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The VAT gap as a limiting factor for economic development of the CEE countries

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Abstract:

Purpose and Originality: The aim of the study was to compare the VAT revenue growth and the GDP growth in the Central and Eastern European countries belonging to the European Union within the 2000-2016 to verify the VAT gap estimations made by European Commission.

Method: To achieve the goal, an analysis of the strength of the correlation between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the Central and Eastern European countries belonging to the European Union within the 2000-2016 period was carried out (chain base indices). On the basis of the statistical analysis of data with the use of Pearson's correlation coefficients, an international comparison also with European Commission's estimates was made with the use of the inductive reasoning methodology.

Results: The results of conducted correlation analysis show very strong positive dependence between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the Central and Eastern European countries belonging to the European Union within the 2000-2016 period (chain base indices) in the case of 8 out of 11 CEE countries (Pearson's r from 0.78 to 0.93) and strong correlation in the case of rest 3 CEE countries (Pearson's r from 0.59 to 0.69). But it must be stressed that the assessment of these results must take into account changes in the VAT rates introduced in almost all CEE countries as the consequence of 2008 crisis. That's why these very high Pearson's correlation coefficients between analyzed values seem to confirm a growing problem with VAT collection, though VAT rates were increased almost in all CEE countries (in some of them significantly).

Society: The high and/or growing VAT gap especially in the case of less credible CEE countries with permanent state budget deficits, growing public debt and higher tax rates, increases instability of sources for public expenditures and increases risk premium, thus market cost of capital, i.e. has an effect on future investment level, entities' creditworthiness, consumption level, the rate of debt growth and the rate of catchin-up process of the CEE countries and the rate of their social and economic development.

Limitations: It must be stressed that the VAT gap analysis is based on estimates, incomplete data and adopted particular estimation method. Furthermore, the estimates of the VAT gap are updated and revised backwards every year, mainly because of updates in the underlying national accounts data published by Eurostat and corrections in estimation methods (for example revision of the parameters of the VTTL model used by European Commission; European Commission, 2017).

Keywords: VAT gap, tax revenue, general government budget, financial security of the state, tax avoidance, tax evasion.

1 Introduction

The VAT gap is a difference between the actually collected VAT revenue and the VAT Total Tax Liability (VTTL), i.e. the theoretical tax liability according to tax law. The VTTL is estimated as the sum of the liability based on theoretical values of consumption and

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investment (plus country specific net adjustments)[1]. It makes difficult to estimate the size of the VAT, its main drivers and its structure, because this phenomenon concerns mainly not registered activity either by statistical offices or by the tax administration. According to the European Commission estimation the total VAT gap in the European Union amounted in 2015 to EUR 151.5bn, i.e. 1.02 % EU28 GDP as a whole. It's a slightly decrease in contrast to previous years, when the VAT gap was growing and reached EUR 162bn, i.e. 1.2 % GDP (figure 1).

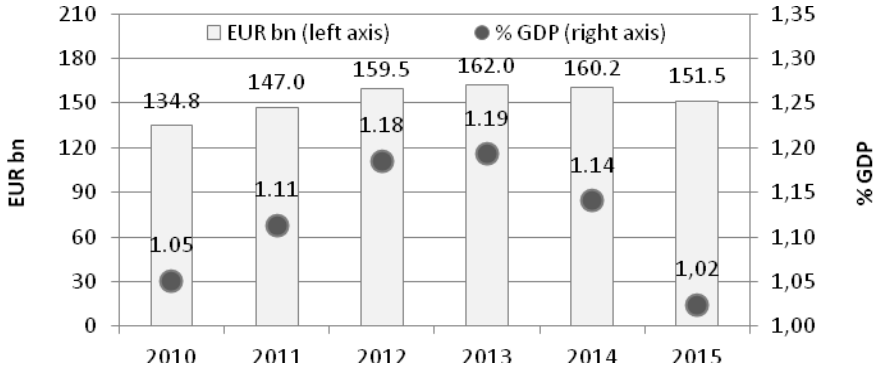


Figure 1. The VAT gap in the European Union countries* in the years 2010-2015 (in EUR bn – left axis and in % GDP – right axis)
* EU28 in 2015, EU27 in 2014 (without Cyprus), EU26 in the years 2010-2013 (without Cyprus and Croatia)
Source: self-reported data on the basis of European Commission's and Eurostat's data (European Commission, 2017; Eurostat 2018a).

It must be stressed that VAT gap can't be treated only as a consequence of criminal activity, tax fraud and tax evasion, which, however, belong to its main determinants. The VAT gap is also an effect of natural bankruptcies, tax arrears, as well as reporting problems in national accounts (errors and omissions) (Poniatowski, 2016). There is one more important factor, namely tax avoidance, which is increasingly contributing to the tax gap in the EU.

2 Theoretical framework

The processes of globalization and internationalization of companies contributed to popularization of the tax optimization phenomenon (*see, e.g.*, Wyciślok, 2013). Tax reduction solutions formerly reserved only for the largest enterprises are now widely available for the average company. It is, on one hand, forced by international competition and, on the other, by especially high public levies in Europe (Redo, 2017) and it is also provoked by complex and diverse legal systems. Explosion of tax consulting services in the area of tax optimization and free internet access to them are also an important factor. Tax planning is currently a standard tool used to manage business finance (Jamroży and Kudert, 2013) and is used not only to

[1] The six main components are: household, government, and non-profit institutions serving households final consumption; intermediate consumption; gross fixed capital formation; and other, largely country-specific, adjustments (European Commission, 2017).

improve net profitability but also financial liquidity (Ballion, 2014). It could have been expected that also enterprises from Central and Eastern Europe, after the period of finding themselves on the single European market, will be more and more actively striving to improve their competitive position, especially that the majority of them belong to some of the most open economies not only within the EU (with the highest relations of export and import to GDP). It must be stressed that the highest benefits from tax optimization achieve those entrepreneurs whose moves cross-border (Kudert et al., 2009; Jamroży, 2014). They are, without a doubt, also attracted by high tax rates in Europe. European VAT rates are one of the highest in the world. The differences in the amount of different public levies are worth noting here, as they explain the tendency for tax optimization in Europe as well as social acceptance of this phenomenon. Especially in the Central and Eastern European countries with the lowest GDP per capita, the highest standard VAT rates in the EU and the propitious legal environment after entering the EU. Apart from the numerous agreements for the avoidance of double taxation, the key role in the process of tax optimization played the transposition of EU tax directives into the national legal systems which opened the door to many interesting solutions. And the last factor that seems to drive the tax gap is greater tolerance of international opinion after 2008 crisis towards actions that are to alleviate the crisis; also towards enterprises' greater measures that are to rationalize and improve their resistance to global downturn after the crisis. This greater tolerance might be a result of lack of conventional tools for economy stimulation and the need to use radical solutions, for example reduction of interest rates to a historically low level and quantitative easing programme with the simultaneous significant increase of public debt (Redo, 2018).

3 Method

The aim of the study was to analyze the strength of the correlation between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the Central and Eastern European countries belonging to the European Union within the 2000-2016 period (chain base indices). On the basis of the statistical analysis of data with the use of Pearson's correlation coefficients, an international comparison also with European Commission's estimates was made with the use of the inductive reasoning methodology.

The data comparability problem. It must be stressed that the VAT gap analysis is based on estimates, incomplete data and adopted particular estimation method. Furthermore, the estimates of the VAT gap are updated and revised backwards every year, mainly because of updates in the underlying national accounts data published by Eurostat and corrections in estimation methods (for example revision of the parameters of the VTTL model used by European Commission; European Commission, 2017). Additionally, in author's opinion there is greater value in presenting the amount of VAT gap in relations to the actual VAT revenue in a given country than to an estimate hypothetical amount of potential VAT revenue (VTTL) used in the analyses of European Commission or CASE (performed also for European

Commission). This is also the view presented in this overview. That's why the figures should be interpreted and compared with other data cautiously.

4 Results and discussion

4.1 The VAT gap in the Central and Eastern European countries

The VAT gap in 11 Central and Eastern European countries is twice as high as in EU15 (table 1) – respectively 29.5% of VAT revenue compared with 14.6%. This disproportion has been maintained for several years. However it must be stressed that there was a decrease in the VAT gap in the CEE countries in the years 2010-2015 from 34.7% of VAT revenues to 29.5%. Although all central measures for the VAT gap in CEE countries in the indicated period have been reduced (the average, the median, the first and third quartiles), the most of the CEE countries still belong to those with the highest VAT gap in relation to VAT revenue in the EU. Eight out of 11 EU countries with the highest VAT gap are the CEE countries[2].

Table 1. Measures of central tendency for the VAT gap in CEE11* countries, EU28** and EU15 in the years 2010-2015 (in % of actually collected VAT revenues)

		2010	2011	2012	2013	2014	2015
01)	**CEE 11**	34.7	31.4	37.3	35.5	32.8	29.5
02)	**$\bar{x}$ CEE 11**	36.9	31.6	34.0	31.2	27.9	24.3
03)	**M CEE 11**	30.0	30.6	29.6	28.7	23.5	21.9
04)	**Q1 CEE 11**	26.5	22.0	25.7	20.5	14.7	10.9
05)	**Q3 CEE 11**	52.2	41.2	42.4	39.8	35.6	34.2
06)	**EU 28**	15.7	16.3	17.3	17.3	16.4	14.6
07)	**EU 15**	13.9	14.8	15.4	15.7	14.8	13.2
08)	**$\bar{x}$ EU 28**	24.5	23.8	24.6	23.7	21.2	17.7
09)	**$\bar{x}$ EU 15**	13.6	15.5	15.1	15.6	13.2	12.8

* CEE11 in the years 2014-2015, CEE10 in the years 2010-2013 (without Croatia)
** EU28 in 2015, EU27 in 2014 (without Cyprus), EU26 in the years 2010-2013 (without Cyprus and Croatia)
Source: own calculations on the basis of European Commission's data (European Commission, 2017).

According to the European Commission's data, Romania has the highest VAT gap not only among CEE countries but also among all EU28 countries, which amounted in 2015 to 59.2 % of actually collected VAT revenue. The VAT gap in Slovakia, Lithuania and Poland reached about 32-42% of collected VAT revenue (respectively 41.6 %, 35.9 % and 32.5 %) and in Bulgaria, Latvia, Czech Republic and Hungary about 16-26% of VAT revenue (respectively 25.9 %, 21.9 %, 19.7 % and 15.9 %) – see figure 2. The VAT gap in all those 8 countries is higher than the VAT gap in whole EU28 (14.6 % in 2015; table 1).

[2] The other three countries in this group are: Greece, Italy and Malta.

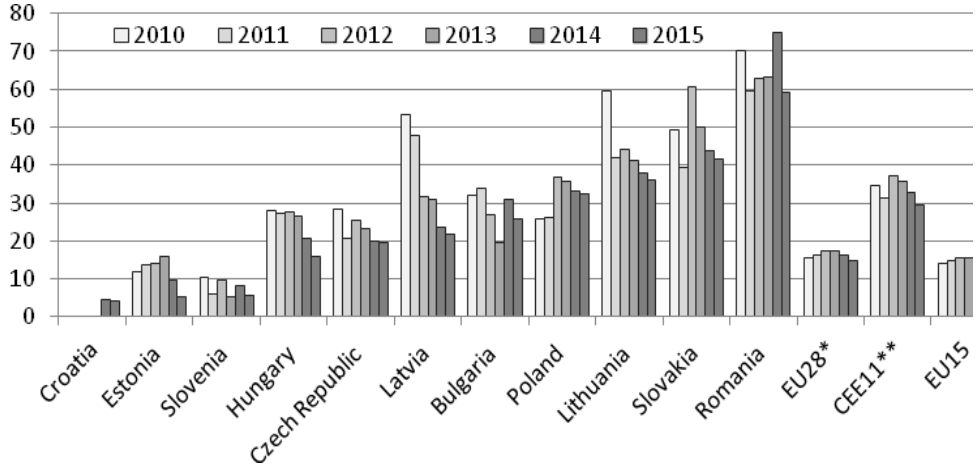


Figure 2. The VAT gap in the Central and Eastern European countries (as a percent of actually collected VAT revenues) in the years 2010-2015
* EU28 in 2015, EU27 in 2014 (without Cyprus), EU26 in the years 2010-2013 (without Cyprus and Croatia)
** CEE11 in the years 2014-2015, CEE10 in the years 2010-2013 (without Croatia)
Source: own calculations on the basis of European Commission's data (European Commission, 2017).

Croatia, Estonia and Slovenia are three exceptions where the VAT gap was estimated in 2015 at only 4.1-5.8 % of actually collected VAT revenue (respectively 4.1 %, 5.1 % and 5.8 %; figure 2). Moreover, they were among the five countries with the lowest VAT gap in relation to VAT revenue in the whole EU.

It must be also noted that there was a VAT gap drop in the 2010-2015 period in almost all CEE countries (figure 3). The biggest decrease took place in the case of Latvia and Estonia (by 57-59 %) and Slovenia, Hungary and Lithuania (by 40-45 %).

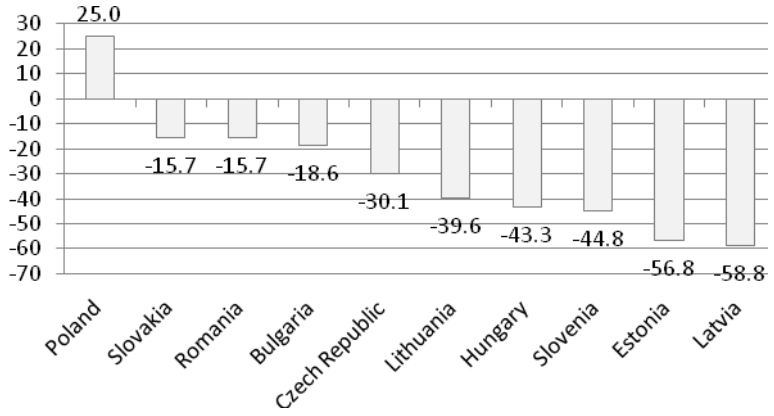
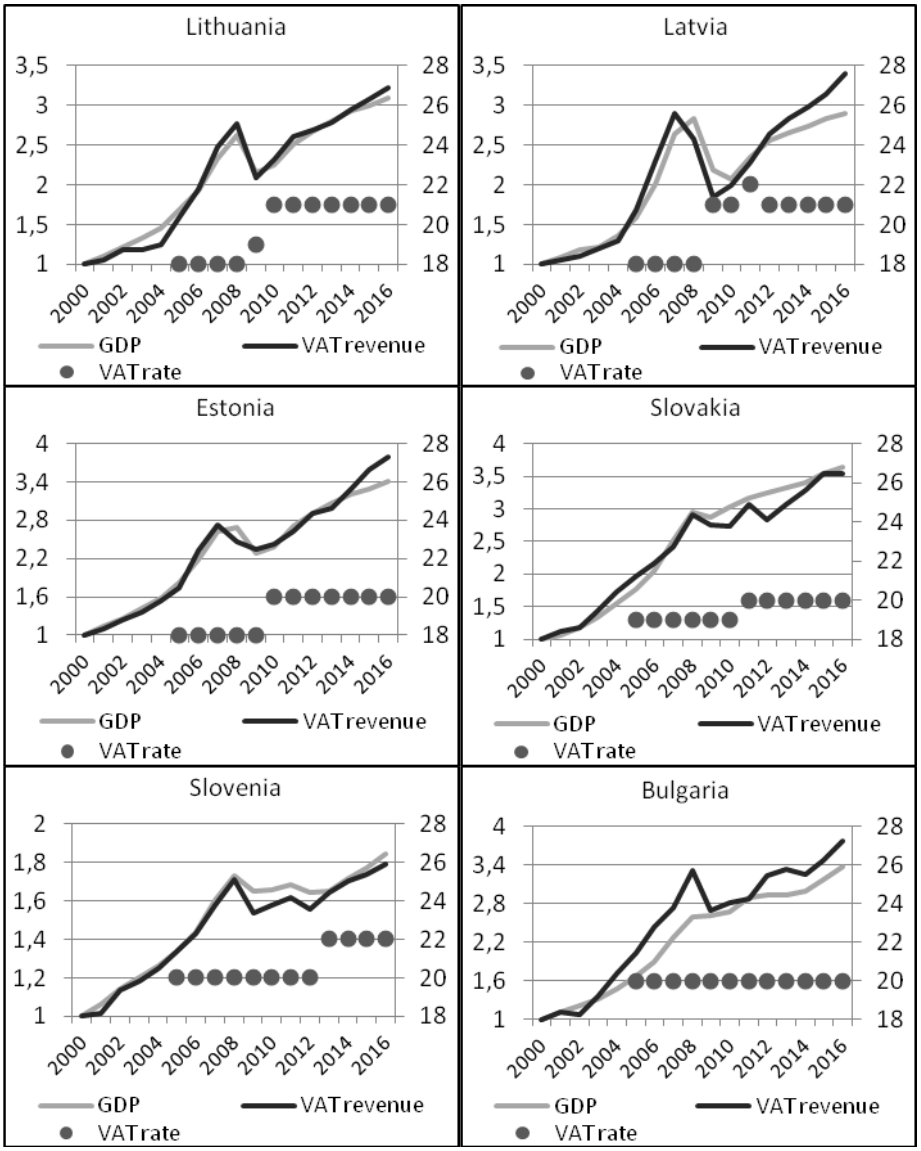


Figure 3. The change in the level of VAT gap (as a percent of actually collected VAT revenue) in CEE countries in the years 2010-2015 (%)
Source: own calculations on the basis of European Commission's data (European Commission, 2017).

Poland was the only CEE country with VAT gap increase (in relation to collected VAT revenue) in the analyzed period: from 26 % in 2010 to 32.5 % in 2015, i.e. by 25 % (see figure 3 and figure 2).

4.2 Comparative analysis of nominal changes in the GDP level and in the VAT revenues level in the CEE11 countries in the period 2000-2016

The comparative analysis of nominal changes in the GDP level and in the VAT revenues level in CEE11 countries in the period 2000-2016 was conducted to verify the VAT gap estimations of the European Commission. The results are presented in the graphs below (figure 4).



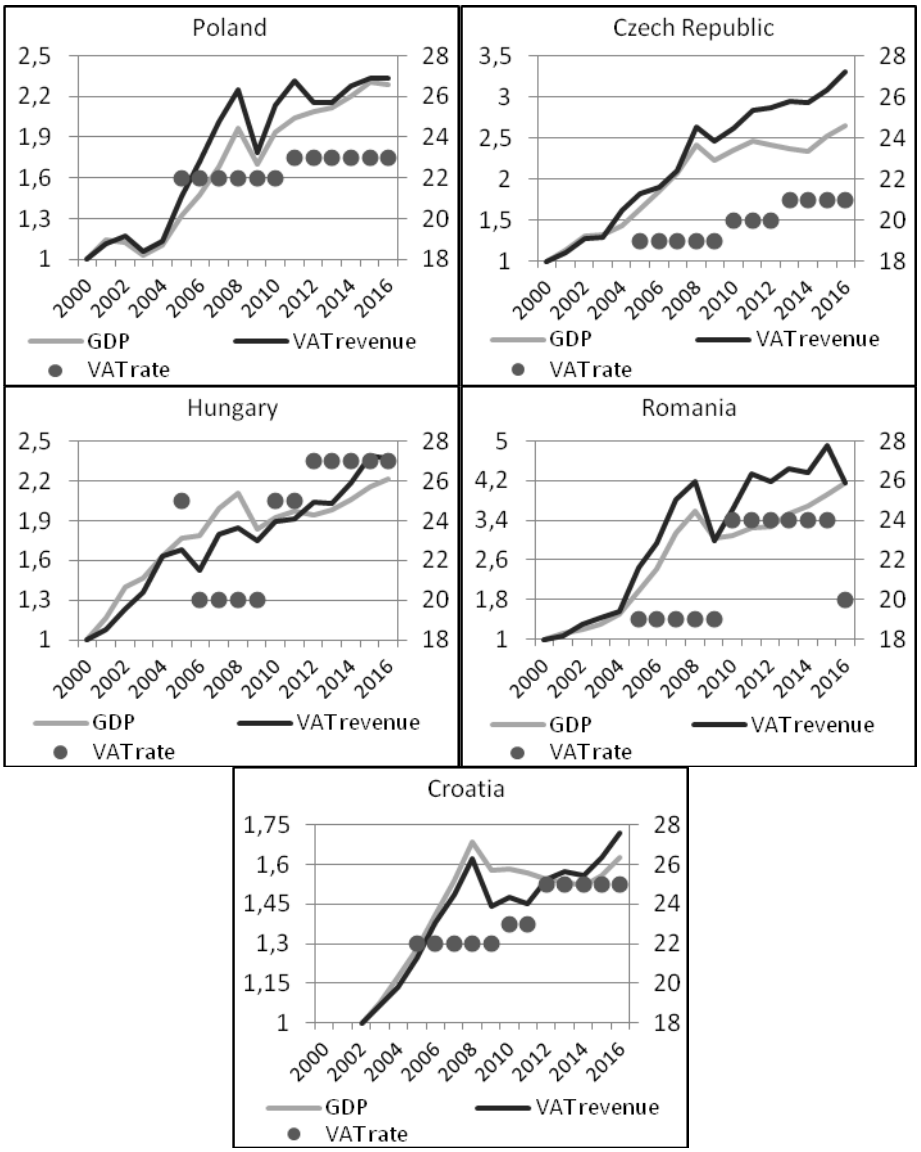


Figure 4. GDP at market prices and VAT revenue (2000=100; left axis) and standard VAT rate (%; right axis) in the CEE countries in the years 2000-2016
Source: self-reported data on the basis of Eurostat 2018b and KPMG 2018.

The above results (figure 4) should be confronted with the European Commission's VAT gap estimates (presented in figure 2). This comparison provides mixed results. In the case of some countries, despite the high convergence between the pace of GDP changes and the pace of VAT revenue changes (figure 4) the VAT gap according to EC data belong to the highest among the CEE11 countries (e.g. in Lithuania). On the other hand, in the case of Slovenia and Estonia visible on the figure high convergence of the pace of changes coincides with the low VAT gap estimate. This may be the effect of maintaining the VAT gap in these countries at the stable level throughout the analyzed period. Unfortunately, the European Commission's VAT gap time series are too short and do not allow to verify this hypothesis.

It must be stressed that reasoning in this area is unfortunately hindered by changes in the level of VAT rates and/or in the range of products and services with reduced VAT rates (introduced

in all CEE countries except Bulgaria to improve public finance stance after the outbreak of 2008 crisis). That's why it's impossible to conclude whether the VAT revenues growth acceleration (in relation to nominal GDP increase; figure 4) is the result of the improvement of VAT collection in Czech Republic, i.e. the decrease in VAT gap, or only the effect of raising VAT. Therefore, it seems that if post-crisis increase in VAT rates is not illustrated in the VAT revenues growth acceleration, this may indicate the VAT gap increase. In addition, data analysis is hindered by the implementation of subsequent EU regulation, resulting, for example, in changes in the place where the tax obligation arises. There was in 2015 the EU-wide change in regulation regarding "place of supply" of electronic services. Before 2015, VAT charged on electronic services was invoiced to the country where the provider of services is registered, like for any other good. Since then, the VAT is to be paid to the country of customer residence (European Commission, 2017).

But it should be noted, that the observed acceleration in the growth of VAT revenues in Latvia since 2012 and in Estonia since 2014 (figure 4) can be seen in the VAT gap decrease in these countries in analyzed period (figure 2).

4.3 The analysis of correlation between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the Central and Eastern European countries belonging to the European Union within the 2000-2016 period

The results of conducted correlation analysis between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the CEE countries in the years 2000-2016 (chain base indices) confirm above mentioned mixed conclusions.

Table 2. Pearson's correlation coefficient between the yearly changes in nominal GDP and the yearly changes in nominal VAT revenue in the years 2000-2016 (chain base indices)

	Pearson's r	Student's t-distribution	critical value $t_{\alpha=0.05, n-2}$
Poland	0.93	9.5156	2.1448
Lithuania	0.91	8.0918	2.1448
Slovenia	0.87	6.7062	2.1448
Croatia*	0.86	5.7701	2.1788
Latvia	0.85	6.0154	2.1448
Romania	0.79	4.7744	2.1448
Czech Republic	0.78	4.6837	2.1448
Estonia	0.78	4.5992	2.1448
Slovakia	0.69	3.5763	2.1448
Hungary	0.67	3.3461	2.1448
Bulgaria	0.59	2.6991	2.1448
CEE11**	0.90	7.6606	2.1448
EU28**	0.92	8.9911	2.1448
EU15	0.91	8.3390	2.1448

* 2002-2016
** 2002-2016 without Croatia
Source: own calculations on the basis of Eurostat's data.

The determined Pearson's correlation coefficients for above variables indicates strong and very strong dependence (according to Guilford classification) between nominal increase in VAT revenues and nominal increase in GDP in all CEE countries in analyzed period (table 2). All results are statistically significant. Such high Pearson's correlation coefficients suggest that the VAT gap may remain at a stable level in analyzed period in the countries without greater changes in VAT rates or that the VAT gap increased in the countries with higher changes in VAT rates. But in the case of Poland despite a small increase in standard VAT rate (from 22% to 23%) and very high r=0.93 the VAT gap (according to the EC estimation) has risen since 2012. In turn, in the case of Lithuania in the situation of a higher standard VAT rate increase, from 18% to 21%, and also very high r=0.91, the VAT gap has been decreasing since 2010 (see figure 2, figure 4 and table 2).

4.4 VAT as the main source of public revenue in member states and an important source of EU budget

There is one more thing. Very high Pearson's correlation coefficients between nominal increase in VAT revenues and nominal increase in GDP for the whole EU28 (r=0.92) despite increases in VAT rates in most EU countries seem to confirm a growing problem with tax collection in the whole EU (table 2). It concerns in particular CEE countries, where the VAT rates increases were higher and took place in 10 out of 11 CEE countries (while in the case of the EU15 in 11 countries; KPMG 2018). The growing tax gaps lower the total public revenues, the public service quality and lead to imposing higher public levies. All of this

suppresses the process of catching up and the social progress in the Central and Eastern Europe. It also contributes to faster public debt's growth, what consequently causes the decrease in creditworthiness, the increase of risk premium requested by investors and the absorption of capital from a rather small domestic financial markets. It results in a higher market cost of capital, what limits economic prospects and increases sensitivity to shocks, because it has an effect on future investment level, entities' creditworthiness, consumption level and the rate of debt growth. That's why it reduces not only the current but also the future economic growth (Redo et al., 2018).

It must be stressed, that the VAT revenues are the main source of public revenues in all CEE countries, so they decide about the economic policy options. VAT provides from one third to even half of total tax receipts in CEE countries and from 17% to 28% of total general government revenues (2016; figure 5).

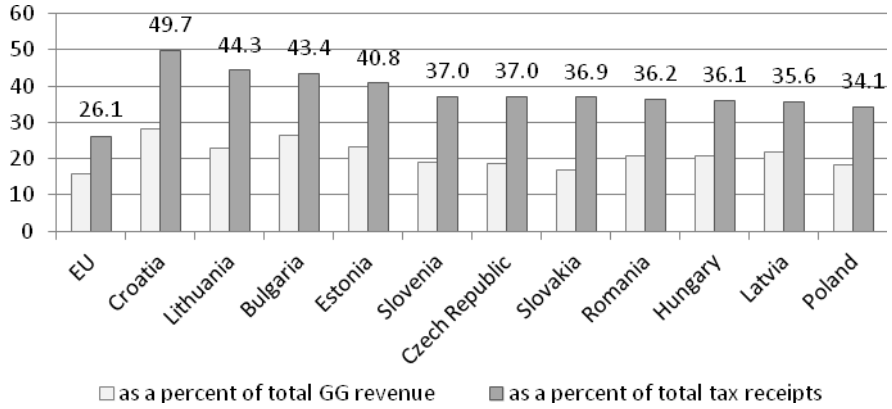


Figure 5. VAT revenue as a percent of total general government revenue and of total tax receipts in 2016 (%)
Source: self-reported data on the basis of Eurostat 2018b and European Commission 2017.

VAT plays the most significant role in public expenditure financing in Croatia, where VAT revenues accounted in 2016 for 49.7% of total tax receipts and for 28.1% of total general government revenues. In Lithuania, Bulgaria and Estonia VAT revenues accounted for 41% to 44% of total tax receipts and in other CEE countries for 34% to 37%.

Finally it must be added, that VAT revenues are also an important revenue source of the European Union budget which is the key source of financing the catching-up process and public investment in less developed EU region, i.e. especially in CEE countries, as they all are net beneficiary of the EU's budget (Redo, 2011).

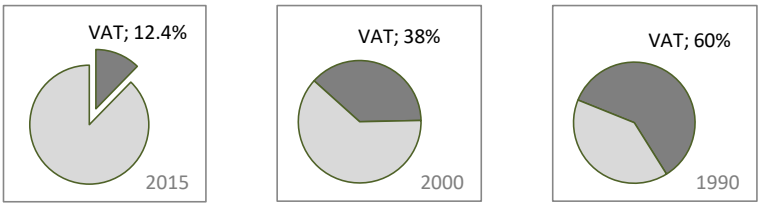


Figure 6. VAT revenue as a percent of total EU budget revenue in the year 1990, 2000 and 2015
Source: self-reported data on the basis of European Commission's financial reports.

In 2015, VAT revenues accounted for 12.4% of all the EU's budget revenue and amounted to EUR 18.1bn. This is a much smaller percentage of the EU budget's total revenue as compared to a few decades ago, when VAT revenues accounted for 38% of the total EU budget in 2000 or for 60% like in 1990 (figure 6). This, however, does not mean that the problem has diminished. The growing issue of the VAT gap is causing further decrease in financial independency of the EU as it increases the weight of the largest EU budget's revenue based on GNI (the so called 4th financing source), dependent on national policy through annually enacted states' budgets (Dynus, 2007). The weight of the 4th source of the EU's budget revenue was previously significantly lower: it accounted for 40.5% of all the EU's budget revenue in 2000, whereas in 2015 for 68.8% (European Commission, 2016). And the financing sources of the "4th source" are the national budgets of all EU member states, whose main source of financing, as mentioned above, is VAT.

5 Conclusion

The internationalization process of enterprises and globalization have contributed to the tax revenues decrease in some countries. This applies in particular to the European countries that belong to those with the highest tax rates in the world, which explain in part together with the differences in the amount of public levies, the tendency for tax optimization in Europe as well as social acceptance of this phenomenon. Especially in the Central and Eastern European countries – the poorer part of the EU. It must be stressed, that there is not only problem with VAT gap, but also with CIT and PIT collection. Tax planning became a standard tool used to manage business and private finance. Solutions once available only for biggest international companies are nowadays also available for free on the internet and used at a much bigger scale by much smaller businesses. And it concerns not only companies. There are also more and more people earning high salaries that look for more favorable tax solutions in other countries. And make use of them.

The problem with decreasing effectiveness in VAT collection is a special one in the Europe, because VAT revenues are the main source of public expenditures in all CEE countries(VAT provides from one third to even half of total tax receipts in CEE countries and from 17% to 28% of total general government revenues), so they decide about the development abilities

and opportunities, and thus about the attractiveness to investors, and the economic policy effectiveness in stimulating economic growth and mitigating crises. This concerns in particular the CEE countries, which are net beneficiary of the EU's budget. And VAT revenues are also an important revenue source of the European Union budget which is the key source of financing the catching-up process and public investment in less developed EU region.

Very high Pearson's correlation coefficients between nominal increase in VAT revenues and nominal increase in GDP for the whole EU28 (r=0.92) within the 2000-2016 period (chain base indices), though VAT rates were increased not only in the CEE countries, seem to confirm a growing problem with tax collection in the whole EU. The growing VAT gap in the EU raises concerns about the further increase in high public debt in most of member states and their fiscal policy effectiveness. But its effects are much more severe in the case of developing economies which have lower credibility and high borrowing needs to finance the catching-up. It must be stressed that 8 of 11 CEE countries are among the 11 EU member states with the largest VAT gap. This problem applies especially to less credible countries with permanent state budget deficits, growing public debt and higher tax rates compared to other CEE countries. The high and/or growing VAT gap in their case increases instability of sources for public expenditures and increases risk premium, thus market cost of capital, i.e. has an effect on future investment level, entities' creditworthiness, consumption level and the rate of debt growth. Without a doubt, it is necessary to tighten the tax system up and track illegal activities, but it must be noted that constant changes in business rules create additional uncertainty and new solutions complicate the situation in already complicated tax systems. It all discourages people from establishing and developing enterprises, as it also encourages them to look for simpler and more profitable solutions in other countries which is easier thanks to globalization and international legal environment.

References

1. Ballion, G. (2014). Wykorzystanie strategii podatkowych w zarządzaniu zasobami finansowymi. *Organizacja i Zarządzanie, 74*.
2. Dynus, M. (2007). Budżet ogólny jako podstawa systemu finansowego Unii Europejskiej. *Toruńskie Studia Międzynarodowe, 1*.
3. European Commission (2016). EU budget 2015. Financial report, Luxembourg.
4. European Commission (2017). Study and Reports on the VAT Gap in the EU-28 Member States: 2017 Final Report.
5. Eurostat (2018a). Gross domestic product at market prices (at current prices). Retrieved from http://ec.europa.eu/eurostat/web/main/home [accessed 16.03.2018].
6. Eurostat (2018b). Main national accounts tax aggregates. Retrieved from http://ec.europa.eu/eurostat/web/main/home [accessed 16.03.2018].
7. Jamroży, M. (2014). Planowanie podatkowe działalności prowadzonej poprzez zagraniczny zakład. *Studia Ekonomiczne, 198*.
8. Jamroży, M., & Kudert, S. (2013). Optymalizacja opodatkowania dochodów przedsiębiorców. Wolters Kluwer Polska SA, Warszawa.

9. KPMG (2018). Indirect tax rates table. Retrieved from https://home.kpmg.com [accessed 30.03.2018].
10. Kudert, S., Klipstein, I., & Jamroży, M. (2009). Szanse i ryzyka podatkowe transgranicznej produkcji − na przykładzie inwestycji w polsko-niemieckim obszarze przygranicznym. *Monitor Podatkowy, 10*.
11. Poniatowski, G. (2016). Problem nieściągalności VAT w Polsce pod lupą. *Zeszyty mBank – CASE*, 142.
12. Redo, M. (2011). Płatnicy i beneficjenci netto budżetu Unii Europejskiej. *Zeszyty Naukowe Wyższej Szkoły Bankowej we Wrocławiu*, 23.
13. Redo, M. (2017). Poziom opodatkowania oraz kondycja finansów publicznych w państwach Unii Europejskiej czynnikiem zagrażającym rozwojowi gospodarczemu w Europie (in) Kryzysy we współczesnej Europie i próby ich przezwyciężenia. Garczewski K. (ed.). Toruń.
14. Redo, M. (2018). The issue of VAT gap in Poland in contrast to the European Union member states as a threat to financial security of the state (forthcoming).
15. Redo, M., Wójtowcz, K., & Ciak, J. (2018). Bezpieczeństwo finansów publicznych. CeDeWu.
16. Wyciślok, J. (2013). Optymalizacja podatkowa. Legalne zmniejszanie obciążeń podatkowych. C.H. Beck. Warszawa.

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Povzetek:
Razkorak DDV kot zavirajoči dejavnik ekonomskega razvoja v srednji in vzhodnji Evropi

Namen: Cilj raziskave je primerajti rast prihodkov DDV in rast BDP v Srednje in Vzhodnoevropskih državah članicah Evropske unije med leti 2000 in 2016 z namenom potrditve ocene primanjkljaja DDV kot ga je predvidela Evropska komisija.
Raziskovalna metoda: Za potrebe doseganja namena bo uporablejna analiza moči povezanosti med letnimi spremembami nominalnega BDP in letnimi spremembami nominalnega DDV v Srednje in Vzhodnevropskih državah članicah EU z uporabo drsne osnove. Na podlagi uporabe Pearsonovega korelacijskega koeficienta in mednarodne primerjave bo uporabljena induktivna metoda vzpostavitve zaključkov.
Rezultati: Rezultati korelacijske analize kažejo zelo močno pozitivno povezanost med letnimi spremembami nominalnega BDP in letnimi sporemembami nominalnega DDV v primeru 8 od 11 analiziranih držav (Pearsonov r se giblje med 0.78 in 0.93) v ostalih treh primerih pa je ta povezava močna (Pearsonov r je med 0.59 in 0.69). Pri tem pa je potrebno poudariti, da je potrebno upoštevati spremembo v višini stopnje DDV v pratkično vseh analiziranih državah zaradi ekonomske krize 2008. To je namreč vpliv, ki povzroča visoko stopnjo povezanosti med danima spremenljivkama in napeljuje na zaključek, da prihaja do težav s pobiranjem DDV, čeprav se je DDV praktično v vseh analiziranih državah povečal (v nekaterih primerih zelo).
Družbeni pomen: Višina in rast primankljaja DDVpredvsem v primeru manj verodostojnih Srednje in Vzhodnoevropskih držav s stalnimi proračunskimi primankljaji, rastjo javnega dolga in visokimi davčnimi stopnjami povečjuje nestabilnost virov za javnofinančne odhodke in povečuje zavarovanje rizika (tržne vrednosti kapitala) ter posledično vpliva na sposobnost nadaljnih investicij, kreditno bonitetno oceno, stopnjo potrošnje, stopnjo rasti dolga ter sposobnost dohajanja omenjenih držav na področju družbenega in ekonomskega razvoja.

Omejitve: Poudariti je treba, da analiza pomanjkljivosti DDV temelji na ocenah, nepopolnih podatkih in sprejetu posebnih metod ocenjevanja. Poleg tega se ocene primanjkljaja DDV vsako leto posodabljajo in popravljajo nazaj, predvsem zaradi posodobitev osnovnih podatkov nacionalnih računov, ki jih objavlja Eurostat, in popravkov v metodah ocenjevanja (na primer revizija parametrov modela VTTL, ki ga uporablja Evropska komisija; Evropska komisija, 2017).

Ključne besede: davčni primanjkljaj, davčni prihodki, javnofinančni proračun, finančna varnost države, izogibanje davkom, davčne utaje.

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Quality Indicators in Primary Healthcare

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Abstract:
Research Question (RQ): Which are the most commonly monitored and gaged quality indicators in primary healthcare?
Purpose: The purpose of this research is to study and research the grounds for quality indicators and measuring thereof in primary healthcare.
Method: For this research we used the method of existing knowledge on quality indicators in healthcare and on monitored quality indicators in primary healthcare by systematical review of existing literature. We used triangulation to ensure better understanding of the problem, check and confirm data, and thus ensure the integrity of the research
Results: Research showed the origin of quality indicators in primary healthcare and quality indicators which are measured by organizations in primary healthcare.
Organization: Primary healthcare organizations will get an overview over most commonly monitored quality indicators in primary healthcare and thus the possibility to compare success and efficiency.
Society: Data on measured quality indicators should be public. Users of primary healthcare services can choose the most successful healthcare organization based only on these data.
Originality: A systematical review of the most commonly monitored and measured quality indicators in primary healthcare.
Limitations/Future Research: The research is limited due to a smaller number of existing sources used and due to a smaller sample of interviewees. In the future it would be meaningful to research which quality indicators are measure by the majority of healthcare centers in Slovenia and establish a new model of monitored or obligatory quality indicators in primary healthcare based on the findings of this research. .

Keywords: quality, triangulation, healthcare, primary healthcare services, quality indicators.

1 Introduction

The safety of healthcare users in Slovene healthcare is often at risk. We are facing declinations of medical treatment, high costs of poor-quality health services, dissatisfactions of healthcare service users, inequality in accessibility to health services and long waiting periods.

The European Union requires that its member states establish and maintain systems for better patient safety. Numerous healthcare practitioners have already established quality management systems. They have established external assessment (audit) of their compliance with quality standards, self-assessment, monitoring of quality indicators and reporting on the later. Quality indicators should be public data because they enable primary healthcare users

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and doctors to choose among healthcare service practitioners and enable doctors to monitor their success and efficiency with regards to goals set in plans and to take necessary measures in case of adverse events. The definition of primary healthcare quality indicators is not uniform and they cannot be found among public data, which consequently leads to inability to compare individual healthcare institutions.

It is generally known that "What's not being measured cannot be improved." If a quality indicator cannot be or is not being measured than there is no possibility of improvement. The most important quality indicator for patients is the result of medical treatment. Quality indicators should be measured based on existing data since this would not impose additional workload on healthcare workers.

With this purpose the method of balanced quality indicators was introduced. In 2010 the Manual on Quality Indicators (Priročnik o kazalnikih kakovosti) in healthcare was drafted, which defines 73 quality indicators, 18 of which were intended for primary healthcare. However, these proved to be useless for primary healthcare level and are not defined as quality indicators by practitioners, who collect these data only to draw up reports for the National Institute of Public Health (Nacionalni inštitut za javno zdravje).

The purpose and goal of this article is to define the origin of quality in healthcare and to determine which quality indicators are most frequently monitored by healthcare practitioners at primary level in Slovenia.

2 Theoretical background

2.1 Background of quality indicator development in healthcare in Slovenia

The European Union requires its member states to fully monitor and coordinate quality. Member states of the World Health Organization have adopted the document HEALTH21 - Health for all in the 21st century. By 2010 all member states had to ensure quality systems for improving patient safety. This was based on high percentage of declinations of medical treatment, high costs of low-quality healthcare services, high costs of medical services, dissatisfaction of patients, long waiting periods, and inequality in accessibility to healthcare services (Ministry of Health, 2006, pp 19-20).

In 2001 documents Quality of Healthcare System in the Republic of Slovenia (Kakovost v sistemu zdravstvenega varstva Republike Slovenije) and the National Program of Healthcare in the Republic of Slovenia (Nacionalni program zdravstvenega varstva Republike Slovenije) were introduced in Slovenia, which determined that professionals shall develop in the manner of improving the quality of healthcare for the healthcare system to comply with wishes and needs of the population and efficient use of sources. As a result of incapability of reaching an agreement a national authority for quality in healthcare wasn't established. Consequently, in 2004 the Department for Quality and Safety (Oddelek za kakovost in varnost) was established within the framework of the Ministry of Health (Ministrstvo za zdravje, 2006, p 32).

Quality indicators can be defined as statistical or other measurable units, showing the quality of healthcare. In this perspective they (in-) directly show the successfulness of the healthcare units and subunits downright to the individual medical experts pursuing the goal of maintaining the positive health level. (Ministrstvo za zdravje, Robida, 2004, str. 1)

General healthcare quality indicators are those, which can be used for any given individual and for any given health condition. Clinical specific healthcare quality indicators, on the other hand, correspond to the non-specific clinical conditions. Process indicators correspond to specific processes, where critical control points should be established in order to collect the data or perform the measurements at these points. Outcome indicators care considered to be seen as current and future health condition of the individual patients in connection to the received treatment. (Ministrstvo za zdravje, Robida, 2004, str. 1)

In November 2010 the Manual on Quality Indicators (Priročnik o kazalnikih kakovosti) was published under the leadership of the Department for Quality and Safety at the Ministry of Health (Oddelek za kakovost in varnost pri Ministrstvu za zdravje). Healthcare practitioners should calculate quality indicators in order to have self-control over services in medical institutions. This way the the Health Insurance Institute of Slovenia -HIIS (Zavod za zdravstveno zavarovanje - ZZZS) would get information on efficient use of resources and patients would have the possibility to choose the best provider of healthcare services (Pribaković et al., 2010, pp 8–10).

Table 1: Comparison of the state of in healthcare in Slovenia between 2006 and 2016

	2006	2016
QIs in hospitals	6 quality indicators	76 quality indicators
Clinical paths	No	yes, 14 and more
Accreditation of hospitals	No	22 hospitals
Questionnaire on patients' experiences in hospitals	No	yes
Patient's rights	No increased attention	legislation
Supervisions of the National Commission for Prevention and Control of Hospital-Acquired Infections and the National Commission for Efficient Use of Antimicrobial Medicine	No	yes (5 audits yearly)
Warning adverse events	4 notifications	10 notifications in 9 months
Commissions for Quality and Safety in Hospitals	No	Yes
Council for Quality and Safety in Healthcare in the Republic of Slovenia	No	Yes
Project group for education on quality and safety in healthcare	No	Yes
e-support (prescriptions, appointments)	No	Yes
Evaluation of quality at primary level of healthcare	No	Partially by introducing referential outpatient clinics
Evaluation of quality of health services in old people's homes and other residential care institutions	No	No
Integrated treatment	yes (preparation of proposal for implementation)	Renewed increase of attention

According to *"10 Years of Quality Management in Slovene Healthcare, Experiences, Good Practice, Obstacles", Ministry of Health, Tušar et al., 9th Days of Angela Boškin, Journal, 2016, p 15" (»10 let vodenja kakovosti v slovenskem zdravstvu, izkušnje, dobre prakse, ovire«, Ministrstvo za zdravje, Tušar et al., 9. dnevi Angele Boškin, Zbornik prispevkov, 2016, str. 15.)*

2.2 Primary healthcare quality indicators in other countries

Kringos et al. (2010, pp 1-8) described the development of primary healthcare quality indicators, which enable trans-European comparison. The dimensions of primary healthcare are classified according to:

- Structure: quality indicators of managements, economic results and development of workforce,
- Processes: quality indicators of continuity, accessibility, integrity and coordination of primary healthcare services,
- Result of medical treatment: quality indicators of success and efficiency, fairness in health.

In 2014 a group of researchers (Rotar et al., 2014, pp 398–404) sent questionnaires to 30 OECD member states in order to find out which quality indicators of healthcare are being monitored and reported on. The results have shown that member states most frequently report on quality indicators of illnesses and quality indicators of healthcare system. The emphasis is

places mostly on quality indicators of cancer and patient treatment. Less common are countries' reports on quality indicators of patient safety and the least on quality indicators of medicine prescription. Reports on quality indicators of mental healthcare and patient's experience with ambulatory treatment are very rare. The main reason for differences among reporting on healthcare quality indicators lies in different organization of healthcare systems.

In their research Rusforth et al. (2015, pp 1–9) have emphasized that quality indicators are often nor measurable so when developing these quality indicators it is necessary to be careful not to include those quality indicators whose measurement would cause additional work for healthcare workers. They have determined 18 most important quality indicators, which focus only on chronical diseases and not on quality of these patients' treatments.

Brubakk et al. (2015, pp 2–8) have established that quality indicators are mainly monitored by healthcare institutions which are certified/accredited. Most commonly monitored quality indicators are: patient satisfaction, number of patients treated with medicine, accessibility do medical data, soundness (completeness) of medical records, completeness of perioperative records, markings of sick leave and evaluation of toilets in hospitals.

According to Saut et al. (2017, p 1–9) the main reasons for accreditation or certification are high costs of healthcare, adverse events, complexity of new technologies, ageing of population and quick spreading of transmissible diseases across the world.

Alameddine et al. (2015, pp 1–14) have conducted a research on willingness of healthcare workers to report on quality indicators in primary healthcare in Lebanon in cooperation with 105 primary level medical centers. Due to fear from sanctions doctors have most difficulties with regards to reporting on adverse events. On the other hand, nurses are complaining about lack of time for reporting on quality indicators, therefore, a restructuring would be useful since this would ensure nurses more time for reporting on quality indicators.

In their study Khampang et al. (2017, pp 1–10) have established that the development of quality indicators in primary healthcare based on clinical guidelines represents the basis for efficient implementation of medical programs and for better medical treatment results. A major problem in monitoring quality indicators is also data, since healthcare personnel forgets or does not have time to keep records on quality indicators. In addition, the information system does not enable monitoring of all desired data for quality indicators.

Croes et al. (2017, pp 1–15) already discuss the effect of better quality evaluations of primary healthcare services on competiveness of healthcare service providers on the market. The research proved that better evaluated quality indicators of healthcare services attract more patients which means that hospitals with higher quality assessments are far more competitive on the market.

3 Method

3.1 Data collection

We have reviewed expert and scientific writings on quality and quality indicators in healthcare systems in Slovenia and abroad with key word quality indicators in healthcare. We have researched monitored quality indicators in primary healthcare abroad, specified starting points for the development of quality in healthcare, therefore, we used a slightly older writings which explain the origin, purpose and development of quality and quality indicators in healthcare. We have reviewed data in financial reports of healthcare centers in Slovenia, which are public documents accessible in the websites of individual healthcare centers. We have combined a questionnaire and an interview in telephone conversations with quality management system administrators and checked the compliance of findings in five healthcare centers in Slovenia. The interviewees wanted to stay anonymous.

4 Results

4.1 Results 1 – The origin of quality in healthcare

The purpose of the quality indicators of healthcare success and patient safety is to encourage patient safety and continuously improve the quality of healthcare services. Hospitals will be able to compare themselves according to structure indicators, process quality indicators and the quality indicators of quality and patient experiences results (Ministry of Health, 2006, p. 8).

4.2 Results 2 – Monitored quality indicators in healthcare centers in Slovenia

Healthcare service is implemented at primary, secondary and tertiary level. Primary level healthcare comprises basic healthcare and pharmacy. Secondary level healthcare includes specialist's clinics and hospital services. Tertiary level of healthcare encompasses performing services of clinics, clinical institutes and other authorized healthcare institutions (Act on health services, Article 2).

In Slovenia healthcare centers are located according to HIIS regional units. There are regional units listed and number of healthcare centers in individual regional unit (RU).

1) RU Celje: 7;

2) RU Koper: 6;

3) RU Kranj: 1;

4) RU Krško: 3;

5) RU Ljubljana: 18;

6) RU Maribor: 5;

7) RU Murska Sobota: 4;

8) RU Nova Gorica: 4;

9) RU Novo Mesto: 4;

10) RU Ravne na Koroškem: 7. Vir: (HIIS, 2017, pp. 15-30)

Business reports of individual healthcare centers are published on their websites. Mandatory items of financial business reports are determined in *Instructions for the closure of accounts of state and municipal budget and methodologies for drawing up a report on achieved objectives and results of direct and indirect budget users (Navodilu o pripravi zaključnega računa državnega in občinskega proračuna ter metodologije za pripravo poročila o doseženih ciljih in rezultatih neposrednih in posrednih uporabnikov proračuna – Ur. L. RS, No. 12/01, with amendment*s). Reporting on quality indicators is not obligatory.

Table 2: Monitored QIs in healthcare centers in Slovenia

Healthcare center	Realization of working program	Waiting periods	Satisfaction of employees	Proportion of those included in e-health	Satisfaction of service users	No. of complaints	Financial indicators of business performance	Quality indicators
Ajdovščina	X	X			X		X	
Brežice	X						X	X*
Cerknica	X		X		X		X	
Črnomelj	X			X			X	
Dravograd	X			X			X	
Gorenjska	X						X	
Gornja Radgona	X						X	
Ilirska Bistrica	X			X			X	
Ivančna Gorica	X		X		X		X	
Izola	X						X	
Kamnik	X	X	X		X		X	
Koper	X				X	X	X	
Krško	X	X	X		X	X	X	
Lendava	X		X	X	X		X	
Litija	X	X		X			X	
Ljubljana	X		X		X	X	X	X
Nova Gorica	X		X		X		X	
Novo mesto	X		X		X		X	
Ormož	X						X	
Ptuj	X	X		X			X	
Slovenska Bistrica	X		X		X	X	X	
Total	21	5	9	6	11	4	21	2

Note: Data are taken from financial business reports of listed healthcare centers, which are publicly accessible data on websites of individual healthcare centers.
*Business report of Healthcare center Brežice mentions quality indicators , however, these are not specifically stated and measured.

4.3 Results 3 – Results of qualitative and quantitative research

The combination of a questionnaire and an interview was performed in five healthcare centers in Slovenia. These differ from each other according to the number of employees. They are located throughout Slovenia – from Pomurje region, Štajerska region and Central Slovenia to Gorenjska and Notranjska region.

The questionnaire includes 26 open and closed-type questions and is anonymous

Table 3: Data on questioned healthcare center

question/interviewee	1	2	3	4	5
Number of employees	107	905	1500	142	410
Certification	yes	yes	yes	yes	yes
Quality standard	ISO 9001:2015	ISO 9001:2015	ISO 9001:2015	ISO 9001:2015	ISO 9001:2015
Year of first certification	2010	2003	2012	2011	2014
No. of years of certification	8	15	6	7	3

Most common reason why an organization decided to initiate the procedure of certification:

Table 4: Reasons for the certification of a healthcare center

Number of reasons	Type of reason	Frequency of reason
1	Improvement of processes	4
2	Transparency Safe and high-quality patient treatment	4
3	Reputation of organization	3
4	Competitiveness on public tenders	2
5	Simplified documentation management	1
6	Efficiency of organization	1

Table 5: Acceptance of activities related to quality in healthcare

Interviewee	1	2	3	4	5
How the employees accept activities related to quality in healthcare?	It is better now, in the beginning they lacked motivation	Badly, because this represents additional work for them	Very well	Well	Positively

Table 6: Are there any individuals among the personnel who stand out in accepting activities related to quality?

Answer/interviewee	1	2	3	4	5	Total
Yes	Doctors	Doctors	Individuals			3
No				X	X	2
Total						5

Table 7:Do you measure quality indicators?

	1	2	3	4	5	Total
Yes	X	X	X	X	X	5
No						0

Table 8: Why did you decide to measure quality indicators?

Reason	Frequency
Improvements	4
Following trends	2
Standard requirement	2

The explanation of quality indicator definition to employees:

- Something that can help them improve their work.
- Result of work, which reflects the quality of undertaken work.
- Result of the work of employees who would like to improve their work or something that can prove the quality of their work.
- Quality indicator is an acceptable result of work.
- Quality indicators means that you provide services with as little personnel and time as possible according to expert guidelines and without errors.

Quality indicators measured by healthcare centers in Slovenia:

1 Patient satisfaction
2 Satisfaction of employees
3 Satisfaction of business partners
4 Number of complaints and praise
5 Waiting periods in specialized clinics
6 Number of non-conformities at external audit
7 Proportion of complaints related to stomatoprothetic products
8 Success in cardio- pulmonary resuscitation
9 Achieving average access time at interventions
10 Average time of patient treatment at emergency department
11 Realization of the plan of dental education and preventive
12 Realization of HIIS programs in individual practices
13 Proportion of preventive check-ups of children, pupils and young persons

14 Proportion of preventive check-ups od adults in reference clinics
15 Proportion of performed preventive check-ups of women
16 High-level of vaccination of pre-school children and pupils
17 Average time from the beginning of the appointment to the issuance of the result for urgent laboratory examination
18 Exclusive breast-feeding of newborns at the end of community nursing
19 Prescription of antibiotics according to professional guidelines in view of Slovene average
20 Number of diagnostically useless radiographs
21 Success of workshops on smoking cessation
22 Success of workshop related to body weight
23 Proportions of complaints related to supplies
24 Number of failures of individual appliances
25 Realization of the plan of trainings and education
26 Realization of the plan of preventive maintenance of monitoring-measuring devices
27 Measures after inspections
28 Timeliness of performed procedures of public procurement
29 Proportion of implemented annual interviews
30 Vehicle fuel consumption

Table 9: Manner of data collection for the purpose of measuring quality indicators

Answer/interviewee	1	2	3	4	5	Total
Routinely collected data	X	X	X	X	X	5
Manually collected data	X	X	X	X	X	5

Despite additional work due to manual data collection for the purpose of measuring quality indicators only one of the interviewed healthcare centers removed one of quality indicators. Other interviewed healthcare centers haven't removed any of the quality indicators due to additional work related to data collection.

When establishing quality indicators at organizations only one of five interviewed healthcare centers considered the guidelines from the Manual on quality indicators.

Table 10: Quality indicators from the Manual on quality indicators measured by organizations

Defined and measured quality indicator	1	2	3	4	5	Total
Proportion of vaccination against measles		X	X			2
Proportion of vaccination against diphtheria, tetanus and whooping cough		X	X			2
Proportion of vaccination against hepatitis B		X	X			2
Proportion of vaccination against influenza of persons older than 65			X			1
Incidence of measles						0
Incidence of whooping cough						0
Incidence of hepatitis B						0
Risk factors for cardiovascular diseases – coronary risk						0
Risk factors for cardiovascular diseases – cholesterol						0
Risk factors for cardiovascular diseases –blood pressure						0
Risk factors for cardiovascular diseases – normal BMI						0
Risk factors for cardiovascular diseases – moderately increased BMI						0
Proportion of smokers	X	X				2
Injuries with sharp objects – personnel		X	X	X	X	4

Table 11: Other data from the questionnaire

Statement/interviewee	1	2	3	4	5	Total
Reporting on quality indicators to the Ministry of Health						0
Feedback information to providers on quality indicators from the Ministry of Health						0
Categorization of quality indicators into process quality indicators, structure quality indicators and quality indicators of results						0
Recording and analysis of medical treatment declination		X				1
Recording and analysis of warning adverse events for the Ministry of Health			X		X	2
Achieving quality indicators goals	90-100%	80-90%	90%	90%	85%	
Increasing of goals	X	X	X	X	X	5
Time range of increasing goals	2–3 years	2–3 years	Once per year	Once per year	Once per year	
Introduction of Corrective actions based on quality indicators	X		X			2
Education on quality indicators	X	X	X	X		4
Monitoring of patient satisfaction	X	X	X	X	X	5
Monitoring of accessibility to healthcare services	X	X	X	X	X	5
Monitoring of employees' treatment of patients	X	X	X	X	X	5

None of the interviewed healthcare centers has categorized quality indicators into structure quality indicators, process quality indicators and quality indicators of medical treatment results. All five interviewed healthcare centers have classified the quality indicators only according to processes.

Table 12: Competitiveness of organizations based on quality indicators measuring

Answer/interviewee	1	2	3	4	5	Total
Yes			X		X	2
No	X					1
I don't know		X		X		2

5 Discussion

By 2010 the European Union member states had to establish healthcare systems which ensure high-quality healthcare services and patient safety. This resulted from bad medical treatment results, adverse events, high costs of low-quality healthcare services, dissatisfaction of service

users, long waiting periods in inequality in accessing healthcare services (Ministry of Health, 2006, pp 22–32)

Researches show that the monitoring of quality indicators increased at the secondary healthcare level. In 2006 only 6 healthcare centers monitored the indicators; in 2016 already 76 centers monitored the quality indicators. In this time numerous healthcare institutions have become certified or accredited. Healthcare centers have started to record quality assessment with the introduction of reference clinics (Ministry of Health, 9th Days of Angela Boškin, Tušar et al., 2016, p 15)

Our research shows that the Ministry of Health never required primary level healthcare to keep records and quality indicators. Most common reason for measuring quality indicators in healthcare centers according to the interviewees is the desire to make improvements in organizations, to follow trends and due to requirements of the international ISO 9001:2015 standard according to which all five interviewed healthcare centers are certified.

All five healthcare centers have defined all quality indicators they are measuring. However, only one of them used the *Manual on quality indicators (Priročnik o kazalnikih kakovosti),* the remaining four healthcare centers identified the manual as useless for the primary level of healthcare. Quality indicators in their organizations are not defined according to the manual. They collect data for quality indicators only due to the requirement of the *National Institute of Public Health (Nacionalni inštitut za javno zdravje)* to report data. Four of the interviewees mentioned that among all proposed quality indicators from the manual they only measure injuries with sharp objects of personnel, two healthcare centers measure also the proportion of vaccinations against measles, diphtheria, tetanus, whooping cough, hepatitis B and the proportion of smokers after attending the workshops for cessation of smoking.

Quality indicators in healthcare centers in Slovenia are not categorized according to structure, processes and medical treatment results. They are divided only according to processes. For all measured quality indicators the healthcare centers have defined goals which they achieve by 80-100%, which is why these are raised every 2 to 3 years.

»Kazalniki procesov kažejo ali delujejo skladno z določenim procesom – v procesu določimo kritične kontrolne točke, kjer bomo izvedli meritev ali zbrali podatke.« (Ministrstvo za zdravje. Robida, A., 2004, p 1)

Despite regular education on quality there are still some individuals among the personnel who do not accept activities related to quality with great enthusiasm. It was doctors who were exposed. Healthcare workers in majority of healthcare centers (4 questioned healthcare centers) accept these activities positively and well.

The interviewed healthcare centers listed following quality indicators as the most frequently measured quality indicators:

- Patient satisfaction,

- Satisfaction of healthcare workers,
- Satisfaction of business partners,
- Number of complaints and praise,
- Waiting periods in specialized clinics,
- Others, mentioned in table 4.3.7, are listed only by an individual healthcare center.

Data for quality indicator measurement are routinely or manually collected by all five healthcare centers. None of the healthcare centers has indicated to have measured quality indicators only based on routinely collected data. Only one of them has abandoned one of measured quality indicator due to additional work of manual data collection.

The reason for monitoring quality indicators is among others also the certification or accreditation of healthcare organizations according to quality standards. Certified or accredited institutions are thus much safer for patients and offer higher-quality healthcare services (Brubakk et al., 2015, pp 2–8).

Questioned healthcare centers most frequently listed following reasons for certification:

- Process improvement,
- Transparency of the institution,
- Safe and high-quality patient treatment and
- Reputation of the organization.

Healthcare institutions decide to get certification or accreditation mainly because of high costs in case of adverse events, complexity of technology, and ageing of the population (Saut et al, 2017, pp 1–9).

Alameddine et al. (2014, pp 1–14) have conducted a research in Lebanon on willingness of healthcare institutions to report on quality indicators. They have determined that doctors are not willing to report on adverse events since they are afraid of sanctions while nurses lack time for making reports.

The interviewed healthcare centers in Slovenia do not report on declinations of medical treatment and warning adverse events to the Ministry of Health since the later does not require them to submit such data.

Croes et al. (2017, pp 1–15) draw attention to the competitive meaning of quality indicators. Highly assessed quality indicators namely attract more patients, therefore the hospital with better results are proved to be more competitive on the market.

We have selected at least two healthcare centers from each HIIS regional unit and thus reviewed 21 healthcare centers' business reports. There are 55 healthcare centers in total in Slovenia.

Research shows that following data are most commonly presented in business reports:

- Realization of work program: all 21 healthcare centers,
- Waiting periods: 5 healthcare centers,
- Satisfaction of employees: 9 healthcare centers,
- Proportion of those included in e-health: 6 healthcare centers,
- Satisfaction of healthcare service users: 11 healthcare centers,
- Number of complaints and praise: 4 healthcare centers,
- Financial indicators: all 21 healthcare centers.

The obligatory items of financial business reports are prescribed in in *Instructions for the closure of accounts of state and municipal budget and methodologies for drawing up a report on achieved objectives and results of direct and indirect budget users - Ur. L. RS, No. 12/01, with amendments (Navodilu o pripravi zaključnega računa državnega in občinskega proračuna ter metodologije za pripravo poročila o doseženih ciljih in rezultatih neposrednih in posrednih uporabnikov proračuna – Uradni list RS, št. 12/01, s spremembami).* Quality indicators are not defined as an obligatory item, therefore they are mainly not included in business reports.

6 Conclusion

The European Union member states are obliged to establish healthcare systems, which enable highest possible quality of healthcare services and patient safety. Reasons for this are mainly high percentage of medical treatment declinations, high costs of poor treatment, dissatisfaction of healthcare service users, long waiting periods and inequality in access to healthcare services (Ministry of Health, 2006, pp 19–20).

Measuring quality indicators presents the basis for healthcare systems to determine their success and efficiency. Quality indicators must be measurable, given in absolute values and comparable among organizations and countries. Reporting on quality indicators and publication of the data will enable patients and doctors to choose healthcare service providers with best quality indicators, while insurance companies will get an insight into efficient use of resources. Healthcare centers in Slovenia do not publish data on measured quality indicators at national level. Therefore, there are no comparable data on quality indicators in primary healthcare since the Ministry of Health does not require reporting on quality indicators.

Since 2010 all healthcare service providers should monitor a smaller set of quality indicators (Kiauta et al., 2010, p 9). Researches show that all five interviewed healthcare centers in Slovenia measure quality indicators mainly in order to ensure improvements in organizations, to follow trends and due to requirements of ISO 9001:2015 standard.

Kringos et al. (2010, pp 1–8) have developed quality indicators for pan-European comparison at the level of three dimensions: structure, process and medical treatment results. After reviewing literature we can establish that in foreign countries the emphasis is placed in

particular on quality indicators of medical treatment results. They have one big disadvantage since there are numerous factors like patient's age, seriousness of illness, social and economic status etc. which have an impact on these quality indicators.

Lawton (2016, pp 1–15) has established that primary level healthcare monitors mainly following quality indicators of medical treatment results: avoiding risky prescription of asteroid medication, treatment of diabetes, treatment of hypertension, use of anticoagulation therapy.

The reason why the emphasis is placed on quality indicators of medical treatment results is probably the accessibility to routinely collected data. Data on chronical illnesses are regularly collected, while for other quality indicators it would be often necessary to subsequently enter the data into the information system, for which the healthcare workers do not have time. In addition, quality indicators of medical treatment results are not the most appropriate for measuring success since patients can affect the value of quality indicators with their way of life and numerous other factors.

According to the research the interviewed healthcare centers did not classify quality indicators into structure quality indicators, process quality indicators and quality indicators of medical treatment results. The quality indicators in these healthcare centers are identified according to processes.

Quality indicators are monitored mainly by institutions which are certified or accredited and are therefore safer for patients (Brubakk, 2015, pp 2–8). The reasons why organizations apply for accreditation or certification have already been identified by Saut (2017, pp 1–9). These are high costs of medical treatment and adverse events. In Slovenia the interviewed healthcare centers decided to get certification mostly due to the introduction of improvements in the organization, transparency of the institution and safe treatment of patients.

Alamedine et al. (2015, pp 1–14) have determined why data on quality indicators are not being reported on or why it is abandoned. Doctors fear to report on adverse events due to sanctions while nurses do not have time for making reports. Unfortunately, the Ministry of Health in Slovenia does not require primary healthcare to report on measured quality indicators despite the fact that they issued *the Manual on quality indicators*.

Consequently, it would be necessary to restructure workplaces with an employee who would be responsible for measuring quality indicators and reporting on them. At the same time, it is still likely in healthcare to accuse individuals of their mistakes without trying to find reasons in the system and introducing corrective measures. Data for measuring quality indicators in healthcare centers in Slovenia are collected both routinely and manually. However, despite the large amount of time necessary for manual data collection only one of the five healthcare centers has abandoned one of the measured quality indicators.

Croes et al. (2017, pp 1–15) already deals with competitive advantages of healthcare centers which monitor quality indicators. If organizations report on quality indicators and if these are published, the patient has the possibility to choose the institution with the best quality indicators. Consequently, such organization is in competitive advantage since there is a far bigger demand after its services.

Currently there is no model of monitoring quality indicators in primary healthcare, only a rough record of the state of measured quality indicators in primary healthcare based on five questioned healthcare centers, which is the scientific contribution of this article. This article will give guidance to authorities for quality with regards to quality development at primary level since this is the only way to achieve successful and efficient healthcare system operation. Consequently, doctors would refer fewer patients to the secondary level, which would shorten waiting periods, decrease medical treatment costs and improve equality in accessibility to healthcare services, which is an important contribution to the society. Individuals/patients will thus have more options to choose among healthcare practitioners with the best quality indicators.

The research is limited to public data of healthcare centers on monitored quality indicators and to a questionnaire with a smaller sample of interviewees. Therefore, it would be meaningful to upgrade the research by interviewing a larger sample of healthcare centers in Slovenia which actually measure quality indicators and to determine to which extent these quality indicators are similarly defined and comparable. Based on this it would be relevant to develop a unified model of advisable or obligatory monitored quality indicators at the primary level of healthcare, which would be recognized as an improvement tool by the primary level healthcare organizations.

References

1. Alemeddine, M., Saleh, S., & Natafgi, N. (2015). *Assessing health-care providers' readiness for reporting quality and patient safety indicators at primary health-care centres in Lebanon: a national cross-sectional survey.* Human Resources for Health, 13:37, 1 – 14, doi: 10.1186/s12960-015-0031-5
2. Brubakk, K., Vist E., G., Bukholm, G., Barach, P., & Tjomsland, O. (2015). *S systematic review of hospital accreditation: the challenges of measuring complex intervention effects.* BMC Helath Services Research. 1 – 10, doi: 10.1186/s12913-015-0933-x
3. Campbell, S. M., Kontopantelis, E., Hannon, K., Burke, M., Barber, A., & Lester, H. E. (2011). *Framework and indicator testing protocol for developing and piloting quality indicators for the UK quality and outcomes framework.* BMC Family Practice 20, 12(85), 1-11, doi: 1471-2296/12/85
4. Carayon, P., Wetterneck, T. B., Rivera-Rodriguez, A. J., Schoofs Hundt, A., Hoonakker, P., Holden, R., Gurses, A. P. (2014). *Human factors systems approach to healthcare quality and patient safety,* Applied Ergonomics, 45, 14 – 25, doi: 10.1016/j.apergo.2013.04.023

5. Collet, T.H., Salamin, S., Zimmerli, L., Kerr, E.A., Clair, C., Picard-Kassovsky, M., Vittinghoff, E., Battegay, E., Gaspoz, J.M., Cornuz, J., & Rodondi, N. (2011). *The Quality of Primary Care in a Country with Universal Health Care Coverage*. J Gen Intern Med (26)7, doi: 10.1007/s11606-011-1674-0
6. Coulter, A. (2017). Measuring what matters to patients*: OECD Health ministers commit to patient reported measures of performance,* BMJ 2017;356:j816, 1-2, doi: 10.1136/bmj.j816
7. Croes, R.R., Krabbe-Alkemade, Y.J.F.M., & Mikkers, M.C. (2017). *Competition and quality indicators in the health care sector: empirical evidence from the Dutch hospital sector*. Eur J Health Econ, 19, 5–19, doi: 10.1007/s10198-016-0862-6
8. Dotan, D. B., & Koski, K.J. (2017). *How Predictive Analytics Will Prevent the Cost of Harm: A Practical Approach for Hospital Management Systems*. Pegwin, 1 – 10, www.pegwin.io, (22. 12. 2017)
9. Duarte Sonia, S., Fonseca, A., (2017). *Portuguese primary healthcare – sustainability through quality management*. International Journal of Quality & Reliability Management, 34 (2), 251 – 264. doi: 10.1108/IJQRM-05-2015-0066
10. Kelley, E., & Hurst, J. (2006). *Health Care Quality Indicators Project: Conceptual Framework Paper.* OECD Health Working Papers, No. 23, doi: 10.1787/440134737301
11. Kersnik, J. (2001). *Kakovost v sistemu zdravstvenega varstva v Republiki Sloveniji.* Pregled stanja in bodoče usmeritev. Kopenhagen: Regionalni urad SZO.
12. Khampang, R., Teerawattananon, Y., Tantivess, S., Cluzeau, F., Foskett-Tharby, R., & Gill, P. (2017). *Developing and testing quality indicators for the Thai Quality and Outcomes Framework. Safety in Health*. 1-10. doi: 10.1186/s40886-017-0065-6,
13. Kiauta, M., Poldrugovac, M., Rems, M., Robida, A., & Simčič, B. (2010). *Nacionalna strategija kakovosti in varnosti v zdravstvu (2010-2015)*. Ljubljana: Ministrstvo za zdravje.
14. Krczal, E., & Mock, T. (2016). *People-Centred Quality Indicators for Primary Care Centres,* International Journal of Integrated Care,16(6):A300, 1-8, doi: 10.5334/ijic.2848
15. Kringos, D. S., Boerma, W. G. W., Bourgueil, Y., Cartier, T., Hasvold, T., Hutchinson, A., Lember, M., Oleszczyk, M., Rotar Pavlic, D., Svab, I., Tadeschi, P., Wilson, A., Windak, A., Dedeu, T., & Wilm, S. (2010). *The european primary care monitor: structure, process and outcome indicators.* BMC Family practice, 11(81), 1-8, doi:10.1186/1471-2296-11-81
16. Kringos, D., Boerma, W., Bourgueil, Y., Cartier, T., Dedeu, T., Hasvold, T., Hutchinson, A., Lember, M., Oleszczyk, M., Rotar Pavlic, D., Svab, I., Tedeschi, P., Wilm, S., Wilson, A., Windak, A., Van der Zee, J., & Groenewegen, P. (2013). *The strength of primary care in Europe: an international comparative study,* British Journal of General Practice, 742-750
17. Lawton, R., Heyhoe, J., Louch, G., Ingelson, E., Glidewell, L., Willis, T., McEachen, R.R.C., & Foy, R. (2016). *Using the Theoretical Domains Framework (TDF) to understand adherence to multiple evidence-based indicators in primary care: a qualitative study*. Implementation science, 11(113), doi: 10.1186/s13012-016-0479-2
18. Ministrstvo za zdravje Republike Slovenije. Robida, A. (2004). *Kazalniki kakovosti. Možen praktični pristop.* http://www.mz.gov.si/fileadmin/mz.gov.si/pageuploads/mz_dokumenti/delovna_podrocja/zdravstveno_varstvo/kakovost/kazalniki/Kazalniki-Pristop_2004_Bolni__nice.pdf, (21. 02. 2018)
19. Ministrstvo za zdravje Republike Slovenije. (2006). *Nacionalne usmeritve za razvoj kakovosti v zdravstvu.* (1. izd.). Ljubljana.
20. Ministrstvo za zdravje. (2016). *10 let vodenja kakovosti v slovenskem zdravstvu, izkušnje, dobre prakse,* ovire. 9. dnevi Angele Boškin, Zbornik prispevkov

21. Ministrstvo za zdravje. (2006). Uvajanje izboljševanja kakovosti v bolnišnice. Pridobljeno na http://www.mz.gov.si/ (25. 01. 2018)
22. OECD, HCQI Expert Group Meeting. (2012). *Prescribing in primary care: proposing a new set of HCQI*, Paris, 1-12
23. *Navodilo o pripravi zaključnega računa državnega in občinskega proračuna ter metodologije za pripravo poročila o doseženih ciljih in rezultatih neposrednih in posrednih uporabnikov proračuna.* (2001, 24. februar). Uradni list RS, št. 12/01.
24. Pribaković Brinovec, R., Masten-Cuznar, O., Ivanuša, M., Leskošek, B., Pajntar, M., Poldrugovac, M., Simčič, B., & Tušar, S. (2010). *Priročnik o kazalnikih kakovosti*. Ljubljana: Ministrstvo za zdravje.
25. Rotar, A. M., Van de Berg, M. J., Kringos, D. S., & Klazinga, N. S. (2016). *Reporting and use of the OECD Health Care Quality Indicators at national and regional level in 15 countries.* International Journal of Quality in Health Care, 2016, 28(3), 398–404, doi: 10.1093/intqhc/mzw027
26. Rotar Pavlič, D., Sever, M., Klemec-Ketiš, Z., & Švab, I. (2015). *Process quality indicators in familymedicine: results of an international comparison*, BMC Family Practice, 16 (172), 1-11, doi: 10.1186/s12875-015-0386-7
27. Rusforth, B., Stokes, T., Andrews, E., Willis A., T., Mceachan, R., Faulkner, S., & Foy, R. (2015). *Developing 'high impact' guideline-based quality indicators for UK primary care: a multi-stage consensus process*. BMC Family Practice ,16(156), 1-9. doi: 10.1186/s12875-015-0350-6,
28. Saut, A. M., Tobal Berssaneti, F., & Moreno, M. C. (2017). *Evaluating the impact of accreditation on Brazilian healthcare organizations: A quantitative study*, International Journal for Quality in Health Care, 1–9, doi: 10.1093/intqhc/mzx094
29. Schäfer, W.L.A., Boerma, W.G.W., Kringos, D.S., Ryck, E. de, Greß, S., Murante, A.M., Rotar-Pavlic, D., Schellevis, F.G., Seghieri, C., Berg, M.J. van den, Westert, G.P., Willems, S., & Groenewegen, P.P. (2013). *Measures of quality, costs and equity in primary health care instruments developed to analyse and compare primary care in 35 countries.* Quality in Primary Care, 21(2), 67-79, https://www.ncbi.nlm.nih.gov/pubmed/23735688, (19. 12. 2017)
30. Schäfer, W., GW Boerma, W., Murante M., A., Sixma JM, H., Schellevisa G., F., & Groenewegena P., P. (2015). *Assessing the potential for improvement of primary care in 34 countries: a cross-sectional survey*. Bull World Health Organ, 93, 161–168 | doi: 10.2471/BLT.14.140368
31. Schäfer, W., GW Boerma, W., Kringos S., D., De Maeseneer, J., Greß, S., Heinemann, S., Rotar-Pavlic, D., Seghieri, C., Švab, I., Van den Berg J., M., Vainieri, M., Westert P., G., Willems, S., & Groenewegen P., P. (2011). *QUALICOPC, a multi-country study evaluating quality, costs and equity in primary care*, BMC Family Practice, 12:115, 1-9, doi: 1471-2296/12/115
32. Shaw, C. D., Groene, O., Botje, D., Sunol, R., Kutryba, B., Klazinga, N., Bruneau, C., Hammer, A., Wang, A., Arah O. A., & Wagner, C. (2014). *The effect of certification and accreditation on quality management in 4 clinical services in 73 European hospitals*, International Journal for Quality in Health Care, 26, 100–107, doi: 10.1093/intqhc/mzu023
33. Shaw, C. D., Braithwaite, J., Moldovan, M., Nicklin, W., Grgic, I., Fortune, T., & Whittaker, S. (2013). *Profiling health-care accreditation organizations: an international survey*, International Journal for Quality in Health Care , 25(3), 222–231, doi: 10.1093/intqhc/mzt011

34. Shaw, C., Groene, O., Mora, N., & Sunol, R. (2010). *Accreditation and ISO certification: do they explain differences in quality management in European hospitals?*. Internatioanl Journal for Quality in Health Care, *22 (6),* 445 – 451. doi: 10.1093/intqhc/mzq054
35. Slovenski inštitut za standardizacijo. (2015). *Slovenski standard SIST EN ISO/IEC 17021-1*
36. Slovensko združenje za kakovost in odličnost. (2017). *Pojmovnik s področja kakovosti v slovenskem in angleškem jeziku.* Ljubljana, str. 11
37. Torres-Vallejo, L., & Morris, S. (2016). *Primary care supply and quality of care in England,* 2016, Eur J Health Econ, 1-6, doi: 10.1007/s10198-017-0898-2
38. Wagner, C., Groene, O., Thompson, A. C., Dersarkissian, M., Klazinga, N. S., Arah, O. A., & Sunol, R. (2014). *DUQuE quality management measures: associations between quality management at hospital and pathway levels*. International Journal for Quality in Health Care, 26 (S1), 66 – 73. doi: 10.1093/intqhc/mzu020
39. Wilson Lionel, L., *The Quality manager*, J. Qual. Clin. Practice, *20*, 127–130
40. Zakon o zdravstveni dejavnosti. (2005, 10. marec). *Uradni list RS št. 23/2005. (29. 12. 2017)*
41. Zavod za zdravstveno zavarovanje Slovenije. (oktober 2017). *Kako do zdravnika in drugih zdravstvenih delavcev. Seznam izvajalcev zdravstvenih storitev in dobaviteljev medicinskih pripomočkov iz obveznega zdravstvenega zavarovanja.* Ljubljana, 15-30. Pridobljeno na http://www.zzzs.si/ (10. 12. 2017)
42. Zdravstveni dom Ajdovščina. (28. februar 2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-ajdovscina.si/ (25. 01. 2018)
43. Zdravstveni dom Brežice. (februar 2016). Letno poročilo zdravstvenega doma Brežice za leto 2015. Pridobljeno na http://www.zd-brezice.si/ (25. 01. 2018)
44. Zdravstveni dom dr. Božidarja Lavriča Cerknica. (2017). Poslovno poročilo posrednega porabnika proračuna, poslovno leto 2016. Pridobljeno na http://www.zd-cerknica.si/ (25. 01. 2018)
45. Zdravstveni dom Dravograd. (24. februar 2017). Letno poročilo za leto 2016. Pridobljeno na: http://www.zd-dravograd.si/ (25. 01. 2018)
46. Osnovno zdravstveno varstvo Gorenjske. (februar 2017). Poslovno poročilo za leto 2016. Pridobljeno na http://www.ozg-kranj.si (25. 01. 2018)
47. Zdravstveno dom Gornja Radgona. (februar 2014). Poslovno poročilo za leto 2013. Pridobljeno na http://www.zd-gr.si/ (25. 01. 2018)
48. Zdravstveni dom Ilirska Bistrica. (2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zdib.si/ (25. 01. 2018)
49. Zdravstveni dom Ivančna Gorica. (februar 2016). Letno poročilo za leto 2015. Pridobljeno na http://www.sl.zd-ivg.si/ (25. 01. 2018)
50. Zdravstveni dom Izola. (februar 2011). Poslovno poročilo javnega zavoda Zdravstveni dom Izola za leto 2010. Pridobljeno na http://www.zd-izola.si/ (25. 01. 2018)
51. Zdravstveni dom dr.Julija Polca Kamnik. (februar 2017). Letno poročilo javnega zavoda Zdravstveni dom dr.Julija Polca Kmanik za leto 2016. Pridobljeno na http://www.zdkamnik.si/ (25. 01. 2018)
52. Zdravstveni dom Koper. (februar 2017). Letno poročilo za leto 2016. Pridobjeno na http://www.zd-koper.si/ (25. 01. 2018)
53. Zdavstveni dom Krško. (24. februar 2016). Letno poročilo za leto 2015.Pridobljeno na http://www.zd-krsko.si/ (25. 01. 2018)
54. Zdravstveni dom Lendava. (28. Februar 2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-lendava.si/ (25. 01. 2018)

55. Zdravstveni dom Litija. (2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-litija.si/ (25. 01. 2018)
56. Zdravstveni dom Ljubljana. (februar 2017). Letno poročilo 2016. Pridobljeno na http://www.zd-lj.si/ (25. 01. 2018)
57. Zdravstveni dom Osnovno varstvo Nova Gorica. (februar 2017). Letno poročilo za poslovno leto 2016. Pridobljeno na http://www.zd-go.si/ (25. 01. 2018)
58. Zdravstveni dom Novo Mesto. (2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-nm.si/ (25. 01. 2018)
59. Zdravstveni dom Ormož. (februar 2017). Letno poročilo Zdravstvenega doma Ormož za leto 2016. Pridobljeno na http://www-zd-ormoz.si/ (25. 01. 2018)
60. Zdravstveni dom Ptuj. (21. februar 2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-ptuj.si/ (25. 01. 2018)
61. Zdravstveni dom Slovenska Bistrica. (februar 2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-sb.si/ (25. 01. 2018)
62. Zdravstveni dom Črnomelj. (2017). Letno poročilo za leto 2016. Pridobljeno na http://www.zd-crnomelj.si/ (25. 01. 2018)

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Povzetek:
Kazalniki kakovosti v primarni zdravstveni dejavnosti

Raziskovalno vprašanje (RV): Kateri so najpogosteje spremljani in merjeni kazalniki kakovosti v primarni zdravstveni dejavnosti.
Namen: Namen raziskovanja je preučiti in raziskati izhodišča in merjenje kazalnikov kakovosti v primarni zdravstveni dejavnosti.
Metoda: Uporabili smo metodo že obstoječega znanja o kazalnikih kakovosti v zdravstvu in spremljanih kazalnikih kakovosti v primarnem zdravstvu s sistematičnim pregledom obstoječe literature in z triangulacijo zagotovili boljše razumevanje problema, podatke preverili, potrdili in tako zagotovili celovitost raziskave.
Rezultati: Raziskava je pokazala izvor kazalnikov kakovosti v zdravstvu in katere kazalnike kakovosti merijo organizacije v primarni zdravstveni dejavnosti.
Organizacija: Organizacije iz primarne zdravstvene dejavnosti bodo dobile pregled nad najpogosteje spremljanimi kazalniki kakovosti v primarni zdravstveni dejavnosti in s tem možnost primerjave uspešnosti in učinkovitosti.
Družba: Merjeni kazalniki kakovosti bi morali biti javno dostopni podatki. Le na podlagi tega lahko uporabnik zdravstvenih storitev izbere najbolj uspešno zdravstveno organizacijo.
Originalnost: Sistematičen pregled najpogosteje spremljanih in merjenih kazalnikov kakovosti v primarni zdravstveni dejavnosti.

Omejitve/nadaljnje raziskovanje: Raziskava je omejena z manjšim številom obstoječih virov, ki so uporabljeni in z manjšim vzorcem anketiranih. V prihodnosti bi bilo smiselno raziskati, katere kazalnike kakovosti meri večina zdravstvenih domov v Sloveniji in na podlagi tega oblikovati nov model spremljanih ali obveznih kazalnikov kakovosti v primarni zdravstveni dejavnosti.

Ključne besede: kakovost, triangulacija, zdravstvo, primarna zdravstvena dejavnost, kazalniki kakovosti.

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Motivational Aspects of Participation in Education of Adults

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Summary:

Research goal and purpose: The purpose of this paper is to explain motivational aspects of participation in education of adults. Motivation plays an important role for adult learners, especially if participants aremotivated by the matter being studied. This will result in achieving goals in adult education and acquiring the subject matter taught much better.

Methods: Methods used in this article include studying relevant papers, articles, and research results published by Croatian Bureau of Statistics and Croatian Agency for Vocational Training an Education of Adults. From methodological point of view quantitative and qualitative methods are going to be triangulated,i.e. the data will be collected from different sources. In analysing the data different tools and approaches will be used, and they will be interpreted by different theoretical models.

Results: The results on adult education in 2016 and 2017 show that besides formal education provided by educational facilities, non-formal education through courses and seminars, is considered to be more and more important, and there is noticeable growth in importance of informal education acquired through personal development, work, communication, reading, developing skills, knowledge and experience.Further research shows that the biggest motive for entering adult education are cognitive interests: furthering knowledge, intellectual development, perfecting acquired skills and knowledge, professional development, and increasing opportunities for better employment.

Organization: The results obtained, serve as indicators to government institutions on the ways to develop strategies and legislation in adult education. They can also be used by institutions specialising in adult learning as guidelines for creating adult education programs.

Originality/further research: Research result showed what kind of educational programmes are preferred by the adult**s,** and what their motivation to join certain education programmes is. This findings are important for further research in the area of adult education, especially considering the fact that we live in the age of changeable trends and education becomes a key factor of development and base capital of modern society.Lifelong education and learning are the lifestyle of the future. Personal development, social status and development of the community depend on it. Investing in education, especially lifelong learning is an investment that will pay off again and again.

Keywords: formal education, non-formal education, informal education, adult education, motivation, research.

1 Intoduction

Our century is marked by scientific and technological revolution as well as, by the new economy. Techniques and business models change radically, and this influences economic activities.The key role is ascribed to knowledge, science and information technology which is present in every segment of society. Creating values means creating new knowledge and exploiting its value. Material goods lose their value to intellectual property.

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Today's economy is based on a new kind of companies that depend on non- material assets like knowledge and information which indirectly puts men and their mental capacity in the centre of the company, and that becomes the basis for growth and development of the company. In such information economy, knowledge is the thing that creates value.Furthering existing and creating new knowledge only adds to this value. (Ohmae, 2005).

In unsure and changeable environment, such as economic environment, we can safely say that knowledge has permanent and competitive advantage and that it represents permanent value. Knowledge is defined by experts, as base capital and growth factor, and education is defined as the process of acquiring knowledge, education and widening of previously acquired knowledge, skills and competence of people who are trained in decision making and taking appropriate action in different situations. (Bahtijarević-Šiber, 1999: 721).

Education as a process plays major role in the society that aims at being successful, especially today, when the level of education of its individuals is basis for drawing conclusions about the society. In accordance with economic and market events, businessmodels have changed. Economy based on capital ventures and work force was left behind and there is growing need to spread knowledge necessary for acquiring and monitoring new knowledge and technology. It is a well-known fact that a company cannot produce adequate results, nor survive without systematic education of its workforce.

Triangulation presupposes integration of different data, theories and methods together with parallel research conducted by different researchers, in order to get more accurate description, from various aspects, viewed, understood and explained, in order to determine the status of a social phenomenon. Complexity of social reality calls for complexity of approach taken by the researcher in attempt to interpret its every fragment. Modern researcher has to be open to various research tools available. From the standpoint of methodology he/she will have to triangulate qualitative and quantitative methods, i.e. The data will be collected in different ways, different tools and approaches will be used anddifferent theoretical models will be applied in their inter interpretation.

Mixed method used in contemporary methodology combines qualitative and quantitative research. It uses content analysis, case study, in-depth interview and grounded theory form qualitative research, and number measurements and indicators from quantitative research. Due to this approach researches get various results that can be compared. At the same time, it provides results for using triangulation, in which case,it enables us to look at the certain social phenomenon from three different angles.Triangulation presupposes integration of data, methods and theories from several different researchers. It helps to make social research results more valid and more objective.

2 Forms of education

There are many ways of including adults in the process of education, starting from various internal forms of education, to external education. (v. Petričević, 1999: 445). Lifelong education refers to the education of adults, and it can be defined as learning activity organised to enable participants to gain new, and expand existing knowledge, skills, and competence. (Croatian Bureau of Statistic, Publication, 2017).

Formal education includes all forms of education, in regular education system, and its institutions, through elementary school, high-school and university and it is regulated by different laws and legal acts. Formal education is often criticised because of the slow response of its institutions, its methods, needs, opportunities, standardization and branching of the institutions. Some authors include workplace education and courses organised by the company, outside regular working hours, for their employees only, to be a part of formal education (Noe, 2006:208).

When talking about institutionalised form of education, recognised by national adult education institutions, programs conducted at the workplace can be considered a part of formal education, if they lead to obtaining qualifications recognised by the national education institutions (or other governing bodies).

Non-formal education consists of wide spectrum of different programmes for innovation of knowledge, aimed at gaining necessary knowledge and skills for a certain job, or perfecting working skills through, for example, learning business English, as a way of improving pre-existing knowledge, in order to increase opportunities for promotion within the company, or for obtaining social skills as a form of personal development. This form of education is organised in adult education facilities, companies, unions, political parties, sports associations and other associations. Non-formal education can be held within or outside of educational facility and it includes all age groups. Depending on the specific situation within the country, it offers literacy programmes for adults, elementary education of children that do not attend school, acquiring life skills, work skills and improving general knowledge. Non-formal education programmes do not have to follow the “system of ladders” and they can differ in duration and length. (Croatian Bureau of Statistic, Publication, 2017).

Informal education includes different , mostly individual, educational activities undertaken by a person who learns or spontaneously gathers experience and knowledge throughout life (from learning in their home, by using new technologies and internet tools, to gaining different knowledge through socialisation with others.) Informal education is learning information about current topics and events. It happens naturally, on unconscious level, in everyday life, and it is therefore different from above mentioned forms of education.

To sum up, formal education is organised learning, i.e.education within school system (from elementary school to university) at the end of which a formal document (a diploma or a

certificate) on the level and form of education is awarded. (Pastuović, 1999: 54). Non-formal education is organised learning that is held outside the regular school system (Kitić, 2012: 54). Informal education happens naturally. It is neither formal nor non-formal. It presupposes learning based on everyday experience and other influences and sources from the surroundings. It is self-learning, usually through the Internet and other forms of communication technology. (Tadin, 2007: 145). Lifelong learning is important for modern society, its individual and professional development.

Regardless of their differences all three forms of learning are important in lifelong learning because they create necessary synergy. This kind of intertwining creates knowledge society in which employees obtain well developed problem solving abilities, critical thinking, communication abilities, computer literacy, entrepreneurial skills, flexibility, initiative, and openness to team work by learning about its principles.

3 Reasons for adult education

Global information society brings faster technological, economic and social changes that require constant adjustment. In order to make modern society efficient, intensive development of human potential is essential, and this development presupposes lifelong learning and adult education.

The quantity of new knowledge increases quickly, and old knowledge becomes obsolete. Adult education development is a key factor in gaining knowledge and competence for different tasks in life, raising the quality of life, ensuring equal opportunities and social inclusion as well as successful economic development. The knowledge should be accessible to all people, in all regions and areas.

More than half of their life people spend at work. Taking into account new achievements and constant trends of progress in science, it is obvious that formal education presents only an entrance ticket to the world of work, and that adult education provides necessary improvement of previous phases of lifelong learning and education (Lavrnja, Klapan, 2003: 159).

Motives for engaging in lifelong learning are intrinsic and extrinsic. Extrinsic motivation comes from an outside source as, for example, higher salary. In some cases employers request from their employees to learn. Intrinsic motivation happens without an outside source, person starts learning because he/she is interested in the specific content. When the person learns more about the topic of interest, there is a feeling of overall satisfaction which is enough to inspire further learning, regardless of the fact that the knowledge acquired in this field may not prove to be necessary in the future. The desire to learn and educational status are closely linked. If the educational status of the individual is higher, the desire for constant learning is greater. This is why it is hard to attract under educated or illiterate individuals to re-enter the process of education (Matijević, 2000). Furthermore, adults in most cases, are not educated in schools. “Most adults who choose lifelong learning do not come back to school, they are educated outside the school system” (Pastuović, 1999: 35). Self-learning and non-formal education therefore carry great significance for adult learners (Pastuović, 1999). There are

skills that are important for learning: sensory skills and psychomotor skills (for example, sharpness of sight and hearing), intellectual and cognitive skills (for example, learning speed and intelligence) emotional and motivational skills (for example, responsibility and emotional stability).

4 Motivation in Adult Learning

Human needs can be identified as lack of, and linked to the notion of wellbeing. This is true when we talk about basic human needs (air, water, food) but when discussing educational needs we no longer speak of lack off, but about conscious or experienced lack off (knowledge, skills, competence), which some authors call motive for education (conscious/experienced need =motive).

Need is central motivational variable, specific desire that releases energy and generates force of certain strength and direction. Need and motivation of adults often mix and it is not possible to understand one without the other. Needs are in fact sources of motivation.

Motivation is an internal drive that makes individual act the way to achieve his/her goals or satisfy his/her needs. Motivation governs human behaviour, while the lack of motivation explains why people are not doing what they are supposed to be doing, or are not doing it as well as they should, why they miss work or leave the company (Tudor, 2010: 12). It is a psychological process that leads to satisfying both personal and company needs, we used to use the term "will", and this term is now being replaced with the term "motivation". This is the drive that determines, keeps constant and governs the action of men. Motivation comes from action and satisfying needs (Vajić, 1994: 138).

Motivation is constant source of new success and knowledge. Once started, the cycle never stops. Each end represents a new beginning, satisfying one need, creates another, and because, once it is satisfied need no longer serves as motivating force. (Obradović, Samardžija, Jandrić, 2015: 171).

Motivation is a part of identity, but is in large part helped by learning. If two persons learn the same material, the result of their learning is not the same, if there is a difference in motivation. If learning comes as a result of intrinsic motivation, it is harder to forget the things that were learned and results of learning can be applied to wider variety of situations than with extrinsic motivation in learning. The amount of material learned will also be greater than it would be with extrinsic motivation. (Rogers, Illeris, 2003). It goes beyond doubt that motivation is a part of every learning and that adult learning and children's learning is differ and the difference is based on motivation.

Weather the role of adult education will be fulfilled or not depends of individual motivation and the motivation of other participants. If the participants are motivated to learn the subject matter than results will be achieved. This is obvious in situations when the knowledge they acquire brings certain benefits, for example, job that will be paid in accordance to their knowledge and work performance, etc. (Bilandžija, 1998: 5).

There are six factors of motivation in adult education (Pastuović, 1999: 293).

- social contact (satisfies the need for social interaction),
- social simulation (getting away from boredom and social frustration),
- professional advancement,
- improvements in civil efficiency,
- other people's expectations (employers, counsellors, friends and others),
- cognitive interests (learning for pleasure).

For learners, temporary, internal, controlled causes are motivating, while permanent external and internal causes of failure that are not controlled have a negative effect on motivation in adult education.

The most negative effect is caused by the following factors, ranked by their intensity (Pastuović, 1999:296):

- feeling of incompetence,
- permanent, unfavourable living conditions (tiredness, not enough time for learning),
- unfavourable learning context in school (inadequate program, equipment, educational surroundings, teaching methods and evaluation).

Young adults are, to great extent motivated by professional reasons. Older adults state different pragmatic and utilitarian motives, while senior adults prefer to learn about health and free time activities. Adults are willing to invest their energy in things that will help them in solving everyday tasks and real life problems. (Kako uspješno poučavati odrasle, 2012: 6).

5 Research on adult education in Croatia in 2016

5.1 Data source

Data come from research results on adult education in Croatia in 2016.The research was conducted on 4 978 people from October to December 2016. It was conducted by Croatian Bureau of Statistics (www.dzs.hr) and it is in accordance with the *Adult Education Surveys,* research conducted in EU every five years.

Survey included questions on adult participation in formal and non-formal education and informal learning in the year before the survey was conducted. It also contained questions on household structure and demographic features, as well as, on the level of education achieved, work status, features of the main employment, access to information about learning possibilities, impediments in adult learning, education and training, knowledge of foreign languages.

5.2 Data collection

Data were collected by using CAPI (on laptops or tablets) and reading questions to people that were chosen to represent the sample. CAPI is a quantitative method of market research in which computer helps the pollster during the survey. The pollster stops people in the street

and if they fall under predefined profile, they are interviewed in the CAPI centre. For each CAPI research the system is programed to contain research questions. Based on the program the computer asks next question depending on the previous answer. This ensures total control of the pollster and eliminates the possibility of omitting questions during the survey. Trained pollsters note the answers in predefined questionnaire on the device, automatically saving their answer in Croatian Bureau of Statistics' database.

The interviews were conducted from October till December 2016, following previously sent notification on pollster's visit. The period that was considered relevant is the period of one year before the survey was conducted i.e. if the survey was conducted in November 2016, the person being interviewed answered questions referring to the period between November 2015 and November 2016.

5.3 Range and comparability

The basis for the research on adult education were data collected in Census in 2011. The basis excluded people who died between 2011 and 2014, people younger than 25 and older than 64, as well as people who did not provide data on the highest education level finished. The framework included 2.307.650 people and the sample was chosen in two statistical regions of NKPJS (Continental and Adriatic part of Croatia), according to age, sex, and acquired education level. Target population was divided into three age groups (25 to 34, 35 to 54 and 55 to 64) and three education levels (ISCED 1-2, ISCED 3-4, ISCED 5-8).

After conducting stratification 36 stratum were obtained. In the name of the stratum the first digit represents sex, the second age group, the third education level and the fourth the region.

By using random choice of the systemmethod, a sample of 5.000 people was created. And implicit stratification was made, people within the same stratum were marked by household markers and the county, to make sure all 21 counties were represented, and for the sample to cover whole Croatia. Due to strict stratification criteria it was not possible to choose only one person from each household. Four households with two people interviewed are within that number. The sample included 4.996 households. The response rate is 66, 8 %

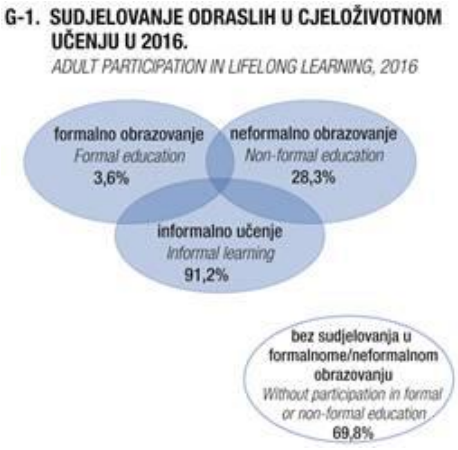
5.4 Participation of adults in education with regard to its form

Survey on adult education is a research which collects data on participation of adults in education, training and learning in the context of lifelong learning (Croatian Bureau of Statistics, Publication 2017).

30,2 % of the people interviewed stated that they participated in some form of education (formal or non-formal) in the period of 12 months prior to the interview.7 of 10 people interviewed (69,8 %) did not take part in either formal or non-formal education. Regarding the form of education, 3,6 % was included in formal education, and majority (28,3 %) opted

for non-formal education. During the period stated, almost all the people interviewed (91,2 %), tried to learn something new in their free time with the intention to further their knowledge, which represents informal learning.

From 107 people interviewed, 4 took part in two or more formal education programmes and 2/3 (62,6 %) have covered the expenses of their education themselves. Of 28,3 % who participated in non- formal education more than half (57,3 %) chose only one activity and only 10,2% chose four or more activities. During the period studied most of the people attended workshops and courses and 90,2 % of them were employed.
When it comes to informal education of 91,2 % who tried to learn informally, acquired their knowledge in roughly the same percentage from: family member, friend or colleague, the press, computer, television, radio or video.The smallest percentage learned from visiting museums, historical, natural or industrial area led by a guide or by visiting learning centres and libraries. (Figure 1 and 2).



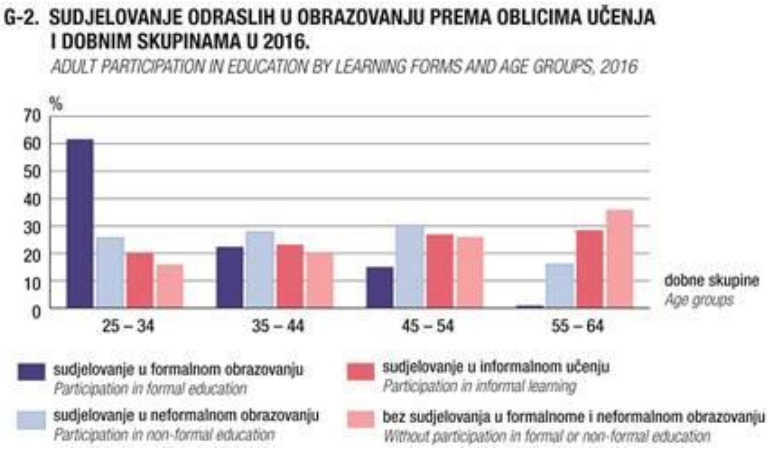


Figure 1. Adult participation in lifelong learning 2016.
Figure 2. Adult participation in education by learning forms and age groups, 2016.
(source: Croatian Bureau of Statistics, Publication 2017)

In the age group 25 to 34 the largest number of people interviewed,attended private lessons, and courses. They were the least attended in the age group 55 to 64. Workshops and seminars were attended the most by people 45 to 54 and age group 35 to 44 shows equal interest in all forms of non-formal education. (Figure 3).

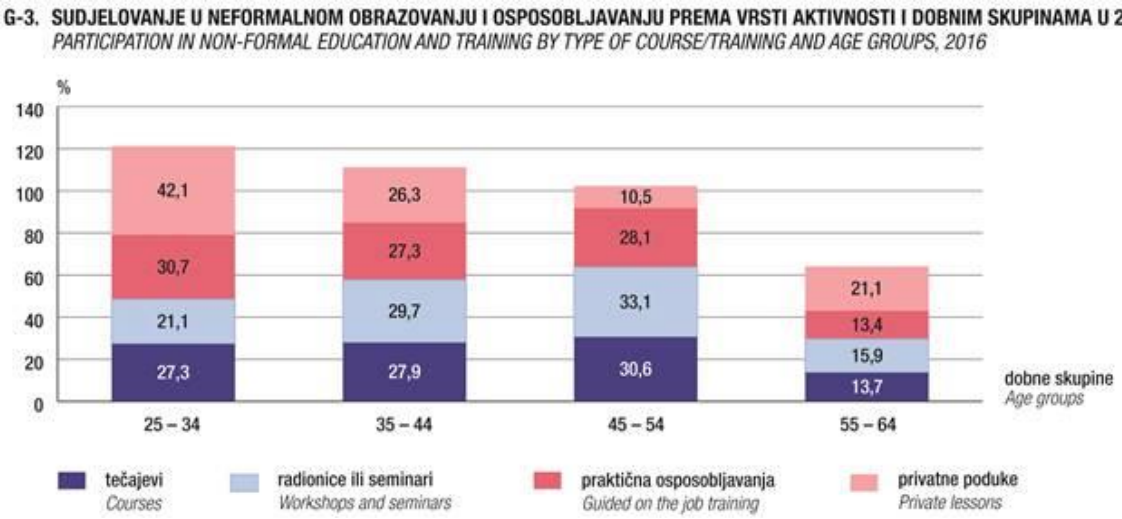


Figure 3. Participation in non –formal education and training by type of course/training and age groups, 2016. (source: Croatian Bureau of Statistics, Publication 2017.)

5.5 Difficulties in participation in education and training

Besides on forms of education, participants were asked about difficulties in participation in forms of education and training. (Figure 4) According to their answers they can be divided in two groups. Of those who participated in some form of education 1/3 (29,3 %) wanted to continue, while 7 of 10 (70,7 %) did not want to continue their education. Of those who did not participate in any form of education 1/5 wanted to participate and 4/5 said that they did not want to participate.

Of the reasons which prevented them in participating in education and training 2/3 of women stated family obligations (72,9 %) and men said that the programmes of education and training were not suitable (61,8 %).

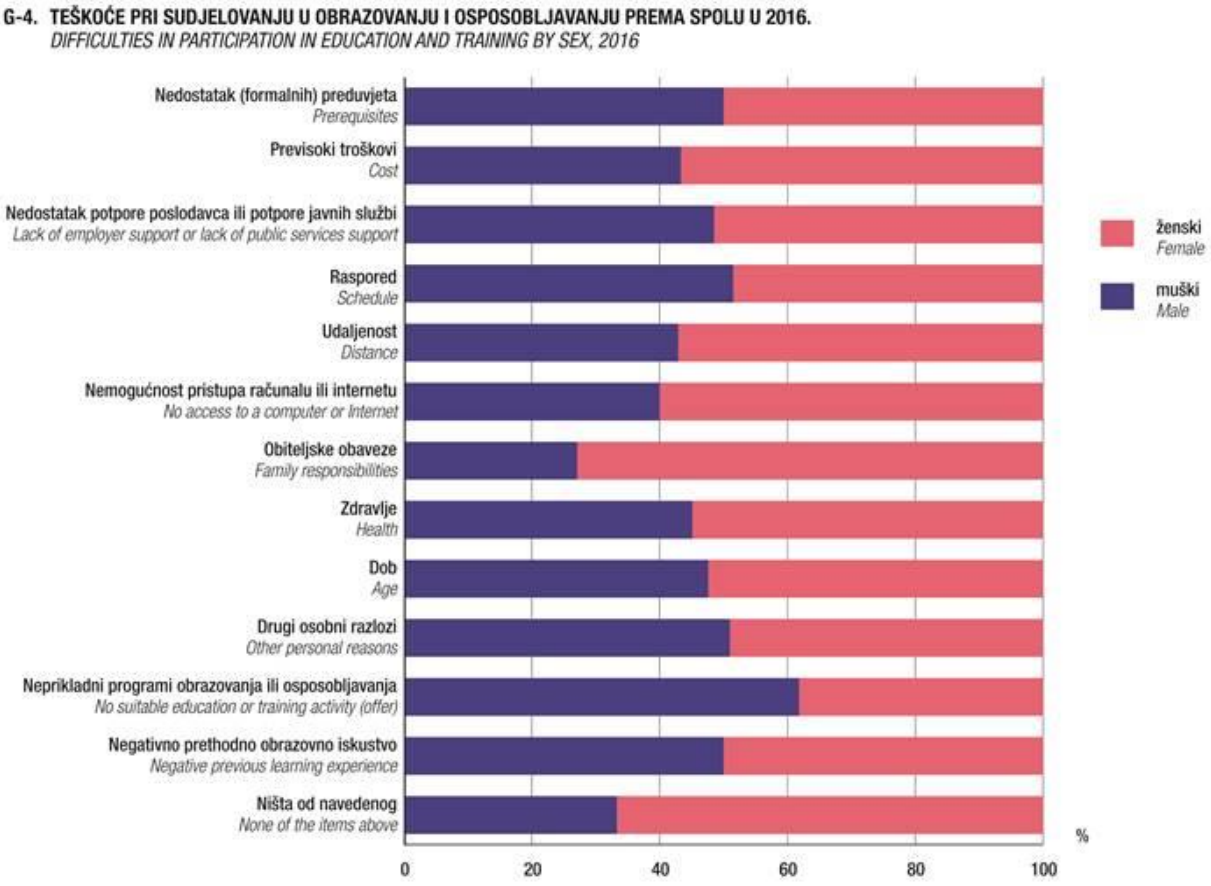


Figure 4. Difficulties in participation in education and training by sex, 2016.
(source: Croatian Bureau of Statistics, Publication 2017)

6 Research on adult education in Croatia in 2017

Agency for Vocational Education and Training of Adults in 2017 published the results of Research on Adult Education and Training in Croatia together with Strategic Framework of Promoting Lifelong Learning in Croatia 2017-2021 (Obrazovanje odraslih u Hrvatskoj 2017, 2017, Strateški okvir promocije cjeloživotnog učenja u Repaublici Hrvatskoj, 2017 - 2021, 2017).

2369 people from all counties in the Republic of Croatia took part in the research. Main goals of the quantitative research conducted were to determine in which forms of education do people in Croatia participate, and to identify the forms of participation in education process, determine sociodemographic structure of people participating in education process, motivation factors and impediments in adult learning, assess learning outcomes and their usefulness. Most relevant data obtained by this research are stated below. (Obrazovanje odraslih u Republici Hrvatskoj, 2017:15-18).

34 % of Croatian citizens between the age of 25 and 64 have participated in some of formal or non-formal education programmes. Taking into consideration that the standard assessment

error on the sample of this proportion is 1,9, the interval of assessment in population, probability variable is 95 % which comes to 32,1% - 35,9 %.

Total number of 6,4 % participants said that they took part in some of the formal education programmes over the period of year previous to the research conducted. Taking into consideration that the standard assessment error on the sample of this proportion, it is estimated that number of people taking part in formal education programmes makes 5,4 % to 7,4% of the population studied.

A number of participants in the research started their formal education after they reached the age of 24, they were 25 or older at that time, the participants were asked, if they had entered formal education before the age of 24, if we take into consideration this criteria, research results suggest that 4,7 % of population entered formal education after the age of 24.

Total number of 31,6 % of participants in the research entered some form of non-formal learning.

Standard assessment error of proportion on the level of significance of 95 % is in this case 1,9, and it can be concluded that the real value is somewhere between 29,7 %-33,5 % of population referred to.

People younger than 40, participate in programmes of formal and non-formal education with the highest percentage. Of all the people that did not participate in formal programmes of education (93,6 % of the sample), 9 % intended to participate in some of the formal education programmes.

The main obstacles for participating in formal education programmes are: high price, other life priorities, obligations at work, family obligations, not enough information about the programme, the programme conducted far away from the place where the person lives, health problems, late application.

19 % of population 25 - 64 wanted to participate in some form of non-formal education but they did not, more frequently, women who live in town, under the age of 50, who finished 4 years of high-school education, higher or university education, of middle or higher social status fall under this category.

The main obstacles for participating in non-formal education programmes are: obligations at work, having other life priorities, family obligations, price, the programme is held too far from home, health problems.

Most frequent motive for entering education process of adults is cognitive interest: learning the things that should have been learned earlier, intellectual development, learning more about the subject that interests them.

Motive that follows is connected to professional development and increasing chances for better employment: additional professional training at work, career advancement, higher ranked position within the company, or promotion, as well as increasing the chances to find a better job in Croatia or abroad.

Motives for socialisation, social contacts and psychosocial stimulation, like meeting new people, making new acquaintances, and using learning as a mean to escape daily routine, are less present. Motives for formal education requirements set at the workplace are the least present.

When it comes to formal learning, motives for professional advancement and training are more common than motives for having better employment prospects, which is not the case in non-formal education. The cause of this lies in the fact that professional advancement and training, in formal learning, is closely connected to attending college or university.

When opting for lower educational programmes (elementary school, two years of vocational school, three years of vocational school or high-school) the motives are: finding employment, social communication, psychosocial simulation and formal requirements. Formal requirements have the biggest influence on choosing these programs.
The largest number of people interviewed believe that the best feature of education is acquiring new professional skills, the second is acquiring knowledge on the topic of long-term interest, new life skills, and meeting previously set expectations.

7 Conclusion

With years, the efficiency of our senses drops: sight, hearing, taste, smell and the ability to speak deteriorate. In all life phases, ability to learn as well as other abilities can be trained, perfected and developed.

Recent data, obtained through different experimental research, confirmed that positive changes in intellectual abilities of the adults can be affected. They also showed that social factors affect human life more than biological restrictions. Only limiting factor is illness. Intelligence of older people (65 and more) is often underestimated in our culture. Intellectual dysfunction is more commonly caused by poor health, social isolation, economic problems, lack of education, lower motivation, and other factors, than the consequence of old age. People older than 65 can learn when their health allows this. For adults to be successful in the process of learning, following conditions have to be met: desire to learn, clear image of the behaviour they want to adopt, positive incentive and adequate learning resources. Research conducted in the Republic of Croatia show that most common motive for entering the process

of education is cognitive interest: learning the things that should have been learned earlier, intellectual development, learning more about the subject that interests them. It is followed by motive for professional development and increasing chances for better employment: additional professional training at work, career advancement, higher ranked position within the company, or promotion, as well as increasing the chances to find a better job in Croatia or abroad. Motives for socialisation, social contacts and psychosocial stimulation like meeting new people, making new acquaintances, and using learning as a mean to escape daily routine, are less present, while motives for formal education requirements set at the workplace are the least present.

Lifelong learning is the lifestyle of the future. It will influence personal development, social status and the development of the community. This makes investment in education, especially in lifelong learning, an investment that will bring multiple benefits. The concept of lifelong learning becomes more important in times of economic crisis and high unemployment, and its main goal is raising the quality of life. It plays an important role in the process of developing knowledge and education. Croatia and Countries in EU have incorporated improvements in lifelong learning in their national policy, thus creating globally competitive economy.

References

1. Agencija za strukovno obrazovanje i obrazovanje odraslih (2012). Kako uspješno poučavati odrasle, Zagreb
2. Bahtijarević Šiber, F. (1999), Menadžment ljudskih potencijala, Zagreb, Golden Marketing.
3. Balenović, K. (2011). Motivacija odraslih učenika za učenje engleskog jezika u kontekstu globalizacije. Napredak, 152(2), 189-209.
4. Bilandžija, D. (1998), Obrazovanje odraslih, Zagreb, Madrid d.o.o.
5. Carre, P. (2004).Motivacija u obrazovanju odraslih: od zapošljavanja do načina realizacije. Andragoške studije, (1-2), 41-49.
6. Despotović, M., Kulić, R. (2005). Uvod u andragogiju. Beograd: Svet knjige
7. Državni zavod za statistiku, www. dzs.hr, visited 4.3.2018.
8. Klapan, A. (2004). Teme iz Andragogije. Rijeka: vlastita naklada.
9. Kulić, R., Despotović, M. (2001). Uvod u andragogiju. Beograd: Nauka.
10. Lacković-Grgin, K., Ćubela Adroić,V. (2006). Odabrane teme iz psihologije odraslih. Jastrebarsko: Naklada Slap.
11. Lavrnja, I., Klapan, A. (2003), Obrazovanje odraslih u Hrvatskoj u konceptu cjeloživotnog učenja, u zborniku radova Sabora pedagoga Hrvatske: Odgoj, obrazovanje i pedagogija u razvitku hrvatskog društva,pp. 157.- 163., Zagreb, Hrvatski pedagoško-književni zbor.
12. Matijević, M. (2000). Učiti po dogovoru – uvod u tehnologiju obrazovanja odraslih. Zagreb: Birotehnika.
13. Noe, R. (2006), Menadžment ljudskih potencijala, 3. izdanje, Zagreb, Mate.
14. Obradović, Vladimir, Samardžija, J., Jandrić, J. (2015): Menadžment ljudskih potencijala u poslovnoj praksi, Zagreb, Plejada d.o.o.

15. Obrazovanje odraslih u Hrvatskoj, Rezultati istraživanja (2017), Agencija za strukovno obrazovanje i obrazovanje odraslih, Zagreb2017.
16. Ohmae, K. (2005), Nova globalna pozornica: Izazovi i prilike u svijetu bez granica“, Zagreb, Mate.
17. Pastuović, N. (1999), Edukologija, Zagreb, Znamen.
18. Petričević, D. (1999), Cjeloživotno obrazovanje, from: Osnove suvremene pedagogije, pp. 423.-460., Zagreb, Hrvatski pedagoško-književni zbor.
19. 11. Priopćenje, Državni zavod za statistiku, 2017, Zagreb, LIV, No 8.1.13.
20. Rogers, A., Illeris, K. (2003). How Do Adults Learn? Adults Learning 15(3) pp. 24-27. https://eric.ed.gov, visited 4.3.2018.
21. Strateški okvir promocije cjeloživotnog učenja u Republici Hrvatskoj 2017- 2021, Agencija za strukovno obrazovanje i obrazovanjeo draslih, Zagreb, 2017.
22. Tudor, G. (2010.) et al. Vođenje i motiviranje ljudi: Kako nadahnuti svoje ljude: Jedinstveni primjer iz prakse, Zagreb: M.E.P. d.o.o.
23. Vajić, I. (1994), Management i poduzetništvo. Zagreb, Centar za poduzetništvo d.o.o. i Mladost d.d.

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Povzetek:
Motivacijski vidiki participacije v izobraževanju odraslih

Namen raziskave: Namen tega članka je pojasniti motivacijske dejavnike vključevanja v programe izobraževanja odraslih. Motivacija namreč igra pomembno vlogo za izobraževanje odraslih, posebno z vidika motivacijske povezanosti z vsebino študija. To pa rezultira v doseganju cilje ter osvojitvi znanja na višjem nivoju.
Metode raziskovanja: Članek je osnovan na fokusirani sintezi ter podatkih hrvaškega statističnega urada in hrvaške agencije za poklicno usposabljanje in izobraževanje odraslih.
Rezultati: Rezultati raziskave na podatkih iz 2016 in 2017, kažejo da so poleg formalnega izobraževanja vedno bolj pomembne neformalne oblike izobraževanja, ter da pomembno prispevajo k osebnemu razvoju in rasti in krepitvi drugih kompetenc. Nadalje raziskava kaže da je največji motiv za vstop v programe izobraževanja odraslih v želji po intelektualni rasti, izpopolnjevanju potrebnih spretnosti, kariernem razvoju in povečevanju zaposljivosti.
Organizacija: Podatki lahko služijo kot osnova vladnim institucijam za razvoj strategij in zakonodaje na področju izobraževanja odraslih. Hkrati pa lahko pripomorejo institucijam, ki se ukvarjajo z izobraževanjem odraslih pri razvoju ustreznih vsebin.
Izvirnost/ nadaljnje raziskovanje: Raziskovalni rezultati razkrivajo kateri izobraževalni programi so bolj zaželeni med odraslimi ter kakšna je njihova motivacija za udeležbo. Ugotovitve

so pomembne za nadaljnje raziskovanje na področju izobraževanja odraslih, predvsem z vidika življenja v nestabilnem okolju, kjer je izobrazba ključnega pomena za razvoj in osnovni kapital moderne družbe. Vseživljenjsko izobraževanje in učenje sta življenjska stila prihodnosti. Osebni razvoj, družbeni položaj in razvoj družbe so odvisni od tega. Investicija v izobraževanje, predvsem v vseživljenjsko učenje je investicija, ki se bo vedno znova obrestovala.

Ključne besede: formalno izobraževanje, neformalno izobraževanje, izobraževanje odraslih, motivacija, raziskave

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Aktivno staranje v slovenskih domovih za starejše: prostočasne dejavnosti starostnikov

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Povzetek:
Raziskovalno vprašanje: Kako imajo v domovih za starejše organizirane prostočasne dejavnosti?
Namen: Namen raziskave je bil ugotoviti stališča vodstev domov za starejše in njihovih varovancev, kakšna je ponudba in kolikšen je interes za prostočasne dejavnosti.
Metode dela: Uporabljena je bila namizna in terenska raziskava. Poleg študije literature so bili analizirani statistični podatki Statističnega urada RS. Za pridobitev stališč smo izvedli terensko raziskavo po slovenskih domovih za starejše. Vključeni so bili naključni starejši in vodstva. Kot metodo za pridobivanje podatkov smo izvedli anketiranje, za obdelavo podatkov pa smo uporabili SPSS 20. V raziskavi sta sodelovala 202 starostnika, od tega 122 žensk in 80 moških. Anketiranje je potekalo od 15. oktobra do 12. novembra 2017.
Rezultati: Ugotovili smo, da domovi organizirajoprostočasne dejavnosti, varovanci pa se zanimajo zanje. Glede na trende naravnega gibanja in podaljševanja starostne dobe ter vedno bolj aktivnega prebivalstva, bo ta potreba v prihodnosti še bolj izražena.
Zaključki: Ponudniki domov za starejše in programov za starejše se bodo morali prilagoditi tudi starejšim, ki si želijo aktivnega staranja in si lahko privoščijo prostočasne dejavnosti. Temu primerno se bo morala ustrezno prilagoditi tudi infrastruktura.

Ključne besede: domovi za starejše, staranje, starost, upokojenci, prostočasne dejavnosti, Slovenija.

1 Uvod

Splošno zaznan trend padanja števila prebivalstva je prisoten v vseh razvitih zahodnih državah in tudi v Sloveniji. Starejši pa so ob tem vedno bolj aktivni in mobilni, saj se udeležujejo različnih delavnic, srečanj in turističnih potovanj. Družba, tudi slovenska, se bo morala sprijazniti z dejstvom, da so starostniki v tretjem in tudi četrtem življenjskem obdobju

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še vedno vitalni, polni energije, predvsem pa z veliko znanja in sposobnosti ter veščin (SURS, 2017). Večinoma starost razumemo kot obdobje po upokojitvi, torej po tem, ko posamezniki prenehajo biti delovno aktivni državljani in ob dosegu izbrane starostne meje, ki je v Sloveniji določena na 60 ali 65 let (Vertot, 2010). Dolgoletne študije (Ku, Fox, & Chen, 2016) so pokazale, da starostniki, ki živijo bolj aktivno in so podvrženi stalnim aktivnostim, živijo dlje od svojih kolegov.

Namen prispevka je analizirati, katere prostočasne dejavnosti imajo v slovenskih domovih za starostnike in katerih aktivnosti se starostniki dejansko udeležujejo. Oblikovali smo naslednje raziskovalno vprašanje*: »Kako imajo v domovih za starejše organizirane prostočasne dejavnosti?«* in raziskovalne hipoteze. Da bi potrdili oz. ovrgli hipotezo in odgovorili na raziskovalno vprašanje, smo izvedli terensko anketiranje vodstev v slovenskih domovih za starejše in starostnikov, ki bivajo tamkaj.

Ves čas jepotekalo organizirano in načrtovano delo pri izvedbi raziskave. V uvodu je predstavljen predmet raziskave, raziskovalno vprašanje, uporabljene raziskovalne metode in vsebinska struktura. V drugem delu je predstavljeno teoretično ozadje glede starostnikov, domske oskrbe in potovanj starejših oseb. Tretji del predstavlja raziskovalno metodologijo in rezultate raziskave, zadnji pa je namenjen razpravi, ki se navezuje na teoretsko ozadje z zaključki in predlogi za nadaljnje raziskovanje.

2 Teoretična izhodišča

2. 1 Starost in staranje

Starost je sestavni del procesa staranja in odvisna od tega, kako jo posameznik sprejema, ugotavlja Macuh (2017). To pa je odvisno od njegovega načina življenja, skrbi za zdrav način življenja in kakovostnega doživljanja samega sebe v procesu staranja, katerega definicije predstavljamo v nadaljevanju. Zato nas ne preseneča, da so si avtorji blizu pri definiranju pojma starosti oz. da enako ali podobno pojmujejo doživljanje starosti in skrb za zdravje v starosti. Življenjska doba se dviguje. Družba, tudi slovenska, se bo morala sprijazniti z dejstvom, da so starostniki v tretjem in tudi četrtem življenjskem obdobju še vedno vitalni, polni energije, predvsem pa z veliko znanja in sposobnosti / veščin(prav tam).

J. Goriup (2015) meni, da sodobna slovenska potrošniška postmoderna in storilnostno naravnana družba ustvarja podobo starega človeka v skladu z lastnim interesom, saj v ospredje postavlja mlado in aktivno populacijo. Enostranska stigmatizacija starosti in staranja je usmerjena k posploševanju in ju ustvarja kot grožnjo vsakdanjemu življenju ter stalno opozarja na nemoč, odvisnost in nesamostojnost starih ljudi. Specifične politike za stare in specializirane institucije ustvarjajo starost kot posebno negativno življenjsko obdobje. Prevladujoča družbena paradigma pa močno vpliva na neavtonomno držo starostnikov (prav tam).

V nadaljevanju opredeljujemo vrste starosti. Hojnik-Zupanc (1997) navaja tri vrste starosti (kronološka, biološka in psihološka oz. doživljajska), nekateri drugi strokovnjaki govorijo o petih vrstah starosti, tudi Ramovš (2003) in Milavec Kapun (2011), in sicer:

- kronološka starost se nanaša na to, koliko smo ljudje stari po koledarju. Definirana je z rojstvom. Starosti ni mogoče spreminjati in nanjo tudi ne moremo vplivati. S starostjo se ljudje tudi spremenijo;
- funkcionalna starost nam pove, v kolikšni meri je posameznik sposoben samostojno opravljati svoja temeljna življenjska opravila (stari smo toliko, kot se počutimo);
- biološka starost se nanaša na starost telesa glede na delovanje funkcij in celičnih procesov. Nekateri organi se hitreje starajo. Je bolj realen kazalnik zdravstvenega stanja posameznika (možnosti odločanja upokojitve na podlagi biološke starosti človeka);
- psihološka ali doživljajska starost je počutje posameznika in odnos do starosti: na to starost lahko intenzivno vpliva posameznik s svojim mišljenjem, oblikovanjem stališč, kar se nekako močno nanaša na delovanje človeka in upočasni staranje;
- socialna starost se nanaša na spremembo posameznikove vloge, na odnos do družine in prijateljev ter na odnos znotraj različnih organizacij (verskih in političnih skupin). V procesu staranja se spreminjajo družbene vloge in odnosi glede na potek staranja. Pri tej vrsti starosti so ohranjeni socialni stiki, sposobnost ohranjanja in širitve socialne mreže, ki kaže vrednost posameznika in njegove vloge v ožjem in širšem socialnem okolju (Milavec Kapun, 2011; Ramovš, 2003).

Starejši v tretjem in kasneje v četrtem življenjskem obdobju se srečujejo z veliko ovirami, ki jim tako ali drugače onemogočajo tudi udeležbo pri prostočasnih dejavnostih. Te so lahko: subjektivne (osebno zavračanje vseživljenjskega učenja zaradi ekonomskih, zdravstvenih in psihosocialnih težav) ali objektivne narave (težko dostopna mesta in pripomočki za vseživljenjsko učenje). Pri vključevanju starostnikov v procese vseživljenjskega učenja (tudi dejavnostmi, povezanimi s turizmom) je zelo pomembna motivacija. Ta je tista, ki jih spodbudi, da so aktivni. Razreševanje nastalih ovir je v veliki meri odvisno od stopnje njegove osebne pripravljenosti, »da se v izobraževanje in druge aktivnosti vključi in v njih vztraja. Kadar je starostnik dovolj motiviran, lahko pričakujemo, da bo premagal marsikatero oviro, ki mu preprečuje učenje in aktivnosti, kadar pa je nizka, je njegova udeležba manj verjetna«(Goriup, 2015).

Cross (1981) in drugi avtorji[1] izpostavljajo, da morajo starostniki za vključevanje v različne aktivnosti premagati tri vrste ovir, ki izhajajo iz prej navedenih dejavnikov. To so:

[1]Rubenson in Gongli (1997) dodajata neustrezno ponudbo izvedb izobraževanja in s tem, posledično, neustrezno vsebino, pogoje izvajanja, pomanjkanje informacij in neustrezne »učitelje« (npr. zaposlene v domovih za starejše, ki so neposredni izvajalci tovrstnih oblik učenja). Rubenson in Gongli (prav tam) še dodajata stopnjo aspiracije, odnos do učenja, strah pred neuspehom, utrujenost in seveda občutek, da so že prestari.

- situacijske ovire, ki izvirajo iz starostnikovega trenutnega položaja. Najprej morajo premagati družinske, finančne in zdravstvene težave ter morebitne težave s prevozom (odvisno od kraja bivanja);
- institucionalne ovire so tiste, ki so pomembne za starostnike, glede na kraj bivanja in za starostnike, ki bivajo v domovih za starejše še posebej izstopajo (učna ponudba vseživljenjskega učenja);
- dispozicijske ovire, ki so povezane s psihosocialnimi značilnostmi starostnika, kot so stališča, samopodoba, lastna prepričanja o sposobnostih itd.

2.2 Trend staranja prebivalstva

Prebivalstvo sveta, posebej njegovega razvitega dela, se intenzivno stara. V bolj razvitih regijah sveta je že danes 22 % prebivalcev starih 60 let in več, do leta 2050 pa naj bi se ta delež povečal na 33 %. Na splošno demografska gibanja v razvitem svetu, katerega del je tudi Slovenija, napovedujejo intenzivno staranje prebivalstva, posledično pa vse večje »pomanjkanje« mladega prebivalstva.

Strokovnjaki se že dalj časa soočajo z izzivom, kako pripraviti starostnike na kakovostno življenje v 3. in 4. življenjskem obdobju oz. kako izboljšati njihov življenjski slog v tem obdobju, ne glede na bivanje doma ali v domovih za starejše. Nas predvsem zanima, kako so starejši v tretjem in četrtem življenjskem obdobju v domu za starejše vključeni v prostočasne aktivnosti.

2.3 Telesna in duševna aktivnost in zdravje

Teorija aktivnosti poudarja zvezo med dejavnostjo in zadovoljstvom, zlasti življenjskim zadovoljstvom (Ku idr., 2016). Teorija kaže, da sta tako pogostost udeležbe v aktivnostih kot njihova stopnja intimnosti pomembna za zadovoljstvo z življenjem. Večja je pogostnost dejavnosti, večje je zadovoljstvo z življenjem. Podobno je intimnejša dejavnost, večje zadovoljstvo z življenjem, kar vodi do bolj specifične hipoteze, da bi morale neformalne družbene dejavnosti bolj povezati z življenjskim zadovoljstvom kot formalna dejavnost, ki bi morala biti bolj povezana z zadovoljstvom pri življenju kot samotna dejavnost (Menec, 2003). Starost je samo eden od dejavnikov tveganja za zdravje. Če je starost pojmovana primarno kot slabšanje zdravja in upad telesnih sposobnosti, in posledično kot povečanje odvisnosti od zdravstvenega in socialnega sistema, kaj hitro lahko postane pojmovana kot breme za širšo družbo (Maučec-Zakotnik in Lainščak, 2003). Z večjo aktivnostjo se lahko zmanjša in upočasni določene bolezni, ki so pri starostnikih bolj izrazite. Srčnožilne bolezni predstavljajo glavno zdravstveno in pomembno socialnoekonomsko breme v Sloveniji. S povečanim, predvsem pa s pravilnim gibanjem jih lahko vsaj delno obvladujemo (Maučec-Zakotnik in Lainščak, 2003). Vzporedno z daljšo življenjsko dobo je v sodobni družbi naraslo število pacientov z demenco oziroma ljudi z upadom kognitivnih sposobnosti (Klanjšček, 2009). Darovec in sodelavci pravijo, da se z vsakim petletnim podaljšanjem življenjske dobe podvoji možnost, da oseba zboli za demenco(Darovec idr., 2013). Klein Demenco opisuje kot

bolezen. Je skupek simptomov, povezanih z upadom spominskih in miselnih sposobnosti terje napredujoča in neozdravljiva(Ljubič in Kolnik, 2017). Demence sicer ni možno ozdraviti, jo pa lahko za določenimi vajami vsaj upočasnimo. Metoda montessori se je izkazala kot uspešna pri aktivnem vključevanju pacientov z demenco in izboljšanju njihove stopnje delovanja v različnih okoljih, kot so dnevni centri za odrasle in negovalne ustanove(Vance, Camp, Kabacoff, & Greenwalt, 1996). Zaključimo lahko, da obstaja kar nekaj študij (Wang, Xu, & Pei, 2012) in (Agahi, Ahacic, & Parker, 2006), ki dokazujejo, da se lahko z dnevnimi aktivnostmi podaljša zadovoljstvo in zdravje starostnikov.

2.4 Prostočasne dejavnosti in starejši

Pod prostočasne dejavnosti ne smemo vključevati zgolj turistična potovanja, ampak vse aktivnosti, ki jih izvajamo v prostem času in niso v neposredni zvezi z našo eksistenco. Prostočasne dejavnosti so različne glede na starost status in interese. Tako imajo mladi prostočasne dejavnosti po zaključenih šolskih obveznosti v popoldanskem času in čez vikende, zaposleni, ki so v delovnem razmerju, pa v času dopusta in ob prostih dnevih. Starostniki, še posebej tisti, ki imajo ustrezne dohodke, imajo za te aktivnosti še več časa. Tako lahko potujejo, ali pa preprosto uživajo v vsakodnevnih druženjih, branju, spremljanju medijev, krožkih, športu in drugih dejavnostih. Dejavnejše udejstvovanje v prostem času, pogostejša potovanja in spremenjene potrebe starejših spodbujajo razvoj novih proizvodov (Weiermair in Mathies, 2004). Starejše je treba spodbujati, da čim dlje ostanejo aktivni na številnih področjih. Možne dejavnosti niso vedno povezane le z zaposlitvijo in družinskim življenjem, dobrodošlo je tudi vključevanje v različne družbene aktivnosti, ki preprečujejo osamljenost in izolacijo. Mobilnost običajno razumemo v njenem bistvu kot pozitivno, vendar je pravzaprav odvisna od osebnih in socialnih razmer. Praviloma se ta dogaja v okviru turističnih potovanj in obiskov sorodnikov. Meddomska mobilnost pa je urejena na ravni države.

3 Metoda

3.1 Splošno o metodi

V okviru raziskave, ki smo jo izvajali v domovih za starejše po Sloveniji, smo izvedli dve raziskavi: prvo med vodstvi domov za starejše in drugo med starostniki, ki so varovanci teh domov za starejše.

Podatke za potrebe raziskave smo zbirali s pomočjo anketnega vprašalnika. Ta je za vodstva vseboval 13, za starostnike pa 14 vprašanj. V nadaljevanju navajamo le tista vprašanja, ki so relevantna za ta znanstveni prispevek (zaradi omejenega obsega ne predstavljamo vseh zaključkov). Za vodstvo domov za starejše je vključeval demografske podatke (oblika zavoda; podružnice; skupno število starostnikov) in vprašanja, ki se nanašajo na predmet raziskave (prostočasne dejavnosti imate v domu). Pri starostnikih je poleg demografskih podatkov (spol, starost, čas bivanja v domu za starejše, izobrazba) vključeval še vprašanja, ki so predmet raziskave (Katere prostočasne dejavnosti obiskujete v domu za starejše?). Anketiranci so

imeli možnost pri nedemografskih vprašanjih podati tudi odprte opisne odgovore. Prav ti so obogatili raziskavo in povečali njeno relevantnost.

Raziskava je potekala od 15. oktobra do 12. novembra 2017. Izvajali so jo strokovni delavci domov za starejše, neposredno tudi starostniki, ki bivajo v domovih za starejše in študenti Fakultete za uporabne družbene študije v Novi Gorici.

V raziskavo smo vključili vse domove v Sloveniji in starostnike, ki bivajo v teh domovih za starejše v Sloveniji. Glede na to, da se vsi domovi niso odzvali, je raziskovalni vzorec zajel 43 od skupaj 99 (43,4 %) domov za starejše v različnih regijah Slovenije in 202 od skupaj 20.537 bivajoča starostnika (1 %).

3.2 Obravnavana populacija

Najprej predstavljamo demografske podatke o številu domov za starejše v Sloveniji in podatke za vodstva domov za starejše (Preglednica 1) ter starostnike v teh domovih za starejše (Preglednica 2), kjer smo izvajali raziskavo.

V Sloveniji je 99 domov za starejše in posebnih domovih, v njih pa je na voljo 20.537 mest. Od tega je v 54 javnih domovih za starejše 13.165 mest, v 40 zasebnih domovih za starejše s koncesijo 5.010 mest in 5 posebnih zavodih za odrasle 2.362 mest. Mi smo izvedli raziskavo v 43 domovih za starejše (25 javnih, 15 zasebnih, 2 zasebnih domovih za starejše – Karitas in enem posebnem zavodu za starejše) (www.seniorji.info/index.php?ids=0).

Preglednica 1: Podatki o domovih za starejše

	n	Delež (%)
POPULACIJA (vsi slovenski domovih za starejše)	**99**	
VZOREC (vključeni domovi za starejše)	**43**	**43,4 %**
OBLIKA DOMA ZA STAREJŠE		
Javni dom za starejše	25	58,1 %
Zasebni dom za starejše	15	34,9 %
Zasebni dom za starejše –Karitas	2	4,7 %
Posebni zavod za starejše	1	2,3 %
Skupaj	**43**	
ŠTEVILO VAROVANCEV		
Do 100	8	18,6 %
101 do 300	28	65,1 %
Od 301 do 600	4	9,3 %
Od 601 do 1.000	1	2,3 %
Več kot 1.000	2	4,7 %
Skupaj	**43**	100 %

V nadaljevanju (Preglednica 2) predstavljamo demografske podatke o starostnikih v domovih za starejše. V raziskavi sta sodelovala 202 starejša (122 žensk in 80 moških). V našem vzorcu je bilo največ (79) starejših anketirancev v starosti med 79 in 84 let, sledijo starejši od 85 let (55), stari od 65 do 74 let (49), najmanj pa je bilo anketiranih starih do 65 let (načeloma so to

gibalno ovirani starejši ali drugi, ki imajo posebne potrebe in zadostijo kriterijem bivanja v domovih za starejše zelo mladi).

Glede na trajanje bivanja je bila največja skupina tistih, ki so v domu do 5 let (119). Sledijo jim tisti, ki so v domu med 6 do 10 let (59) in tisti, ki so v domu za starejše od 6 do 10 let (19). Največ anketiranih (100) ima poklicno oziroma srednje šolsko izobrazbo. Sledijo jim tisti z osnovnošolsko (72) in nato starejši, ki imajo končano višjo oziroma visoko šolsko izobrazbo. V vzorcu ni bil zajet nihče z magisterijem ali doktoratom.

Preglednica 2: Demografski podatki o starostnikih, ki bivajo v domovih za starejše

	n	Delež (%)
POPULACIJA (vsi starostniki v slovenskih domovih za starejše)	**20.537**	
VZOREC (vključeni starostniki)	**202**	**1 %**
SPOL		
Moški	80	39,6 %
Ženski	122	60,4 %
STAROST		
Do 65 let	19	9,4 %
Od 65 do 74 let	48	23,8 %
Od 75 do 84 let	79	39,1 %
Nad 85 let	55	27,2 %
LETA BIVANJA V DOMU ZA STAREJŠE		
Do 5 let	119	58,9 %
Od 6 do 10 let	59	29,2 %
Nad 10 let	19	9,4 %
IZOBRAZBA		
Osnovna šola	72	35,6 %
Poklicna oz. srednja šola	100	49,5 %
Višješolsko oz. visokošolsko izobraževanje	29	14,4 %
Magisterij, doktorat	0	0,0 %

4 Rezultati in razprava

4.1 Splošno o rezultatih

Glede na postavljene cilje in raziskovalna vprašanja nas je najprej zanimalo, katere prostočasne dejavnosti imajo v domu za starejše (Preglednica 3). Poleg izbirnih odgovorov: Verski obredi; Dopoldanski izlet; Celodnevni izlet; Večdnevne počitnice; Vrtnarjenje in urejanje okolice; Branje časopisov in revij; Gledanje televizije; Joga; Sprehodi, tek ali kolesarjenje in Druženje s sostanovalci, so imeli možnost še dopisati ponudbo prostočasnih aktivnosti pod drugo. Prav ta del odprtega odgovora nam je dal veliko uporabnih informacij.

Preglednica 3: Organizacija prostočasnih dejavnosti v slovenskih domovih za starejše

	Javni dom za starejše.	Zasebni dom za starejše.	Zasebni dom za starejše-karitas.	Posebni zavod za starejše.	Skupaj
Branje časopisov in revij	25	15	1	1	42
Druženje s sostanovalci	24	15	2	1	42
Gledanje televizije.	25	14	1	1	41
Verske dejavnosti	22	15	2	1	40
Sprehodi, tek ali kolesarjenje	22	13	1	1	37
Dopoldanski izlet	15	7			22
Celodnevni izlet	6	7	2	1	16
Vrtnarjenje in urejanje okolice	2	11	2	1	16
Pevski zbor	9	3	2	1	15
Telovadba	8	4	1		13
Gospodinjski in slaščičarski krožek	4	5	1		10
Skupine za samopomoč	8			1	9
Bralna skupina (op. s knjižničarko)	7	1			8
Filmoteka		8			8
Pogovorna skupina	1	7			8
Žogabend	5	3			8
Praznovanja (verski, državni, občinski, mednarodni dnevi, šege in običaji, rojstni dnevi)	4	2	1		7
Terapija z živalmi	5	2			7
Plesna ustvarjalnica		6			6
Druženje s prostoovljci	1	2	2		5
Kreativne skupine,	1	2	2		5
Literarni krožek		5			5
Tombola	2	2	1		5
Vaje za spomin	1	3	1		5
Bio-sinhron	4				4
Dramska sekcija	3	1			4
Družabne igre	3	1			4
Joga.	3	1			4
Kviz		4			4
Likovna in ročna dela	2			1	3
Rokodelske delavnice	2	1			3
Vezenje, pletenje		2	1		3
Zgodovinski krožek	2	1			3
Kognitivni trening....	2				2
Križanke	1	1			2
Medgeneracijski center	2				2
Molitvena skupina	1	1			2
Pikniki (kostanjev, s svojci ob živi glasbi)	1	1			2
Predavanja (potopisna ,...)		2			2
Šah/šahovski turnirji	1	1			2
Tečaj jezikov (nemščine, angleščine, italijanščine)		2			2
Ustvarjelne delavnice	1	1			2
Aktivna pot		1			1
Balinanje				1	1
Bowling		1			1
Čajanke	1				1
Delovna terapija	1				1
Dihalne vaje		1			1
Gledališka skupina				1	1

»se nadaljuje«

»nadaljevanje«

Igranje z zvočnim tubami	1				1
Izdelava glasila	1				1
Joga smeha		1			1
Kickboks	1				1
Kmetovanje (Vinogradništvo, živali, delo na njivi)	1				1
Komunikacijsko interakcijske aktivnosti	1				1
Košarka				1	1
Lokostrelstvo	1				1
Metanje v tarčo		1			1
Muzikoterapija	1				1
Nagradne uganke		1			1
Nirvana fitnes		1			1
Pikado		1			1
Pospravljenje perila		1			1
Razne igre	1				1
Razstave				1	1
Rusko keglanje		1			1
Skupina za jedilnike		1			1
Skupina za nordijsko hojo		1			1
Športne aktivnosti	1				1
Tekmovanja	1				1
Terapija z gongi	1				1
Urjenje senzorike			1		1
Vadba za pokretne		1			1
Vadba za težje pokretne		1			1
Vaje za ravnotežje		1			1
Zelišča		1			1

Vodstva domov za starejše organizirajo ali omogočajo velik nabor prostočasnih aktivnosti. Skupaj smo zbrali 76 aktivnosti. V kolikor navedemo najpogostejše (tiste, ki so dobile več kot 10 % delež): Branje časopisov in revij in Druženje s sostanovalci (97,67 %); Gledanje televizije (95,35 %); Verske dejavnosti (93,02 %); Sprehodi, tek ali kolesarjenje (86,05 %); dopoldanski izlet (51,16 %); Celodnevni izlet in Vrtnarjenje in urejanje okolice (37,21 %); Pevski zbor (34,88 %); Telovadba; Gospodinjski in slaščičarski krožek (23,26 %); Skupine za samopomoč (20,93 %); Bralna skupina (op. s knjižničarko) (18,60 %); Filmoteka; Pogovorna skupina; Žogabend 30,23 %); Praznovanja (verski, državni, občinski, mednarodni dnevi, šege in običaji, rojstni dnevi); Terapija z živalmi (16,28 %); Plesna ustvarjalnica (13,95 %); Druženje s prostovoljci; Kreativne skupine; Literarni krožek; Tombola; Vaje za spomin (11,63 %).

V Preglednici 4 so predstavljene ugotovitve, kako se starostniki vključujejo v prostočasne aktivnosti. Glede na postavljene cilje in raziskovalna vprašanja nas je najprej zanimalo, katere prostočasne dejavnosti imajo v domu za starejše (Preglednica 3). Poleg izbirnih odgovorov: Verski obredi; Izlet; Vrtnarjenje in urejanje okolice; Branje časopisov in revij; Gledanje televizije; Joga; Sprehodi, tek ali kolesarjenje in Druženje s sostanovalci, so imeli možnost še dopisati ponudbo prostočasnih aktivnosti pod drugo. Prav ta del odprtega odgovora nam je dal veliko uporabnih informacij.

Preglednica 4: Vključevanje starostnikov v slovenskih domovih za starejše v prostočasne aktivnosti

	Spol		V katero starostno skupino spadate?				Koliko časa ste že v domu za starejše?			Izobrazba		
	Moški	Ženski	Do 65 let.	Od 65 do 74 let.	Od 75 do 84 let.	Nad 85 let.	Do 5 let.	Od 6 do 10 let.	Od 6 do 10 let.	OŠ	Pok. oz. sred. šola.	Viš. oz. visok. izobr.
Obiskovanje verskih obredov	69	110	19	41	68	50	106	51	17	62	90	26
Druženje s sostanovalci	61	93	17	37	60	39	94	45	10	56	77	20
Gledanje televizije	58	89	13	35	60	39	87	44	12	52	77	17
Branje knjig, časopisov, revij, pravljic	58	73	13	32	57	30	80	38	10	46	68	18
Sprehodi, tek in kolesarjenje	40	69	12	25	51	21	70	30	7	35	58	15
Izleti	40	47	13	23	35	16	48	31	6	20	49	18
Vrtnarjenje in urejanje okolice	10	28	3	14	14	7	17	14	6	12	19	7
Telovadba	4	20	2	2	14	6	20	3	1	10	11	3
Joga, gimnastika	7	5	3	4	5		5	2	1	1	6	5
Miselne vaje	1	9	1	1	4	4	8	2		1	7	2
Pogovorna skupina	1	9	2		4	4	8	1	1	7	3	
Pevski zbor	1	8	1	1	7	0	6	2	1	3	5	1
Obiskovanje prireditev	3	4			6	1	5	1	1	2	3	2
Skupina za samopomoč	1	4	1		4		5			1	1	3
Kviz	1	3	2		1	1	3	1		3	1	
Šahovski krožek, igranje šaha	4			2	2		4				2	2
Ustvarjalne delavnice	1	3		1	2	1	3	1		1	1	2
Bio-sinhron		3				3	3			1	2	
Ročna dela		3			3	1	3				2	
Delovna terapija	1	1	1	1			1		1	1	1	
Fizioterapija		2			2		1	1			1	1
Kegljanje	1	1			2		2			1		1
Poslušanje radia		2			1	1	1	1			1	1
Tapkanje		2				2	2				1	1
Tombola		2			2		1	1			2	
Izdelovanje voščilnic		1				1	1			1		
Izdelovanje voščilnic in punčk iz cunj		1		1				1			1	
Kartanje		1			1		1			1		
Kulinarika		1			1		1				1	
Literarna sekcija	1				1		1					1
Lokostrelstvo	1			1			1				1	
Meditacija	1				1		1				1	
Metoda Feldenkrais		1		1				1			1	
Naravoslovna, foto in elektronika	1			1			1				1	
Obiski pokopališča		1			1		1				1	
Pikado		1			1		1			1		
Razne igre		1		1			1			1		

Zaposleni se vključujejo v prostočasne aktivnosti. Skupaj smo zbrali 37 aktivnosti. V kolikor navedemo najpogostejše (tiste, ki so dobile več kot 10 % delež): Obiskovanje verskih obredov (88,61 %); Druženje s sostanovalci (76,24 %); Gledanje televizije (72,77 %); Branje knjig, časopisov, revij, pravljic (64,85 %); Sprehodi, tek in kolesarjenje (53,96 %); Izleti (43,07 %); Vrtnarjenje in urejanje okolice (18,81 %) in Telovadba (11,88 %).

V Preglednici 5 je razvidno število prostočasnih dejavnosti, v katere so vključeni starostniki, glede na demografske podatke.

Preglednica 5: Število prostočasnih dejavnosti

		Število prostočasnih dejavnosti							Skupaj
		1	2	3	4	5	6	7	
Spol	Moški	71	1	3	5				80
	Ženski	107	2	2	2	6	1	2	122
	Skupaj	178	3	5	7	6	1	2	202
V katero starostno skupino spadate?	Do 65 let	18			1				19
	Od 65 do 74 let.	45		1	1	1			48
	Od 75 do 84 let.	67	1	4	3	3		1	79
	Nad 85 let.	47	2		2	2	1	1	55
	Skupaj	177	3	5	7	6	1	2	201
Koliko časa ste že v domu za starejše?	Do 5 let.	104	2	2	4	5		2	119
	Od 6 do 10 let.	52		3	3	1			59
	Od 6 do 10 let.	17	1				1		19
	Skupaj	173	3	5	7	6	1	2	197
Izobrazba	Osnovna šola.	61	1	2	5	1	1	1	72
	Poklicna oz. srednja šola.	88	2	2	2	5		1	100
	Višješolsko oz. visokošolsko izobraževanje.	28		1					29
	Skupaj	177	3	5	7	6	1	2	201

Ugotavljamo, da se vsi starostniki udeležujejo prostočasnih dejavnosti.

4.2 Interpretacija hipotez

Namen prispevka je analizirati, katere prostočasne dejavnosti imajo v slovenskih domovih za starostnike in katerih aktivnosti se le-ti dejansko udeležujejo. Oblikovali smo naslednje raziskovalno vprašanje*: »Kako imajo v domovih za starejše organizirane prostočasne dejavnosti?«* in raziskovalne hipoteze:

- H1: Menimo, da se moški pogosteje udeležujejo prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše.
- H2: Menimo, da mlajši starostniki pogosteje udeležujejo prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše.
- H3: Menimo, da tisti starostniki, ki so v domu dlje časa, pogosteje udeležujejo prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše.
- H4: Menimo, da bolj izobraženi starostniki pogosteje udeležujejo prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše.

Pri tem smo uporabili spremenljivke, ki jih predstavljamo v kontigenčni tabeli (preglednica 4):

- spol,
- starostni razredi,
- čas bivanja v domu za starejše,
- izobrazba in
- poznavanje možnosti za prostočasne dejavnosti.

Najprej smo se lotili preverjanja hipoteze H1. Pri preverjanju smo uporabili kontingenčne tabele (Preglednica 6) in pripadajoči hi.kvadrat test, s katerim smo preverili, ali je povezanost statistično značilna. Iz rezultata izhaja (preglednica 6), da je signifikanca pri Pearsonovem $\chi 2$ testu znašala 0,134, kar pomeni, da je $p > 0,05$ in povezanost med spremenljivkama ni statistično značilna, zato rezultata ne moremo posplošiti na celotno populacijo starostnikov.

Na podlagi rezultatov smo ugotovili, da ni statistično značilnih razlik, da ženske pogosteje koristijo prostočasne aktivnosti, ki jih organizirajo v domovih za starejše. Na podlagi tega smo H1 *zavrnili.*

Preglednica 6: $\chi 2$ test med spremenljivkama spol in koriščenjem prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše

Preizkusi Chi-Square			
	Vrednost	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9,791[a]	6	,134
Razmerje verjetnosti	12,881	6	,045
Linearno združevanje	,983	1	,322
N veljavnih primerov	202		

a.12 celic (85,7 %) je pričakovano manj kot 5. Najmanjše pričakovano število je 0,40.

Sledilo je hipoteze H2. Pri preverjanju smo uporabili kontingenčne tabele (Preglednica 6) in pripadajoči hi.kvadrat test, s katerim smo preverili, ali je je povezanost statistično značilna. Iz rezultata izhaja (Preglednica 7), da je signifikanca pri Pearsonovem $\chi 2$ testu znašala 0,832, kar pomeni, da je $p > 0,05$ in povezanost med spremenljivkama ni statistično značilna. Rezultata ne moremo posplošiti na celotno populacijo starostnikov.

Na podlagi rezultatov smo ugotovili, da ni statistično značilnih razlik, da mlajši kot so starostniki, bolj starostniki koristijo prostočasne aktivnosti, ki jih organizirajo v domovih za starejše. Na podlagi tega smo H2 *zavrnili.*

Preglednica 7: $\chi 2$ test med spremenljivkama starostni razredi in koriščenjem prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše

Preizkusi Chi-Square			
	Vrednost	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	12,284[a]	18	,832
Razmerje verjetnosti	15,253	18	,645
Linearno združevanje	2,540	1	,111
N veljavnih primerov	201		

a.24 celic (85,7 %) je pričakovano manj kot 5. Najmanjše pričakovano število je ,09.

Sledilo je preverjanje hipoteze H3. Pri preverjanju smo uporabili kontingenčne tabele (Preglednica 7) in pripadajoči hi.kvadrat test, s katerim smo preverili, ali je povezanost statistično značilna. Signifikanca pri Pearsonovem $\chi 2$ testu (preglednica 8) je znašala 0,109 ($p > 0,05$). Iz tega izhaja, da povezanost med spremenljivkama ni statistično značilna in rezultata ne moremo posplošiti na celotno populacijo starostnikov.

Preglednica 8: $\chi 2$ test med spremenljivkama čas bivanja v domu za starejše in koriščenjem prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše

Preizkusi Chi-Square			
	Vrednost	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	18,217[a]	12	,109
Razmerje verjetnosti	15,849	12	,198
Linearno združevanje	,315	1	,574
N veljavnih primerov	197		

a.0 celic (0,0 %) je pričakovano manj kot 5. Najmanjše pričakovano število je 7,79.

Na podlagi rezultatov smo ugotovili, da ni statistično značilnih razlik, da dlje kot starostniki bivajo v domu za starejše, bolj koristijo prostočasne aktivnosti, ki jih organizirajo v domovih za starejše. Na podlagi tega smo*zavrnili* H3.

Sledilo je še preverjanje hipoteze H4. Pri preverjanju smo uporabili kontingenčne tabele (preglednica 5) in pripadajoči hi.kvadrat test, s katerim smo preverili, ali je povezanost statistično značilna. Signifikanca pri Pearsonovem $\chi 2$ testu (preglednica 9) je znašala 0,588 ($p > 0,05$). Iz tega izhaja, da povezanost med spremenljivkama ni statistično značilna in rezultata ne moremo posplošiti na celotno populacijo starostnikov.

Na podlagi rezultatov smo ugotovili, da ni statistično značilnih razlik, da višja kot je izobrazba, bolj starostniki koristijo prostočasne aktivnosti, ki jih organizirajo v domovih za starejše. Na podlagi tega smo H4 *zavrnili.*

Preglednica 9: $\chi 2$ test med izobrazba in koriščenjem prostočasnih dejavnosti, ki jih organizirajo v domovih za starejše

Preizkusi Chi-Square			
	Vrednost	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10,318[a]	12	,588
Razmerje verjetnosti	12,612	12	,398
Linearno združenje	2,495	1	,114
N veljavnih primerov	201		

a. 18 celic (85,7 %) je pričakovano manj kot 5. Najnižje pričakovano število je ,14.

5 Zaključek

V raziskavo smo vključili domove v Sloveniji in starostnike, ki bivajo v teh domovih za starejše v Sloveniji. Raziskovalni vzorec je zajel 43 domov za starejše v različnih regijah Slovenije in 202 bivajoča starostnika.

Ugotovili smo, da imajo v vseh domovih za starejše, kateri so se odzvali na raziskavo, prostočasne dejavnosti in s tem odgovorili na raziskovalno vprašanje*: »Kako imajo v domovih za starejše organizirane prostočasne dejavnosti?«* Prav tako vsi vključeni starostniki v raziskavo koristijo le-te. Nismo pa našli nobene statistično značilne razlike pri demografskih podatkih. To je z vidika raziskave celo dobro, saj ni nobena demografska skupina zapostavljena oz. ima enake možnosti ali želje po prostočasni dejavnosti. Zaključimo lahko, da je to področje v slovenskih domovih za starejše zgledno urejeno in dobro sprejeto med starostniki.

Na podlagi ugotovitev predlagamo pristojnemu Ministrstvu za delo, družino, socialne zadeve in enake možnosti kakor tudi vodstvom domov, da oblikujejo še dodaten nabor prostočasnih aktivnosti. Te naj trajajo od le nekaj minut na sami lokaciji, pa do več dnevnih izletov v druge kraje. Dokazano je namreč, da če so starostniki bolj aktivni in zadovoljni, potem je tudi njihovo zdravstveno stanje boljše, prav tako pa starostniki s tem ohranjajo fizično in psihično kondicijo. To veliko pripomore pri vzdrževanju spomina in oblikah bolezenskih stanj, povezanih z njimi. Starostniki lahko trenirajo svoje psihofizične sposobnosti prav s prostočasnimi aktivnostmi.

Raziskovalcem priporočamo, da ugotovitve o naboru prostočasnih aktivnosti grupirajo na neko smiselno in obvladljivo število, da bi se lahko raziskava ponovila. Tam bi morali dopolniti še podatek o standardnih in nadstandardnih (plačljivih) prostočasnih dejavnostih in njihovem vplivu na zdravje starostnikov.

Reference

1. Agahi, N., Ahacic, K., & Parker, M. G. (2006). Continuity of leisure participation from middle age to old age. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences*, *61*(6), S340–S346.
2. Cross, K. P. (1981). *Adults as Learners*. San Francisco: Jossey-Bass.
3. Darovec, J., Kogoj, A., Kores-Plesničar, B., Muršec, M., Pišljar, M., Pregelj, P., … Tomori, M. (2013). *Smernice za obravnavo pacientov z demenco*. Slovensko zdravniško društvo, Združenje psihiatrov.
4. Goriup, J. (2015). *Vpliv institucionalnega bivanja na družbeni status in avtonomijo starostnika*. Novo Mesto: Fakulteta za zdravstvene vede.
5. Hojnik-Zupanc, I. (1997). *Dodajmo življenje letom: nekaj spoznanj in nasvetov, kako se smiselno in zdravo pripravljati na starost in jo tako tudi živeti*. Ljubljana: Gerontološko društvo Slovenije.
6. Klanjšček, G. (2009). Zdravljenje bolnika z demenco. *Bolezni in Sindromi v Starosti*, *3*, 37–50.
7. Ku, P.-W., Fox, K. R., & Chen, L.-J. (2016). Leisure-time physical activity, sedentary behaviors and subjective well-being in older adults: An eight-year longitudinal research. *Social Indicators Research*, *127*(3), 1349–1361.
8. Ljubič, A., & Kolnik, T. Š. (2017). Prednosti metode Montessori pri obravnavi oseb z demenco. *Obzornik Zdravstvene Nege*, *51*(1).
9. Macuh, B. (2017). Življenski slog starejših v domovih za starejše. *Andragoška Spoznanja*, *23*(1), 53–71. Pridobljeno dne 16. 04. 2018 s spletne strani http://doi.org/http://dx.doi.org/10.4312/as.23.1.
10. Maučec-Zakotnik, J., in Lainščak, M. (2003). Preventiva bolezni srca in ožilja.*Slovenian Medical Journal*, *72*(5).
11. Menec, V. H. (2003). The Relation Between Everyday Activities and Successful Aging: A 6-Year

Longitudinal Study. *The Journals of Gerontology: Series B, 58*(2), S74–S82. Pridobljeno dne 26. 03. 2018 s spletne strani http://dx.doi.org/10.1093/geronb/58.2.S74.
12. Milavec Kapun, M. (2011). *Starost in staranje [Elektronski vir]: gradivo za 2. letnik*. Ljubljana: Zavod IRC.
13. Ramovš, J. (2003). *Kakovostna starost: socialna gerontologija in gerontagogika*. Ljubljana: Inštitut Antona Trstenjaka in Slovenska akademija znanosti in umetnosti.
14. Rubenson, K., & Gongli, X. (1997). Barriers to Participation in Adult Education and Training: Towards a New Understanding. In P. Belanger & A. Tuijnman (Eds.), *New Patterns of Adult Learning* (pp. 77–100). Oxford, New York, Tokio: Pergamon.
15. Seniorji.info – spletna stran za starejše – seniorje in upokojence. (2017). Pridobljeno 07. 03. 2018 s spletne strani http://www.seniorji.info/index.php?ids=0.
16. SURS. (2017). Statistični urad Republike Slovenije. Pridobljeno dne 16. 04. 2018 s spletne strani http://www.stat.si.
17. Vance, D., Camp, C., Kabacoff, M., & Greenwalt, L. (1996). Montessori methods: Innovative interventions for adults with Alzheimer's disease. *Montessori Life, 8*, 10–12.
18. Vertot, N. (2010). *Starejše prebivalstvo v Sloveniji*. Ljubljana: Statistični urad Republike Slovenije.
19. Wang, H.-X., Xu, W., & Pei, J.-J. (2012). Leisure activities, cognition and dementia. *Biochimica et Biophysica Acta (BBA)-Molecular Basis of Disease, 1822*(3), 482–491.
20. Weiermair, K., & Mathies, C. (2004). *The Tourism and Leisure Industry: Shaping the Future*. Binghampton, NY: Haworth Press.

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Dr. **Andrej Raspor** je po osnovni izobrazbi strojni tehnik, uni. dipl. organizator dela in doktor družbenih – upravljavskih ved. Pri svojem delu združuje poslovno in akademsko delo. Predava in svetuje s področja organizacije dela, prenove poslovnih procesov, turizma in igralništva, kakovosti storitev ter razvoja kadrov. Ima več kot 32 let delovnih izkušenj, od tega več kot 17 let na različnih vodilnih mestih. Preden se je zaposlil kot direktor v lastnem podjetju, je bil vodja splošnih poslov, vodja komisije za nadzor stroškov, direktor razvoja kadrov in direktor strateških projektov. Vodil prenovo poslovnih procesov razvoja kadrov in trženja ter organiziral poslovanje za kitajske goste z območja Italije in Kitajske. Je podjetnik, ustanovitelj več start-upov, poslovni svetovalec in mentor. Sodeloval je na številnih mednarodnih konferencah, objavil izsledke svojih raziskav v znanstvenih revijah z recenzentskim postopkom. Je avtor več znanstvenih in strokovnih monografij ter uporabnih priročnikov iz področja kakovosti storitve, turizma in igralništva.

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Dr. **Bojan Macuh** je prof. soc. in slov., zaključil je doktorski študij na Pedagoški fakulteti Univerze na Primorskem, pred tem pa magistrski študij sociologije na Filozofski fakulteti Univerze v Mariboru. Od leta 2009 je predavatelj na Fakulteti za poslovne in komercialne vede v Celju, kjer predava sociologijo in psihologijo in etiko. Na Gea College v Ljubljani predava od leta 2013, in sicer poslovno etiko in organizacijsko kulturo, medtem ko na Višji šoli za kozmetiko in velnes predava predmet čustvena inteligenca in osebnostni razvoj. Občasno predava še na Fakulteti za družbene in uporabne študije v Novi Gorici in Fakulteti za medije v Ljubljani.V več kot 30 letih pedagoškega dela je avtor znanstvenih monografij ter več znanstvenih, strokovnih in poljudnih člankov. Hkrati je avtor tudi več leposlovnih del za odrasle, mladino in otroke. Sodeloval je na več mednarodnih znanstvenih konferencah.

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Abstract:
Active Aging in Slovenian Homes for the Elderly: Leisure Activities of the Elderly

Research question: How are leisure activities organised in homes fort he elderly?
Purpose: The purpose of the research was to determine the positions of the management of nursing homes and of the occupants on the offer and the interest for participation in leisure activities.
Methods of approach: A desk and field research was used. In addition to the literature study, statistical data of the Statistical Office of the Republic of Slovenia were analyzed. A field research in Slovenian nursing homes was conducted to obtain the positions. Randomly chosen elderly and management were included. A survey was used as a method for obtaining data. SPSS 20 was used for data processing. In the survey, there were 202 older people, of which 122 women and 80 men. The survey was conducted from October 15 to November 12, 2017.
Results: We have found that nursing homes are organized and elderly are interested in leisure activities. Given the trends in natural movement and the prolongation of the old age and the growing number of active population, this need will be even more pronounced in the future.
Conclusions: The providers of nursing homes and programmes will also have to adapt to the elderly who want active aging and can afford leisure activities. Infrastructure will have to adapt accordingly.

Keywords: nursing homes, aging, old age, pensioners, leisure activities, Slovenia.