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Elderly Koreans who consider suicide: Role of healthcare use and financial status

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ABSTRACT

This study investigated associations between the use of healthcare services and financial status and suicidal ideation (SI) in the past year among elderly people. Additionally, this study explored gender differences in such associations. Cross-sectional data of 1743 elderly people aged 65 years and above, who participated in the 2009 Korea National Health and Nutrition Examination Survey, were analyzed. The results showed that lack of preventive care and failure to obtain necessary healthcare services during the last 12 months had a significant effect on SI, especially among elderly women. Low financial status (i.e., receipt of National Basic Livelihood Security (NBLS) assistance) was significantly associated with SI among elderly men. The findings of this study emphasize the need for community-based suicide intervention services, especially for elderly men who receive NBLS and elderly women who do not undergo medical checkups and fail to obtain necessary medical services. Multiple intervention approaches, including the provision of community-based geriatric psychiatric services, improved social support, links with general hospital services, and local monitoring programs, are likely to be useful.

1. Introduction

In recent decades, suicide among adults older than 65 years has become a significant issue in South Korea (Chen et al., 2011; Kim et al., 2011). The suicide rate among adults older than 65 years was 80.3 deaths per 100,000 individuals in 2010, which is significantly higher than that in young and middle-aged adults in the age groups of under-14 years of age (9.4 deaths) and 15–64 years of age (30.9 deaths) (Korea National Statistical Office, 2011). Suicide rates among older adults have increased rapidly, with a steep increase from 28.6 deaths in 1996 to 80.3 deaths per 100,000 individuals in 2010 (Korea National Statistical Office, 2011).

The sharp increase in suicide rates among older Korean people was caused by a combination of social and cultural factors, including a weakened social support network due to rapid urbanization and changes in family structure (Han et al., 2009; Jung, 2011; Shin and Shaw, 2003). The urban population in Korea has shown an increase, from 39% in 1960 to 90% in 2010 (Korean Ministry of Land, Infrastructure and Transport, 2013). Urbanization has also contributed to changes in the Korean family structure, from an extended family system to a nuclear family system (Choi, 1996; Han et al., 2009). The extended family network in Korea is based on Confucian philosophy, in which the eldest son in the family is responsible for the care of his family and elderly parents (Shin and Shaw, 2003). The shift to a nuclear family system has brought about a deleterious effect, including the weakening role of familial emotional and material support and social and psychological alienation of the Korean elderly people (Han et al., 2009; Jung, 2011). Suicide is an individual behavior that is influenced by interpersonal support and attachment (Joiner, 2005; Van Orden et al., 2008). The interpersonal-psychological theory of suicide proposes that the perception of being a burden on family (i.e., I am a burden) and thwarted sense of belonging (i.e., I am alone), due to a lack of social connectedness are proximal causes of suicidal desire (Joiner, 2005; Van Orden et al., 2008). Earlier studies have shown that perceived burdensomeness has been linked to suicidal ideation (SI) in terminally ill cancer patients of a wide variety of ages (Wilson et al., 2005), including adolescents (Hershberger et al., 1997) and adults (DeCatanzaro, 1995; Koivumaa-Honkanen et al., 2001). However, self-perceived burden may be especially relevant for SI, especially in older adults.

Older adults sometimes depend on others to provide physical care, including use of medical services or financial assistance (Kim, 1996; Mireault and de Man, 1996; Yip et al., 2003; Rowe et al., 2006). Coulton and Frost (1982) demonstrated that the utilization of medical care among older adults is affected by social support, including familial support. Expressions of concern relating to physical illness, functional impairment, and financial difficulties in elderly people lead to individuals seeing themselves as becoming a burden on family members (Noor-Mahomed et al., 2003;

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Cukrowicz et al., 2011). An unmet need of healthcare services and poor financial status due to perceived burdensomeness and the absence of familial support may have a negative impact on the psychological well-being among older adults.

Meanwhile, the need for healthcare services and the ability to cope with low financial status may differ between genders. Generally, women use more medical services because they are more sensitive to symptoms and are more interested in health and social networks than men (Möller-Leimkühler, 2003; Park et al., 2010). Men tend to be less socially integrated and have fewer sources of social support than women (Green and Pope, 1999; Redondo-Sendino et al., 2006; Suominen-Taipale et al., 2006). Studies that have demonstrated an association between SI and lack of interpersonal support, including the failure to obtain the use of necessary healthcare services and low financial status due to the absence of familial support, have focused on elderly people, but gender differences in the association among older adults have not been investigated.

The aim of this study was to investigate the influence of use of healthcare services and financial status on SI among elderly people. First, we hypothesized that significant associations exist between the presence of SI in the past year and both the failure to use healthcare services and low financial status (hypothesis 1). Second, there are gender differences in the association between the presence of SI in the past year and both the failure to use healthcare services and low financial status (hypothesis 2).

2. Materials and methods

2.1. Subjects

Elderly people ($n=1743$; 1007 elderly women, 736 elderly men) aged 65 years and over were recruited through the 2009 KNHANES conducted by the Korea Centers for Disease Control and Prevention. The mean age of elderly people aged 65 years and above was 72.1 ± 5.7 years (elderly men: 71.8 ± 5.7, elderly women: 72.3 ± 5.7).

2.2. Procedures

Raw data were obtained from the 2009 KNHANES conducted by the Korea Centers for Disease Control and Prevention. KNHANES has been repeated with very similar cross-sectional designs at 3- to 4-year intervals since 1998 with a nationally representative sample of the health status and related practice in Korea. The 2009 KNHANES comprised four sections: health interview, health attitude and behavior, health examination, and nutrition. To acquire a nationwide probability sample of the population, this survey used a stratified multistage probability sampling design based on age, gender group, and geographic areas using the 2005 Korean National Census Registry. The respondents' data were assigned weightings to assure an equal probability of being sampled.

Investigators selected 13,800 households from the primary sampling units (600 areas). The selected households included a population of 12,722 individuals. From January 2009 to December 2009, a total of 10,533 individuals completed face-to-face interviews with 140 trained and experienced interviewers, which is a response rate of 82.8%.

These 10,533 individuals included 2640 individuals <20 years of age, 5722 adults (20–64 years of age), and 1743 older adults (≥ 65 years). The data analysis was limited to the weighted population of 1743 elderly people aged 65 years and above.

2.3. Measures

The dependent variable, SI, was assessed with the following question: "During the past 12 months, did you ever seriously consider suicide?" This question was answered with a "yes" or a "no" response. The independent variables were classified into four categories: health utilization, financial status, sociodemographic variables, and health status.

Healthcare utilization was estimated with respect to two parameters: routine-health checkups and use of necessary medical services. Routine-health checkups were assessed specifically by asking the question: "During the past 2 years, did you ever undergo health checkups?" This question was answered with a "yes" or a "no" response. National Health Insurance provides free health checkups for the entire population every 2 years. Most elderly Koreans are enrolled in National Health Insurance because South Korea introduced mandatory social health insurance in 1977 and extended it to the entire population in 1989. Routine-health checkups, which take place in the school and workplace, are required for young and middle-aged adults, respectively; however, these are optional for elderly individuals. Use of necessary medical services was evaluated by asking the question: "During the past 12 months, have you ever not received medical services when you needed medical treatment because you were unable to go to the clinics or hospitals?" Responses regarding healthcare utilization were divided into two categories: "yes" and "no."

Financial status, which was coded according to whether respondents received government welfare, known as National Basic Livelihood Security (NBLS) assistance, was assessed with the following question: "Are you now a recipient of NBLS assistance?" This question was followed with three response options: "yes (current recipient)," "not now, but I am a former recipient," or "no (non-recipient)." Participants were divided into two groups: "recipients of NBLS (current recipient)" and "non-recipients of NBLS (former recipient and the individual who has never received NBLS)." To reduce underreporting because of a recipient concealing the NBLS benefit, the 2009 KNHANES has rechecked the status of registered NBLS recipients at local community centers, based on the residential address of the participants of this survey. Local community centers identify the recipients, formally accept them and assist with applications, and then assist with delivery.

Sociodemographic variables included the elderly people's age, living arrangement, and educational attainment. Elderly people's age was classified into groups aged 65–69, 70–79, and 80 or above years. The living arrangement of elderly people was classified into "Alone at home" or "At home with others (one or more people)." Educational attainment was also classified into elementary school graduate or less, middle school graduate, and high school graduate or more.

Health status included self-rated health, limitation in daily activities, number of chronic conditions, and experience of depressed feelings for at least 2 weeks. Self-rated health was assessed by asking about how they perceived their current health status. Responses were rated on a five-point scale: 1=excellent, 2=good, 3=fair, 4=poor, 5=very poor. Limitation in daily activities was assessed, specifically by asking the question: "Do you have functional disability in daily activities due to physical illness or impairment now?" This question was answered with a "yes" or a "no" response.

Furthermore, information was obtained through self-reports of physician-diagnosed chronic diseases, including hypertension, arthritis, osteoarthritis, osteoporosis, diabetes, hyperlipidemia, stroke, and rheumatoid arthritis with need for treatment. Subjects were classified into four groups: absence of disease, presence of one, two, and three or more chronic diseases.

Depressed feelings were evaluated by asking the question: