

Role of social professions in the process of sustainable development of rural area. Study case

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Abstract

It is already known and accepted in Romania the reality of the consequences produced by the social or other reforms, the transformations that reach precisely the category of the citizens from the rural area, with socio-economic problems. In 2017, the awareness of the fact that the population in the rural area, mainly consisting of socially, economically or medically vulnerable groups, need this type of services, trying to compensate for the reality of the dismantling of several sanitary units, O.U.G no.18 attempts an approach through the corroboration of this state of affairs with the objectives of developing community services. Our conclusions set out in this article are paving the way for de lege ferenda proposal to ensure proper regulations from the perspective of providing training for the social professions to be involved in the functioning of integrated centers at the level of rural communities.

Keywords: social professions, integrated community center, sustainable development, rural area.

JEL Classification: K23, K32, K39

1. General considerations. Integrating social services in the rural environment

The regulation area of the rural space has a legislative void, a lack of corroboration of normative acts in vigor when we refer to the problem of integrating social professions, support-professions with the purpose to help society as a whole by insuring it has access to quality services, to current occupations, integrated in the social, health and educational sector.

Concepts such as “economy” and “rural economic development” are component parts of the economic sciences family. Professions represent the qualifications obtained through studies in direct connection by the competences earned with the attributions exerted at the work place and we consider the point of view belonging to Prof. Ion Schileru, PhD: “projecting future professions is hindered by the principle of social economics and efficiency, claiming a proper correlation for the needs to professionalize with the human and financial resources

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available⁴ as accurate according to the social and economic reality which characterizes the rural community.

An analysis of the economic processes conducted on the rural space does not currently permits, after the passing of a considerable amount of time from 1989 up to now, only the focalization towards adopting a normative act in order to truly assure the reform of the social classes from the rural level through correspondence with the socioeconomic reality, with the purpose of insuring a collective wellbeing for all the groups, according to each group's vulnerability. I encountered the concept of wellbeing in the paper regarding the theory of social policy, entitled "Romanian social policy between poverty and globalization"⁵, in interdependence with the term "state of welfare". Here it's presented the fact that Pierson⁶ brings in the specialty literature three types of welfare: "social welfare" which generally speaking refers to the collective provision or acceptance of welfare; "economic welfare" which describes mostly the forms of welfare provided by the mechanisms of the market or of the official economy; "state welfare" which refers to the social welfare provided by the state.

One thing is certain, consolidating a multifunctional rural development can be the measure which starts from providing social welfare through the state, reflected in the anticipated results at a rural level by socioeconomic welfare.

Thus, the substantiation note of the normative act should be initiated from the idea that a decent living standard at the community level requires a superposition of the interest for providing certain professional social services in tight corroboration with the medical services specific to the characteristics of the area, in fact, medical-social services to be provided by qualified personnel at all the levels, attracted in that area by offering the possibility to carrying out the activity according to the standards requested by the European Union.

Drawing up a certain normative act project requires cumulating the expertise of three organs of the central public administration which regulate the governmental policies in the following fields: labor, health and education. As it happened a few years ago when we witnessed the adoption of a normative document that reformed the whole field of health, including the specifically professions, we consider that in order to relaunch the socioeconomic rural environment a similar measure would be more than welcome.

We considered that the Governmental Resolution no. 867/2015 for the approval of the nomenclature of the social services⁷. We did not understand though, why even if the nomenclature of the social services was established, the structures throughout which these services are offered, respectively the functions

⁴ Ion Schileru, *Abordări noi în domeniul economiei ocupaționale*, available at www.ase.ro/upcpr/profesorii/367/Ocupatii%20final.doc, accessed at 5 April 2018.

⁵ Marian Preda, *Politica socială românească între sărăcie și globalizare (Social romanian politics between poverty and globalization)*, Publishing House: Polirom, Iasi, 2002, p. 16.

⁶ Christopher Pierson, *Beyond the Welfare State?* Polity Press, Cambridge, 1991, p. 27.

⁷ Published in the Official Gazette with the number 834 from the 9th of November 2015.

and the main activities, everything was left at the level of "indicative"⁸ assessment. We do not consider to be responsible for the lack of provisions of the type of qualifications that can guarantee these services, but we can imply a circumstantial lack of preoccupation for the beneficiaries, the vulnerable groups represented by the overaged population of the rural environment, by the Roma population, by the various medical and social problems that combine economical or/and social reasons with physical or/and mental reasons. Some jobs could be labelled as mandatory, at least those such as: psychologist or social assistant, a specialist in the evaluation of those with disabilities or instructor for activities of resocialization, leaving those such as occupational therapist or art therapist as optional ones. The mention of psychological counselling and emotional support" among the category of main activities will eventually be identified in practice as subcontracted, which does neither offer psychological stability to the patient who has completely or partially lost his autonomy, nor the psychological comfort to the grown-up who being unable to move because of a disease, his physical or mental condition, does not have the psychologist at hand.

In consideration the beneficiaries of these services, mainly social ones, are the vulnerable groups that belong to the communities, the Emergency Ordinance no. 18/2017 was approved as a normative document that states that the population is in need of such kind of services, trying at the same time to compensate also the reality of the disappearance of many sanitary structures, including the locations where the community medical assistance was assured. Basically we are witnessing the recurrence from central to local reality, reestablishment in agreement with policies and strategies to empower the local authorities of the European countries in the assurance of a fair addressability towards the medical-social services for every individual regardless of their social status in the community. The local authorities have the responsibility, especially for people belonging to the vulnerable groups from the medical, economic and social point of view, but under the condition to assure human resources and financial resources.

Thus we have noticed that regarding human resources that a collaboration, a constructive correlation in which we have the personnel of the local community center on one side and the personnel belonging to the medical community assistance alongside the employees of the public social assistance and on the other side there are the laborers from the family doctor office and of course other health, social and educational providers.

Professionals involved at the community center? Absolutely, because they can only be graduates of some curriculums that offer them expertise in the line of social assistance, medical assistance services, personnel that is qualified in supervising the access of the vulnerable groups to the particular social services, dietitians for observing the proper nutritional methods, occupations particular for social practice etc. Hence we enlist professions such as social assistant, community medical assistant, sanitary mediators (depending on the particularity of the

⁸ Resolution no. 867 from the 14th of October 2015 for the approval of the nomenclature of the social services as well as that of the frame regulations of organizing and functioning of the social services.

community), obstetricians or dietitians. Of major importance is that the enlisted occupations, more precisely specialties of professional competences gained through study and practiced at the workplace, in the field of social activities. For a better understanding of the situation, a dietitian is a provider of services connected to the medical act, but the dietitian graduate works in various social practice fields with the specification that other fields of practice can be added through the order of the Health Minister, the Minister of Education and the Labour, Family, Social Protection and Full-aged people Minister. Thus we have according to the 10th article of the Law no. 256/2015 regarding the practicing as a dietitian, and also the creation, the constitution and functioning of the Nutritional Association of Romania⁹, the following occupations:

”Dietitian for public health or community: practices with the direct role in promoting health and in wording the policies for promoting food selections at the level of an individual/group that will lead to the improvement and the maintenance of nutritional health, simultaneously with the reduction of risks that can be caused by diseases of nutritional nature;

- administrative dietitian: works in the management of services and food products with the responsibility to provide information’s regarding the adequate nutritional products, quality food for people and groups with health conditions and diseases, that are part of an institution or community;

- clinical dietitian: works at the level of primary, secondary and tertiary medical care with the responsibility to plan, to educate, to observe and evaluate a clinically created nourishment plan, in order to assure the best nutritional health to patients/ beneficiaries of nutritional services; clinical dietitians can also work in individual cabinets, in medical institutions, medical cabinets, hospitals, stationary units and nursing homes”.

Nevertheless, these kind of occupations particular to the profession of dietitian can’t be activated effectively at the community level in the above mentioned fields of practice, because after two years since the adoption of the law that manages them we still do not have any application standards, even though that they should have been issued 60 days since the normative act entered into force. A similar situation is one regarding a profession in the social field, namely that of a sanitary mediator. Laconically regulated by Order no. 619 of the 14th of August 2002 for the approval of the occupation of sanitary mediator had technical standards established for organizing, functioning and financing the activity of sanitary mediators only for the year of 2002. We are hoping the methodological standards regarding organizing, functioning and financing the activity community medical assistance won’t be too late, so that this occupation can profit from having its own headquarters because of a reglementation¹⁰.

All these professions that can be activated in the social field need to be provided in approved structures of institutions that are ment to assure ”services and

⁹ Published in the Official Gazette with the number 825 on the 5th of November 2015.

¹⁰ Emergency Ordinance no. 18/2017.

benefits which can satisfy the need of the people, hence providing welfare and which are funded and produced in the country¹¹.

2. Providers of medical-social-educational services.

Case study: Arad County

By reference to the configuration that must characterize a developed medical-social-educational assistance system particular for the rural environment, we can come across of either the absence of the corroboration as part of the same structure between the social, medical or educational attributes, or in terms of bonding with other units that can assure a continuity regarding the monitoring of each case in difficulty. A combination of the three attributes would be ideal if their limits would be easy to determine, while the indicated model basis is represented in fact by a pilot model that can be adapted and implemented by combining the medical, social and educational functions. So how the social assistance service system meets the functions of development of their own capacities, of assuring a high standard professional support and of enabling the addressability towards the social support, we value that the same method can be used in the case of creating a relation between the three components, by adapting to these functions and involving the community.

Elena Zamfir underlined the appearance of social assistance in Romania in her work "Social School" from Bucharest by the fact that "social services comprehend three major categories of services: education, health and social assistance, while social assistance services were representing the third major pillar of social services¹².

Legally speaking, we have got three types of present structures that dwell on mainly the same set of problems, being adopted mainly out of identical reasons, comprehend the social, medical and, in some cases the educational component, while enforcing a relationship with the public local/county administrative authorities, but are organized without any initial teamwork at the central level, even though this was recommended. In addition, they are lacking structure of personnel in which the occupations of the social field would find their own place in. Thus we bring into discussion that the community center integrated due to the Emergency Ordinance nr.18 from the 27th of February 2017 regarding the medical community assistance, the medical-social units due to the Government Order no. 412/2003 regarding the standards of organization, functioning and funding of the medical-social units, respective of the multifunctional health centers due to the Order no. 1144/2011 issued at the level of the Health Minister for the approval of the methodological standards for organizing and functioning of the multifunctional health centers.

The integrated community centers were created subordinate to the executive authorities of the public local administration, at the level of the

¹¹ Marian Preda, *op. cit.*, p. 18.

¹² Elena Zamfir underlined the appearance of social assistance in Romania.

communities, depending on the identified needs of each zone and they assure the providing of medical-social-educational services. The funding for these structures was made entirely out of the local budget of the administrative territorial unit/subdivision. In the structure of the integrated community center the minimal staff must consist of a communitary medical assistant and a social assistant, depending on the specific of the community and other professional categories.

Medical-social units are specialized public institutions, subordinated to the public local administrative authorities, that provide care services, medical services, as well as social services to individuals in need of medical-social services depending on their situation, needing supervision, assistance, care, treatment, as well social insertion and reinsertion. Funding for the current expenses and capital expenses are assured through from own income and grants from the local or county budget. Grants from the local budget are offered for assuring social services and for current administrative expenses, repairs, consolidations or various endowments. Own incomes are part of the main percentage out of settled amounts from the health insurance homes, destined for provided medical services, but also for personal contributions of the beneficiaries. Medical and social staff are both imperative in the staff structure of the medical-social assistance units, without referring precisely to social services. This aspect has been not even been observed since the end of 2016 and no preoccupation towards this regarding the set-up of the term „other staff categories” and of other social professions, when throughout the Government Decision no. 932 there have been made modifications to the Government Decision no. 459/2010 for approving the standard of costs per year for services provided to medical-social units and some normative documents regarding staff from medical-social assistance units and personnel that have got community medical assistance activities¹³. In fact it is confirmed that medical-social units have only verbal a social component, that exists only through a passive manifest that cannot lead through organization to achieving the goal that has lead to their creation, namely: assuring a package of social-medical services adapted to the needs of patients according to the particularity of the local communities of the county.

Multifunctional health centers are established at the proposal of local public administrative authorities that have the hospital management as units without a legal personality in the structure of hospitals or as units with legal personality, so that they can assure a medical services package adapted to the needs of the local communities, isolated places or other situations determined by the regional particularity. The funding for the multifunctional health centers is assured by the county and local hospitals that have got units of this kind in their structure, from own income established in accord with the present legal constitution

¹³ Government Decision no. 932 from the 8th of December 2016 regarding the modification to the Government Decision no. 459/2010 for approving the standard of costs per year for services provided to medical-social units and some normative documents regarding staff from medical-social assistance units and personnel that have got community medical assistance activities, was published in the Official Gazette at the number 1025 on the 20th of December 2016.

regarding the funding of public hospitals, from necessary additions of the budgets of these sanitary units through additional documents for the closed contracts with the health insurance houses, as well as through amounts provided from the budget of the Health Ministry and local budgets.

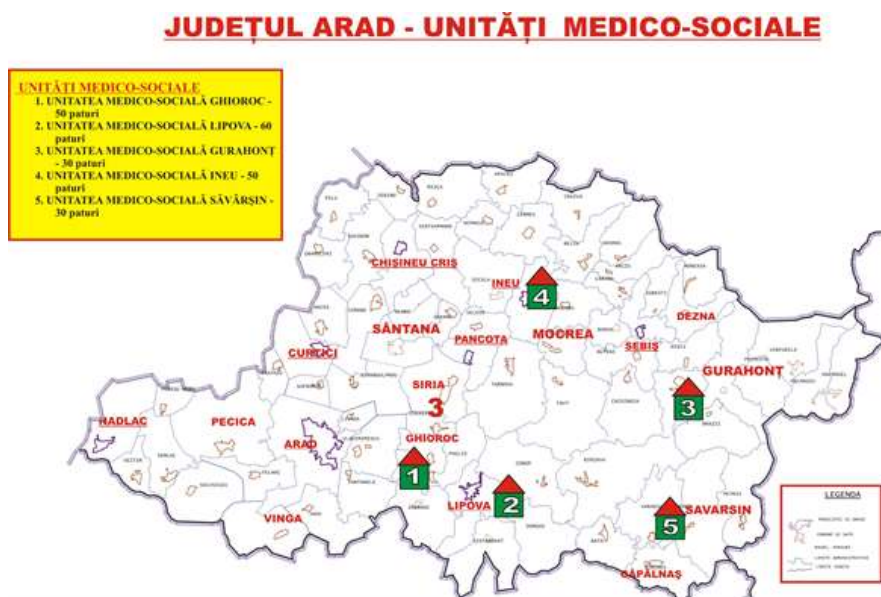
3. Case study

The county of Arad lies in the western part of Romania with an area of 7754 quarter kilometers, representing 3.2 % of the area of the country and is thus the sixth biggest county. According to the data provided from the Arad County Statistics Department it is stated that the county has a population of 461236 inhabitants since the last census. Out of them 51% live in cities, while 49% live in the rural area. The population of the county is grown-up, 20.3% representing a population over the age of 60. Out of the administrative territorial organization does Arad County comprehend the following: the municipality of Arad, 9 cities (Chişineu-Criş, Curtici, Ineu, Lipova, Nădlac, Pâncota, Sebiş, Sântana, Pecica), 65 communes and 273 villages. 167024 out of the total of 461236 represent the labor force in various economical fields, while the rest an active labor force in the rural environment is.

Since the adoption of the Emergency Ordinance no. 18/2017 regarding the communitary medical assistance has the county policy no priority in working alongside with the executive authorities of the local public administration at the level of the communities for establishing integrated community centers for medical-social-educational services. Thus it is true that the application standards are yet to be adopted, but there is still no strategy in this matter. The short time since the adoption of the legal frame for defining the integrated community centers identified as essential providers for communitary medical assistance has lead to the loss of almost 4 years since the start of 2014-2020 European Financing Cycle, a legal vacuum that determined the impossibility of accessing European funds planned with this aim through Operational Program of Human Capital, axis 4.10 or the Regional Operational Program, axis 8.

Medical-social units are structures that were established since 2003 in Arad County and there are 5 such structures with a total of 220 beds, as follows: the medical-social unit Ghioroc - 50 beds, the medical-social unit Lipova - 60 beds, the medical-social unit Gurahonţ - 30 beds, the medical-social unit Ineu - 50 beds and the medical-social unit Săvîrşin - 30 beds. The necessity of medical-social assistance beds from that date has been appreciated depending on the age groups of the chronic sick persons from the hospitals that needed to be cleared. Expressed in percentage we can observe the persons between the ages of 65-74 have only a percent of 5 that need permanent care, while those over 74 are 22% who need permanent care, while 25% need only care for a short period.

The situation in 2003:



In the present day, in 2018, after 15 years, in Arad county only one medical-sanitary unit is still in function, the reason why the rest were closed was the financial sustainability criteria, its addressability being insured as the sick people ration from the area but not necessarily from the administrative-territorial area of the local public authority of which is subordinated although this was the only one which granted subventions from the local budget. Probably this kind of thinking led to the adoption of the Emergency Ordinance no. 70/2002 regarding the administration of the public sanitary units of a local and county-wide importance in which „In order to insure financing, the medical-social assistance units established by decisions of the local councils by towns with over 5.000 people may be passed in the administrative and financial responsibility, should the local councils and the county councils mutually agree”.

Other reasons were invoked. Such reasons were related to the impossibility of hiring professionals to cover the psychological part, counseling families, encouraging visits, physical rehabilitation and then legal-administrative counseling, scarce funding from health insurance, almost no donations or sponsorships, in fact losing the funding year after year.

The measures which we recommend for the Gurahont area need to be taken urgently and are related to establishing an integrated community center which provides medical, social and educational services. Gurahont commune has a population of 3.973 people according to a census conducted in 2011. It is formed by the villages Bonțești, Dulcele, Feniș, Gurahont (residence), Hontîșor, Iosaș, Mustești, Pescari, Valea Mare and Zimbru. Some of these villages are dispersed in the territory and are hard to reach during the months of winter and there is relatively a long distance to the closest sanitary unit in order to receive emergency

medical services. The population is mostly formed by elderly people and the state of health of this population is characterized by data and statistics emphasizes its precarious state. The vulnerable people of this area are identified in situation which point out an economic level below the poverty threshold, unemployment, chronic diseases, terminal diseases which require alleviatory treatments, disabilities, old age or they belong to single parent families. The commune is in deficit also in relation to the social services provided at a local level, by comparison to other areas of Arad County which have diverse social services, as you can see on the map below:



4. Conclusions

We used the method of comparative research between the initial meaning of the norms which regulated and still regulate in a partially modified way and without a corroboration with other normative documents related to the social field and the meaning which we consider opportune and we think it is necessary in its effective application. Our purpose is to reach a constructive evolution on the legislative domain considering the local problems which we have encountered during all these years.

The role of social occupations in the process of durable development of the rural regions holds the same importance as the establishment of integrated community centers and insuring the population that at the level of administrative territorial authorities there is a constructive collaboration with the Ministry of Labor and Social Justice, the Ministry of Health and the Ministry of National Education, in order to implement these integrated community services which would prevent social exclusion and would combat poverty.

At a county level, for each commune and its villages in administration, a development strategy which systematically approaches the needs, the real characteristics of the area and the correlation to cover with state funded services on the social-medical-educational segment in order to create a viable and continuous process.

We chose to have a rural system meant to avoid juridical structures with limited competences and passive or non-existent social functions, a rural system which develops integrated systems, to recognize the importance and determining role of the social occupations, of relevant competences which lead to employability, for the access to informal educational programs, counselling services and career orientation services, to attract professional by granting incentives in due time, to really protect the elderly and every other vulnerable group, by managing continuous observance of each social case in difficulty and establishing collaborations with other specialized institutions. „Addressing problems at a macrosocial level takes into consideration various actions regarding organization and community development: in a neighborhood report, the functional organization of communities, social and economic development, coalitions, political and social actions and also social movements.”¹⁴

The view of modifying and completing the incidental provisions referring to the integrated social services had to consider the general context of the legislation and should follow the creation of a general and unitary framework, a corroboration in enunciation and applicability of the following normative documents: Government Decision nr.867 from 14th October 2015 for the approval the Nomenclature of social services, also of the framework regulations for the organization and functionality of social services; Government Decision nr.459 from 5th May 2010 for the approval of the yearly cost standard for services provided in the medical-social assistance units, of fixed organization charts regarding the personnel of the medical-social assistance units and the personnel which provides activities of community medical assistance, modified and completed by Government Decision no. 932/2016, G.D. no. 412 from the 2nd of April 2003 and Law nr.292/2011 of social assistance, Order no. 619 from the 14th of August 2002 for the approval of functioning in the profession of a sanitary mediator and the Technical Norms, of application norms of the Law no. 256/2015 regarding the profession of dietitian and the place regulation regarding the community dietitian's and of the community assistant's place etc.

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¹⁴ Viorel Prelici, *Methodological aspects and approaches in social assistance*, Mirton Publishing House, Timisoara, 2002, p. 55.