Appendix 6

Report of the Working Group on Elderly Suicide

July 1999

Chapter 1
The Situation of Elderly Suicide in Hong Kong

Introduction

Suicide is a multi-dimensional problem, the understanding of which requires consideration along social, psychological and biological dimensions. Suicide is not only a personal loss of life, but is also distressing and painful to friends and family of the victim. Prevention of suicide is of universal concern, but generally speaking, attention has tended to be more focused on youth suicides than suicides among the elderly. However, according to a 1995 report of the World Health Organisation on international data on suicide, for the countries under study, suicide rates among the elderly are in general higher than that of the nation as a whole (Annex). There is no intention to play down the tragedy of youth suicide, yet suicide in the elderly is equally tragic, and deserves as much attention and concern from the community.

2. In Hong Kong, the known suicide deaths among the elderly from 1990 to 1997 are as follows:

Year	Age 65-74	Age 75 or over	All age
1990	104	101	679
1991	95	92	689
1992	102	113	727
1993	112	87	638
1994	115	108	741
1995	106	104	718
1996	84	85	646
1997	103	100	645

(source: Census & Statistics Department, HKSARG 1998)

3. Reading from the statistics above, we note that over the years, elderly suicide rate remained fairly constant at about one-third of all known suicide deaths in Hong Kong. Looking at the issue in juxtaposition with other countries, Hong Kong does have a comparatively high elderly suicide rate.

Year	Country / City	Elderly Suicide Rate (60 or over)	Suicide Rate of General Population
1994	Australia	16	12
1994	China (Beijing, Urban)	13	4
1994	China (Beijing, Rural)	38	14
1995	Hong Kong	28	12
1993	New Zealand	12	12
1994	Singapore	50	14
1991	U.S.A.	20	12

(source: Elderly Suicide in Hong Kong, Chi, Yip, Yu (1997))

4. We must of course treat the above-mentioned data with care, as they relate to figures of different years and different reporting systems. Divergences among the countries, such as culture and socio-economic conditions, may have also accounted for some of the differences (Yip, 1996, 1998). Having said that, the figures by themselves do draw our attention to the need to look seriously into the issue of elderly suicide and to map out a strategy to prevent our elderly from ending their own lives.

5. There are a number of studies on the topic in Hong Kong. One study (Chi, Yip & Yu, 1997) analysed the suicide rates among different age groups in the local population from 1981 to 1995. The study showed that the average number of elderly suicide deaths is 30 per 100,000. Elderly females have a lower suicide rate, while males aged 75 or above have the highest suicide rate among all age groups, with the average number of deaths at 50 per 100,000. It also pointed out that the suicide rate for the elderly is 12 times higher than that for younger individuals. Almost all suicide cases under study had suffered from at least one chronic and painful but not necessarily terminal illness (such as arthritis, asthma and diabetes). About 40% of the cases had consulted a doctor about his/her physical illness within a month before committing suicide. Very few cases had totally lost their self-care abilities. The findings on illness of the elderly are largely similar to those of a study conducted by the Association for the Rights of the Elderly ("ARE", 老人權益促進會) in 1997. The latter pointed out that elderly suicide cases in general suffered from more than one illness, and about 40% suffered from depression.

6. The study by Chi et al (1997) noted that 70% of the suicide cases under study lived with family, and 17% of the cases were living alone. Nearly 68% had indicated to their family members or others their suicidal intent before the fatal act. Financially speaking, majority of the cases was supported by their family, and only 7% received government assistance. The suicide rates for those economically inactive were higher than that of the economically active. On this basis of classification, the retired individuals had the highest suicide rate, and the next highest was housewives. The sample study by ARE (1997) showed that 60% of the cases had a monthly income ranging from $2,000 to $2,999, and 20% with $1,000 to $1,999. Those with less than $1,000 income, as well as those with income above $3,000, each took up 10% of the cases under study.

7. Among the cases studied, only about 18% of cases left a death note (Ho et al, 1997), out of which, most of them were written by males. This might be related to the low literacy level among the females in the age cohort under study.

8. The study by ARE (1997) focused on the perspective of social workers coming into contact with suicidal elderly or who had committed suicide. For the suicide cases under study, 33% of them had personally indicated their suicidal intent to the social workers while for another 29% of the cases, the intent came to the notice of the social workers through their observation or intervention.

9. We have only quoted some of the findings of local studies on the issue of elderly suicide. But the findings already pointed to the severity of the issue and the need for a better understanding of the reasons driving the elderly towards suicide.

Chapter 2
Risk Factors in Elderly Suicide

10. As mentioned earlier, suicide is a complex problem. There may be a variety of reasons that lead to suicide, including social, psychological, emotional and situational factors, and it would be more often than not that it is interplay of these factors that led to the tragedy. More in-depth understanding of these risk factors would surely go a long way to help us prevent our elderly from suicide.

Coming to terms with Aging

11. Coping with ageing can be a traumatic experience. The loss of social status and income upon retirement can bring about disillusionment. Deterioration in self-care abilities and increased dependence are blows to the self-esteem. The traditional perception of age and ageing among Chinese community tend to look at an elderly as dependent and non-productive, which only adds to the negative stereotype of ageing.

Socio-economic Developments

12. Hong Kong has been advancing at a rapid pace. Adjusting to the pace of development is already quite strenuous. With the social economic developments also come a variety of changes in the traditional family structure and support. The nuclear family becomes more widespread. The influence of the Western culture tends to develop in the younger generations an outlook with more emphasis on self-actualisation. All these impinge on the traditional role of the elderly in the family, who used to be revered and consulted on all matters. A gap develops between the elderly's expectations of the younger generations' respect for them and the actual attitudes of the latter. Coming to terms with such realities can be harsh.

Stress arising from Tragic Life Events

13. Tragic life events, especially bereavement of spouse, have been cited as contributory to suicidal behaviour (Canetto, 1991), but the effect seems to be stronger for men than for women. In the United States, females aged 65 or over are 3.5 times more likely to be widowed than their male peers. Older widows are less likely to have the opportunity to re-marry than older widowers. Yet, widowers are at higher suicidal risk than are widows. One reason for this observation may be because many older men depend on their wives for emotional support. Older women tend to have more emotional connections with friends than older men. Losing a spouse may therefore disrupt social support and emotional functioning more for a man than for a woman. A man may also be more dependent on a woman for personal care and running of the home. Thus, losing a spouse may disrupt personal stability and physical well-being more for a man. However, the reasoning also works for older women in the sense that they may depend on their spouse for financial security and management of financial assets. Bereavement would mean being responsible for one's own finances, which may be more stressful and discomforting to older women than older men. In any case, bereavement is a high risk factor that we should watch out for.

Prolonged Illnesses

14. Studies share similar observations that prolonged illness is one of the major risk factors leading to elderly suicide. Faced with unbearable physical pain and terminal illness, the elderly sees suicide as a way out, as well as a means to relieve the burden on the family. Sainsbury (1955) estimated that whereas physical illness contributed to suicide in

10% of the younger victims, the figure rose to 27% in middle-age persons and to 35% in elderly persons. Dorpat et al (1968) found that medical illness directly contributed to suicide in almost 70% of the victims over 60 years of age. In the local scene, from the death notes left by the elderly, we noted that most of the elderly expressed unbearable pain from prolonged illnesses, while some of them explicitly indicated that their suicide was to relieve the burden of the family (Chi et al, 1997).

Mood Disorders

15. There have been various studies on the link between the presence of affective illnesses in the elderly and their suicidal intent. In one local research (Chiu, Lam, Pang, Leung and Wong, 1996), 55 elderly patients with suicidal attempts were studied. 49.1% of the elderly suffered from a mood disorder (27.3% with major depression, 20% with adjustment disorder with depressed mood and 1.8% had dysthymia). A very low rate of dementia (3.6%) was found among the patients and 36.4% of the cases had no psychiatric illness. Compared with other age groups, the prevalence of psychiatric illness among elderly suicide cases is low. 24% of the elderly who committed suicide had a history of psychiatric treatment as opposed to 50% found among teenage suicide cases (Chi et al, 1997).

Support Network

16. In an earlier study on 390 suicides in London from 1936 to 1938 (Sainsbury, 1955), the correlation between suicide and living alone was higher in older than in younger generations. In a study on the circumstances of 30 elderly suicide cases, Barraclough (1971) noted that 50% of the victims lived alone, as compared to 20% of the general community in which they were living. However, in recent studies (Conwell et al, 1990) it was noted that the proportion of completed suicides aged 50 or over who lived alone at death did not increase with age in later life. In fact, living alone does not necessarily mean social isolation. In a psychological autopsy study of 54 completed suicides committed by elderly 65 years old and over (Clark, 1991), 40% were living alone at death, but 60% had weekly visits with others outside the home and 98% had weekly contact with friends and relatives. We mentioned the study by Chi et al (1997) which showed that 70% who committed suicide were in fact living with their families. Physical solitude may contribute to the sense of isolation, but the above-mentioned findings do suggest that we have apparently overlooked the need for care and concern of the elderly around us.

Financial Disposition

17. The lack of financial means can add to the worries of the elderly and may be contributory to suicides, but the correlation would warrant a more detailed study. The study by the ARE showed that the income of the suicide cases was on the low side, whereas the study by Chi et al. (1997) indicated that the majority of the suicide cases were supported by their families. On the other hand, there was a slightly higher proportion among the homeless and those living in caged homes who were suicidal.

Chapter 3
Existing Services Provided for Elderly

18. It is the policy objective of the Government to provide a sense of security, a sense of belonging and a feeling of health and worthiness among our elderly. To this end, various services are provided by Government and Non-governmental Organisations (NGOs) to help the elderly to, inter alia, resolve the problems of living, promote mental wellness, and to promote an active lifestyle.

Services to resolve the problems of living

19. It is important for the elderly to have a place call home. Studies (Deloitte and Touche, 1997) indicated that majority of our elderly wish to continue to live at home and be cared for by their families. Many families also prefer to take care of their elderly at home provided that support services are available. The Government has been providing community-based care services for frail elderly. At present, 30 day care centres provide care and rehabilitative services for 1 320 elderly whose health conditions are deteriorating, and who do not have full-time carers at home. Home-helpers provide meal services as well as escort, home-making and personal care services to elderly living at home who are not capable of taking care of themselves. There are now 134 home-helper teams, from April to December 1998, these teams are serving about 13 500 cases.

20. On the other hand, for elderly who cannot be adequately taken care of at home, residential care services are provided. Over 16 500 residential care places are provided by NGOs-operated care homes, which are subvented by the Government. The private sector provides another 2 000 subsidised places through the "Bought Place Scheme" and "Enhanced Bought Place Scheme", a scheme under which the Government purchases suitable care places from private care homes for the elderly. 1 400 nursing homes places are available to care for elderly of higher frailty. For elderly in financial needs, government financial assistance, such as the Comprehensive Social Security Assistance (CSSA) provides a safety net for them. Charitable trust funds are also provided in times of needs.

21. The family is the basic unit of the society, which provides care, mutual support and emotional security to its members. The Social Welfare Department (SWD) and NGOs provide a variety of welfare services for the family, the overall objective being to preserve and strengthen family as a unit through assisting individuals and prevent or tackle their problems. Family caseworkers provide counselling and referral services for family members, including the young and elderly. Education programmes are conducted to promote inter-generational care and respect.

Services on Healthcare

22. The Department of Health (DH) establishes elderly health centres to enhance primary healthcare to the elderly and to improve their self-care ability. Apart from conducting annual health assessment, which includes the physical, psychological and social aspects of the elderly, information or his/her health history and problems are collected to assess the risk factors. In-depth individual counselling will be provided to the elderly after assessment and follow-up and curative treatment will be arranged whenever necessary. 12 elderly health centres have been set up in various districts and a further six centres will be established in 1999-2000.

23. An effective way of preventing suicide is to enhance individual's inner

strength and empower them to cope with life events. DH's Elderly Health Services develop health education programmes to promote mental wellness for the older persons. They include health talks and interactive small groups conducted by nurses and clinical psychologists in Elderly Health Centres, social and multi-service centres for the elderly, and elderly hostels. Themes covered understanding psychological and physical changes in old age, communication skills, relaxation techniques, managing bereavement and loss, and coping with stress. Community education is also provided in multi-service centres for the elderly operated by various NGOs to help elderly to be aware of the changes during old age, enhance the self-image of the elderly and face the issue of ageing in a more positive manner.

Services to promote active lifestyle

24. To promote a sense of worthiness among the elderly, it is important that they should enjoy an active life, to make use of their skills and knowledge to participate in the community. The SWD organises an "Elderly Volunteer Programme" to encourage elderly to contribute and participate as active members of the community. Through support teams for the elderly, the spirit of senior volunteerism is promoted and elderly people are encouraged to carry out community networking and neighbourhood support projects, including outreach to elderly at risk, and to organise recreational and social activities for the elderly. Over 5 000 elderly volunteers are now enrolled in this programme.

25. SWD has also launched a three-year experimental project, "Opportunities for the Elderly Project" (OEP) from January 1999, the purpose of which is to provide opportunities for elderly people and volunteers of all ages to run innovative projects for elderly people. The objectives of the OEP are, inter alia, to assist the elderly to acquire new knowledge and skills, to participate in community affairs, to foster community spirit of care and respect for the elderly, and to encourage elderly people and other age groups to serve as volunteers in supporting and serving vulnerable elderly. Projects may be in the form of continuing learning, civic awareness, promotion of respect and care for the elderly and inter-generational programmes. It is expected that more than 200 000 elderly persons will benefit from the Project.

26. To maintain the vitality of the elderly people, various services covering socialisation, recreation, continuing education and employment are run jointly or severally by government departments and NGOs. The Adult Education Section of the Education Department works together with NGOs to provide courses specifically for the elderly, such as courses on pre-retirement/retirement education, social/moral education and basic literacy in Chinese. In 1997/98 school year (ending August 1998), 183 programmes were organised for the elderly, with the number of participants totalling 8 344.

27. To cultivate a sense of respect and appreciation to the elderly, the SWD introduced the Senior Citizen Card Scheme in 1994, under which elderly aged 65 or over would be accorded concessionary benefits and priority service by public and private corporations. As at 30 April 1999, about 590 000 elderly are now enjoying the privileges of the Senior Citizen Card, with more than 1 629 companies/institution (4 063 outlets) participating in the Scheme.

Social networking

28. The "Social Networking for the Elderly Project" was conducted by SWD in 1996, together with other government departments and the Hong Kong Council of Social Service. The aim was to establish a network of service providers and volunteers to provide care and support to vulnerable elderly people living alone, so as to enable them to continue

living in the community. This two-year project was launched in 1996. About 15 000 vulnerable elderly were identified and over 7 000 elderly people were matched with volunteers. A study on the Project indicated that elderly people and volunteers participating in the Project both considered it fruitful and beneficial. The Project was effective in improving the sense of well-being and social support for the elderly. While improvement to the format of service was recommended to increase its impact and effectiveness, the social networking service was considered a worthwhile project that should be maintained. With effect from October 1998, support teams based in multi-service centres are conducting the service. 31 teams have now been set up, with five more teams coming into service before end of March 2001.

NGO-initiated project

29. Various NGOs have taken the initiative to study the issue of elderly depression and suicide. Among the initiatives, a pioneering project was conducted by the Samaritans (Cantonese Speaking Service) to reach out to vulnerable elderly and to promote public awareness on elderly suicide. With a Lotteries Fund grant of $2.7m, the agency has started a two-year Elderly Suicide Prevention Project since May 1998 to enhance the community's understanding of the issue, with the aim to preventing elderly suicide. The project comprises two components. The first part is a community education programme made up of seminars, training courses, exhibitions and community activities, aiming to increase the awareness of the elderly, their carers, medical professionals and the public at large on elderly suicide and prevention. Professionals and volunteers working with elderly will be given training in preliminary detection of signs of suicidal intent. The second part of the programme is a befriending service for suicidal or depressed elderly referred to the agency. Trained volunteers, usually with experiences in handling the Samaritans suicide hotline services, will visit the elderly immediately and/or at regular intervals, depending on the urgency of the situation. The volunteers will be given training on counselling techniques and will be supported by experienced volunteers and social workers. Through talking and listening to the elderly during the visits, the volunteers provide emotional support and counselling to the elderly to avert their suicidal inclination. The befriending service commenced in January 1999. It is estimated that about 80 to 100 suicidal elderly cases would be handled.

Staff Training

30. In-service training courses on how to work with vulnerable elderly are organised for social workers, nurses, and other staff working in elderly, medical, psychiatric rehabilitation, casework and other service settings. The courses cover attitude assessment and psychosocial needs of the elderly as well as counselling skills.

Observation

31. As outlined above, a range of services are currently provided for the elderly to cater for their various needs. However, we recognise that for the purpose of prevention of elderly suicide, a more focused, multi-disciplinary approach would be needed to tackle the issue. Apart from reaching out to vulnerable elderly, training and education need to be provided for formal and informal carers to raise their awareness to the psychosocial needs of the elderly. Family members should be alerted to the important role they have in supporting their elderly. Professionals in frequent contacts with the elderly should also be alerted to the risk factors and be given adequate training to intervene when necessary. Better co-ordination among various professionals is called for to work together on the issue.

Chapter 4
Recommendations on Prevention of Elderly Suicide

32. The suicidal act is usually the climax of a crisis in an individual. But given timely support and counselling, suicide can be prevented in many cases. Taking into account current services provided for elderly at risk and overseas experiences through literature search, the Sub-Group on Elderly Suicide puts forward the following recommendations on healthy ageing, training, intervention, awareness, database compilation and public education to address the psycho-social needs of the elderly and to prevent elderly suicide.

Publicity and Public education

33. As a society, we need to improve and change our stigma towards the elderly and ageing, that it connotes dependency and non-productiveness. The awareness of our general public towards elderly suicide is on the low side. There is also a general misconception that public discussion about suicide may induce the elderly to do so. Publicity and educational programmes should be conducted to bring the correct messages to the public. Respect and concern for the elderly should be fostered in the society. Publicity and educational programmes should be conducted to enhance respect for the elderly and to increase the public understanding on the importance of the psychosocial needs of the elderly and depression in elderly people to put the issues in their proper contexts.

Family Support

34. We cannot over-emphasise the importance of family care and support for the elderly. That 70% of the elderly had indicated their suicidal idea to family members (Chi et al, 1997) is an indication that our elderly are yearning for help. But somehow these help-seeking behaviours may have been overlooked or have not been taken seriously. It is important to raise the awareness of family members to possible suicidal indications, so that they can be more vigilant of the elderly's emotional needs. Spending more time talking and listening to the elderly may already provide an outlet for their emotions. Publicity pamphlets and relevant information on channels for referral and treatment should be made available in Carers' Support Centres, as well as in family programmes of SWD's Family Life Education Unit. Families should be encouraged to overcome the stigma to seek outside help for the elderly. Training packages for carers is another way to get the message across.

Training for Front-line Staff

35. In the ARE study, over 90% of the social workers interviewed indicated that they did not have sufficient training and skills to handle the elderly at risk (ARE, 1997). The findings of the study by Chi et al (1997) also draw our attention to a group of vulnerable elderly in residential care institutions. 5% of the 279 cases under study committed suicide while staying in residential care homes. The fact that intervention actions had not been taken to stop the tragedy is a matter of concern. Pre-service training for front-line workers to look out for possible signs of depression and to improve their skills to manage the elderly are highly recommended. Priority for training should be accorded to front-line staff, such as home-helpers and personal care workers as well as volunteers. Referrals to Family Service Centres for more intensive management of the elderly should be provided. More emphasis should be put in this aspect as well as the psycho-social needs of the elderly. Skills in professional counselling are also important and more in-service training conducted by SWD for social workers.

Training for Medical Professionals

36. Both overseas and local studies showed that a significant portion of suicidal elderly, as much as three-quarters of the cases, did consult medical practitioners shortly before they committed suicide (Conwell 1994; Chi et al, 1997). However, it is not unusual that their suicidal inclinations go unnoticed since some of the elderly may conceptualise their depressive moods as physical problems (e.g. headaches, insomnia), while some doctors may not be alerted to the problem. The awareness of medical practitioners towards these hidden signs would go a long way to help prevent elderly suicide. Psychosocial needs of the patients should be given adequate emphasis in pre-service training on detection and crisis intervention for medical professionals, including not only doctors, but also nurses and other allied health personnel. In-service training should also be conducted in the form of seminars, talks and courses conducted by relevant medical colleges and associations. It is suggested for consideration that in-service training in this area should be included as part of the medical professionals' continuing medical education (CME).

Outreach to Vulnerable Elderly

37. Elderly living alone or those encountering tragic life events (e.g. bereavement) are possible vulnerable groups. Awareness of the need for support for this group is also an important area in preventing elderly suicide. SWD's Social Networking Project has proven to be effective in reaching out to vulnerable elderly. In view of this, it is recommended that efforts in networking elderly at risk should be further strengthened. Volunteers, both young and old, should be encouraged to participate and contribute to support the vulnerable. As mentioned in para. 4, training and support should be accorded to volunteers to prepare them for the out-reaching tasks.

Depression intervention

38. Depression was identified as one of the major affective illnesses among suicidal elderly (Chiu et al, 1996). For elderly at the brink of committing suicide, immediate intervention would be necessary. It would be worth considering arranging timely specialist medical intervention for vulnerable elderly.

Compilation of database

39. It is useful for clinical and research purpose to understand the psychological and emotional state of the elderly in their contemplation of suicides. However, for various reasons, not all of the elderly who committed suicide would leave a death note. Systematic collection of information on suicide cases, including completed and attempted cases, as well as suicidal elderly, are recommended. It would also be useful to identify possible areas of under-reporting of suicide cases to obtain a more accurate assessment of the situation. Monitoring the suicidal trends is useful for understanding the causes of suicide and to map out targeted approach to prevent the elderly from taking their own lives.

Research

40. There are many reasons behind the suicide of an elderly. It is imperative that we should understand the issues involved. More in-depth and comprehensive research should be conducted to identify the risk factors and the relative significance of these factors towards elderly suicide. It is suggested that through evaluation and assessment of the research results, more targeted actions can be taken to tackle the issue. The scope of study may include groups of elderly who have attempted suicide, elderly with suicidal inclinations, as well as data on completed suicides. Psychological autopsy can be conducted to look into the personal and medical history of the victims to "reconstruct" the case to understand the factors behind.

Medical and Health Services for the Elderly

41. Studies indicated that illnesses are major causal factors to elderly suicide. It is important to promote and maintain physical and mental health of our elderly to reduce the suicidal risks. It is recommended that a more structured, comprehensive approach be undertaken to consider strengthening medical and health services for the elderly.

Chapter 5
Conclusion

42. Suicide is a tragedy. The elderly has contributed to the social and economic developments of our community, and they should be respected and cared for in their old age. There are many reasons behind the tragedy. It is not possible to eradicate the problem totally, but we should strive to reduce the incidents.

43. The case of suicide is a complex one. Elderly do not usually commit suicide on impulse, and studies indicated that they would usually be contemplating about it for some time before actually committing it. Reasons for their so doing are many. Desolation, pain, worries, inability to cope and frustration may all play a part. Awareness of the elderly's psycho-social needs is an important area we should improve on, especially given that many elderly had in fact expressed their suicidal wish before the tragedy.

44. Family plays a pivotal role. Majority of our elderly is living with and cared for by their families. Family members are often the first one the elderly would turn to for assistance and support. Greater awareness on the part of the family to the needs of the elderly would surely go a long way to alleviate the depression and frustration faced by the elderly.

45. Early prevention is important to reduce elderly suicide crises. Front-line professionals and staff coming into contact with the elderly may not be conscious of the important role they play in identifying and averting the suicidal risks. Training and support would be useful to enable them to manage vulnerable elderly and to refer them for suitable services. Good co-ordination between the social services workers and medical professionals would help to strengthen the supporting network.

46. The attention of the community at large should be drawn to the severity of the issue and be encouraged to care for our elderly. Early preparation for old age would be useful to enable psychological preparation for the soon-to-be old.

47. There are many overseas and local studies on the issue, looking at it from different perspectives. It would be useful to research into and compile a solid database on the risk factors leading to elderly suicide, so as to target our service resources more effectively to help the elderly.

48. Suicide is a social problem, and we need the collective efforts of the community to prevent our elderly from taking their own lives. Suicide represents a premature death at any age. The premature deaths of older adults are a loss of talent and resources that we as a society cannot afford. The old of today and the future deserve our attention and prevention efforts (McIntosh, 1990).

Working Group on Elderly Suicide and Depression
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Annex

Suicide Rates (per 100,000) by Gender, Age and Country

Country	Year	Gender	15-24	25-34	35-44	45-54	55-64	65-74	75&+	All ages
China (Rural Area)	1994	M	16.7	21.9	23.1	30.1	48.6	101.5	142.6	**23.7**
		F	33.0	42.0	29.0	31.1	44.8	74.7	100.5	**30.5**
China (Urban Area)	1994	M	3.6	6.3	7.5	8.3	9.0	16.9	38.2	**6.5**
		F	6.4	7.1	7.1	7.3	8.6	15.9	32.8	**7.0**
Hong Kong	1994	M	9.5	13.7	12.1	14.2	19.4	39.2	62.7	**13.4**
		F	8.7	9.8	9.5	9.7	19.7	26.0	49.1	**11.3**
Japan	1994	M	12.0	19.8	24.1	35.6	38.9	29.7	55.1	**23.1**
		F	5.1	8.3	8.2	12.0	15.1	19.1	35.2	**10.9**
Korea	1994	M	11.0	15.7	16.5	20.3	22.4	28.6	46.1	**12.8**
		F	5.9	8.1	6.5	7.7	8.5	11.3	18.1	**6.1**
Singapore	1994	M	11.7	14.8	16.0	19.0	17.2	34.4	88.7	**14.0**
		F	10.2	8.4	10.2	9.0	13.9	20.3	56.3	**9.6**
Australia	1993	M	23.7	27.7	21.1	22.9	22.2	22.2	30.9	**18.7**
		F	3.7	5.4	6.5	7.3	5.0	5.8	6.7	**4.5**
New Zealand	1993	M	39.4	29.3	22.2	20.7	15.8	24.8	25.0	**20.5**
		F	5.9	9.7	5.5	7.3	8.6	4.8	3.9	**5.4**
Canada	1993	M	23.8	28.1	28.4	27.9	23.8	23.0	26.9	**21.0**
		F	4.7	5.8	7.9	8.7	6.8	5.5	6.4	**5.4**
Finland	1994	M	45.5	51.2	67.0	58.1	54.5	37.6	60.2	**43.6**
		F	7.8	10.7	18.5	23.6	15.0	11.3	9.3	**11.8**
Hungary	1994	M	20.2	46.4	76.6	91.8	83.9	92.7	178.5	**55.5**
		F	5.2	9.0	18.6	23.3	20.0	26.3	66.2	**16.8**
Norway	1993	M	21.9	25.1	27.4	28.2	20.5	28.1	36.6	**21.1**
		F	6.0	7.5	7.6	6.3	9.6	10.1	9.6	**6.5**
United Kingdom	1994	M	11.5	18.5	17.4	15.4	12.0	10.7	16.2	**11.9**
		F	2.2	3.8	4.0	4.6	4.5	4.3	5.7	**3.3**
USA	1992	M	21.9	24.0	23.7	22.4	24.1	29.9	52.3	**19.6**
		F	3.7	5.0	6.6	7.3	6.5	5.9	6.5	**4.6**

Source: World Health Organization Yearbook 1995, WHO