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ORIGINAL ARTICLE

Family support and dementia screening participation among older adults: Evidence from a South Korea fact-finding survey on the status of older adults

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Abstract

Objectives: South Korea is one of the most rapidly aging societies worldwide and the prevalence of dementia is expected to rise to 10.3% by 2025. Early diagnosis requires early access to support, information, and medication. Dementia screening is important for the success of dementia-related healthcare programs. We investigated the rate of participation in dementia screening and the relationship with family support.

Methods: We used data from the 2020 "South Korea fact-finding survey on status of older adults," a cross-sectional survey targeting adults aged ≥65 years. A total of 9558 respondents were analyzed. We used multivariable logistic regression to analyze the associations between sociodemographic characteristics, including family support, and dementia screening participation.

Results: A total of 62.2% participants received emotional support from their family, and 20.6% received physical support with cleaning, meal preparation, and laundry, general care, nursing, and traveling to the hospital. Of the respondents, 41.8% had participated in dementia screening during the previous 2 years. Older adults with emotional support (OR = 1.41, 95% CI, 1.28–1.54) and physical support (OR = 1.46, 95% CI, 1.31–1.62) were more likely to undergo dementia screening than those without such support. Age, annual household income, education, reason for working, drinking status, exercise, emotional support, and physical support were significantly associated with dementia screening in older adults.

Conclusions: Older adults with low emotional or physical support from family should be considered a vulnerable population with respect to non-participation in dementia screening. Therefore, policies targeting these high-risk groups are needed to increase the dementia screening rate.

KEYWORDS
dementia screening, family support, older adults

1 | INTRODUCTION

South Korea is one of the most rapidly aging societies worldwide, and it is predicted to become a super-aged society by 2025.[1] People aged 65 years or older will account for an estimated 20.5% of the total population by 2025. Many potential economic and social challenges arise from South Korea's unparalleled rate of population aging.[2] Dementia is now the seventh leading cause of mortality globally and one of those with the highest cost to society.[3] Europe and the United States have reported a stable or decreasing prevalence of dementia, whereas the prevalence in South Korea is expected to rise to 10.3% (1.07 million patients) in 2025 and 15.9% (3.2 million patients) in 2050.[4] The cost of dementia management in South Korea will increase to approximately $27.2 billion in 2030 and $83.2 billion in 2050.[4] Dementia leads to an increase in the need for nursing care, suffering, and distress experienced by the patient, the burden on the family members, and significant economic burden on the healthcare system. Early detection of dementia is thus a key public health imperative of the world.[5]

Delays in diagnosing dementia may lead to suboptimal care.[6,7] Estimates of dementia prevalence compared with numbers of known cases suggest that in developed countries, approximately half of the people with dementia are not diagnosed and cannot access the treatment and support that may help them and their caregivers.[8] Dementia screening facilitates timely diagnosis, optimal medical management, and prompt access to healthcare services.[9] A lack of support, stigma, and financial constraints among patients and caregivers are barriers to early diagnosis of dementia.[10]

For early diagnosis of dementia, the UK government implemented "active case finding," which aimed to achieve a 66% dementia diagnosis rate by 2015.[8] In Japan, the Comprehensive Strategy for the Promotion of Dementia Measures was adopted in 2015, and dementia screening has been introduced in several local governments.[11]

In South Korea, the government enacted the Dementia Management Act in 2011. The purpose of this act is to mitigate the personal suffering from dementia and the burden to society, and to contribute to enhancing national health by establishing and implementing a comprehensive policy on dementia prevention, medical treatment and nursing for dementia patients, and research for dementia eradication. A national dementia screening program was implemented to protect and support dementia patients; it is conducted every 2 years for those aged ≥60 years using the Cognitive Impairment Screening Test. In addition, the Korean Dementia Screening Questionnaire-Cognition is provided for those aged ≥66 years, based on the Framework Act on Health Examinations (Ministry of Government Legislation, Framework Act on Health Examinations; Ministry of Government Legislation, Implementation Criteria of Health Examinations). Organized screening services using both the Cognitive Impairment Screening Test and Korean Dementia Screening Questionnaire-Cognition are provided free of charge. Individuals older than the screening age can choose any government screening program. In addition, all individuals can take an optional screening program for dementia.

Several determinants of dementia screening acceptance have been reported including sex,[12–14] perception of health status,[14] and education and belief in prevention options for dementia.[13] Previous studies suggest that the very elderly, men, and those living alone may be at particular risk of missed diagnosis.[8] Previous studies have reported an association between cancer screening and family support; however, little attention has focused on the association between dementia screening and family support. Older adults with/without dementia need help from their spouse or adult children,[15] and family support affects dementia screening participation. Therefore, we investigated the association between dementia screening and emotional support and physical support from family.[16]

2 | METHODS

2.1 | Data source

We analyzed cross-sectional data, from the fact-finding survey on the status of older adults conducted by the Welfare of Senior Citizens Act in South Korea. The survey has been conducted every 3 years since 2008 by the Ministry of Health and Welfare (Ministry of Government Legislation, Welfare of Senior Citizens Act), targeting 400 adults aged ≥65 years who were residents in each of 17 cities and provinces in South Korea. To prevent the spread of COVID-19, the 2020 survey was conducted using the Tablet-PC Assisted Personal Interview method, while complying with social distancing and quarantine guidelines. The survey period was from September 14, 2020 to November 20, 2020.[17]

2.2 | Ethical considerations

The study design and contents of the survey were approved by Statistics South Korea (no. 117071) and also by the South Korea Institute for Health and Social Affairs IRB (no. 2020-36). These public data are provided free and are available through the Microdata Integrated Service portal operated by Statistics South Korea.

2.3 | Study participants

A total of 10,097 participants completed the survey in 2020. Proxy respondents (177), those medically diagnosed with dementia (189), or those with missing response data (173) were excluded from the analysis. Finally, 9558 study participants were included in the analysis.

2.4 | Dependent variable

Participants were asked "Did you undergo screening for dementia in the last 2 years?" with a response of yes or no. Individuals who responded yes were categorized as having dementia.

2.5 | Independent variable

The independent variable of interest was emotional and physical support from family, determined by whether they received emotional or physical help from their spouse, child, or parents. Physical support[16] was assessed by asking whether participants received help with cleaning, meal preparation, laundry, general care, nursing, or traveling to the hospital within the last year. Emotional support[18] was assessed by asking whether the participants received help with counseling about their concerns. Emotional or physical support was categorized as receiving abundant help, moderate help, little help, or no help within the last year. These categories were divided into receiving abundant or moderate help and receiving little or no help.

In addition to these variables, sociodemographic characteristics were included as covariates. Annual household income was categorized into three groups: <$8700, $8700–$29,000, and >$29,000. An annual household income of $8700 is the standard for livelihood benefits for two-person households under the National Basic Living Security Act, Articles 6 and 8. An annual household income of $29,000 is the standard median income for two-person households under this act.[18] Education was divided into uneducated (illiterate) or uneducated or elementary school graduates, and junior high school graduates, high school graduates, college graduates, university graduates, or greater.

The reason for doing one's current job was classified as follows: earn money, earn pocket money, maintain health, form social relationships, demonstrate ability, spending time, contributing to society, others, or unemployed. In this study, these were classified into three categories: unemployed was labeled "not working," earn money and earn pocket money were labeled "for money," and all other categories were labeled "for social relationships." Smoking status was divided into current smokers and current non-smokers. Drinking status was divided into non-drinkers (those who did not drink alcohol at all during the past year) and current drinkers (those who drank alcohol more than once during the past year). Exercise activity was divided into those who usually exercise ("yes") and those who do not usually exercise ("no"). Subjective health status was measured on a five-point scale: very healthy, healthy, moderately healthy, unhealthy, and very unhealthy. In this study, these were classified into three categories: very healthy and healthy were labeled "high," moderately healthy was labeled "middle," and unhealthy and very unhealthy were labeled "low."

2.6 | Statistical analyses

The frequencies and percentages of the study participants in each group were calculated. Chi-square analysis was used to determine the association between undergoing dementia screening and other variables. A multivariable logistic regression model was used to analyze the association between dementia screening and emotional and physical support from family after adjusting for covariates.

Goodness-of-fit was assessed using the Hosmer and Lemeshow test; the result was $p > 0.5$. Before performing the regression analysis, multicollinearity among variables was assessed using the variance inflation factor (VIF). A variable with a VIF >10 indicates potential collinearity of that variable with other variables in the model. The VIF values in this study were 1.047–1.491. All analyses were performed using SAS version 9.4 (SAS Institute Inc., Cary, NC).

3 | RESULTS

Of the 9558 participants, 59.6% were women, and 39.1% were aged ≥75 years. A total of 62.2% participants received emotional support from their family, and 20.6% received physical support with cleaning, meal preparation, and laundry, general care, nursing, and traveling to the hospital. Over half of the respondents (56.0%) were junior high school graduates or greater, and 10.9% were current smokers (Table 1).

Table 2 shows the dementia screening rate according to demographic and socioeconomic characteristics, health behavior, and support from family. Over the previous 2 years, 41.8% of respondents had participated in dementia screening. The screening rate for 65 to 74-year-olds was 36.5%. Non-drinkers were likely to have a higher screening rate compared with current drinkers. Participants who exercised were significantly more likely to accept dementia screening than those who did not exercise. Participants with emotional or physical support from family were significantly more likely to accept dementia screening than those without support.

As shown in Table 3, the older adults with emotional support were significantly more likely to undergo dementia screening than those without emotional support (OR = 1.406, 95% CI, 1.283–1.541). Participants with physical support were significantly more likely to undergo dementia screening than were those without physical support (OR = 1.456, 95% CI, 1.307–1.621). Participants aged ≥75 years were more likely to have dementia screening compared with those aged 65–74 years (OR = 1.665, 95% CI, 1.507–1.840). Participants with an annual household income of >$29,000 were more likely to undergo dementia screening than were those with an annual household income of <$8700 (OR = 1.211, 95% CI, 1.067–1.374). The older adults who did not work were significantly less likely to undergo dementia screening than were those working to make social relationships (OR = 1.309, 95% CI, 1.098–1.560). Low education is positively associated with dementia screening (OR = 1.296, 95% CI, 1.174–1.431). Age, annual household income, education, reason for working, drinking status, exercise, emotional support, and physical support were significantly associated with dementia screening in older adults.

4 | DISCUSSION

This study found that 41.8% of participants had undergone dementia screening in the last 2 years. This screening rate is lower than the rates of 81%[19] and 49%[12] reported in the USA. Undetected dementia is an important clinical and public health problem. From a policy perspective, there has been longstanding emphasis on earlier, more timely

TABLE 1 General characteristics of the participants ($n = 9558$).

Variable	*n*	%
Sex		
Men	3860	40.4
Women	5698	59.6
Age (years)		
65–74	5817	60.9
≥75	3741	39.1
Marital status		
Never married, Separated, Divorced, Widowed	3772	39.5
Currently married	5786	60.5
Annual household income (USD)		
<8700	2787	29.2
8700–29,000	4525	47.3
≥29,000	2246	23.5
Education		
≥ Junior high school graduate	5355	56.0
< Junior high school graduate	4203	44.0
Reason for working		
Unemployed	5883	61.6
To make social relationships	616	6.4
To earn money	3059	32.0
Smoking status		
Current smoker	1041	10.9
Current non-smoker	8517	89.1
Drinking status		
Current drinker	3586	37.5
Non-drinker	5972	62.5
Exercise		
No	4518	47.3
Yes	5040	52.7
Subjective health status		
High	4842	50.7
Middle	3007	31.4
Low	1709	17.9
Emotional support		
No	3610	37.8
Yes	5948	62.2
Physical support		
No	7592	79.4
Yes	1966	20.6

diagnosis to allow people with dementia and their families the option to undertake future shared decision making.[19,20] Policies targeting high-risk groups are needed to increase the dementia screening rate.

Participants aged ≥75 years were more likely to be screened for dementia than those aged 65–74 years. Similarly, in another study, older age participants were more likely to be examined for dementia.[14] The older they are, the more likely they are to fear dementia and undergo screening.[21–24] Though not statistically significant, we found that women were more likely than men to be screened for dementia. This is consistent with studies showing that women undergo more frequent cancer screening[25] and general health screening[26] than men. Respondents with a higher household income were more likely to undergo dementia screening.[26,27]

People with a lower education level were more likely to be screened for dementia. Education level was inversely associated with the probability of receiving a diagnosis of dementia.[13] The effect of literacy on cognitive performance is greater than that of the number of years of education.[28]

Our results showed that emotional and physical support from family was significantly and positively associated with dementia screening. Previous research on the relationship between family support and health-related behaviors has reported similar results.[29] People with perceived low family support were more likely to delay an activity that requires planning, such as colorectal cancer screening. People with infrequent contact with friends and family were less likely to participate in breast and cervical cancer screening.[30,31]

The finding of a significant association between dementia screening participation and family support can be explained by the fact that it is easier to detect early signs of dementia in older adults who have family support.[32] People tend to be screened for cognitive impairment if family members express concerns about changes in their memory or thinking.[33]

Dementia screening would facilitate successful implementation of dementia-related healthcare programs. Any strategy for dementia screening should be informed by the characteristics of the undiagnosed population.[8,34] Families are seldom substantively considered in policy and program development, implementation, and evaluation.[35] Policymakers should consider the importance of the family's emotional and physical support and identify target groups.[12]

4.1 | Strengths and limitations

This study had some limitations. First, we did not consider all possible confounding factors such as individual psychological factors.[9] Second, these are cross-sectional survey data, and thus causality cannot be inferred. Third, because the survey was conducted during the COVID-19 pandemic, social distancing may have affected family support and screening participation rates. However, there were also strengths to this study. The analyses used representative survey data from older adults in South Korea. In particular, it is important to confirm the association between dementia screening and family support in South Korean society, which values family ties and has a Confucian social culture. The findings provide formative data to design interventions to encourage participation of the older population in dementia screening in South Korea.

TABLE 2 Dementia screening rate according to general characteristics ($n = 9558$).

Variables	Dementia screening (Yes)		Dementia screening (No)		*P*-value
	n	%	*n*	%	
Total	3998	41.8	5560	58.2	
Sex					0.001
Men	1534	39.7	2326	60.3	
Women	2464	43.2	3234	56.8	
Age (years)					<0.000
65–74	2121	36.5	3696	63.5	
≥75	1877	50.2	1864	49.8	
Marital status					<0.000
Never married, Separated, Divorced, Widowed	1700	45.1	2072	54.9	
Currently married	2298	39.7	3488	60.3	
Annual household income (USD)					0.725
<8700	1179	42.3	1608	57.7	
8700–29,000	1894	41.9	2631	58.1	
≥29,000	925	41.2	1321	58.8	
Education					<0.000
≥Junior high school graduate	2004	37.4	3351	62.6	
<Junior high school graduate	1994	47.4	2209	52.6	
Reason for working					0.053
Unemployed	2490	42.3	3393	57.7	
To make social relationships	276	44.8	340	55.2	
To earn money	1232	40.3	1827	59.7	
Smoking status					0.135
Current smoker	413	39.7	628	60.3	
Current non-smoker	3585	42.1	4932	57.9	
Drinking status					<0.000
Current drinker	1353	37.7	2233	62.3	
Non-drinker	2645	44.3	3327	55.7	
Exercise					<0.000
No	1762	39.0	2756	61.0	
Yes	2236	44.4	2804	55.6	
Subjective health status					0.002
High	1948	40.2	2894	59.8	
Middle	1284	42.7	1723	57.3	
Low	766	44.8	943	55.2	
Emotional support					<0.000
No	1263	35.0	2347	65.0	
Yes	2735	46.0	3213	54.0	
Physical support					<0.000
No	2969	39.1	4623	60.9	
Yes	1029	52.3	937	47.7	

5 | CONCLUSIONS

This study analyzed national representative data from South Korea and showed that emotional or physical support from family were significantly and positively associated with dementia screening. These findings reinforce the importance of family support in the promotion of dementia screening among older adults in South Korean. In addition, we suggest that interventions and activities for

TABLE 3 Odds ratios of dementia screening.

Variables	OR	95% CI
Sex		
Men	1.000	Reference
Women	1.040	0.937–1.154
Age (years)		
65–74	1.000	Reference
≥75	1.665	1.507–1.840
Marital status		
Never married, Separated, Divorced, Widowed	1.000	Reference
Currently married	0.965	0.876–1.064
Annual household income (USD)		
<8700	1.000	Reference
8700–29,000	1.161	1.044–1.290
≥29,000	1.211	1.067–1.374
Education		
≥Junior high school graduate	1.000	Reference
<Junior high school graduate	1.296	1.174–1.431
Reason for working		
Unemployed	1.000	Reference
To make social relationships	1.309	1.098–1.560
To earn money	1.108	1.005–1.223
Smoking status		
Current smoker	1.000	Reference
Current non-smoker	0.894	0.772–1.035
Drinking status		
Current drinker	1.000	Reference
Non-drinker	1.212	1.099–1.336
Exercise		
No	1.000	Reference
Yes	1.352	1.241–1.473
Subjective health status		
High	1.000	Reference
Middle	0.968	0.877–1.068
Low	0.956	0.845–1.081
Emotional support		
No	1.000	Reference
Yes	1.406	1.283–1.541
Physical support		
No	1.000	Reference
Yes	1.456	1.307–1.621

older adults with low levels of family support will improve dementia screening.

AUTHOR CONTRIBUTIONS

Conceptualization: All authors. *Formal analysis*: Jieun Kim. *Project administration*: Hooyeon Lee. *Supervision*: Hooyeon Lee. *Visualization*: Jieun Kim. *Writing-original draft*: Jieun Kim. *Writing-review and editing*: All authors.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interests.

ETHICS STATEMENT

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