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The Economic Cost of Bereavement in Scotland

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Aspects of the socioeconomic costs of bereavement in Scotland were estimated using 3 sets of data. Spousal bereavement was associated with increased mortality and longer hospital stays, with additional annual cost of around £20 million. Cost of bereavement coded consultations in primary care was estimated at around £2.0 million annually. In addition, bereaved people were significantly less likely to be employed in the year of and 2 years after bereavement than non-bereaved matched controls, but there were no significant differences in income between bereaved people and matched controls before and after bereavement.
In Scotland in 2012 there were 54,937 deaths (General Register Office Scotland, 2013), and as many as 220,000 people may have been affected by related grief. Scotland has the highest rates of death in younger working age men and women in Western Europe (Whyte & Ajetunmobi, 2012). However, large-scale studies of the impact of bereavement in Scotland have so far been limited to the work of Boyle, Feng, and Raab (2011), who found spousal bereavement was associated with significantly increased mortality. These findings are in line with those from the international literature (e.g., Manor & Eisenbach, 2003).

The link between bereavement and a range of mental and physical health risks, costly to individuals and healthcare providers, is well established (Stroebe, Schut, & Stroebe, 2007). For example, cardiovascular disease, with particularly high incidence in Scotland, may be a risk for bereaved individuals, and there is some evidence of higher risk in early bereavement (Buckley, McKinley, Tofler, & Bartrop, 2010). Circumstances around the death may influence an individual’s well-being in bereavement, and protracted health problems of a dying spouse and caring are significant predictors of limitation in postbereavement activity level for bereaved widow(ers) (Lee & Carr, 2007). One in eight people in Scotland have caring responsibilities, and their well-being and economic activity postbereavement may be severely compromised. Also, bereaved people require significantly more new prescriptions for hypnotics and antidepressants and have more general practitioner (GP) consultations, than nonbereaved people (King et al., 2013). In Scotland, overall antidepressant use is high and may cost up to £29.5 million annually to a statutorily funded National Health Service (NHS: ISD Scotland, 2013).

Overall, the international literature indicates that bereavement leads to greater risk of morbidity and mortality, resulting in higher use and increased costs for individuals and healthcare services (Guldin, Jensen, Zachariae, & Vedsted, 2013). It thus makes sense to try to gauge these health impacts in financial terms in Scotland.

For those bereaved of a partner, the financial impact of the death is highly influenced by circumstances and experiences prior to the death (Corden, Hirst, & Nice, 2008). Low-income families and those dependent on welfare benefits are at particular risk of postbereavement financial difficulties. Scotland has high levels of poverty, with 14% of the population facing relative poverty, and living in households with an income below 60% of the UK median. The average direct cost of dying in the United Kingdom in 2013 was £7,622 (about US$12,500; Sun Life Direct, 2013).

Bereaved people take time off work, both as formal and hidden (other sick or unpaid leave) bereavement leave, and at any one time up to 5% of the working population may be on bereavement-related leave (Wojcik, 2000). In addition, when bereaved employees return to work they may function at a reduced level (Charles-Edwards, 2005). A study carried out in Northern Ireland, limited by its sample size of only 11 parents and only exploring one form of bereavement, suicide of a child, estimated required time off work ranged from 1 to 12 weeks (Gibson, Gallagher, & Jenkins, 2010). Time off work for bereavement is challenging to assess and there is a resultant paucity of research on the socioeconomic impact of bereavement on individuals and businesses, with Scotland no exception in this regard.

We may conclude from the above that there are substantive but as yet unquantified economic implications of bereavement for families, businesses, and statutory sector organizations as employers, as well as for organizations supporting bereaved people, for example, the welfare state, local authority, healthcare services and third-sector organizations. However, a counterargument maintains that the sick population enables economic prosperity based on increased numbers of people employed in caring roles and able to contribute in terms of tax and insurance, and with spending power in the economy (Stack, 2007). In Scotland, increasing numbers of people live to old age and deaths are predicted to rise in the next two decades, so there is growing pressure on healthcare resources, especially as healthcare workforces are not expected to grow accordingly. More information about actual costs of bereavement may enable planning ahead to improve self-management strategies and resilience in communities. In addition, problems of low incomes and poverty persist in Scotland and some clarity about what bereavement means in terms of costs may inform support for employment and sustainability of workforces.

METHOD

The datasets used to analyze health, income, and employment costs were The Scottish Longitudinal Study (SLS); Practice Team Information (PTI), and the British Household Panel Survey (BHPS). The SLS and PTI datasets specifically hold information on Scotland’s residents. BHPS data includes participants resident in other parts of the United Kingdom and, as such, has limitations in specifically addressing the Scottish context. The SLS was used to identify the impact of spousal bereavement on mortality and inpatient days. The sample for the SLS is drawn from the Scottish Census conducted every 10 years, which collects data on all residents in Scotland. The first wave of data collection took place in 1991 and drew a representative sample of 5.3% of the Scottish population based on 20 semirandom...
birthdays (113,878 people). The second wave (2001 Census data) comprised members in 1991 still alive and living in Scotland, new members born after 1991 or who moved into Scotland after 1991, and household members of SLS members in 2001. SLS members were followed over time such that their data from 1991 and 2001 could be linked. The dataset provided extensive information on demography, socioeconomic status, household composition, housing status, ethnicity, and long-term illness, but not income. For this study, SLS members were linked to their death records, spousal deaths records, and the Scottish Morbidity Record 1, which included information on inpatient admissions.

To estimate the impact of spousal bereavement on mortality and hospitalization, only SLS members who were known to be in their first marriage in 1991 were considered. This information is available in Scotland’s Census as participants are asked to categorize a marriage as the first or as a remarriage. The sample included the bereaved group ($n = 15,007$) in which members suffered spousal bereavement in the period of analysis (1991–2009) and the nonbereaved group ($n = 79,703$).

We used a Cox-proportional hazard survival model relating time to death and a range of variables, and a two-part difference-in-differences (DiD) model for inpatient days conditional on survival. In the survival analysis, the average annual inpatient days in the year before bereavement, and long-term illness indicator in the entry year (1991) were the variables used as proxies to control for potential unobserved common factors that influence the health status of both the bereaved individual and their deceased spouse. The DiD analysis controlled for unobserved common factors when estimating hospitalizations. Propensity score matching was used to balance the distribution of confounding factors between bereaved and nonbereaved members. A predicted probability of group membership (e.g., bereaved members and controls) based on observed predictors measured in 1991 was used in all models. This created a nonbereaved group, with hypothetical bereavement dates, comparable with the bereaved group and thus placed greater weight on the longitudinal experience of those in the nonbereaved group who more closely matched characteristics of the bereaved cohort.

For the DiD model a two-stage estimation was used where the first stage estimated the probability of there being any hospitalization within the year, and the second stage estimated the number of inpatient days, only considering those members who had at least one inpatient day. To explore the robustness of the results another two-part model was estimated that allowed for a possible trend for impact postbereavement.

PTI data, broadly representative of the Scottish population in terms of age, gender, deprivation, and urban/rural mix, collected from a sample of Scottish general practices were used to test whether bereavement would result in costs for primary care. It defines face-to-face consultations between patients and practice staff. Consultations for bereavement from 2003/2004 to 2009/2010 were enumerated and descriptive statistics were used to analyze the dataset.

BHPS data was used to test whether bereaved individuals were more likely to visit a GP postbereavement, were more distressed post- than prebereavement, had less income post- than prebereavement, and were less likely to be employed post- than prebereavement.

The BHPS, a UK representative survey, takes place annually with the main objective of increasing understanding of social and economic change at the individual and household level in Britain. The present study focused on the BHPS from 1991 to 2008. However, the number of Scottish households surveyed was too small to yield adequate statistical power; therefore, it was decided to draw on data from across the United Kingdom to inform the study. We looked across households of deceased BHPS participants and assumed all others in the household to be bereaved. Some participants of the BHPS may have experienced bereavement outside the household, which would not have been detected or included in the present analyses. The year of death of a household member (bereavement year) was considered as Time Point 0 (zero) and the evolution of outcomes both before and after bereavement were analyzed.

In 1991, there were 10,264 BHPS participants, and of these 964 became bereaved sometime between 1992 and 2008. Thus, there were 9,300 (potential) participants who did not become bereaved between 1992 and 2008. The overall mean age for bereaved participants taking part in the BHPS in 1991 was 61.10 ($SD = 16.51$).

To measure health and healthcare utilization, variables used were visits to GP, General Health Questionnaire-12 score (GHQ-12; Goldberg & Williams, 1988), and self-reported health (Bierman, Bubolz, Fisher, & Wasson, 1999). Income was measured using household equivalized income, which is household income adjusted by the McClements Equivalence Scale and takes the size and composition of the household into account. As a reference point, the scale uses a couple with no children.

Propensity scoring was used to correct the estimation of the bereavement effects. Propensity score matching summarized prebereavement characteristics (1991) of each participant into a single index variable. The variables included in the propensity score matching were age; gender; average self-reported health in the household in the last 12 months; whether or not they had visited their GP in the last 12 months; whether the household had an individual with higher education; the age of the oldest person in the household; the household equivalized income; and whether or not household members were employed.
In the BHPS sample, this put 4,109 men and 3,619 women in the matched control group for 1991. Their mean age was 58.34 (SD = 18.58).

RESULTS

For the SLS survival analysis, the following variables had significant associations with post- (hypothetical) bereavement duration: the bereavement indicator, age, sex, education, social class, long-term illness indicator, and average inpatient days per year prior to bereavement (Table 1). The bereaved group had an 18.2% higher mortality rate than the nonbereaved group. Those reporting long-term illness prior to bereavement had 35.4% higher mortality rate than those not, and the mortality rate increased by 0.5% when the average annual inpatient days prior to bereavement increased by one. In addition, the results of the two-part model showed that even for those who did survive, bereavement increased the probability of hospitalisation and the length of stay in hospital increased by 0.1 days per annum (Table 2). Taking the decay of bereavement impact into consideration, hospitalization slightly reduced over time to 0.078 of a day.

The average inpatient days were 0.34 and 0.16 for bereaved and non-bereaved SLS members, respectively. The cost of an average inpatient day (excluding long stay) in Scotland in 2011/2012 is estimated to be £561.63 per day. Thus, the total extra cost of inpatient days required for a bereaved person over a non bereaved person with similar characteristics approximates to between £43.80 and £62.90 per year. According to Scotland’s Census in 2011, the total resident population aged 16 years old or more was 4,089,946 and 9.06% of this population was widowed. Thus, the total extra cost of inpatient days required for bereaved spouses over nonbereaved spouses was estimated to be about £16,230,051 to £23,307,539 (in the United States, about $26.6 million to $38.3 million) per year.

Estimated cost of GP consultations for bereavement from the period 2009/2010, based on the PCT, was £2,030,720 (63,460 GP/practice nurse consultations £32.00) (about US$ 3.3 million). Thus, GP consultations explicitly made for bereavement account for an extremely small part of overall spending on general medical services in Scotland (i.e., 0.3%; £2.0 M ÷ £741 M × 100).

BHPS data showed bereaved people were significantly less likely to visit their GP, relative to the nonbereaved matched controls, at 5 to 4 years prebereavement (p = .013). The bereaved group reported significantly worse health 2 years prebereavement (p = .001), 1 year prebereavement (p < .05), in the year of the bereavement (p < .001), and in the year after bereavement (p = .001) compared to the nonbereaved matched controls. In the 10 to 16 years postbereavement, bereaved people also reported significantly higher GHQ-12 scores indicating more distress relative to nonbereaved matched controls (p < .05). In addition, bereaved people recorded significantly better self-reported health (i.e., for the last 12 months) in both the 17- to 10-year prebereavement period (p < .001) and the 9- to 6-year prebereavement period (p < .001) compared with nonbereaved matched controls. Bereaved people also had a significantly higher household equivalized income in the period 10 to 16 years postbereavement (p < .05) than nonbereaved matched controls. In terms of employment, when compared with nonbereaved matched controls bereaved individuals were significantly less likely to be in work during the year of bereavement (p < .05) and 2 years postbereavement (p < .05).

DISCUSSION

Innovative methods were developed and used in this study to create comparison groups from within the datasets, of nonbereaved individuals closely matched with bereaved individuals. The identification strategy,
difference-in-differences, was successfully employed to compare inpatient hospital utilization of the bereaved group with the nonbereaved group before and after the occurrence of spousal bereavement. The one-to-one propensity score matching approach estimated a propensity score with individual characteristics and matched a nonbereaved individual with a bereaved individual if they had identical or similar propensity scores. This enabled generation of hypothetical bereavement dates for those who were in the nonbereaved group and gave added weight to individuals more closely related characteristically to bereaved persons, with whom comparisons were generated.

Apart from investigating the impact of spousal bereavement on inpatient hospital utilization, the impact on mortality was also a concern in this study. The Cox-proportional hazard analysis was successfully used to estimate the impact on mortality controlling for the unobserved common mortality factors within a couple with the proxy variables, the indicators of long-term illness in the entry year (1991) and average inpatient days per year before (hypothetical) bereavement. A further strength in our methods of analysis, for SLS looking at spousal bereavement, was in the ability to reduce contamination by excluding any member who had been widowed from a previous marriage. These methods may be adaptable to other studies using large national datasets to explore health outcomes.

Present results indicate that spousal bereavement significantly impacts hospital inpatient days and adds to the cost for healthcare services by between £16.2 million (about US$26.6 million) and £23.3 million (about US$38.3 million) per year. Further, bereavement impact on inpatient days does not diminish but instead increases over time. Length of stay doubled after the loss and stayed elevated with only slight reduction up to 2 years postloss. Guldin et al. (2013), in their Danish population study, also found people who were bereaved of their spouse due to cancer were at greater risk of general or psychiatric hospitalization in the year postbereavement than nonbereaved matched controls. That people who are bereaved of their spouse remain in hospital longer than nonbereaved counterparts, as our study shows, may indicate difficulties associated with complex health and social care needs and living alone (Ou et al., 2009).

The small increase in hospitalization over time for bereaved individuals identified in the SLS analysis, may be further explained by a lagged effect from bereavement through mental health problems to medical utilization. After bereavement, a small but significant minority of bereaved individuals demonstrate long-term mental health difficulties, with some who have low levels of depression before the loss going on to develop higher levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013). A further trajectory that may also provide explanation, identifies a small number with depression before a loss continuing to have lower levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013). A further trajectory that may also provide explanation, identifies a small number with depression before a loss continuing to have lower levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013). A further trajectory that may also provide explanation, identifies a small number with depression before a loss continuing to have lower levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013). A further trajectory that may also provide explanation, identifies a small number with depression before a loss continuing to have lower levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013). A further trajectory that may also provide explanation, identifies a small number with depression before a loss continuing to have lower levels from 6 to 18 months postloss (Boerner, Mancini, & Bonanno, 2013).

| Constant bereavement impact | Decaying bereavement impact |
|-----------------------------|-----------------------------|
| **Group** | **Average inpatient days per bereaved per year (95% confidence interval)** | **Group** | **Average inpatient days per person per year (95% confidence interval)** |
| Bereaved group (Sample size: 15,007 members) | 0.3384 (0.3375 ~ 0.3395) | Bereaved group (Sample size: 15,007 members) | 0.3394 (0.338 ~ 0.34) |
| Non-bereaved group (Sample size: 79,703 members) | 0.1638 (0.1636 ~ 0.1641) | Non-bereaved group (Sample size: 79,703 members) | 0.1636 (0.1633 ~ 0.1638) |
| Increase in inpatient days required for bereavement | 0.1114 (0.110 ~ 0.113) | Increase in inpatient days required for bereavement | 0.0781 (0.077 ~ 0.079) |
The PTI data show a strikingly low prevalence of GP consultations explicitly related to bereavement. The contrast to the secondary care findings is highlighted when this is translated into an annual economic cost of about £2.0 million (about US$3.3 million) per year for NHS Scotland. Clearly, one explanation for this rather counterintuitive finding is that the impact of bereavement may be a causative factor in many GP visits that is not recorded explicitly as bereavement-related. In addition, a controlled trial of an information intervention for GPs and bereaved individuals indicates difficulties in making diagnoses of depression and complicated grief that may compromise appropriate support provision (Guldin et al., 2013). GPs and community nurses view bereavement care as an important and satisfying aspect of their job. However, they feel underprepared and practice varies markedly across services (Nagraj & Barclay, 2011). Accordingly, the true cost of bereavement in terms of consultations at Scottish GP practices may be more substantial.

Results of the SLS analysis appear to suggest larger costs in terms of healthcare utilization continuing to occur as years since bereavement increase. However, findings from BHPS comparing utilization in a matched control group revealed that from 4 years prebereavement onward there were no significant differences in terms of whether each group visited their GP. We suggest that for general practice, bereavements are not noted by the patient or GP as the reason for contact. However, people may access services in other ways, for example, as existing patients in mental health services and be reflected in the SLS results.

Turning now to the BHPS data as a whole, one of its potential strengths was coverage of all three areas (health, income, and employment), and our ability to compare trends preceding and following death in a bereaved and matched control group. However, the 17-year longitudinal window that this opened up did not reveal many definitive patterns that distinguished these groups.

Our present findings contrast with those of Corden et al. (2008) who identified poorer economic status for widowed people, particularly older women, in the years postloss. It may be labor market effects and changes in the economy that are reflected in income changes for our bereaved persons rather than demographic changes (Jenkins, Vignoles, Wolf, & Galindo-Rueda, 2010). Changes in later years may be driven by bereaved widow(er)s accessing both partners’ pension payments when they reach retirement age, leading to higher equalized income for the single person household. There may also be a latent effect as more of the bereaved persons in BHPS start to reach retirement age. However, this is an average result so while some bereaved people may be better off, perhaps those whose spouse died at a younger age may have accumulated less pension contributions and be poorer. The present study is limited by its use of secondary data not collected specifically for analysis of postbereavement effects.

Considering care and surveillance of bereaved people, it is worth noting lower socioeconomic status has been found to be consistent with higher risk of mortality across age groups (Martikainen & Valkonen, 1998). We recommend increasing the awareness of bereaved individuals and health and social care professionals enabling early recognition of developing problems that may benefit from professional help or more general social support. Similar progress in research is needed to capture the true impact in primary care, where we believe we are only seeing a small proportion in relation to bereavement effects. Systems for collection of appropriate data to facilitate accurate estimation of costs and planning of services should therefore be developed.
Further, a limitation of the present results is that we focused on one country, Scotland. We invite readers in other countries, with different systems for the administration of health and social care services, to consider where costs of bereavement fall.

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