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Correlations of Self-rated Health and Healthcare Utilization among Widowed Older Adults in Taiwan

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Abstract

Background:

Taiwan has a rapidly aging population. It is well known that older adults usually have worse health than younger adults, with widowed older adults at a particularly high risk of poor health. Widowed older adults experience the effects of bereavement, which affects their health. Therefore, health topics related to widowed older adults deserve special attention.

Purpose:

The aim of this study was to discuss self-rated health for chronic diseases and healthcare utilization among widowed older adults.

Methods:

A cross-section of data was used to analyze self-rated health-related issues. Data were adopted from the National Health Interview Survey in Taiwan, with the data on adults aged 65 years and over extracted and included in the assessment. Multinomial logistic regression models were used to investigate the relationships between healthcare utilization and self-rated health and chronic disease variables.

Results:

The main empirical results show worse self-rated health status among widowed older adults in comparison with their nonwidowed peers and worse health status for widowers than widows. Next, age was negatively

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Chronic Disease, and Healthcare Utilization among Widowed Older Adults in Taiwan

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correlated with health rating, whereas a positive correlation with health was found for education. In addition, chronic diseases, particularly stroke, were found to be a significant predictive factor related to poor health status. Similar results were observed for healthcare utilization, apart from traditional Chinese medicine. Older adults who habitually purchased and used traditional Chinese medicine were shown to enjoy relatively better health statuses.

Conclusions/Imp

These findings identify health for widowed older Health Insurance System responsible for develop

Introduction

Taiwan is a rapidly aging increase to 20% of the t increasing in Taiwan. N General of Budget, Accounti expectancy was 79.8 in older adults are not hea

Older adults, particular alive. Widowed older ac health and survival rate

(Liu, & Subramanian, 2013; Shah et al., 2012). In general, widowed older adults have been regarded as one homogenous group, although some variability has been shown based on socioeconomic status. Studies on whether being widowed affected adults in their later lives have produced mixed results. Moreover, studies have obtained few definitive results regarding the relationship between a widowed adult and health status. Some studies empirically examined the marriage protection hypothesis, which posits that widowed people are less likely to show good health and face a higher risk of death (Espinosa & Evans, 2008; Moon et al., 2013). Nevertheless, Bennett, Chen, Soroui, and White (2009) showed that health status depends on health literacy. In addition, Sarah and Richard (2014) found gender differences in health status change tendencies. These disparate results indicate that further studies are needed to clarify the age-related health issues faced by widowed persons.

In assessing the health of older adults, an abundance of studies (Bennett et al., 2009; Campos et al., 2015; French et al., 2012; Ho, Li, & Liu, 2009; Li, Chi, Krochalk, & Xu, 2011; Moriconi & Nadeau, 2015) have used self-rated health (SRH) as a screening tool. However, Clarke and Ryan (2006) and Crossley and Kennedy (2002) questioned the reliability of SRH. Thus, SF-36 (short form-36) and SF-12 have been applied in several research studies (Ngo-Metzger, Sorkin, Mangione, Grandek, & Hays, 2008; Wee, Davis, & Hamel, 2008; Younsi, 2015). Nevertheless, Chamberlain et al. (2014) and Wolinsky et al. (2008) found no significant difference between the results obtained by SRH and other measures. Moreover, SRH utilizes a single-item health measurement. In addition, the World Health Organization also recommended this indicator to verify health in population-based studies. Therefore, the present article uses SRH as a dependent variable in an investigation of health-related issues.

The SRH has been widely discussed to explain social demographic factors (Campos et al., 2015; French et al., 2012; Ho et al., 2009; Li et al., 2011), chronic diseases (Ho et al., 2009; Wolinsky et al., 2008; Wu et al., 2013), and healthcare utilization in health (Chamberlain et al. 2014; Ho, 2016; Ho & Hung, 2013; Ho et al., 2009). In addition, some articles have indicated that chronic disease has a negative effect on SRH. Similar results were found for older adults who had healthcare utilization experience. Most of these older adults reported poorer health than those without healthcare utilization. However, the level of SRH, as rated by healthcare utilization, varied based on disease type and severity. Of these diseases, widowed older adults who had experienced stroke usually showed worse health and were more likely to die than those with other chronic diseases (Ho et al., 2009; Larsen, Biering, Johnsen, Andersen, & Hjollund, 2016). In addition, Campos et al. (2015), French et al. (2012), and Sarah and Richard (2014)

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gly with self-rated tool by the National officials who are ed in Taiwan.

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ose spouses are still impact on their Moon, Glymour, Vable,

found gender differences in predictors of SRH among older adults in Brazil, Chile, and the United States, respectively. Li et al. (2011) further suggested that, for widowed older adults living with family and children in China, filial piety may have a buffering effect on bereavement. Thus, the traditional East Asian cultural encouragement of children and relatives living together may promote the enjoyment of later years of life (Ho & Hung, 2013).

As mentioned, previous demographic factors, such as these factors, particularly in this study aimed to examine

Methods

Design

The data used in this research. The NHIS adopted a multistage probability proportional to size without replacement sampling regions, *housholds*, and *individuals*, which were selected randomly from the population by trained interviewers

Sample

The original NHIS sample population was 22,942,706. In accordance with the sampling program, 25,632 participants completed the survey. Among these, 21,531 participants submitted complete and valid survey responses (valid response rate = ~84.0%). For the purposes of the current study, qualified participants were restricted to those aged 65 years or over. Consequently, the data on 2,904 participants were reviewed for this study. Omitting the subjects who reported having never been married or having been divorced or separated left 1,801 sets of data for married older adults with a currently living spouse and 998 sets of data for widowed older adults available for analysis. This study included the data of 2,799 participants and analyzed their SRH status.

Measures

Dependent variables

The health status of the subject was self-rated, with possible responses including “excellent,” “good,” “average,” “not so good,” and “poor.” For the purpose of this study, health responses were combined into a multinomial form—“healthy,” “average,” and “unhealthy”—which has been reported elsewhere (Wu et al., 2013). “Healthy” was defined to include reported health statuses of “excellent” and “good,” “average” correlated with the “average” health status, and “unhealthy” includes reported health statuses of “not so good” and “poor.” The relative risk ratios (RRRs) for healthy and unhealthy peers were calculated based on the average peers, using multinomial logistic regression and controlling for sociodemographic factors, chronic diseases, and healthcare utilization status.

Independent variables

The purpose of this study was to test the relationships between SRH status and chronic diseases and healthcare utilization status among widowed older adults. Thus, variables included widowed people, chronic diseases, and healthcare utilization. First, the marital types as defined in the NHIS were divided into six groups: never married; married, with spouse currently alive; separated; divorced; married, with spouse deceased; and “other.” On the basis of the stated study purpose, the fifth group was used to assess the health status of older widowed individuals.

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facet such as SRH has not been investigated across different regions. To fill this gap, this study was conducted in Taiwan.

(NHIS) in Taiwan. In addition to geographic location and probability of probability, at the second-stage level, the second-stage households were selected and investigated

To examine SRH among widowed older adults, the methods of previous studies were followed (Ho et al., 2009; Schnittker & Bacak, 2014; Wolinsky et al., 2008) and chronic diseases and healthcare utilization were discussed. First, in terms of chronic diseases, older adults were asked to report whether they had been diagnosed with chronic diseases such as hypertension, diabetes, heart disease, cholesterol, stroke, asthma, kidney disease, osteoporosis, or arthritis. On the basis of the research of Shah et al. (2012), this study hypothesized that widowed older adults with chronic diseases might show higher RRRs for poor health status and lower RRRs for healthy status than those without chronic diseases.

In terms of healthcare utilization (Shah et al., 2011), Western medicine was considered as healthcare. If a participant took Western medical treatment, inpatient or outpatient, it was counted as healthcare. In line with prior research (Shah et al., 2011), we hypothesized that older adults with chronic diseases and lower educational resources might have worse SRH.

Control variables

To control the variables of chronic diseases, and healthcare utilization (Shah et al., 2012; Li et al., 2011) and control variables such as age, gender, educational level (less or more than high school), living arrangement (alone or with others), living with spouse, and living with children.

On the basis of the findings of previous studies (Shah et al., 2012; French et al., 2015; French et al., 2015), we hypothesized that older age and lower educational level would be associated with poorer SRH status and that those who lived alone would report a poorer SRH status than those who lived with family members.

Ethics

The National Health Research Institutes approved the use of NHIS data for analysis. Furthermore, this study was approved by the research ethics committee (NCUEREC SOP/05/01.5) of National Changhua University of Education, Changhua, Taiwan.

Modeling Self-Rated Health

This study used chi-square to test the difference in SRH status between older adults with a spouse and those without. Next, multinomial logistic regression models were used simultaneously to examine SRH status among widowed older adults. Following the methods of Greene (2012), the general equation used for the conditional probability model is

where j is the $j + 1$ possible choices, y_i denotes the dependent variable of SRH, y_0 is average groups, y_1 is healthy groups, and y_2 is unhealthy groups. x_i is the vector of the independent variables, including sociodemographic factors, chronic diseases, and healthcare utilization. β_j is the corresponding coefficient vector.

In addition, this study compared the SRH between widowers and widows, with the estimation function formulated as

where p_j is the probability of SRH j (SRH of a widower) and p_0 is the probability of the reference (the SRH of a widow).

Results

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Shah et al., 2012; Weiss et al., 2015; French et al., 2015). The dependent variable was SRH, which was coded as 1 if the participant did not receive emergency healthcare and 0 otherwise.

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Table 1 shows the data for the 1,801 married older adults whose spouses were still alive and the 998 widowed older adults. Of these, more than 30% ($n = 358$, 35.9%) of widowed older adults rated their current health as unhealthy, whereas 23.7% ($n = 236$) felt that they had worse health status than before. A similar proportion (24.1%) was found to be in relatively worse health than others. As expected, all of these proportions are larger than older adults whose spouses were still alive. The chi-square test was used to examine the SRH difference between widowed and nonwidowed older adults. As shown in Table 1, empirical results showed a statistically significant difference between widowed and nonwidowed older adults before, and SRH compared with others.



TABLE 1.:

Self-Rated Health

This study also tested the healthcare utilization. From Table 2. In terms of age relatively poor economic average peers. The RRR education, lived alone, was higher among the unhealthy [1.77, 2.54]]. In addition healthy and unhealthy ($p = 254.81$) and p value illustrated



TABLE 2.:

Sociodemographic Factors of Elderly Widowed Participants, by Self-Rated Health

Table 3 shows the prevalence of various chronic diseases among widowed older adults by SRH, including hypertension, diabetes, heart disease, cholesterol, stroke, asthma, kidney disease, osteoporosis, and arthritis. Multinomial logistic regression results found that significant increases in the prevalence of all diseases were associated with the unhealthy groups, with the log likelihood (-2980.810 , $\chi^2(18) = 384.61$) and p value showing significance ($p < .001$) in this model. The RRRs were greater than 1 in the unhealthy groups when compared with the average groups, apart from high blood cholesterol (RRR = 0.80, 95% CI [0.65, 0.98]). Notably, the largest RRRs were for stroke, which had an RRR of 3.56 (95% CI [2.58, 4.90]).



TABLE 3.:

Disease Prevalence Among Elderly Widowed Participants, by Self-Rated Health

In contrast, the empirical results indicated that a significantly lower prevalence of all chronic diseases was associated with the healthy groups, which had RRRs between 0.50 and 0.75. Among these, diabetes and stroke only showed half of RRRs (0.50, 95% CI [0.39, 0.65], and 0.50, 95% CI [0.31, 0.80], respectively).

Healthcare utilization by SRH status is shown in Table 4, indicating significantly higher RRRs for emergency treatment (2.85, 95% CI [2.28, 3.54]) and inpatient care (2.71, 95% CI [2.15, 3.42]) in unhealthy groups than in the average groups. However, a lower RRR for Chinese medicine (0.60, 95% CI [0.42, 0.86]) was found in the same comparison groups. In addition, all of these healthcare utilizations were significantly less than one in the healthy groups when compared with the average groups, but dentistry did not show significance. The log likelihood (-3015.844 , $\chi^2(10) = 314.54$) and p value illustrated significance ($p < .001$) when multinomial logistic regression analysis was used.



TABLE 4.:

Healthcare Utilization of Elderly Widowed Participants, by Self-Rated Health

To compare the different RRRs of SRH between widowers and widows, as classified by sociodemographic factors, healthcare utilization, and chronic diseases, this study used four different models to describe the relative risk of widowhood for older adults. Model 1 controlled for widowed groups only. Models 2 and 3 described the impact of sociodemographic factors and healthcare utilization on relative risk of SRH. Model 4

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nic disease, and risks are shown in rent life status, and 7 peers than the ary school us were significantly RRs (2.12, 95% CI icant effects on 5.710, $\chi^2(12) =$ on analysis was used.

considered the combined impact of socioeconomic factors, healthcare utilization, and chronic diseases on relative risk of SRH. The final test results are listed in [Table 5](#).

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TABLE 5.:

Self-Rated Health Estimation Between Elderly Widower and Widow

For the widowhood group, the RRRs of chronic diseases were not significant in Model 4, and the RRRs of chronic diseases were most important for the healthy group when compared with the average group.

Discussion

This study focused on the impact of socioeconomic factors, healthcare utilization status, and chronic diseases on the relative risk of SRH. The RRRs of unhealthy status were found for both widowers and widows (Moon et al., 2013; Wu et al., 2013).

Notably, most widowed older adults (26.4% for widows and 25.8% for widowers) reported their health as “excellent” or “good,” a proportion slightly higher than the 24.1% reported in China (Li et al., 2011).

Thus, the influence of bereavement on health appears to be similar between Chinese and Taiwanese older adults. The reasons may be that China and Taiwan share similar values and ethnic, cultural, moral, and linguistic backgrounds.

Significantly older age (over 75 years) was associated with significantly higher unhealthy status (RRR = 2.12). This phenomenon reflects that the health status of older adults decreases significantly with age. Similar results have been found in most previous studies (Bennett, Ehrenfeld, Markham, & Eagle, 2014; Ho, 2016; Li et al., 2011; Wu et al., 2013). Nevertheless, for the “healthy” groups, age lost significance. This finding differed from the results of Wu et al. (2013) and Ho (2016). Moreover, there was a significant education gradient in SRH. The RRR for unhealthy status in the below primary school education group was significantly higher (1.60) than that in subjects with more than a primary school education. One reason for this may be that subjects with less education were more likely to be in lower income categories (Li, Chen, & Kuo, 2005), facing more difficulties covering living and household expenditures and less likely to be satisfied with their current lifestyle (Dinh, Hébert, Mill, Prentice, & Ward, 2012). Thus, widowed older adults who had less education were less likely to report healthy status. Moreover, regarding living arrangements, this study found that older adults who lived alone had a higher RRR in the unhealthy groups and a lower RRR in the healthy groups in comparison with their average group peers. This finding supports the findings of previous studies (Ho, 2008; Li et al., 2011), which indicate that older adults who live alone show weak social function and networks and are thus at a higher risk of showing poor health. In general, older adults living alone, particularly those who are widowed, typically lack assistance and care from family and thus face a higher relative health risk ratio. This result is consistent with traditional Asian cultural mores that encourage two or three generations to live together and take care of each other (Ho, 2008). In fact, children are more important social and emotional sources. Family function has always been the primary societal institution for providing social support, particularly for widowed older adults (Ho, 2008; Li et al., 2011).

The empirical results indicate that chronic diseases are an important health indicator, as reflected in the poor SRH for older widows. Of the chronic diseases considered, this study further found that the largest RRR was present for stroke in the unhealthy groups and that the smallest RRR was found in the healthy groups when compared with the average groups. This finding supports the opinions of Ho et al. (2009) and Larsen et al. (2016) that individual reports of stroke were generally more strongly associated with SRH than with other related chronic diseases. The individuals with stroke experience were less likely to perform activities of daily living

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important direction for future research. Finally, one of the obvious limitations of our demonstrated link between SRH and chronic diseases and healthcare utilization is that the study is limited to the country of Taiwan. To show that this link is typical rather than special will require replicating the results in other countries. The extension of the findings to other countries is a matter for future research.

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