of rights holders and the files are firstly treated. The report established with the patient or victim of social exclusion is therefore objective and impersonal. We find the idea according to which, in the bureaucracy, the rule protects and creates apathy. This element is stronger in a country in transition which inherits even a stronger bureaucratic culture.

However, the Romanian and the French state hesitated between different modes of regulation before permanently favouring a conventional and territorialised regulation.

2.2 The hesitation between different modes of regulation

In the health and social sector the state will intervene to judge certain conflicts but mainly to try producing new standards (C. Du Tertre 1999). In this issue, the state can choose between four modes of regulation. The tutelary regulation that developed the welfare state or the collectivist state is seeking equality for the access to the minimum public service. The state can continue producing these services by itself or to ensure their strict control. If it delegates the service, it will perform an extremely severe control of action and professionalization. The objective is to guarantee certain equity in the access to different services. The increase in demand and the pressure exerted by budget constraints will determine the French state to propose, in the 1980s, a competitive deregulation where there is the logic of market economy dominates. Romania will be tempted much too late by this perspective especially in the sectors where everything is financed by the state. The state will then reduce its financial commitments by transforming beneficiaries in employers (the case of cheque employment services in France). It will encourage beneficiaries to do so by giving them tax credits.

In the 1990s, two new positions will oppose: one who defends the idea of a subsidized market regulation, the other supports the idea of a subsidised and territorialized regulation. The first type of regulation, which is defended by the syndicate of French business leaders, aims the permanent elimination of the tutelary character of the regulation because it impedes sector's development. On the other hand, it will encourage the user to address the sector companies instead of being itself an employer. In order to achieve this, the state should make the demand solvent and introduce a reduced VAT. The second type of regulation is intended to find an intermediary regulation between the competitive and the tutelary regulation. This mechanism is based on the generalisation of the job title service on mutualisation funds at the level of a specific territory on territorial administration of agreement to favour the partnerships that will meet the criteria of service quality and equity.

2.3 The Choice of a Subsidised and territorialized Regulation

The French state finished by choosing the subsidised and territorialized regulation because it allows it to deal with market failures and its own failures. The state is actually searching for a local governance of problems from the health and social system (P. Duez 2008).

The state territorializes its policy to the extent that it turned more and more to local authorities although it remains the financer of the service. The same phenomenon is found in Romania. This reduces the

bureaucratic nature of public policy because communities are closer to the population. However, the risk of fiscal illusion remains present. Although it is no longer the sole financier of the service, it also decreases the risk of fiscal illusion, since the links between the expenditures performed and the increase of taxes are more visible. There is actually a better internalisation of collective costs. Finally, they are not necessarily less sensitive to the maximisation of their political support since it remains the temptation to use public services as a propaganda tool or to facilitate its local electorate by hiring for example.

It territorializes its policy to the extent that it turns more and more to private structures and especially to structures within the social economy. The structures that deal with the health and social system are actually numerous (nearly 30 000 institutions). Certain structures have maintained their character of public institution such as hospitals, but in most cases, health and social system management is ensured by associations that eventually received a delegation of public service in particular in the field of personal services. The law of 2002 nominatively mentions the associations for evoking the health and social sector institutions. In this sector, local initiatives are numerous and are the result of an institutional creation movement that meets most often the needs which the state refuses to take in charge (J.L Laville 1992). It created the need to develop a social entrepreneurship which in France the law of July 2, 2010 entrusts rather oddly to the Chambers of Commerce, probably because this sector generates many workplaces while at least in what concerns the social entrepreneurship purpose, it cannot be qualified as commercial. This is especially true for all human services. Romania is committed to this process of local initiatives but it still remains too focused on state intervention.

The theory of clubs of J. Buchanan (1965) allows a better understanding of the difficulties for this type of service. In a club, the optimal size must be determined, knowing that as the number of members increases, the budget balance may be maintained within a given structure. On the contrary, service quality will be reduced by reason of the presence of negative externalities since the time we can devote to each member will decrease. The structures of the health and social sector are actually constantly torn between the two constraints. In this regard, we can speak about squaring the circle even though they reach that point better than the state or the market. Using this type of structure we reach what the Anglo-Saxons called a "quasi-market" (Le Grand 1992, Hugues et alii 1997) or a welfare market (B. Enjolras 1995 b). The works on non-profit organizations are very numerous in the 90s (B. Enjolras 1993 a et 1995 a, E. Archambault 1996, S. Mertens 1999, M. Nyssens 2000). A research program was dedicated to them by John Hopkins University (Anheier H.K et Seibel W 1990, Anheier H.K et Salomon L.M 1996). These works allow justifying the institutional choice that has been done to support the disengagement of the state.

The theory of conventions places its reasoning under the logic or the superior principle that organises the decisions of the agents performing the public service mission. It teaches us that associations can organize a compromise between two types of institutional logics: the commercial logic of the budget constraint and non-commercial logic that requires quality because it relies on civic or charitable motivations (B. Enjolras 1993 b). More specifically, we can say that associations loosen the budget constraint because they have an ability to get donations in cash or in kind that can be measured in full-time equivalent. They determine the occurrence of an internal social sector because they place easier the patient or the victims of social exclusion in the centre of their preoccupation. The relation becomes more interpersonal and subjective as they are less affected by the problems of bureaucracy or the requirements of the economic imperative in terms of efficiency and profitability.

The choice of a subsidized regulation can be explained by networking. All funding is subject to a networking between private structures performed by local authorities. This helps to respond to very heterogeneous requests by placing into the network all actors from a field. This allows maintaining spatial equity in the access to public services. The incentives that must be constituted in the network are very numerous in different texts.

The choice of a subsidized regulation is also explained by the failure of NPOs (Anheier H.K et Salomon L.M 1996). NPOs are primarily victims of a philanthropic particularism. They are able to respond to a heterogeneous request because they manage to mobilize activists prepared to defend a cause but in return they move away from the defence of general interest. The state which is normally the guarantee of this interest will then want to control the activity of health and social sector structures. Subsequently, they are victims of a philanthropic amateurism. The associations dispose of many volunteers prepared to invest but who have neither the time nor the expertise to ensure the quality of the service offered. On this point, the two countries are joined in terms of lack of training for the sector personnel.

3. THE CONTRIBUTION OF THE THEORY OF ADMINISTRATIVE CONTRACTS IN UNDERSTANDING NEW PRINCIPLES OF REGULATION

Administrative contracts have two characteristics (T. Kirat and Marty F. 2007). They are particularly incomplete. The public entity has a command authority in respect to the co-contractor and it also has a power of termination or unilateral modification of the contract. It results that public authorities will continue to manifest merit wants in terms of public service quality and will provide the requirements for the awarding process, of contract evaluation for reducing the opportunistic situations and for ensuring

that their interests are taken into consideration. We leave aside the problems of control that provide little evidence of reasoning.

3.1 Merit Wants in Terms of Public Service

In this sector, administrative contracts are particularly incomplete (P. Duez 2010). They link several principals and several representatives that interfere at different territorial scales with different objectives, while social and medical-social interventions are performed in network and sometimes have a transversal character (disease, disability, exclusion). Elected officials have the objective of maximizing their political support and of avoiding a drift of expenditures. The field structures are designed to serve the patient and to maintain a balanced budget. Employees in the sector coming in contact with patients, residents or the victims of social exclusion can be in opposition with social administrators who would have the tendency to be bureaucratic and to put the economic imperative on the first place. Therefore, information asymmetries are extremely numerous coming from the elected officials and even from the employees from the sector that can firstly defend a corporatist interest and to claim to defend those for whom they work.

We have to add to this the difficulties of monitoring a sector where is difficult to establish a cause – effect relationship between the reduction of a social and sanitary risk and the responsibility of different actors. This is true when there are multiple territorial scales of responsibility. It is especially true if we consider that the service is foremost relational and subject to numerous representations or to contingencies of civilizational nature against which the structure cannot take any measure. As an example, we can evoke the incapacity of the structures to replace the family for producing an affective relationship even though the society encourages the defamiliarization. Therefore, the structure easily becomes a scapegoat in terms of research of life quality of the received public.

Faced with this incompleteness, the state and generally the public authorities may want to manifest certain merit wants when it comes to territorial authorities. These different aspects are especially developed but in a different manner in the 2002 and 2005 laws in the case of France and in the case of Romania in the 2006 law and in the recommendations that followed the examination of its situation. These laws insist on the necessity of separation from the tradition that consists in imposing to the sector structures a simple organization of means. In compliance with the provisions provided by Europe, these laws insist on two elements that have to be taken into consideration in order to manage the social and medical-social action: “respect for equal dignity for all”; “equitable access throughout the territory”. The 2005 French law on disabilities goes further in ensuring a compensation principle for the autonomy loss

of the disabled. A house for people with disabilities was established in each department as well a national fund for solidarity for autonomy.

Similarly, to achieve that result obligation, the French text from 2002 promoted the concept of user-citizen. There is a reverse of the problem, since the respect of dignity, integrity, intimacy and security, of free choice and of adapted services is intended. The person received in the structure is not only fragile, but he/she also has the right to confidentiality of information concerning him/her but only for the communication of all information coming from the structure that may affect him/her. Tools for achieving this purpose are provided. It is about a welcome booklet in the Charter of Rights and Freedoms, the residence contract, the use of qualified personnel and of the council of social life, the establishment project.

The 2009 law on Hospitals allows the state that finances and controls most directly the health system to introduce a desire of complying with a certain social equity between the various institutions and also a certain spatial equity. This is to avoid creating a two-tier sector and to facilitate access to all types of services in each of the territories. It does this by introducing an obligation of price convergence. In Romania, the chosen solution is a solution of treatment rationing by closing a number of hospitals.

The 2002 law separated from a certain tradition the health and social sector functioning on its own and which was poorly opened to the exterior (J.F Bauduret, M. Jaeger 2005). Firstly, we find in both countries a determination of unifying a sector that is still very fragmented in terms of funding and intervention ways. This seems necessary in order to facilitate the implementation of veritable dynamics between the connection and treatment but also to increase the efficiency of both sectors. The openness to civil society, families and territorial communities, as well as networking with other structures becomes mandatory as part of territorial planning plans on health and medical-social services. From this point of view Romania still has progress to make.

In terms of sociology of organizations that should enable in order to avoid possible immunizing strategies that institutions became used to develop in order to cope with external attacks before the transition in the case of Romania and in the case of France after the transformation of the welfare state. Therefore, this openness is particularly favorable in order to increase the quality of offered services as it introduced a law to better monitor what happens within the structures. In a more general manner, one can say that the text from 2002 establishes a real problem of social intervention. It is no longer focused only on the means used for the received public but on a whole environment that can be mobilized to implement prevention devices, which have a significantly less curative character. Romanian legislation

is still too attached to curative interventions, but this is understandable given the magnitude of the problems to be solved.

States can finally express the desire to exercise a certain form of social magistracy. The state may want to limit beneficiaries' fraud because it raises issues of social cohesion and, indirectly, problems of budgetary balance. These magistracies are particularly necessary in Romania, where the income weakness of the professionals from the sector represents a very strong incentive for active or passive bribery.

3.2 Requirements for the Awarding Process and for the Evaluation of Sector Structures

The administrative contract must allow reducing the opportunistic attitudes from the structures, which, in this manner, are obliged to respect the merit wants of public authorities. Afterwards, these structures will have to solve their own problems of internal coordination. Therefore, it must be designed in such manner as to encourage structures to make maximum efforts to comply with a balanced budget and with the service quality. Simultaneously, it must be designed in such manner as to prevent a radical uncertainty for the structures related to their future that would make their management impossible.

The economic theory of contracts provides some elements of answer (E. Brousseau 1993, R. Kirat and F. Marty 2007, P. Duez 2010). The theory is based on the work of JJ Laffont in public economics and on those of J. Tirole on industrial economics. The conclusions of these works apply primarily to the economy of property-network, where there is a natural monopoly (for example, the case of the ERDF network). It also exists for artificially scarce goods as those produced by the health and social sector. Generally, in this type of sector there are situations of opportunism in the rents' appropriation due to an information asymmetry or to an inability to control the action of the representative.

Therefore, the total cost of the establishment is $C = C(e, \varepsilon, \theta)$; it depends on the efforts made to reduce costs which are noted with e and of two other random factors, ε representing a radical uncertainty factor concerning the cost of the project and θ representing a factor observable by the institution but not by the public authorities.

If we would suppose that public authorities would make an endowment, which is a linear function of the cost, we have:

$$D(C) = \beta + S(C - \beta)$$

Values of β and S parameters are to define the incentive characteristics of the administrative contract.

If $S = 0$, the endowment is fixed and the institution will receive the amount β regardless the incurred expenses.

If $S = 1$, the institution will be fully reimbursed for incurred costs, it is said that the contract is "cost plus" or of cost reimbursement.

If $0 < S < 1$, this is an incentive contract based on cost sharing between public authorities and the institution.

The cost reimbursement contract is not incentive at all since the institution will only perform those efforts or investments in which it is interested. It will be able to accept fraud much more easily. The lump sum contract encourages the establishment to a real effort if the pricing is thoroughly performed. If the institution overestimates its costs compared to the fixed price or it does not play its role as a social magistrate than the institution will bear the costs. However, if the market is not competitive, the institution may be tempted to overvalue the negotiated price in order to hedge against the risk of loss or to sacrifice service quality to make sure that it maintains a balanced budget or to still be overzealous in terms of magistracies. The contract with incentive character corresponds to an intermediate situation where, for example, thresholds that must not be exceeded are introduced. This type of contract is quite complex to implement. In addition, we can improve the effectiveness of the lump sum contract by adding incentive provisions to improve quality, making it the best of the three contracts.

In France, the development of texts on budgetary rules and on pricing informs us regarding the contracting choice made in the health and social system. The 1975 text does not establish a strong enough result obligation, while the limiting and opposing character of the financial endowment exists but was never applied. The result is that the chosen contract was a priori a lump sum contract but the costs were always reimbursed. Therefore, rent situations would be possible for institutions and efforts in terms of quality might be insufficient. However, this is understandable in the period's context. Increased problems of financial sustainability of the French state in the 90's and 2000, the multiplication of synonym processes of a judicialization and a power increase of users' exigencies will change completely the situation.

In order to pass to a veritable lump sum contract, a deep reform was needed, which was implemented by the 2002 law. The new device provided a new triptych articulation – planning-permission-funding. The planning is multiannual and it is based on a plan of social and medical-social organization established for 5 years. This plan is binding for all creation authorizations that are not in compliance with it, even if enforceability is stronger in the health sector than in the social sector. This plan provides the coordination means between institutions, evaluation criteria, requirements and adjustments to be made.

The authorization is made according to well established rules. The device is flexible for the person in the services sector since the structures can apply for accreditation. Therefore, they are not subject to authorization rules that will follow and will be settled on their prices but in the limit of the provided price ceiling that fairly amounts to a lump sum contract. To the extent that these structures operate outside organizational plans, regional councils are trying to limit the use of this device.

The authorization rules are the following:

- the record must be in compliance with the organization plan
- the authorizations are given for 15 years and their renewal is subject to an external evaluation
- the authorizations are given based on the best price-quality ratio
- the authorizations are given if there is financing even though the financing is conditioned by a future credit opening
- the authorization is subject to the employment of qualified personnel ensuring the quality of the offered service.

The financing requirements were changed on several points. Currently, we apply entirely the principle of enforceability of financial endowment. All funding will be possible only if the institution meets the balanced budget and service quality requirements, as well as the integration into the organization plan. There is a plan in the social and medical-social domain at a departmental level and a plan at regional level for the health sector, provided by the 2009 law on Hospitals that created regional health agencies. Service quality is the subject of an internal and external evaluation to which we shall have the occasion to return later. The institution will also have to provide activity indicators, describing the characteristics of the received population and indicators of administration and management. On the contrary, the text fixes precisely the termination conditions. Therefore, the budget campaign is organized in three stages:

- first stage: budgetary propositions for the institution that presents a budgetary report and its detailed content
- second stage: progress of the adversarial procedure on a period of 5 months in two stages up to the award of the envelopes and afterwards on a period of up to 60 days
- the decision of budgetary authorisation

Article L 314-1 of the 2002 law specifies the prices which are joint or not, these being under the responsibility of the prefect of the department and the president of the general council. Everything is

implemented in order to ensure that pricing is done in close relation with costs. This helps maintaining equity in access to services and to reduce opportunism situations in terms of pricing. In exchange, institutions recover an almost total autonomy in financial management of their institution. The 2002 law eliminates the prior control of budgets and cannot control more than the loans for a term exceeding one year. Acquisitions of property and their change of personnel selection, as well as receiving donations and legacies are no longer controlled.

In the case of the health sector, the 2009 law comes to complete the 2005 law on orientation of the social security financing. The goal is to decompartmentalise the treatment offer in order to optimize the use of resources, particularly in the context of explosion of health and social costs connected to an aging population. The law establishes an obligation of price convergence for private institutions. This requirement is reflected in the establishment of a price ceiling that the institutions should be required not to exceed until 2016. Endowments for sector functioning are calculated based directly on quality criteria and number of beds.

In the 2002 text, the quality assessment is subject to a special treatment. The assessment is internal every 5 years and external every 7 years, based on a tender of specifications set by decree and using recommendations validated by the National Committee for Social and Medical-Social Assessment, created in 2003. The main quality determinants are presented in the following diagram (Fig. 2):

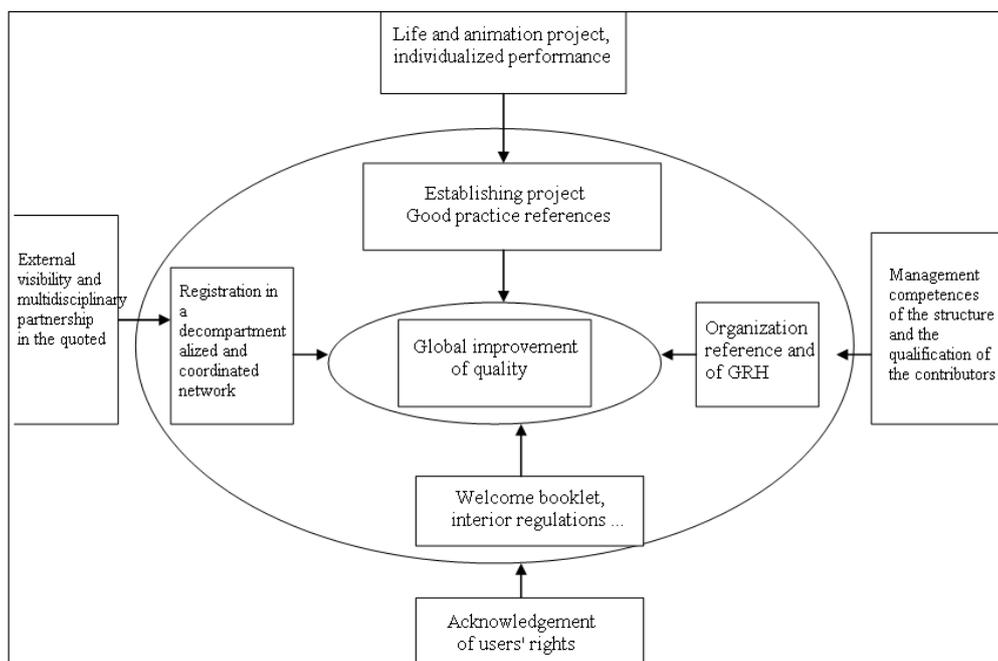


FIGURE 2 - MAIN QUALITY DETERMINANTS
Source: J. F Bauduret et M. Jaeger, 2005: 165.

However, there are grids of needs' assessment that are developed in order to analyze the degree of disability for example and upon which such assessment is based. They are especially the following:

- GIR classification for the elderly based on motor skills (from 1 to 6);
- MAP classification for people with disabilities (the UNAPEI model of personalized accompanying) established according to the capacity of understanding, communication and decision-making (from 1 to 5);
- ROCS (referential observation of social skills) that proposes a program in 5 phases to help implement individualized projects starting from the listed competencies to be developed in children with disabilities
- MPS or medical-physical-social method for child protection based on incurred risks with 9 criteria and three levels of severity.

Computerized evaluation tools to satisfy the assessment needs, such as "qualisnap", "qualiprogress" for the disabled, "QualiPlus" software for the social in general, act on social skills that are to be developed in the case of assisted people (motivation, ability to anticipate, sense of responsibility, positive self-image, space control, ability to use his acquired skills, ability to be recognized by others in reciprocal relationships), "ANGÉLIQUE" (Application Guide for a National Assessment Labeled Internal Quality for Users of Establishments) serve as interventions' guide for dependent elderly people.

4. CONCLUSIONS

Law texts produced by the government do not evoke at all the problem of increased internal costs for coordinating the structures of the health and social sector. It is clear that the state took a deliberate choice to transfer to the structures of health and social sector the financial and psychosocial risks arising from an aging society and this action generates exclusion. Financially, the French legislature did not foresee for example the consequences the 35-hour workweek and the collective agreements had on the financial stability of institutions. As for psychosocial risks, they will be important for the structures.

The retention or the non-treatment of what we call civilizational risks (P. Duez 2011) by the sector's structures will soon become unbearable if the balanced budget rule is applied arbitrarily. Conflicts with patients, residents, the victims of social exclusion or their families or with taxpayers will only increase. As a result, the personnel and particularly the executives of the sector will find themselves in a situation of total "burn out" and the costs of internal coordination will increase. Therefore, the opposite effect will be achieved since the deregulation of the sector will be more expensive for the community or for

families than a real financial commitment of the state and of the authorities. Structures can choose to transfer the financial burden to families or they can practice a negative discrimination through resource. The result is an inevitable dismemberment of the public service and a service differentiation based on family resources. We will also see right holders "voting with one's feet" and seeking the most interesting institutions. Therefore, the spatial and social equity will be challenged. The state, which acknowledged this risk, is already trying to establish a new form of regulation for this type of behavior. One may wonder if this new wave of regulation will even set quotas or implement a health and social card after the model of the school card.

Ultimately, it is especially important to avoid requiring the structures to solve simultaneously problems of financial sustainability of public authorities while maintaining a certain quality of service without taking into account the character often incompatible of the two goals. This is especially true if this raises the question of the livable character of our civilization.

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