Scientific Papers Series Management, Economic Engineering in Agriculture and Rural Development
Vol. 15, Issue 1, 2015
PRINT ISSN 2284-7995, E-ISSN 2285-3952

EDUCATION AND HEALTH: IMPORTANT FACTORS IN THE DEVELOPMENT OF RURAL COMMUNITIES

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Abstract

Rural development and diversification of rural economy depend on the level of education, knowledge and qualification. Though improving and maintaining the proper level of basic infrastructure is an important element in the social and economic development of the rural area, it is professional training that represents the "engine" of good development. Education and training are essential for rural communities, but there are obvious discrepancies from the point of view of school infrastructure. Though we can say that the number of schools in the rural area is above the necessary one, education quality is low because, on one hand, of the poor educational infrastructure and, on the other hand, because of the level o training of the teachers. Most of the schools need to be renovated, to be refurnished, to be reequipped and to be supplied with teaching materials. Infrastructures and facilities proper to professional training and to primary education are important tools for the conversion of agricultural labour force into non-agricultural labour force.

Key words**:** *education, health, rural area, urban area*

INTRODUCTION

The low level of education reflects in the quality of labour force in the rural area and it is a restrictive factor for economic development. Diversification of economic activities is not supported by workers with training specific to the different types of trades, since the educational system was not adapted to the specific requirements in the rural area.

MATERIALS AND METHODS

The research methodology consists in a bibliographical study based on scientific documenting following the steps below: information, data collection, source study, and source grouping.

RESULTS AND DISCUSSIONS

The situation in the rural education during the last 2-3 decades has generated real concerns. Rural education has always been disfavoured compared to education in the urban area.
Gaps between the urban and the rural from the point of view of education deepened rapidly after 1990. The dynamics of education in the rural area cannot be linked to a certain political regime. Development of the rural education knew the strongest dynamics in a capitalist regime and continued in the first decades of the communist regime. The decline of the rural education started in the last decades of the communist regime and continued in a trendy communist regime.
Romanian villages are very diverse from an economic, cultural, and educational point of view. One cannot male clear statements valid for all rural communities. Local educational gaps can be measured and areas lacking or enjoying educational facilities can be mapped in detail.
The **level of school attendance** can be measured by the number of years graduated by somebody. From this point of view, **the level of school attendance in the rural area is limited to secondary school in most children**. High-school attendance rate is higher in localities with high-schools.
Access of young people from the rural area to higher education is a long-lasting phenomenon. In the second half of the 19th

and in the first half of the 20th the access of the young people from the rural area to higher education increased rapidly.

At the end of the '70s and in the '80s, the access of young people from the rural area to higher education decrease dramatically. During the last years of the communist regime, the share of students from the rural area decreased below 25%. This was signalled by sociological research of the time. It was also acknowledged at political level, but no corrective measures were taken.

After 1990, the decrease of the access of young people from the rural area to higher education speeded up, reaching less than 5% in certain universities and even 1% in some others. This was signalled several times by specialists in the field of education. The Governmental programme meant to support through state scholarships young people from the rural area had a lesser impact than expected. This happened not because of lack of funds, of political will or of lack of expertise in managing programmes, but because the possible beneficiaries of such programs are absent from universities. Many universities have used only a small number of scholarships because there were no young people from the rural area attending the courses of those universities. The governmental programme for young people from rural area is a very important tool in ensuring equality of chances in higher education. [2]

In the rural area, there is an **increase of the rate of school abandonment**. In many cases, secondary school attendance is initiated but is not completed, the children interrupting their studies after the first elementary classes and rarely resuming their studies after longer periods of interruption. [1]

Moreover, many changes that have taken place in education, new legislative regulations in the field of education and restructuring of the national education system has led to the reorganization of the schools network in Romania. Therefore, in the period 2008-2011 as a result of measures taken in the national education reform , educational unit number decreased by 1017 (respectively 12.4%). The new configuration of educational network was correlated with the size of the school population and the conditions offered by the existing material basis in order to provide a quality educational process.

School population decreased (especially in rural areas), reaching school/ academic year 2011/2012 to be 11.6% lower than the school / academic year 2008/2009. [6]

It is worth mentioning that this restructuring process has further negative effects among the rural population, since by destroying the village primary schools, increased school dropout because students don't have means of transportation to the center of the village.

The **increase of relative and absolute illiteracy rate** also has high levels. Even if they attend school for a few years many children cannot read or write. At the same time, there is **increase of the rate of absolute illiteracy**. The same phenomenon is present in some working areas as a result of industrial decline. [3]

The **increase of illiteracy in isolated rural areas is more pregnant**. Illiteracy has never been completely eradicated in isolated rural localities. However, this tends to go back to the levels characteristic of rural education development initiation. In some localities, schools have disappeared because there are no longer children to attend them. The number of school children is so low that the functioning of the schools in no longer profitable. On the other hand, moving schoolchildren to larger localities where there are schools is difficult because of the lack of transportation means or because of the impossibility of reaching them during the periods of time with bad weather.

During the last two decades, there have been **discrepancies between the levels of access to modern educational tools and to information technology and communication**. The school laboratories in the rural area are rather rare; teaching materials are old or they simply lack. Information technologies and communication have penetrated the rural area less than the urban area. The access to these technologies and the ability of using them are essential elements for the educational process and for the training of the labour force. Public investments in information technologies and

communication were concentrated mainly in high-schools from urban areas. The budgets of local communities are not enough to achieve such investments. Where there are certain facilities, they have been made with huge efforts from the teachers and the parents.

The number of rural families having a computer is insignificant compared to the situation of the families in the urban area. The gaps in this field tend to deepen more and more.

The **gaps between school attendance quality in the rural area and school attendance quality in the urban areas** are deepening. The rural area is divided from the point of view of the quality of the educational programmes. There are localities that ensure a relatively good quality of school attendance (sometimes above the national average or above the level of some urban schools). This is the case of the schools that can rely on trained, competent teachers that love their profession and who can compensate the lack of finance and material equipment with their efforts. In many villages, schools have no trained teaching staff. The educational process is achieved at low standards and the level of education of the schoolchildren is low. This is why the rate of schoolchildren abandoning school after graduating from secondary school is high.

The decline of rural education is caused mainly by the following causes:

- demographic decline; poverty;
- return to traditional agriculture;
- decrease of learning motivation;
- degradation of school infrastructure;
- lack of trained teaching staff;
- lack of policies concerning the rural area.

The decline of rural education at present has negative, serious consequences that can result, in time, in the following:

- reducing the chances for local development;
- high levels of latent unemployment;
- uncontrolled migrations and appearance of miserable suburban cultures;

accumulating potential of social deviance and criminality. [4]

The rural area benefits from health assistance much below the levels in the urban area. In most communes, there are only primary health services. For specialty services, inhabitants of the rural area need to appeal, as a rule, to medical assistance units in town and municipia. The quality of the medical act in the rural area is relatively low, mainly because of the poor equipment (buildings and apparatuses) which is generally old or even lacking.

Distribution network health units by residence reveals that health network has grown mainly in urban areas where they found: 91.8% of the total number of hospitals, 93.7% of that of medical clinics, 86.6% of the total independent general healthcare centers, 58.3% of independent practices family medicine, 75.6% of the pharmacies, 91.2% of diagnostic and treatment centers, 98.4% of specialized medical centers, 86, 0% of independent dental practices, medical healthcare facilities, 97.4 % of the independent medical experts , 95.8 % of medical laboratories , 95.4 % of dental labs and all institutes and institutions without beds, tuberculosis sanatoriums, clinics, blood transfusion centers, mental health centers, medical students and student dental offices.

Simultaneously, the 2 TB sanatoriums and 8 of the 9 hydro sanatoriums works also in urban areas.

Table 1. Distribution of the main categories of health workers by residence and by ownership of the healthcare organization in 2012.

Medical staff	Total	Public	Private
Physicians	53,681	40,956	12,725
- urban area	48,192	37,470	10,722
- rural area	5,489	3,486	2,003
Of which: family physicians	13,767	8,339	5,428
- urban area	9,216	5,456	3,760
- rural area	4,551	2,883	1,668
Stomatologiests	13,814	3,157	10,657
- urban area	12,017	2,568	9,449
- rural area	1,797	589	1,208
Pharmacists	15,435	831	14,604
- urban area	13,146	805	12,341
- rural area	2,289	26	2,263
ancillary medical staff	125,141	95,484	29,657
- urban area	112,063	87,059	25,004
- rural area	13,078	8,425	4,653
Of which: nurses	112,368	85,851	26,517
- urban area	100,506	78,356	22,150
- rural area	11,862	7,495	4,367
auxiliary medical staff	59,440	55,717	3,723
- urban area	52,304	49,287	3,017
- rural area	7,136	6430	706

Source: Activity health units, 2013

In rural areas works 59.4 % of medical-social units and 66.3 % of the work points of pharmacies and drugstores, as well as the 2 sanatoriums.

In 2012, the degree of medical insurance by a qualified medical staff is generally low, the number of physicians is relatively small compared to the number of inhabitants (1,417 inhabitants to one physician in rural area, compared to 397 inhabitants to one physician, in urban area). [6]

Medical units in urban areas have 89.8% of all physicians, 87.0% of all dentists, 85.2% of pharmacists, 89.5% of medical staff and 88.0% of auxiliary health workers. 25.6% out of all the physicians, are general practitioners, 66.9% of them activate in urban areas and 33.1% in rural areas.

If in 322 communes (12% of the total number of communes) the presence of doctors is satisfactory compared to the number of inhabitants (1 doctor per 600 inhabitants, particularly in areas in the neighbourhood of towns), in **148 communes (6%) there is no doctor**, and in 378 communes (14%) there is 1 doctor for over 3,500 inhabitants. Areas lacking proper health services are mainly in eastern Romania: in the Region North-East (counties of Botoşani and Vaslui and, partially, the eastern part of the Bacău County) and in the Region South-East (the mountain area of the counties of Vrancea and Buzău, central Dobrogea and particularly the Danube Delta).

As a result of the low quality of medical assistance, the average duration of the life of an inhabitant of the rural area is 2 years shorter than that of an inhabitant of the urban area. At the same time, in the rural area infant mortality rate reaches very high levels; in almost the entire rural area of the region North-East, in Dobrogea from the region South-East, in the plain area in Southern Romania, in the regions South and South-West, infant mortality is above 27%, i.e. 35% more than that of the urban area. [5]

CONCLUSIONS

While urban Romania has evolved rapidly these last years towards the level of life and civilisation of the European Union, **the Romanian village is still some kind of medieval village of modern Europe**. Compared to the rural localities in Austria, Germany or even Hungary, Romanian villages seem to be part of the Middle Ages.

The lack of health services, the degradation of the rural education, the lack of infrastructure (mainly facilities), **the ageing of the population** caused by the massive exodus towards urban areas or even foreign countries make up a dark image of the Romanian village 3 years after is acceded the European Union.

Because of the large share of the rural population – **almost 1 in 2 Romanians live in poverty** – Romania has a low GDP per capita. Even for the urban area, the GDP range Romania among other Central-European and Eastern-European countries.

The population categories most exposed to poverty in Romania are the children, the lonely old people, the agriculturists, the unemployed people, and the retired agriculturists. The **poverty risk is higher in the population from the rural area** and in the population in the regions North-East, South-East and South-West.

The Romanian village could supply lots of reasons for **investments** due to its resources. One of them could be the low price compared to the urban area which could favour the initiation of production activities.

Another target of investments in the rural area could be **agritourism**, since Romania has numerous genuine natural attractions.

The gap between regions and between rural and urban areas from the point of view of its infrastructure and of its medical and pharmaceutical facilities is huge and it results in inequalities in the access to health services. Thus, 88.8% of the hospitals, 91.7% of the medical practices, 92.3% of the diagnosis and treatment centres, 98.1% of the specialised medical practices, and 79.5% of the total pharmacies are in the urban area. Medical units in the urban area concentrate 88.6% of the total doctors, 87.3% of the dentists, 88.5% of the pharmacists, and 89.8% of the nurses. [7]

But there is a quantitative and qualitative

gap between the rural and the urban: secondary school graduates attend higher education more than those from the rural area, who make an option for a professional training. School abandonment is low in both areas, but on the whole of the educational system it becomes more and more important, ranking among the highest in the European Union. Higher education attendance rates show a continuation of the inequality determined by social origin.

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