Acta geographica Slovenica, 54-1, 2014, 67–87

THE WELLBEING OF SLOVENIA'S POPULATION BY REGION: COMPARISON OF INDICATORS WITH AN EMPHASIS ON HEALTH

BLAGINJA PREBIVALCEV SLOVENIJE PO REGIJAH: PRIMERJAVA KAZALNIKOV S POUDARKOM NA ZDRAVJU

Lilijana Šprah, Tatjana Novak, Jerneja Fridl

Wellbeing is an abstract, multidimensional, and complex concept that includes not only components of the subjective experience of happiness, satisfaction, and prosperity, but also objectively measurable indicators, and so it can be only measured indirectly (Artist: Metod Frlic, academic sculptor. Untitled (2008). Painting on plywood, acrylic, 158 cm × 202 cm).

Blaginja je abstrakten, večrazsežen in kompleksen pojem, ki vključuje tako komponente subjektivnega doživljanja sreče, zadovoljstva in prosperitete, kakor tudi objektivno merljive kazalnike, zato jo lahko merimo le posredno (Avtor: Metod Frlic, akademski kipar. Brez naslova (2008). Slika na vezani plošči, akril, 158 cm × 202 cm).

The wellbeing of Slovenia's population by region: comparison of indicators with an emphasis on health

DOI: http://dx.doi.org/10.3986/AGS54104
UDC: 913:330.59(497.4)
330.59:613(497.4)
COBISS: 1.01

ABSTRACT: In broader definitions, wellbeing is commonly described as a multidimensional concept, defined by the state of happiness, health, and prosperity. However, due to various understandings of conceptual issues regarding wellbeing, professionals encounter a number of methodological problems connected with measuring it. Composite indicators are thus being increasingly used to measure population's wellbeing. Health is an important area of wellbeing and is connected with indicators similar to those used for measuring general wellbeing. This article uses composite indicators to compare various areas of wellbeing, and especially health-related wellbeing, among the twelve Slovenian statistical regions. The findings show great differences between Slovenian regions. In western Slovenia (the Central Slovenia, Soča, Coastal-Karst, and Upper Carniola regions), the level of wellbeing is generally high, and in eastern Slovenia (the Carinthia, Lower Sava, Mura, and Central Sava regions) it is lower. Except for minor deviations, the level of general wellbeing in the regions matches the level of health-related wellbeing.

KEYWORDS: geography, medicine, population's wellbeing, composite wellbeing indicator, health, region, mental disorder

The article was submitted to the editorial board on September 13, 2012.

ADDRESSES:
Lilijana Šprah, Ph. D.
Sociomedical Institute
Scientific Research Centre of the Slovenian Academy of Sciences and Arts
Novi trg 2, SI – 1000 Ljubljana, Slovenia
E-mail: lilijana.sprah@zrc-sazu.si

Tatjana Novak
Sociomedical Institute
Scientific Research Centre of the Slovenian Academy of Sciences and Arts
Novi trg 2, SI – 1000 Ljubljana, Slovenia
E-mail: tnovak@zrc-sazu.si

Jerneja Fridl, M. Sc.
Anton Melik Geographical Institute
Scientific Research Centre of the Slovenian Academy of Sciences and Arts
Gosposka ulica 13, SI – 1000 Ljubljana, Slovenia
E-mail: jerneja@zrc-sazu.si

1 Introduction

An overview of the literature on conceptual issues of wellbeing and its measurements reveals many methodological problems (Matthews 2006; Costanza et al. 2009). Wellbeing is a complex concept, defined as a state of happiness, health, and prosperity (Cowie and Lewis 1989, 1450). Due to its abstract and multidimensional nature, it can only be measured indirectly using a series of selected indicators, which must also be appropriately contextualized within a specific economic, social, and cultural environment, and primarily include those social values that reflect the perception of wellbeing in a specific environment. Recently, there has been increased interest among the professional and research community in studying wellbeing as well as many discussions on suitable methodological approaches to measuring it (Matthews 2006). In this regard, the main question is whether wealth and economic development are crucial to defining wellbeing. Ever since the establishment of the Organization for Economic Cooperation and Development (OECD) in 1961, the gross domestic product (GDP) has been the main indicator of measuring and understanding economic and social progress, which has also been connected with wellbeing. However, current studies point to a multilayered nature of the concept of wellbeing, which also includes subjective and nonmaterial components such as happiness, satisfaction, freedom, health, and education (Diener and Seligman 2004; Costanza et al. 2009).

The OECD has also responded to some methodological and content-related problems connected with measuring wellbeing. On its fiftieth anniversary, as part of the project »OECD Wellbeing Indicators« (OECD 2011), it presented a new method of monitoring general wellbeing as a response to demands for comparative information on the living conditions of people in countries with varying levels of development. The OECD wellbeing indicators include indicators of material conditions (income and wealth, jobs and housing), and quality of life (health, work-life balance, education, community, civil engagement and government, quality of the environment, safety, and life satisfaction; OECD 2011, 18, 19). The majority of indicators are based on statistical data, but some are also developed based on opinion polls.

The current financial and economic crisis opens numerous new aspects of understanding wellbeing, also in connection with the current global and social challenges related to climate changes, demographic trends, and public health (Stuckler et al. 2009). Evidence suggests that economic development is not necessarily connected with better wellbeing (Boarini, Johansson and D'Ercole 2006; Mikulić, Sándor and Leoncikas 2012). Especially topical is the question of how the crisis will be reflected in people's health. The findings show that during crises specific diseases and death rates increase due to distinctive reasons (e.g., suicide rate), mental health deteriorates (more depression and anxiety disorders), and the rates of domestic violence and other violence increase, as does drug and alcohol abuse (Levy & Sidel 2009; Avčin et al. 2011; Stuckler et al. 2011). Alarming is also the prediction that the crisis will increase inequalities in health, which will result in a lower level of wellbeing in a number of population groups (Buzeti et al. 2011; Gabrijelčič Blenkuš et al. 2012).

Improving population's wellbeing is one of the main development goals of any country, and therefore Slovenia also included this in Slovenia's Development Strategy (2005). Even when an individual country as a whole shows a fairly high level of wellbeing at an international scale, there can be considerable differences between individual areas or regions within the country. Regional differences in wellbeing can result from social, economic, and environmental problems that hinder balanced social and regional development. Therefore it is vital to continually monitor the geographically dependent levels of wellbeing, especially as they relate to effectively planning and implementing measures as part of spatial, economic, and healthcare policies, and ensuring access to public services, work, and high-quality living conditions (Rovan, Malešič and Bregar 2009, 71; Kerbler 2012, 175–176).

2 Purpose of the study and description of methodology

The aim of the present study is to explore the general wellbeing in individual statistical regions of Slovenia, and analyze the differences between them in terms of various aspects of wellbeing and selected health-related indicators.

Even though in recent years methodologies using composite indicators have become increasingly established in measuring wellbeing (OECD 2008), no »super« indicator is currently available that could be

regarded as an official wellbeing measure. Therefore, based on the available statistical data and taking into account the methodology recommended by the OECD (2008, 2011), composite wellbeing indicators (CWBI) were developed for the purposes of this study. There are several regionalizations or divisions of Slovenia in place (Perko 1998), but for this study the division into statistical regions proved to be the most appropriate.

2.1 Selection criteria for basic indicators of wellbeing

In selecting the basic sociodemographic, economic, healthcare, and environmental indicators for the CWBI, the conceptual adequacy of indicators, their availability in statistical regions, accessibility during the reference period (2006–2010), quality, and capacity to sum up several features of the phenomenon (expressed in the form of indexes, ratios, and coefficients) were taken into account.

The following secondary sources of statistical data were used:

1. SI-STAT online information portal of the Statistical Office of the Republic of Slovenia /SURS/ (Internet 1);
2. Electronic publications of the *Slovenske regije v številkah* (Slovenian Regions in Numbers) from 2006 to 2010 (SURS 2006–2010);
3. *Zdravstveni statistični letopis* (Health Statistics Yearbook), 2006–2008 (IVZ 2006–2008);
4. Statistical appendices to the publication of the Institute of Macroeconomic Analysis and Development /UMAR/ (Apohal Vučkovič et al. 2010, 127).

3 Identification of regional wellbeing on the basis of composite wellbeing indicators

3.1 Structure of a composite indicator of wellbeing

The CWBI areas and dimensions were identified based on the areas of the OECD indicators of wellbeing (OECD 2011). The CWBI of every region includes seventy basic indicators that were divided into sixteen areas (dimensions) of wellbeing: income, education, housing, jobs, environment, general health, safety, parental benefits, social transfers, availability of health and social services, risk behaviors, occupational health, neonatal health, stability of partnerships, developmental prospects, and demographic profile. The number of basic indicators included differs across dimensions, as indicated by the values provided in parentheses in Figure 1.

Before the development of the composite indicator, the statistical data of basic indicators that were not expressed as ratios (percentages, coefficients, and indexes) were recalculated into comparable units (per population and area of region) and standardized. A multivariate principal component analysis, which aims to reduce the scope of data or, in our case, indicators, while losing as little information as possible, was then used to develop a composite wellbeing indicator from a selection of basic indicators. Basic indicators were retained in an individual dimension only if they had relevant content for a particular area of wellbeing and if, based on the results of the principal component analysis, they explained the highest possible variance of data behind the basic indicators making up this component. The numerical value of an individual dimension was calculated by multiplying basic indicators by component weights and then the results obtained were averaged across the time period studied. A linear transformation of a STEN score, a standard scale running from 1 to 10, was used to classify regions according to their wellbeing levels in particular areas. A value of 1 represented the lowest calculated value pertaining to a particular dimension of wellbeing (the lowest level of wellbeing in a particular area), whereas a value of 10 was assigned to the highest calculated value of dimension of wellbeing (the highest level of wellbeing in a particular area). The CWBI value was calculated as a mean value of all sixteen dimensions of wellbeing within a particular statistical region. Regions were classified according to their CWBI values into four categories: regions of high wellbeing, regions of moderately high wellbeing, regions of moderately low wellbeing, and regions of low wellbeing.

Table 1 shows basic indicators included in the dimensions of wellbeing and their influence on wellbeing. The plus sign was assigned to indicators when their high values (e.g., working population) contributed

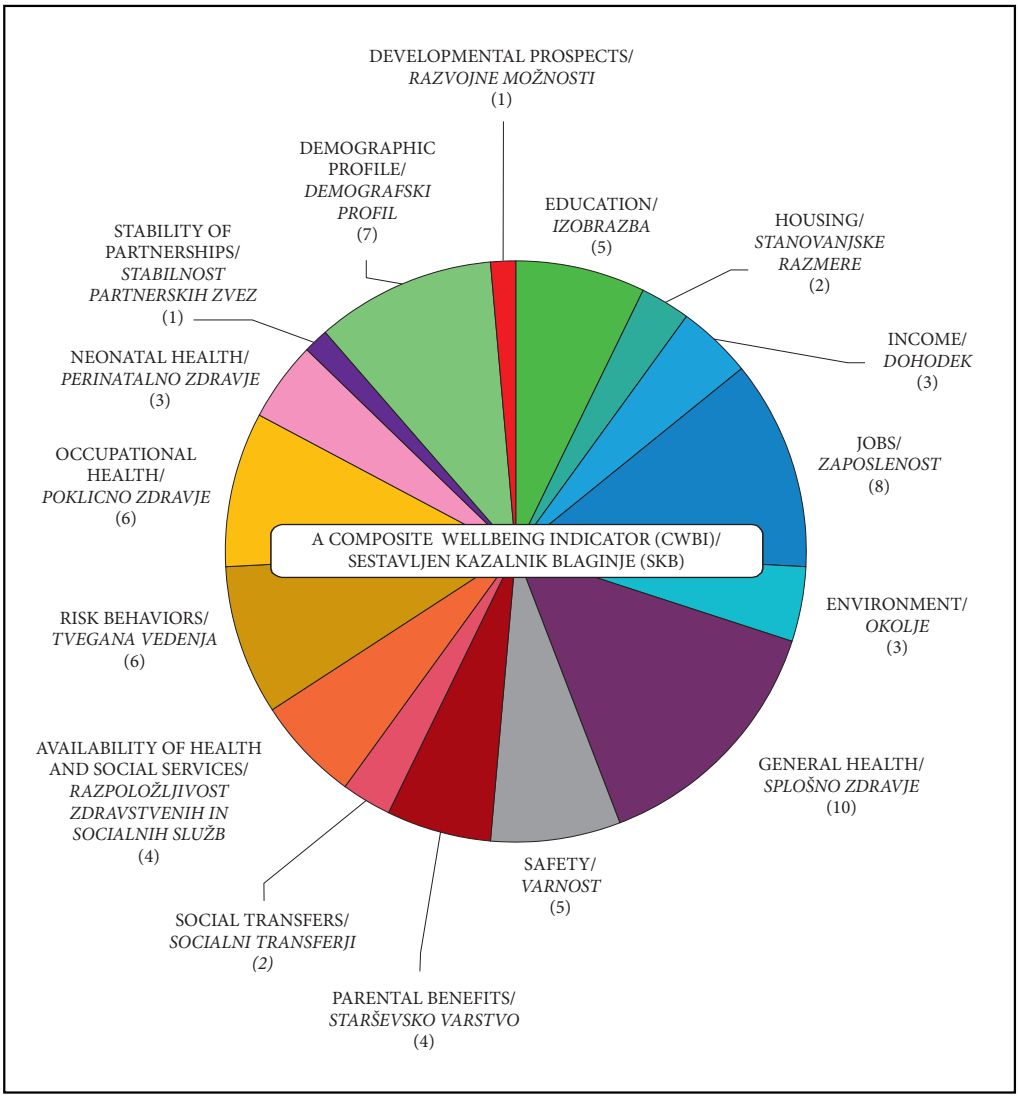


Figure 1: Structure of a regional composite wellbeing indicator in terms of wellbeing dimensions and the number of basic indicators included in them.

to a higher level of wellbeing within a region. The minus sign stands before indicators whose higher values (e.g., unemployment rate) signal lower levels of wellbeing in the region. A shorter time period (three or four years) was taken into account regarding those indicators that were not available for the full reference time period (2006–2010).

3.2 Inter-regional comparison with respect to different levels and areas of wellbeing

Figure 2 compares social, demographic, health, economic, and environmental dimensions of wellbeing between statistical regions of Slovenia. The regions were divided into four groups in terms of their CWBI

Table1: Overview of basic wellbeing indicators comprising the composite indicator of wellbeing and their influence on wellbeing.

DERIVED INDICATOR	BASIC INDICATOR	INFLUENCE ON WELL-BEING	DATA SOURCE AND REFERENCE PERIOD
Income	GDP per capita[a] index	+	*SURS, 2006–2008*
	GDP per capita in purchasing power standard units index	+	*SURS, 2006–2008*
	Net monthly salary of an employed person	+	*SURS, 2006–2010*
Education	Share of population 22–64 years of age with no education, with an incomplete education, or primary education	–	*SURS, 2006–2009*
	Share of population 22–64 years of age with secondary education	+	*SURS, 2006–2009*
	Share of population 22–64 years of age with tertiary education	+	*SURS, 2006–2009*
	Proportion of student population within the actively working population	+	*SURS, 2006–2009*
	Share of adult population 22–64 years of age engaged in lifelong learning	+	*SURS, 2006–2009*
Housing	Average household floor space (m^2) per person	+	*SURS, 2006–2010*
	Number of completed dwellings (new constructions, additions, changes in intended use)	+	*SURS, 2006–2010*
Jobs	Share of actively working population	+	*SURS, 2006–2010*
	Employment-population ratio	+	*SURS, 2006–2009*
	Registered unemployment rate	–	*SURS, 2006–2010*
	Share of unemployed with primary education	–	*SURS, 2006–2010*
	Share of unemployed with secondary or tertiary education	–	*SURS, 2006–2010*
	Job vacancies	+	*SURS, 2006–2010*
	Share of employed persons 55–64 years of age	+	*SURS, 2007–2009*
	Number of active enterprises	+	*SURS, 2006–2009*
Environment	Annual volume of water supplied to households from public water supply	+	*SURS, 2006–2010*
	Discharge of unpurified wastewater from public sewage system	–	*SURS, 2007–2009*
	Estimated damage caused by natural disasters as percentages of regional GDP	–	*SURS, 2006–2008*
General health	Number of drug prescriptions per person	–	*IVZ, 2007–2009*
	Rate of hospital treatment of diseases	–	*IVZ, 2006–2009*
	Number of cases with circulatory diseases as the most frequent causes of death	–	*IVZ, 2006–2009*
	Number of cases with digestive diseases as the most frequent causes of death	–	*IVZ, 2006–2009*
	Number of visits in general practice for endocrine, metabolic, and eating disorders	–	*IVZ, 2006–2008*
	Number of visits in general practice for mental and behavioral disorders	–	*IVZ, 2006–2009*
	Number of visits in general practice for circulatory disorders	–	*IVZ, 2006–2008*
	Number of visits in general practice for metabolic and eating disorders	–	*IVZ, 2006–2008*
	Number of visits in general practice for musculo-skeletal disorders	–	*IVZ, 2006–2008*
Safety	Total number of convicted adults	–	*SURS, 2006–2010*
	Number of convicted adults by criminal offense against spouses, family, and children	–	*SURS, 2006–2010*
	Total number of convicted minors (under the age of 18)	–	*SURS, 2006–2010*
	Number of cases of self-harm	–	*SURS, 2006–2009*
	Number of cases of assault on other persons	–	*SURS, 2006–2009*
Parental benefits	Number of children 1–5 years of age in preschools	+	*SURS, 2006–2009*
	Number of beneficiaries with the right to part-time work because of parenting duties	+	*SURS, 2006–2009*
	Number of beneficiaries with the right to paternity leave compensation	+	*SURS, 2006–2009*
	Number of marriages	+	*SURS, 2006–2010*
Social transfers	Number of recipients of financial social assistance	–	*SURS, 2006–2009*
	Number of recipients of scholarships among upper secondary and tertiary students	+	*SURS, 2008–2010*
Availability of health and social services	Number of physicians	+	*SURS,2007–2009*
	Number of nurses	+	*SURS,2007–2009*
	Number of hospital beds	+	*SURS, 2007–2009*
	Number of beds available in retirement homes	+	*SURS, 2006–2009*
Risk behaviors	Number of persons seriously injured in traffic accidents	–	*SURS,2006–2009*
	Number of persons killed in traffic accidents	–	*SURS, 2007–2009*
	Hospitalization rates due to suicide	–	*IVZ, 2006–2009*
	Number of suicides	–	*IVZ, 2006–2009*
	Number of visits due to alcohol consumption	–	*IVZ, 2006–2009*
	Number of drug abuse cases in primary care	–	*IVZ, 2006–2009*

Occupational health	Number of reported injuries at work	–	*IVZ, 2006–2009*
	Share of work days lost due to sick leave per person	–	*IVZ, 2006–2010*
	Frequency index (IF) [b]	–	*IVZ,2006–2010*
	Seriousness of sick leave [c]	–	*IVZ, 2006–2010*
	Rate of hospital treatment of diseases	–	*IVZ, 2006–2009*
	Average duration of hospitalization due to illness	–	*IVZ, 2006–2009*
Neonatal health	Stillbirths	–	*IVZ, 2007–2009*
	Number of women giving birth via caesarian section	–	*IVZ, 2006–2009*
	Share of newborns with low birth weight (under 2500 g)	–	*IVZ, 2007–2009*
Stability of partnerships	Number of divorces	–	*SURS, 2006–2010*
Developmental prospects	Development hazard index [d]	–	*UMAR, 2007–2013*
Demographic profile	Population density	–	*SURS, 2006–2009*
	Number of live births	+	*SURS, 2006–2010*
	Number of deaths	–	*SURS, 2006–2010*
	Total increase in population (natural and migration increase)	+	*SURS, 2006–2010*
	Coefficient of age dependency [e]	–	*SURS, 2006–2010*
	Aging index [f]	–	*SURS, 2006–2010*
	Number of farmers within actively working population	–	*SURS, 2006–2010*

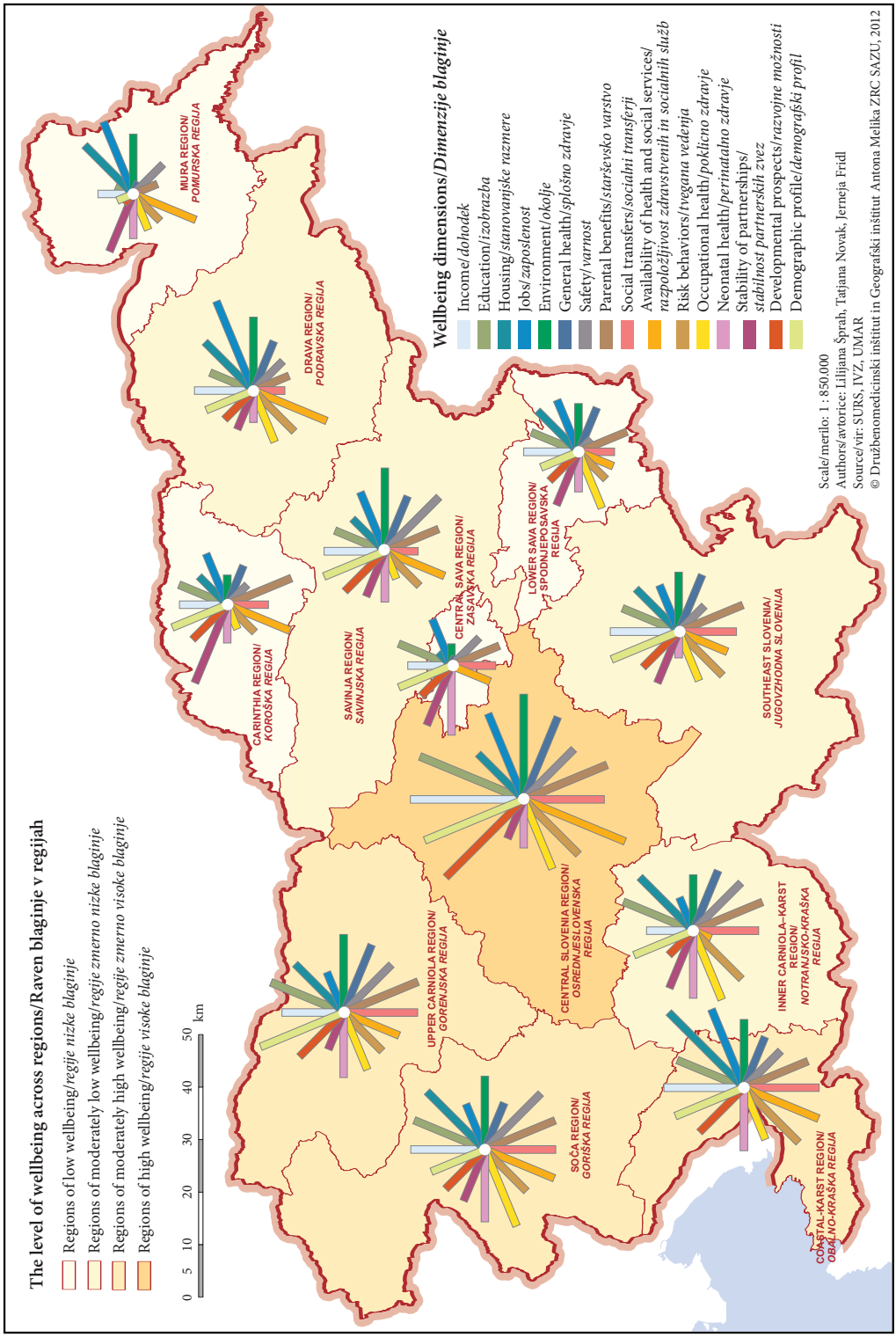
Notes:
[a] The *GDP per inhabitant index* compares the GDP per inhabitant with the national GDP within the same year.
[b] The *Frequency index* describes the number of sick leaves per 100 employees in one year.
[c] *Seriousness of sick leave* signals the average duration of one sick leave due to illness, injury, or other medical reason.
[d] The *Development hazard index* comprises eleven indicators (development, regional burden, and developmental prospects; Pečar & Kavaš 2006).
[e] The *Coefficient of age dependency* is the ratio between the young (0–14 years), old (over 65 years), and work-capable (over 15 years) population.
[f] The *Aging index* shows the ratio between the old (over 65 years) and young population (0–14 years), multiplied by 100.
Definitions *a* and *d–f* are taken from data sources (Internet 1), whereas definitions *b–c* are taken from the Health Statistics Yearbook (IVZ 2006d).

value (the values ranged from 7.6 to 3.3; interval: 1.07) and are represented in various shades of orange in the figure:

- Group 1: Regions of high wellbeing (CWBI = 7.6 to 6.52): Central Slovenia region /*Osrednjeslovenska regija*/ (CWBI = 7.58).
- Group 2: Regions of moderately high wellbeing (CWBI = 6.53 to 5.45): Soča region /*Goriška regija*/ (CWBI = 5.94), Coastal-Karst region /*Obalno-kraška regija*/ (CWBI = 5.90), Upper Carniola region /*Gorenjska regija*/ (CWBI = 5.78), and Inner Carniola–Karst region /*Notranjsko-kraška regija*/ (CWBI = 5.20).
- Group 3: Regions of moderately low wellbeing (CWBI = 5.46 to 4.38): Savinja region /*Savinjska regija*/ (CWBI = 4.91), Southeast Slovenia /*Jugovzhodna Slovenija*/ (CWBI = 4.88), and Drava region /*Podravska regija*/ (CWBI = 4.75).
- Group 4: Regions of low wellbeing (CWBI = 4.39 to 3.32): Carinthia region /*Koroška regija*/ (CWBI = 4.21), Lower Sava region /*Spodnjeposavska regija*/ (CWBI = 4.04), Mura region /*Pomurska regija*/ (CWBI = 3.45), and Central Sava region /*Zasavska regija*/ (CWBI = 3.37).

There were considerable differences in wellbeing among the regions, with Central Slovenia standing out as the region with the highest level of wellbeing, and the Mura and Central Sava regions as having the lowest levels of general wellbeing (Figure 2). In western Slovenia there is a group of regions with relatively high levels of general wellbeing (the Central Slovenia, Soča, Coastal-Karst, and Upper Carniola regions), and in eastern Slovenia there is a group of regions with the lowest levels of general wellbeing (the Drava, Carinthia, Lower Sava, Central Sava, and Mura regions). Regions with higher levels of general wellbeing also exhibit high levels of wellbeing in all other areas. The residents of these regions have higher education profiles and higher incomes, experience better housing and environmental conditions, and also have more employment opportunities and better parental benefit opportunities. At the same time, these regions have better development opportunities and a more favorable demographic profile.

Figure 2: Inter-regional comparison with respect to different levels and areas of wellbeing. ► p. 74


The level of wellbeing across regions/Raven blaginje v regijah
Regions of low wellbeing/regije nizke blaginje
Regions of moderately low wellbeing/regije zmerno nizke blaginje
Regions of moderately high wellbeing/regije zmerno visoke blaginje
Regions of high wellbeing/regije visoke blaginje
0 5 10 20 30 40 50 km
Wellbeing dimensions/Dimenzije blaginje
Income/dohodek
Education/izobrazba
Housing/stanovanjske razmere
Jobs/zaposlenost
Environment/okolje
General health/splošno zdravje
Safety/varnost
Parental benefits/starševsko varstvo
Social transfers/socialni transferji
Availability of health and social services/razpoložljivost zdravstvenih in socialnih služb
Risk behaviors/tvegana vedenja
Occupational health/poklicno zdravje
Neonatal health/perinatalno zdravje
Stability of partnerships/stabilnost partnerskih zvez
Developmental prospects/razvojne možnosti
Demographic profile/demografski profil
MURA REGION/POMURSKA REGIJA
DRAVA REGION/PODRAVSKA REGIJA
CARINTHIA REGION/KOROŠKA REGIJA
SAVINJA REGION/SAVINJSKA REGIJA
CENTRAL SAVA REGION/ZASAVSKA REGIJA
LOWER SAVA REGION/SPODNJEPOSAVSKA REGIJA
SOUTHEAST SLOVENIA/JUGOVZHODNA SLOVENIJA
UPPER CARNIOLA REGION/GORENJSKA REGIJA
CENTRAL SLOVENIA REGION/OSREDNJESLOVENSKA REGIJA
INNER CARNIOLA-KARST REGION/NOTRANJSKO-KRAŠKA REGIJA
SOČA REGION/GORIŠKA REGIJA
COASTAL-KARST REGION/OBALNO-KRAŠKA REGIJA
Scale/merilo: 1 : 850.000
Authors/avtorice: Lilijana Šprah, Tatjana Novak, Jerneja Fridl
Source/vir: SURS, IVZ, UMAR
© Družbenomedicinski inštitut in Geografski inštitut Antona Melika ZRC SAZU, 2012

3.3 Inter-regional comparison with respect to basic indicators of health-related wellbeing

A comparison of regions in terms of the level of wellbeing in health-related areas showed that regions of high and moderately high wellbeing also display a generally higher level in general, occupational, and neonatal health and the availability of health and social care services (comparing columns in Figure 2; higher CWBI values in Table 2). This was followed by an analysis of how certain selected indicators of health-related wellbeing are distributed across regions. Because health-related wellbeing can also be linked with drug and alcohol consumption, suicidal behavior, and injuries in car accidents, indicators making up the dimension of »risk behaviors« were also included (Table 2).

Table 2 shows that the general level of wellbeing does not necessarily reflect the wellbeing in individual areas within a specific region. Thus the Central Slovenia region (a region of high wellbeing in terms of its CWBI value) ranks high on the majority of basic indicators of wellbeing, but compared to other regions it exhibits some deviations in health-related areas such as the highest level of hospitalization due to disease, a fairly high share of newborns with a low birth weight, a large number of treatments for drug abuse, and a large number of persons injured in car accidents. Such deviations can also be observed in other regions. In the Central Sava region (which has the lowest level of general wellbeing), a low level of health-related wellbeing predominates, but the region stands out with relatively good status in some other areas, such as the largest number of primary healthcare appointments due to musculo-skeletal disorders and a small number of injured in car accidents, fewer stillborn babies, and a relatively good availability of beds in retirement homes.

4 Discussion

Until recently, wellbeing was predominantly measured with approaches that used either macroeconomic statistics such as the GDP or people's subjective opinions about their satisfaction with the quality of life as an approximation for the wellbeing assessment. It turned out that subjective opinions of wellbeing as part of international and interregional comparisons are not reliable because they depend strongly on the cultural context and various psychological factors (Diener 2000). Therefore, the use of composite indicators is becoming increasingly established in measuring wellbeing (Matthews 2006; OECD 2011); this method was also used in the study presented here.

Slovenia is treated as a homogenous regional unit in international comparisons, but many Slovenian economic, sociological, anthropological, and healthcare studies show great differences and special features at the level of its territorial units (municipalities and statistical regions), which are consequently reflected in access to services, commodities, and infrastructure, in economic and employment opportunities, in the accessibility and availability of healthcare and social services, and elsewhere (Nared 2002; Bole 2004; Ravbar, Bole and Nared 2005; Nared 2007; Bole 2008a, Bole 2008b; Dernovšek and Šprah 2008; Bole 2011; Ravbar 2011; Knežević Hočevar 2012; Korenič and Mavec 2012). In various international studies, these differences and special features in Slovenia remain unnoticed because the data are aggregated at the national level. This can also be seen from the findings of an OECD study (2011), in which interactive tools for measuring wellbeing were used to compare wellbeing across the OECD member states. Among the thirty-four members, Slovenia was ranked twenty-first overall. In some dimensions of wellbeing, it came close to the OECD average (health, social inclusion), or even higher (employment, personal safety); it fell below the OECD average with regard to housing and life satisfaction (Internet 2).

This study focused on the level of wellbeing in Slovenian statistical regions as measured by the adapted methodology of the OECD indicators. The results showed that, in terms of general wellbeing defined with a mean CWBI value, regions differ greatly from one another because the range of the CWBI was considerable: from 7.58 to 3.37. The situation in health-related wellbeing is especially interesting because in some regions it deviates from the general wellbeing status. That the estimated general wellbeing and health-related wellbeing match is also confirmed by the fact that a high level of wellbeing coincides with economically and socially better developed urban centers; however, a mismatch of these estimates in some regions also draws attention to the fact that favorable living and environmental conditions in municipalities do not necessarily reflect high economic and social development (Malešič, Bregar, and Rovan 2009, 47, 51).

Table 2: Selected basic indicators of various health-related areas of wellbeing.

AREA OF WELLBEING	VALUE OF CWBI DIMENSION / BASIC INDICATOR	CE	SO	CO	UP	IN	SA	SE	DR	CA	LO	MU	CN
		High wellbeing		*Moderately high wellbeing*			Moderately low wellbeing			Low wellbeing			
General health	*Value of CWBI dimension*	*7.8*	*4.4*	*4.8*	*6.4*	*5.7*	*5.2*	*5.3*	*4.7*	*3.7*	*4.2*	*1.1*	*0.9*
	Number of drug prescriptions per person	7.1	7.0	7.1	7.0	7.9	8.1	7.7	8.6	7.9	8.6	9.1	8.7
	Rate of hospital treatment of diseases	110.3	151.0	159.2	128.6	114.2	146.6	128.4	130.7	151.7	145.0	165.7	149.6
	Number of visits in general practice for mental and behavioral disorders	38	48	44	44	52	39	41	45	45	37	56	57
	Number of visits in general practice for musculo-skeletal disorders	181	211	234	217	214	223	196	215	247	198	233	181
Occupational health	*Value of CWBI dimension*	*6.5*	*7.2*	*4.9*	*5.4*	*6.5*	*2.6*	*4.6*	*4.9*	*2.3*	*5.3*	*3.4*	*0.3*
	Number of reported injuries at work	23.4	29.3	20.2	29.0	29.6	36.2	31.8	29.9	35.8	26.6	22.8	30.7
	Share of work days lost due to sick leave per person	3.82	3.83	4.75	3.84	4.93	4.74	4.54	4.33	4.69	4.14	4.60	5.30
	Frequency index (IF) [a]	82.2	117.6	102.4	81.2	118.6	76.9	84.9	82.0	76.1	88.6	74.8	62.0
	Seriousness of sick leave [b]	17.1	11.9	17.0	17.3	15.2	22.5	19.5	19.3	22.6	17.0	22.7	31.3
	Rate of hospital treatment of diseases	110.3	151.0	159.2	128.6	114.2	146.6	128.3	130.7	151.7	145.0	165.7	149.6
	Average duration of hospitalization due to illness	8.94	7.85	6.98	7.96	8.80	7.25	8.63	8.36	6.91	7.69	7.51	8.70
Neonatal health	*Value of CWBI dimension*	*4.2*	*6.3*	*5.5*	*5.7*	*5.9*	*4.4*	*2.3*	*2.8*	*3.3*	*3.5*	*3.9*	*6.1*
	Stillbirths	4.8	3.0	4.7	4.0	3.6	5.5	8.0	6.2	5.2	6.9	6.2	3.7
	Number of women giving birth via caesarian section	5.0	6.4	5.3	4.7	5.9	4.2	4.5	5.6	4.6	5.2	5.6	5.8
	Share of newborns with low birth weight (under 2,500 g)	6.6	5.7	5.8	5.8	6.3	5.7	6.9	7.5	6.9	6.7	6.3	6.2
Risk behaviors	*Value of CWBI dimension*	*6.8*	*5.1*	*6.7*	*4.8*	*6.0*	*4.3*	*5.4*	*5.0*	*3.4*	*3.4*	*3.3*	*0.1*
	Number of persons seriously injured in road traffic accidents	6.0	5.2	7.3	6.0	6.2	6.0	5.8	5.3	4.9	4.7	5.4	2.4
	Number of persons killed in road traffic accidents	0.9	1.1	1.0	0.9	1.6	1.3	1.4	1.2	1.0	0.9	1.4	1.0
	Hospitalization rates due to suicide	0.08	0.20	0.22	0.25	0.09	0.35	0.22	0.21	0.42	0.11	0.23	0.57
	Number of suicides	1.8	2.0	1.8	1.4	1.6	2.7	2.3	2.7	2.7	2.9	2.7	2.7
	Number of visits due to alcohol consumption	19.5	28.9	18.0	30.6	27.8	26.4	24.0	23.2	27.4	33.9	31.1	36.2
	Number of drug abuse cases in primary care	7.1	7.2	7.7	7.0	6.6	6.8	6.3	4.3	4.7	6.5	28.6	9.1
Availability of health and social services	*Value of CWBI dimension*	*9.6*	*6.6*	*7.0*	*5.2*	*1.7*	*5.6*	*4.6*	*6.9*	*5.9*	*3.3*	*5.9*	*3.7*
	Number of physicians	41.6	17.3	22.7	20.2	10.2	18.6	18.8	22.8	19.4	13.6	16.5	14.9
	Number of nurses	98.0	61.8	80.8	85.4	39.3	72.8	67.5	81.4	83.5	54.4	84.8	60.5
	Number of hospital beds	72.9	57.2	57.7	33.6	10.6	45.0	26.1	55.3	48.1	18.1	37.1	27.4
	Number of beds available in retirement homes	46.3	30.0	37.8	51.0	66.8	46.5	50.3	40.3	54.0	54.3	37.0	64.0

Abbreviations: *CWBI – composite wellbeing indicator; CE – Central Slovenia region; SO – Soča region; CO – Coastal-Karst region; UP – Upper Carniola region; IN – Inner Carniola–Karst region; SA – Savinja region; SE – Southeast Slovenia; DR – Drava region; CA – Carinthia region; LO – Lower Sava region; MU – Mura region; CN – Central Sava region.

Notes: [a] The *Frequency index* describes the number of sick leaves per 100 employees in one year.

[b] *Seriousness of sick leave* signals the average duration of one sick leave due to illness, injury, or other medical reason.

Special attention was directed to health as an important component of social wellbeing and its impact on the people's quality of life. This is also proved by various measures of economic development (Suhrcke et al. 2006; Buzeti et al. 2011, 17–28), in which an increasingly larger set of health indicators are used. Especially in light of the current economic crisis, in public health one can observe that the issue of mental disorders will become especially topical for the duration of the crisis (WHO 2011). More recent international and Slovenian studies are already reporting an increase in suicidal and violent behavior, increased drug and alcohol abuse, and increased incidence of depression and anxiety disorders, which are also connected with the general social insecurity, loss of jobs, and increased social and economic differences between various population groups (Levy & Sidel 2009; Avčin et al. 2011; Mikulić, Sándor and Leoncikas 2012). Therefore, in future planning and implementing social and healthcare policies, regional differences and the related cultural differences will also have to be taken into account; these have a great impact on regional development (Urbanc, Boesch and Jelen 2007; Razpotnik, Urbanc and Nared 2009). Only in this way can the objectives of various strategies for ensuring wellbeing and health to all Slovenians be followed.

5 Conclusion

This article presents a study of wellbeing in Slovenian regions using composite indicators. The study was based on the OECD methodological recommendations, but only objectively measureable indicators of wellbeing were included. Special attention was dedicated to health-related wellbeing, in which regional differences in general, occupational, and neonatal health, risk behaviors, and the availability of health and social care services were analyzed. The findings reveal a fairly heterogeneous pattern of wellbeing in Slovenian regions because there are significant differences in the development, living standards, and population health among certain regions. In this respect, Central Slovenia stands out as the region with the highest level of wellbeing. Western Slovenia is dominated by regions of moderately high wellbeing (the Soča, Coastal-Karst, and Upper Carniola regions), whereas eastern Slovenia is characterized by regions with the lowest levels of wellbeing (the Carinthia, Lower Sava, Mura, and Central Sava regions). These differences are likely to become even larger in the upcoming period of global crisis.

The levels of health-related wellbeing differ considerably across Slovenian regions. Because the good health of the population is vital for reducing poverty, the long-term development of the society, and raising the level of general wellbeing in the society, it is especially important for the government to work towards reducing differences between regions. Therefore, in the future more attention should be directed towards geographically specific data. Only a good knowledge of special regional features makes it possible to effectively plan and implement economic, social, environmental, and healthcare policy measures.

6 Acknowledgments

This article was written as part of the research program *Jezik, spomin in politike reprezentacije* (Language, Memory, and Politics of Representation; P6-0347), co-funded by the Slovenian Research Agency (ARRS).

7 References

Apohal Vučkovič, L., Kajzer, A., Čelebič, T., Ferk, B., Kersnik, M., Kovačič, S., Kmet Zupančič, R., Kraigher, T., Lavrač, I., Murn, A., Pečar, J., Primožič, S., Zver, E. 2010: Socialni razgledi 2009. Ljubljana.

Avčin, B. A., Kučina, A. U., Sarotar, B. N., Radovanović, M., Plesničar, B. K. 2011: The present global financial and economic crisis poses an additional risk factor for mental health problems on the employees. Psychiatria Danubina 23-1.

Boarini, R., Johansson, A., d'Ercole, M. M. 2006: Alternative measures of wellbeing. OECD social, employment and migration working papers 33.

Bole, D. 2004: Daily mobility of workers in Slovenia. Acta geographica Slovenica 44-1. DOI: http://dx.doi.org/10.3986/AGS44102

Bole, D. 2008a: Ekonomska preobrazba slovenskih mest. Geografija Slovenije 19. Ljubljana.

Bole, D. 2008b: Cultural industry as a result of new city tertiarization. Acta geographica Slovenica 48-2. DOI: http://dx.doi.org/10.3986/AGS48202

Bole, D. 2011: Changes in employee commuting: a comparative analysis of employee commuting to major Slovenian employment centers from 2000 to 2009. Acta geographica Slovenica 51-1. DOI: http://dx.doi.org/10.3986/AGS51104

Buzeti, T., Djomba, J. K., Gabrijelčič Blenkuš, M., Ivanuša, M., Jeriček Klanšček, H., Kelšin, N., Kofol Bric, T., Koprivnikar, H., Korošec, A., Kovše, K., Maučec Zakotnik, J., Mihevc Ponikvar, B.,

Nadrag, P., Paulin, S., Pečar, J., Pečar Čad, S., Rok Simon, M., Tomšič, S., Truden Dobrin, P., Zadnik, V., Zver, E. 2011: Neenakosti v zdravju v Sloveniji. Ljubljana.

Costanza, R., Hart, M., Posner, S., Talberth, J. 2009: Beyond GDP: the need for new measures of progress. The Pardee papers 4.

Cowie, A. P., Lewis, J. W. 1989: Oxford advanced learner's dictionary. Oxford.

Dernovšek, M. Z., Šprah, L. 2008: Assessment of mental health services in Slovenia with the European Service Mapping Schedule. Psychiatria Danubina 20-3.

Diener, E. 2000: Subjective well-being: the science of happiness and a proposal for a national index. American Psychologist 55-1. DOI: http://dx.doi.org/10.1037/0003-066X.55.1.34

Diener, E., Seligman, M. E. P. 2009: Beyond money: toward an economy of well-being. Social Indicators Research Series 37. DOI: http://dx.doi.org/10.1007/978-90-481-2350-6_9

Gabrijelčič Blenkuš, M., Koprivnikar, H., Drev, A., Vračko, P., Pirnat, N., Hočevar, T., Vrdelja, M., Jeriček Klanšček, H., Pucelj, V., Kofol Bric, T., Martinovič, B., Kranjc, I.,

Martinovič, A. 2012: Vsevladni pristop za zdravje in blaginjo prebivalcev in zmanjševanje neenakosti v zdravju. Ljubljana.

Internet 1: http://pxweb.stat.si/pxweb/dialog/statfile2.asp (21. 10. 2011).

Internet 2: http://www.oecdbetterlifeindex.org/countries/slovenia/ (21. 10. 2011).

IVZ 2006–2008: Zdravstveni statistični letopis Slovenije. Inštitut za varovanje zdravja Republike Slovenije. Internet: http://www.ivz.si/Mp.aspx?ni=202 (29. 8. 2012).

Kerber, B. 2012: Ageing at home with the help of information and communication technologies. Acta geographica Slovenica 52-1. DOI: http://dx.doi.org/10.3986/AGS52107

Knežević Hočevar, D. 2012: Family farms in Slovenia: Who did the measures »setting up of young farmers« and »early retirement« actually address? Anthropological notebooks 18-1.

Korenič, R., Mavec, B. 2012: So ekonomske razlike med slovenskimi regijami velike? Statistični urad republike Slovenije. Internet: http://www.stat.si/novica_prikazi.aspx?id=4878 (29. 8. 2012).

Levy B. S., Sidel, V. W. 2009: The economic crisis and public health. Social medicine 4-2.

Malešič, K., Bregar, L., Rovan, J. 2009: Metodologija merjenja blaginje za občine v Sloveniji. IB revija 3-4. Ljubljana.

Matthews, E. 2006: Measuring wellbeing and societal progress: a brief history and the latest news. OECDJRC workshop »Measuring Wellbeing and Societal Progress.« Internet:
http://crell.jrc.ec.europa.eu/Wellbeing/papers (30. 8. 2012).

Mikulić B., Sándor E., Leoncikas T. 2012: Experiencing the economic crisis in the EU: changes in living standards, deprivation and trust. European foundation for the improvement of living and working conditions. Internet: http://www.eurofound.europa.eu/pubdocs/2012/07/en/1/EF1207EN.pdf (29. 8. 2012).

Nared, J. 2002: Razvitost slovenskih občin in nadaljnje razvojne perspektive. Geografski vestnik 74-2.

Nared, J. 2007: Prostorski vplivi slovenske regionalne politike. Geografija Slovenije 16. Ljubljana.

OECD 2008: Handbook on constructing composite indicators: methodology and user guide. Paris.

OECD 2011: How's life? Measuring well-being. Paris. DOI: http://www.dx.doi.org/10.1787/9789264121164-en

Pečar, J., Kavaš, D. 2006: Metodologija izračuna indeksa razvojne ogroženosti za obdobje od 2007 do 2013. Delovni zvezek 6. Ljubljana.

Perko, D. 1998: The regionalization of Slovenia. Acta geographica 38.

Ravbar, M. 2011: Creative social groups in Slovenia: contribution to geographic studying of human resources. Acta geographica Slovenica 51-2. DOI: http://dx.doi.org/10.3986/AGS51204.

Ravbar, M., Bole, D., Nared, J. 2005: A creative milieu and the role of geography in studying the competitiveness of cities: the case of Ljubljana Acta Geographica Slovenica 45-2. DOI: http://dx.doi.org/10.3986/AGS45201

Razpotnik, N., Urbanc, M., Nared, J. 2009: Prostorska in razvojna vprašanja Alp. Georitem 12. Ljubljana.
Rovan, J., Malešič, K., Bregar, L. 2009: Blaginja občin v Sloveniji. Geodetski vestnik 53-1. Ljubljana.
Strategija razvoja Slovenije/Slovenia's Development Strategy. Urad Republike Slovenije za makroekonomske analize in razvoj. Ljubljana, 2005.
Stuckler, D., Basu, S., Suhrcke, M., Coutts, A., McKee, M. 2011: Effects of the 2008 recession on health: the first look at European data. The Lancet 378-9786. DOI: http://dx.doi.org/10.1016/S0140-6736(11)61079-9
Stuckler, D., Basu, S., Suhrcke, M., McKee, M. 2009: The health implications of financial crisis: a review of the evidence. The Ulster medical journal 78-3.
Suhrcke, M., McKee, M., Stuckler, D., Sauto Arce, R., Tsolova, S., Mortensen, J. 2006: The contribution of health to the economy in the European Union. Public health 120. DOI: http://dx.doi.org/10.1016/j.puhe.2006.08.011.
SURS 2006–2010: Slovenske regije v številkah. Internet: http://www.stat.si/publikacije/pub_regije.asp (30. 8. 2012).
Urbanc, M., Boesch, M., Jelen, I. 2007: Kultura in regionalna politika: kultura kot dejavnik regionalnega razvoja Alp. Geografski vestnik 79-1.
WHO 2011: Impact of economic crises on mental health. Copenhagen.

Blaginja prebivalcev Slovenije po regijah: primerjava kazalnikov s poudarkom na zdravju

DOI: http://dx.doi.org/10.3986/AGS54104
UDK: 913:330.59(497.4)
330.59:613(497.4)
COBISS: 1.01

IZVLEČEK: Blaginja se v širših definicijah najbolj pogosto opisuje kot večrazsežen pojem, opredeljen s stanjem sreče, zdravja in prosperitete. Vendar se zaradi različnih razumevanj konceptualnih vprašanj blaginje, strokovnjaki srečujejo s številnimi metodološkimi težavami na področju njenega merjenja. Metodologija sestavljenih kazalnikov se vse bolj uveljavlja tudi na področju merjenja blaginje prebivalcev. Zdravje predstavlja pomembno področje blaginje, z njim pa se povezujejo podobni kazalniki kot pri merjenju splošne blaginje. V prispevku smo z metodo sestavljenih kazalnikov blaginje primerjali različna področja blaginje in še posebej blaginjo, povezano z zdravjem, med dvanajstimi statističnimi regijami Slovenije. Ugotavljamo, da obstajajo med slovenskimi regijami velike razlike v blaginji. V regijah zahodne Slovenije (Osrednjeslovenska, Goriška, Obalno-kraška, Gorenjska) je raven blaginje v glavnem višja, v regijah vzhodne Slovenije (Koroška, Spodnjeposavska, Pomurska, Zasavska) nižja. Z izjemo manjših odstopanj raven splošne blaginje v regijah sovpada z ravnijo blaginje na področju zdravja.

KLJUČNE BESEDE: geografija, medicina, blaginja prebivalcev, sestavljeni kazalnik blaginje, zdravje, regija, duševna motnja

Uredništvo je prejelo prispevek 13. septembra 2012.

NASLOVI:
dr. Lilijana Šprah
Družbenomedicinski inštitut
Znanstvenoraziskovalni center Slovenske akademije znanosti in umetnosti
Novi trg 2, SI – 1000 Ljubljana, Slovenija
E-pošta: lilijana.sprah@zrc-sazu.si

Tatjana Novak
Družbenomedicinski inštitut
Znanstvenoraziskovalni center Slovenske akademije znanosti in umetnosti
Novi trg 2, SI – 1000 Ljubljana, Slovenija
E-pošta: tnovak@zrc-sazu.si

mag. Jerneja Fridl
Geografski inštitut Antona Melika
Znanstvenoraziskovalni center Slovenske akademije znanosti in umetnosti
Gosposka ulica 13, SI – 1000 Ljubljana, Slovenija
E-pošta: jerneja@zrc-sazu.si

1 Uvod

Pregled literature o konceptualnih vprašanjih blaginje in njenem merjenju razgrne številne metodološke težave (Matthews 2006; Costanza in ostali 2009). Blaginja je kompleksen pojem, opredeljen kot stanje sreče, zdravja in prosperitete (Cowie in Lewis 1989, 1450). Zaradi njene abstraktnosti in večdimenzionalnosti jo je mogoče meriti le posredno z naborom izbranih kazalnikov, ki pa se morajo tudi ustrezno umeščati v določeno ekonomsko, socialno in kulturno okolje ter vključevati predvsem tiste družbene vrednote, ki odražajo pojmovanje blaginje v konkretnem okolju. Zadnje čase smo priča povečanemu zanimanju strokovne in raziskovalne javnosti za preučevanje blaginje ter številnim razpravam o ustreznih metodoloških pristopih njenega merjenja (Matthews 2006). Pri tem se zastavlja osrednje vprašanje, ali sta bogastvo in ekonomski razvoj ključna za opredeljevanje blaginje. Vse od ustanovitve Organizacije za ekonomsko sodelovanje in razvoj (OECD) leta 1961 je namreč bruto domači proizvod (BDP) predstavljal osrednji kazalnik merjenja in razumevanja ekonomskega ter družbenega napredka, ki se ga je povezovalo tudi z blaginjo. Vendar aktualne študije kažejo na večplastnost pojma blaginje, ki vključuje tudi subjektivne in nematerialne sestavine, kot so npr. sreča, zadovoljstvo, svoboda, zdravje, izobrazba (Diener in Seligman 2004; Costanza in ostali 2009).

Na nekatere metodološke in vsebinske dileme, povezane z merjenjem blaginje, se je odzvala tudi OECD. Ob svoji petdesetletnici je v okviru projekta »OECD kazalniki blaginje« (OECD 2011) predstavila nov način spremljanja širše pojmovane blaginje kot odgovor na zahteve po primerjalnih informacijah o življenjskih razmerah ljudi v različno razvitih državah. OECD kazalniki blaginje vsebujejo kazalnike materialnih razmer življenja (dohodek in bogastvo, zaposlitev in stanovanjske razmere) in kakovosti življenja (zdravstveno stanje, usklajenost dela in zasebnega življenja, izobraževanje, družbena povezanost, civilna gibanja in vlada, kakovost okolja, osebna varnost in subjektivna blaginja) (OECD 2011, 18 in 19). Večina kazalnikov temelji na statističnih podatkih, nekateri pa so oblikovani tudi na podlagi javnomnenjskih anket.

Aktualna finančna in gospodarska kriza odpira številne nove vidike razumevanja blaginje, tudi v povezavi s sedanjimi svetovnimi in družbenimi izzivi na področjih podnebnih sprememb, demografskih trendov in javnega zdravja (Stuckler in ostali 2009). Dokazi govorijo, da gospodarska razvitost ni nujno povezana z večjo blaginjo (Boarini, Johansson in D'Ercole 2006; Mikulić, Sándor in Leoncikas 2012). Še posebej postaja aktualno vprašanje, kako se bo kriza odrazila na zdravju prebivalcev. Izsledki raziskav namreč kažejo, da v obdobju kriz naraščajo specifične bolezni in umrljivost zaradi svojevrstnih vzrokov (npr. stopnja samomorilnosti), poslabšuje se duševno zdravje (več depresivnih in anksioznih motenj razpoloženja) in stopnja nasilja v družinah ter v širšem okolju, povečuje pa se tudi zloraba drog in alkohola (Levy in Sidel 2009; Avčin in ostali 2011; Stuckler in ostali 2011). Skrb vzbuja tudi napoved, da bo kriza poglobila neenakosti v zdravju, kar se bo posledično odrazilo v nižji ravni blaginje številnih prebivalstvenih skupin (Buzeti in ostali 2011; Gabrijelčič Blenkuš in ostali 2012).

Izboljševanje blaginje prebivalcev je eden od poglavitnih razvojnih ciljev vsake države, zato jo je tudi Slovenija vključila v Strategijo razvoja Slovenije (2005). Četudi posamezna država kot celota v mednarodnem merilu izkazuje dokaj visoko raven blaginje, so znotraj nje lahko precejšnje razlike med posameznimi območji oziroma regijami. Regionalne razlike v blaginji so lahko izvor socialnih, ekonomskih in okoljskih težav, ki zavirajo uravnotežen družbeni in regionalni razvoj. Zato je pomembno sprotno spremljanje geografsko pogojene ravni blaginje, še posebej v luči učinkovitega načrtovanja in izvajanja ukrepov prostorskih, ekonomskih in zdravstvenih politik ter zagotavljanja dostopnosti do javnih storitev, dela in kakovostnih bivalnih razmer (Rovan, Malešič in Bregar 2009; Kerbler 2012).

2 Namen raziskave in metodološka pojasnila

Namen predstavljene raziskave je preučiti splošno blaginjo posameznih statističnih regij Slovenije in preveriti razlike med njimi z vidika različnih področij blaginje ter izbranih kazalnikov, povezanih z zdravjem.

Čeprav se v zadnjih letih na področju merjenja blaginje vse bolj uveljavljajo metodologije s sestavljenimi kazalniki (OECD 2008), pa trenutno še ne razpolagamo s »super« kazalnikom, ki bi obsegal vse njene dimenzije, niti s posebej definiranim, ki bi bil sprejet kot uradna mera blaginje. Zato smo na osnovi razpoložljivih statističnih podatkov in ob upoštevanju metodoloških priporočil OECD (2008; 2011) za potrebe te raziskave oblikovali sestavljene kazalnike blaginje (SKB). V Sloveniji poznamo več različnih regionalizacij oziroma delitev Slovenije (Perko 1998), za našo raziskavo pa je zaradi dostopnosti podatkov najprimernejša delitev na statistične regije.

2.1 Kriteriji za izbor temeljnih kazalnikov blaginje

Pri vključevanju temeljnih sociodemografskih, ekonomskih, zdravstvenih in okoljskih kazalnikov v SKB smo upoštevali vsebinsko primernost kazalnikov, njihovo razpoložljivost na ravni statističnih regij in dostopnost v referenčnem obdobju (2006–2010) ter njihovo kakovost in zmožnost povzemanja več značilnosti pojava (izraženost v obliki indeksov, stopenj ali koeficientov).

Uporabili smo sledeče sekundarne vire statističnih podatkov:

1. SI-STAT spletni podatkovni portal Statističnega urada RS (Internet 1);
2. elektronske publikacije Slovenske regije v številkah, od 2006 do 2010 (SURS 2006–2010);
3. Zdravstveni statistični letopisi, od 2006 do 2008 (IVZ 2006–2008);
4. statistične priloge publikacije Urada RS za makroekonomske analize in razvoj (Apohal Vučkovič in ostali 2010, 127).

3 Določanje ravni blaginje regij s pomočjo sestavljenih kazalnikov blaginje

3.1 Struktura sestavljenega kazalnika blaginje regije

Področja oziroma dimenzije SKB smo opredelili na podlagi področij OECD kazalnikov blaginje (OECD 2011). SKB vsake regije vključuje 70 temeljnih kazalnikov, ki smo jih po vsebinski sorodnosti razvrstili v 16 področij (dimenzij) blaginje: dohodek, izobrazba, stanovanjske razmere, zaposlenost, okolje, splošno zdravje, varnost, starševsko varstvo, socialni transferji, razpoložljivost zdravstvenih in socialnih služb, tvegana vedenja, poklicno zdravje, perinatalno zdravje, stabilnost partnerskih zvez, razvojne možnosti in demografski profil. Število vključenih temeljnih kazalnikov se med dimenzijami razlikuje, kot je razvidno iz vrednosti v oklepaju na sliki 1.

Slika 1: Struktura sestavljenega kazalnika blaginje regije z vidika dimenzij blaginje in števila vanje vključenih temeljnih kazalnikov.
Glej angleški del prispevka.

Statistične podatke temeljnih kazalnikov, ki niso bili izraženi v relativnih ocenah (odstotki, koeficienti, indeksi), smo pred zasnovo sestavljenega kazalnika preračunali v primerljive enote (glede na število prebivalcev oziroma površino regije) in jih standardizirali. Iz nabora temeljnih kazalnikov smo nato z multivariantno statistično metodo glavnih komponent, katere namen je zmanjšati razsežnost podatkov oziroma v našem primeru kazalnikov ob čim manjši izgubi informacij, oblikovali sestavljeni kazalnik blaginje. V posamezni dimenziji blaginje smo zadržali zgolj tiste temeljne kazalnike, ki so bili vsebinsko smiselno povezani s področjem in so glede na rezultate metode glavnih komponent pojasnili kar največ razpršenosti podatkov iz temeljnih kazalnikov, ki sestavljajo to komponento. Številsko vrednost posamezne dimenzije blaginje smo izračunali z obtežitvijo temeljnih kazalnikov z dobljenimi komponentnimi utežmi in dobljeno vrednost povprečili za preučevano obdobje. Za razvrščanje regij glede na raven blaginje po posameznih področjih smo uporabili linearno »STEN« transformacijo z razponom vrednosti od 1 do 10. Vrednost 1 je predstavljala najmanjšo izračunano vrednost dimenzije blaginje (najnižja raven blaginje na določenem področju), vrednost 10 pa največjo izračunano vrednost dimenzije blaginje (najvišja raven blaginje na določenem področju). Vrednost SKB je bila izračunana kot povprečna vrednost vseh 16 dimenzij blaginje v posamezni statistični regiji. Regije smo nato glede na njihove vrednosti SKB razvrstili v štiri kategorije: regije visoke blaginje, regije zmerno visoke blaginje, regije zmerno nizke blaginje in regije nizke blaginje.

Preglednica 1 kaže temeljne kazalnike, vključene v dimenzije blaginje, in njihov vpliv na blaginjo. Z znakom (+) so označeni kazalniki, kjer njihove višje vrednosti (npr. obseg delavno aktivnega prebivalstva) prispevajo k višji ravni blaginje v regiji. Znak (–) je pred kazalniki, kjer njihove višje vrednosti (npr. stopnja brezposelnosti) znižujejo raven blaginje v regiji. Pri tistih kazalnikih, za katere statistični podatki na regionalni ravni niso bili dostopni za referenčno obdobje (2006–2010), smo upoštevali krajše referenčno obdobje (tri oziroma štiri leta).

Preglednica 1: Pregled vključenih temeljnih kazalnikov v sestavljen kazalnik blaginje regije in njihov vpliv na blaginjo.

PODROČJE BLAGINJE	TEMELJNI KAZALNIK	VPLIV NA BLAGINJO	PODATKOVNI VIR IN REFERENČNO OBDOBJE
Dohodek	Indeks BDP (bruto domačega proizvoda) na prebivalca [a]	+	*SURS, 2006–2008*
	BDP na prebivalca, izražen v standardih kupne moči	+	*SURS, 2006–2008*
	Povprečna mesečna neto plača na zaposleno osebo	+	*SURS, 2006–2010*
Izobrazba	Delež prebivalcev, starih 22–64 let, brez izobrazbe, z nedokončano ali dokončano osnovnošolsko izobrazbo	–	*SURS, 2006–2009*
	Delež prebivalcev, starih 22–64 let, s srednješolsko izobrazbo	+	*SURS, 2006–2009*
	Delež prebivalcev, starih 22–64 let, z višje ali visokošolsko izobrazbo	+	*SURS, 2006–2009*
	Število študentov glede na delovno aktivno prebivalstvo	+	*SURS, 2006–2009*
	Delež odraslih oseb, starih 25–64 let, vključenih v vseživljenjsko izobraževanje	+	*SURS, 2006–2009*
Stanovanjske razmere	Povprečna površina stanovanja na osebo	+	*SURS, 2006–2010*
	Število dokončanih stanovanj (novogradnje, povečave, spremembe namembnosti)	+	*SURS, 2006–2010*
Zaposlenost	Delež delovno aktivnega prebivalstva	+	*SURS, 2006–2010*
	Stopnja delovne aktivnosti	+	*SURS, 2006–2009*
	Stopnja registrirane brezposelnosti	–	*SURS, 2006–2010*
	Delež brezposelnih z osnovnošolsko izobrazbo	–	*SURS, 2006–2010*
	Delež brezposelnih z višje- oz. visokošolsko izobrazbo	–	*SURS, 2006–2010*
	Število prostih delovnih mest glede na delovno aktivno prebivalstvo	+	*SURS, 2006–2010*
	Delež delovno aktivnega prebivalstva, starega 55–64 let	+	*SURS, 2007–2009*
	Število aktivnih podjetij glede na delovno aktivno prebivalstvo	+	*SURS, 2006–2009*
Okolje	Količina vode, dobavljene gospodinjstvom iz javnega vodovoda	+	*SURS, 2006–2010*
	Delež neprečiščene odpadne vode, izpuščene iz kanalizacije	–	*SURS, 2007–2009*
	Ocenjena škoda zaradi elementarnih nesreč, izražena v deležu regionalnega BDP	–	*SURS, 2006–2008*
Splošno zdravje	Število zdravniških receptov	–	*IVZ, 2007–2009*
	Stopnja hospitalizacije zaradi bolezni	–	*IVZ, 2006–2009*
	Število primerov bolezni obtočil kot najpogostejših vzrokov smrti	–	*IVZ, 2006–2009*
	Število primerov bolezni prebavil kot najpogostejših vzrokov smrti	–	*IVZ, 2006–2009*
	Število obiskov v primarnem zdravstvu zaradi endokrinih, prehranskih in presnovnih motenj	–	*IVZ, 2006–2008*
	Število obiskov v primarnem zdravstvu zaradi duševnih in vedenjskih motenj	–	*IVZ, 2006–2009*
	Število obiskov v primarnem zdravstvu zaradi bolezni obtočil	–	*IVZ, 2006–2008*
	Število obiskov v primarnem zdravstvu zaradi bolezni prebavil	–	*IVZ, 2006–2008*
	Število obiskov v primarnem zdravstvu zaradi bolezni mišično-skeletnega sistema in veziva	–	*IVZ, 2006–2008*
Varnost	Število obsojenih polnoletnih oseb ne glede na vrsto kaznivega dejanja	–	*SURS, 2006–2010*
	Število obsojenih polnoletnih oseb glede na kazniva dejanja zoper zakonsko zvezo, družino in otroke	–	*SURS, 2006–2010*
	Število obsojenih mladoletnih oseb ne glede na vrsto kaznivega dejanja	–	*SURS, 2006–2010*
	Število primerov samopoškodbenega vedenja	–	*SURS, 2006–2009*
	Število primerov napada na drugo osebo	–	*SURS, 2006–2009*
Starševsko varstvo	Delež otrok v vrtcih med vsemi otroki, starimi 1–5 let	+	*SURS, 2006–2009*
	Število upravičencev do dela s skrajšanim delovnim časom zaradi starševstva	+	*SURS, 2006–2009*
	Število upravičencev do očetovskega nadomestila zaradi starševstva	+	*SURS, 2006–2009*
	Število sklenjenih zakonskih zvez	+	*SURS, 2006–2010*
Socialni transferji	Število prejemnikov denarnih socialnih pomoči	–	*SURS, 2006–2009*
	Delež štipendistov med dijaki in študenti	+	*SURS, 2008–2010*
Razpoložljivost zdravstvenih in socialnih služb	Število zdravnikov	+	*SURS, 2007–2009*
	Število medicinskih sester	+	*SURS, 2007–2009*
	Število bolnišničnih postelj	+	*SURS, 2007–2009*
	Število ležišč v domovih za ostarele	+	*SURS, 2006–2009*

Tvegana vedenja	Število hudo poškodovanih v cestnoprometnih nesrečah	–	*SURS, 2006–2009*
	Število umrlih v cestnoprometnih nesrečah	–	*SURS, 2007–2009*
	Stopnja hospitalizacije zaradi samomora	–	*IVZ, 2006–2009*
	Število samomorov	–	*IVZ, 2006–2009*
	Število obravnav zaradi uživanja alkohola	–	*IVZ, 2006–2009*
	Število obravnav zaradi zlorabe drog	–	*IVZ, 2006–2009*
Poklicno zdravje	Število prijavljenih poškodb pri delu glede na delovno aktivno prebivalstvo	–	*IVZ, 2006–2009*
	Delež izgubljenih koledarskih dni na zaposlenega zaradi bolniškega staleža	–	*IVZ, 2006–2010*
	Indeks frekvence (IF) [b]	–	*IVZ, 2006–2010*
	Resnost (R) bolniškega staleža [c]	–	*IVZ, 2006–2010*
	Stopnja bolnišničnih obravnav zaradi bolezni	–	*IVZ, 2006–2009*
	Povprečno trajanje hospitalizacije zaradi bolezni	–	*IVZ, 2006–2009*
Perinatalno zdravje	Mrtvorojenost	–	*IVZ, 2007–2009*
	Delež porodnic s carskim rezom v anamnezi	–	*IVZ, 2006–2009*
	Delež novorojenčkov z nizko porodno težo (pod 2500 g) med živorojenimi	–	*IVZ, 2007–2009*
Stabilnost partnerskih zvez	Število razvez glede na število prebivalcev v posamezni regiji	–	*SURS, 2006–2010*
Razvojne možnosti	Indeks razvojne ogroženosti [f]	–	*UMAR, 2007–2010*
Demografski profil	Gostota naseljenosti	–	*SURS, 2006–2009*
	Delež živorojenih	+	*SURS, 2006–2010*
	Delež umrlih	–	*SURS, 2006–2010*
	Skupni prirast prebivalstva (naravni in selitveni prirast)	+	*SURS, 2006–2010*
	Koeficient starostne odvisnosti [d]	–	*SURS, 2006–2010*
	Indeks staranja [e]	–	*SURS, 2006–2010*
	Delež kmečkega prebivalstva	–	*SURS, 2006–2010*

Opombe:
[a] *Indeks BDP* na prebivalca primerja bruto družbeni proizvod na prebivalca regije v primerjavi s podatkom za Slovenijo v istem letu.
[b] *Indeks frekvence* odraža število primerov odsotnosti z dela zaradi bolniške odsotnosti na 100 zaposlenih v enem letu.
[c] *Resnost bolniškega staleža* je povprečno trajanje ene odsotnosti z dela zaradi bolezni, poškodbe ali drugega zdravstvenega vzroka.
[d] *Koeficient starostne odvisnosti* je razmerje med mladim (stari od 0 do 14 let) in starim (nad 65 let) ter delovno sposobnim (nad 15 let) prebivalstvom.
[e] *Indeks staranja* je razmerje med starim (stari 65 let ali več) in mladim prebivalstvom (stari od 0 do 14 let), pomnoženo s 100.
[f] *Indeks razvojne ogroženosti* je izračunan iz 11 kazalnikov (kazalniki razvitosti, razvojne ogroženosti in razvojnih možnosti) (Pečar in Kavaš 2006).
Opredelitve izrazov *a, d–f* so povzete iz podatkovnih zbirk (Internet 1), definiciji *b–c* pa iz Zdravstvenega statističnega letopisa (IVZ 2006).

3.2 Primerjava regij glede na različne ravni in področja blaginje

Slika 2 prikazuje primerjavo socialnih, demografskih, zdravstvenih, ekonomskih in okoljskih dimenzij blaginje med slovenskimi statističnimi regijami. Regije smo glede na vrednost SKB razvrstili v štiri skupine (razpon vrednosti SKB: od 7,6 do 3,3; interval 1,07) in so na sliki obarvane v različnih odtenkih oranžne barve:

- 1. skupina: Regije visoke blaginje (SKB = 7,6 do 6,52): Osrednjeslovenska regija (SKB = 7,58).
- 2. skupina: Regije zmerno visoke blaginje (SKB = 6,53 do 5,45): Goriška regija (SKB = 5,94), Obalno-kraška regija (SKB = 5,90), Gorenjska regija (SKB = 5,78) in Notranjsko-kraška regija (SKB = 5,20).
- 3. skupina: Regije zmerno nizke blaginje (SKB = 5,46 do 4,38): Savinjska regija (SKB = 4,91), Jugovzhodna Slovenija (SKB = 4,88) in Podravska regija (SKB = 4,75).
- 4. skupina: Regije nizke blaginje (SKB = 4,39 do 3,32): Koroška regija (SKB = 4,21), Spodnjeposavska regija (SKB = 4,04), Pomurska regija (SKB = 3,45) in Zasavska regija (SKB = 3,37).

Med regijami so se pokazale precejšnje razlike v blaginji, pri čemer izrazito izstopa Osrednjeslovenska regija, kot regija z najvišjo, ter Pomurska in Zasavska kot regiji z najnižjo ravnijo splošne blaginje (slika 2). V zahodnem delu Slovenije se je oblikovala skupina regij z višjimi ravnmi splošne blaginje (Osrednjeslovenska, Goriška, Obalno-kraška in Gorenjska regija) in v vzhodnem delu skupina regij z najnižjimi ravnmi splošne blaginje (Podravska, Koroška, Spodnjeposavska, Zasavska in Pomurska regija). V regijah z višjo ravnijo splošne blaginje se pojavlja tudi višja raven blaginje na skoraj vseh drugih področjih. Prebivalci v teh regijah imajo višjo izobrazbo, več dohodka, prebivajo v boljših stanovanjskih in okoljskih razmerah, imajo tudi več zaposlitvenih možnosti in boljše razmere glede starševskega varstva. Hkrati so to regije z večjimi možnostmi za razvoj in iz ugodnejšim demografskim profilom.

Slika 2: Primerjava slovenskih regij glede na različne ravni in področja blaginje.
Glej angleški del prispevka.

3.3 Primerjava regij glede na temeljne kazalnike blaginje, povezane z zdravjem

Primerjava regij glede na raven blaginje področij, povezanih z zdravjem, je pokazala, da se v regijah visoke in zmerno visoke blaginje odraža tudi na splošno višja raven blaginje na področju splošnega, poklicnega in perinatalnega zdravja ter razpoložljivosti zdravstvenih in socialnih služb (primerjava stolpcev na sliki 2; višje vrednosti dimenzij v sklopu SKB v preglednici 2). Preverili smo tudi, kako se po regijah razvrščajo nekateri izbrani temeljni kazalniki blaginje, povezani z zdravjem. Ker se blaginja na področju zdravja lahko povezuje tudi z uživanjem drog in alkohola, samomorilnim vedenjem in poškodbami v cestnoprometni nesrečah, smo vključili tudi kazalnike, ki sestavljajo dimenzijo blaginje *tvegana vedenja* (preglednica 2).

V preglednici 2 lahko vidimo, da splošna raven blaginje ne odraža vedno blaginje na posameznih področjih v določeni regiji. Tako se Osrednjeslovenska regija (regija visoke blaginje glede na vrednost SKB) pri večini temeljnih kazalnikov uvršča na mesta, ki jih lahko povezujemo z večjo blaginjo, vendar pa se v primerjavi z ostalimi regijami na področju zdravja pojavljajo tudi nekatera odstopanja, npr. najvišja stopnja hospitalizacije zaradi bolezni, dokaj visok delež novorojenčkov z nizko porodno težo, večje število obravnav zaradi zlorabe drog in več huje poškodovanih v cestnoprometnih nesrečah. Takšna odstopanja lahko opazimo tudi v drugih regijah. V Zasavski regiji (z najnižjo ravnijo splošne blaginje) prevladuje nizka raven blaginje na področju zdravja, vendar pa izstopa v primerjavi z ostalimi regijami z relativno dobrim stanjem na nekaterih področjih, kot so npr. najmanj obiskov v primarnem zdravstvu zaradi bolezni mišično-skeletnega sistema in veziva in manj hudo poškodovanimi v cestnoprometnih nesrečah, manj mrtvorojenimi otroci in z relativno dobro razpoložljivostjo ležišč v domovih za ostarele.

4 Razprava

Za merjenje blaginje so še do nedavnega prevladovali pristopi, ki so kot približek ocene blaginje uporabljali bodisi makroekonomske statistike, kot je npr. BDP, bodisi subjektivne presoje ljudi o njihovem zadovoljstvu s kakovostjo življenja. Izkazalo se je, da subjektivne presoje blaginje v okviru mednarodnih in medregijskih primerjav niso zanesljive, saj jih močno pogojuje na eni strani kulturni kontekst in na drugi različni psihološki dejavniki (Diener 2000). Zato se na področju merjenja blaginje vse bolj uveljavlja metoda sestavljenih kazalnikov (Matthews 2006; OECD 2011), ki smo jo uporabili tudi v predstavljeni raziskavi.

Kljub temu, da je v okviru mednarodnih primerjav Slovenija obravnavana kot homogena regionalna enota, pa številne domače ekonomske, geografske, sociološke, antropološke in zdravstvene študije kažejo, da se na ravni njenih teritorialnih enot (občin, statističnih regij) pojavljajo velike razlike in posebnosti, ki se posledično izkazujejo tudi v dostopu do storitev in blaga ter infrastrukture, v ekonomskih in zaposlitvenih možnostih, v dostopnosti in razpoložljivosti zdravstvenih ter socialnih storitev in drugje (Nared 2002; Bole 2004; Ravbar, Bole in Nared 2005; Nared 2007; Bole 2008a, Bole 2008b; Dernovšek in Šprah 2008; Bole 2011; Ravbar 2011; Knežević Hočevar 2012; Korenič in Mavec 2012). V različnih mednarodnih študijah ostajajo te razlike in posebnosti Slovenije neopažene, saj so podatki agregirani na državni ravni. To lahko razberemo tudi iz izsledkov študije OECD (2011), v kateri so s pomočjo interaktivnega orodja merjenja blaginje opravili mednarodno primerjavo blaginje v državah članicah OECD. Slovenija je med 34 članicami OECD zasedla skupno 21. mesto. Pri nekaterih dimenzijah blaginje se je uvrstila blizu povprečja držav OECD (zdravje, vključenost v družbo), ali celo višje (zaposlenost, osebna varnost), pod povprečje držav OECD pa je zdrsnila pri dimenzijah stanovanje in zadovoljstvo z življenjem (Internet 2).

V prispevku nas je zanimala raven blaginje v statističnih regijah Slovenije, kot jo omogoča prilagojena metodologija OECD kazalnikov. Rezultati so pokazali, da se regije glede na splošno raven blaginje, opredeljeno s srednjo vrednostjo SKB, med seboj zelo razlikujejo, saj je bil razpon vrednosti SKB med regijami precejšen, od 7,58 do 3,37. Posebej je zanimivo stanje blaginje na področju zdravja, ki v nekaterih regijah odstopa od stanja splošne blaginje. Ujemanje ocen splošne blaginje in blaginje na področju zdravja potrjuje spoznanje, da visoka raven blaginje sovpada z gospodarsko in socialno bolje razvitimi urbanimi središči, vendar pa neujemanje teh ocen v nekaterih regijah tudi opozarja na to, da se ugodne

Preglednica 2: Izbrani temeljni kazalniki za različna področja blaginje, povezana z zdravjem.

PODROČJE BLAGINJE	VREDNOST DIMENZIJE V SKB*/ TEMELJNI KAZALNIK	OS	GR	OB	GO	NO	SA	JV	PD	KO	SP	PO	ZA
		regija visoke blaginje	*regije zmerno visoke blaginje*				regije zmerno nizke blaginje			regije nizke blaginje			
Splošno zdravje	*Vrednost dimenzije v SKB*	*7,8*	*4,4*	*4,8*	*6,4*	*5,7*	*5,2*	*5,3*	*4,7*	*3,7*	*4,2*	*1,1*	*0,9*
	Število zdravniških receptov na prebivalca	7,1	7,0	7,1	7,0	7,9	8,1	7,7	8,6	7,9	8,6	9,1	8,7
	Stopnja hospitalizacije zaradi bolezni	110,3	151,0	159,2	128,6	114,2	146,6	128,4	130,7	151,7	145,0	165,7	149,6
	Število obiskov v primarnem zdravstvu zaradi duševnih in vedenjskih motenj	38	48	44	44	52	39	41	45	45	37	56	57
	Število obiskov v primarnem zdravstvu zaradi bolezni mišično-skeletnega sistema in veziva	181	211	234	217	214	223	196	215	247	198	233	181
Poklicno zdravje	*Vrednost dimenzije v SKB*	*6,5*	*7,2*	*4,9*	*5,4*	*6,5*	*2,6*	*4,6*	*4,9*	*2,3*	*5,3*	*3,4*	*0,3*
	Število prijavljenih poškodb pri delu	23,4	29,3	20,2	29,0	29,6	36,2	31,8	29,9	35,8	26,6	22,8	30,7
	Delež izgubljenih koledarskih dni na zaposlenega zaradi bolniškega staleža	3,82	3,83	4,75	3,84	4,93	4,74	4,54	4,33	4,69	4,14	4,60	5,30
	Indeks frekvence (IF)[a]	82,2	117,6	102,4	81,2	118,6	76,9	84,9	82,0	76,1	88,6	74,8	62,0
	Resnost (R) bolniškega staleža[b]	17,1	11,9	17,0	17,3	15,2	22,5	19,5	19,3	22,6	17,0	22,7	31,3
	Stopnja bolnišničnih obravnav zaradi bolezni	110,3	151,0	159,2	128,6	114,2	146,6	128,3	130,7	151,7	145,0	165,7	149,6
	Povprečno trajanje hospitalizacije zaradi bolezni	8,94	7,85	6,98	7,96	8,80	7,25	8,63	8,36	6,91	7,69	7,51	8,70
Perinatalno zdravje	*Vrednost dimenzije v SKB*	*4,2*	*6,3*	*5,5*	*5,7*	*5,9*	*4,4*	*2,3*	*2,8*	*3,3*	*3,5*	*3,9*	*6,1*
	Mrtvorojenost	4,8	3,0	4,7	4,0	3,6	5,5	8,0	6,2	5,2	6,9	6,2	3,7
	Delež porodnic s carskim rezom v anamnezi	5,0	6,4	5,3	4,7	5,9	4,2	4,5	5,6	4,6	5,2	5,6	5,8
	Delež novorojenčkov z nizko porodno težo (pod 2500 g) med živorojenimi	6,6	5,7	5,8	5,8	6,3	5,7	6,9	7,5	6,9	6,7	6,3	6,2
Tvegana vedenja	*Vrednost dimenzije v SKB*	*6,8*	*5,1*	*6,7*	*4,8*	*6,0*	*4,3*	*5,4*	*5,0*	*3,4*	*3,4*	*3,3*	*0,1*
	Število hudo poškodovanih v cestnoprometnih nesrečah	6,0	5,2	7,3	6,0	6,2	6,0	5,8	5,3	4,9	4,7	5,4	2,4
	Število umrlih v cestnoprometnih nesrečah	0,9	1,1	1,0	0,9	1,6	1,3	1,4	1,2	1,0	0,9	1,4	1,0
	Stopnja hospitalizacije zaradi samomora	0,08	0,20	0,22	0,25	0,09	0,35	0,22	0,21	0,42	0,11	0,23	0,57
	Število samomorov	1,8	2,0	1,8	1,4	1,6	2,7	2,3	2,7	2,7	2,9	2,7	2,7
	Število obravnav zaradi uživanja alkohola	19,5	28,9	18,0	30,6	27,8	26,4	24,0	23,2	27,4	33,9	31,1	36,2
	Število obravnav zaradi zlorabe drog	7,1	7,2	7,7	7,0	6,6	6,8	6,3	4,3	4,7	6,5	28,6	9,1
Razpoložljivost zdravstvenih in socialnih služb	*Vrednost dimenzije v SKB*	*9,6*	*6,6*	*7,0*	*5,2*	*1,7*	*5,6*	*4,6*	*6,9*	*5,9*	*3,3*	*5,9*	*3,7*
	Število zdravnikov	41,6	17,3	22,7	20,2	10,2	18,6	18,8	22,8	19,4	13,6	16,5	14,9
	Število medicinskih sester	98,0	61,8	80,8	85,4	39,3	72,8	67,5	81,4	83,5	54,4	84,8	60,5
	Število bolnišničnih postelj	72,9	57,2	57,7	33,6	10,6	45,0	26,1	55,3	48,1	18,1	37,1	27,4
	Število ležišč v domovih za ostarele	46,3	30,0	37,8	51,0	66,8	46,5	50,3	40,3	54,0	54,3	37,0	64,0

Okrajšave: *SKB – sestavljeni kazalnik blaginje; OS – Osrednjeslovenska regija; GR – Goriška regija; OB – Obalno-kraška regija; GO – Gorenjska regija, NO – Notranjsko-kraška regija; SA – Savinjska regija JV – Jugovzhodna Slovenija; PD — Podravska regija; KO – Koroška regija; SP – Spodnjeposavska regija; PO – Pomurska regija; ZA – Zasavska regija.

Opombe: [a] *Indeks frekvence* odraža število primerov odsotnosti z dela zaradi bolniške odsotnosti na 100 zaposlenih v enem letu.

[b] *Resnost bolniškega staleža* je povprečno trajanje ene odsotnosti z dela zaradi bolezni, poškodbe ali drugega zdravstvenega vzroka.

življenjske in okoljske razmere občin ne odslikavajo vedno tudi v njihovi gospodarski in družbeni razvitosti (Malešič, Bregar in Rovan 2009, 47 in 51).

Posebno pozornost smo namenili zdravju kot pomembni komponenti družbene blaginje in vpliva na kakovost življenja prebivalcev. To dokazujejo tudi različne mere gospodarskega razvoja (Suhrcke in ostali 2006; Buzeti in ostali 2011, 17–28), v katerih se pojavlja vedno širši nabor kazalnikov zdravja. Še zlasti v luči trenutne gospodarske krize lahko na področju javnega zdravja zasledimo, da bo problematika duševnih motenj v času trajanja krize še posebej aktualna (WHO 2011). Novejše mednarodne in domače raziskave namreč že poročajo o porastu samomorilnega in nasilnega vedenja, povečani zlorabi drog in alkohola ter višji incidenci depresivnih in anksioznih motenj razpoloženja, ki jih med drugim povezujejo tudi s splošno družbeno negotovostjo, izgubami zaposlitev ter poglabljanjem socialnih in ekonomskih razlik med različnimi prebivalstvenimi skupinami (Levy in Sidel 2009; Avčin in ostali 2011; Mikulić, Sándor in Leoncikas 2012). Zato bo pri bodočem načrtovanju in izvajanju socialnih in zdravstvenih politik potrebno poznati tudi regionalne razlike in z njimi povezane kulturne razlike, slednje imajo velik vpliv na regionalni razvoj (Urbanc, Boesch in Jelen 2007; Razpotnik, Urbanc in Nared 2009). Le tako bomo sledili ciljem različnih strateških usmeritev za zagotavljanje blaginje in zdravja vsem prebivalcem Slovenije.

5 Sklep

V prispevku smo predstavili raziskavo blaginje v slovenskih regijah s pomočjo metodologije sestavljenih kazalnikov. Pri tem smo izhajali iz metodoloških priporočil OECD, a vključili le objektivno merljive kazalnike blaginje. Posebno pozornost smo namenili področju blaginje, povezane z zdravjem, kjer smo preučili regionalne razlike na področju splošnega, poklicnega in perinatalnega zdravja, tveganih vedenj ter razpoložljivosti zdravstveno socialnih storitev. Izsledki raziskave razkrivajo dokaj heterogeno sliko blaginje v slovenskih regijah, saj se med nekaterimi regijami kažejo precejšnje razlike v razvitosti, v življenjskem standardu kot tudi na področju zdravja prebivalcev. Izstopa Osrednjeslovenska regija kot regija z najvišjo ravnijo blaginje. V zahodni Sloveniji prevladujejo regije zmerno visoke blaginje (Goriška, Obalno-kraška in Gorenjska regija), medtem ko vzhodni del Slovenije geografsko zaokrožajo regije z najnižjimi ravnmi blaginje (Koroška, Spodnjeposavska, Pomurska in Zasavska regija).V prihajajočem obdobju svetovne krize se bodo verjetno razlike še dodatno poglobile.

Blaginja, povezana z zdravjem, je v slovenskih regijah precej različna. Ker je dobro zdravje populacije pomembno tako za zmanjševanje revščine kot za dolgoročni razvoj družbe in dviganje splošne blaginje v družbi, je še posebej pomembno, da država deluje v smeri zmanjševanja razlik med regijami. Zato bo treba v bodoče posvetiti več pozornosti geografsko razčlenjenim podatkom. Le poznavanje regionalnih posebnosti bo omogočilo učinkovito načrtovanje in izvajanje ukrepov na področju ekonomskih, socialnih, okoljskih in zdravstvenih politik.

6 Zahvala

Prispevek je bil pripravljen v okviru raziskovalnega programa Jezik, spomin in politike reprezentacije (P6-0347), ki ga sofinancira Javna agencija za raziskovalno dejavnost Republike Slovenije (ARRS).

7 Literatura

Glej angleški del prispevka.