

## SUICIDE

Suicide is often considered as an extreme manifestation of depression and of poor quality of life. Because of its extreme nature, suicide can be viewed as the tip of an iceberg, with inter-temporal changes in rates of suicide, and differences between countries, giving an indicator of the extent of broader problems of depressive illness.

### Definition

Data on suicide rates are based on official registers on causes of death based on international conventions surrounding the International Statistical Classification of Diseases and Related Health Problems (ICD). The rates shown here are standardised using the OECD population structure of 1980, so as to allow controlling for differences in the age structure of the population across countries and over time. Suicide rates are expressed as deaths per 100 000 individuals.

### Overview

Overall, suicide rates increased in the 1970s and peaked at the beginning of the 1980s. However, Japan and Ireland do not share this pattern. In Japan, suicide rates are today somewhat lower than in 1960, but have remained at relatively high levels (around 20 deaths per 100 000 persons) since 1997. Ireland shows a strong and continuous increase of suicide rates until 2000, followed by a small but continuous decline since then.

Suicide rates have fallen for both men and women, with little changes in the gender gap. Suicide continues to be a predominantly male phenomenon. On average, for each female suicide there are about 3 male deaths. Gender gaps are larger in Mexico, Poland and the Slovak Republic and smaller in Korea, the Netherlands and Norway. Gender gaps in suicide rates are also smaller for younger cohorts.

Across OECD countries, suicide rates show no systematic relation with GDP per capita, while there is a weak negative correlation between suicide rates and subjective life-evaluations (as shown under “Subjective well-being”).

### Comparability

Despite the ICD, there are comparability problems with suicide data. Countries have different procedures for recording suicide as the underlying cause of death, and these procedures may have changed over time. In addition suicide may be under-reported because of a societal stigma attached to it. This socio-cultural norm may vary across countries and over time.

Studies assessing the reliability of suicide statistics suggest that sources of error are random. Thus they have little impact on comparing rates between countries, between demographic groups or over time (Sainsbury and Jenkins, 1982).

The data on life satisfaction are based on the Gallup World Survey. Regarding the comparability of these data, please see “Subjective well-being”.

### Sources

- OECD (2007), *Health at a Glance 2007: OECD Indicators*, OECD, Paris.
- Gallup World Survey.
- OECD (2008), *National Accounts of OECD Countries*, OECD, Paris.

### Further information

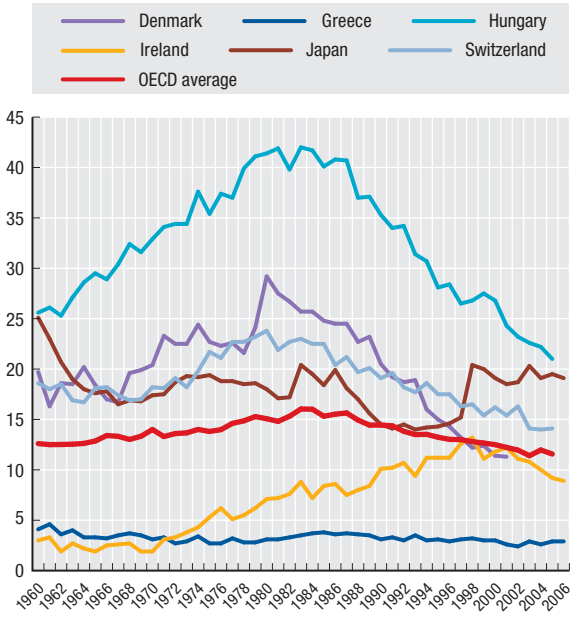
#### Analytical publications

- Sainsbury P. and J.S. Jenkins (1982), “The accuracy of officially reported suicide statistics for purposes of epidemiological research”, *Journal of Epidemiology and Community Health*, 36: 43-48.



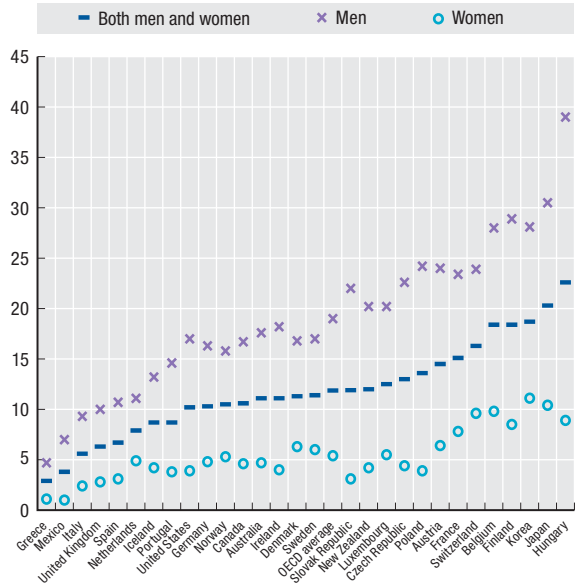
### Suicide rates

Per 100 000 persons



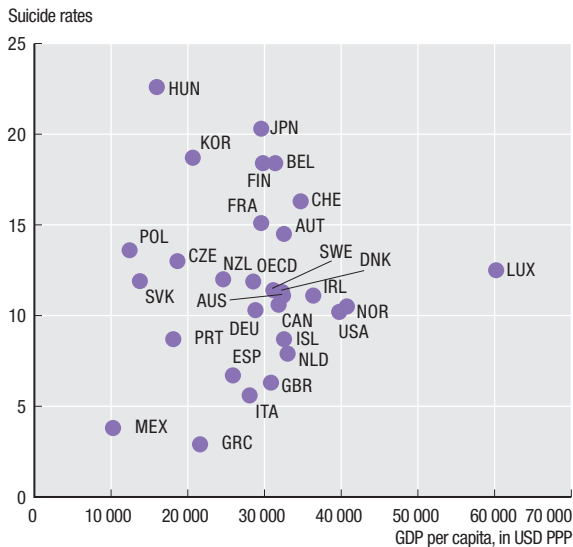
### Suicide rates by gender

Per 100 000 persons, 2004 or latest available year



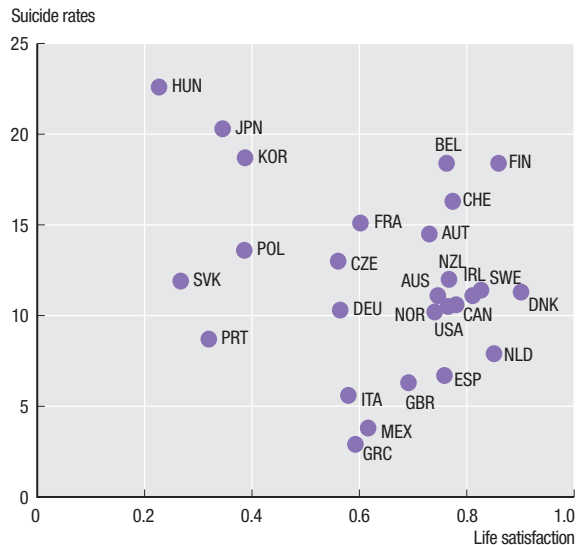
### Suicide rates and per capita GDP

2004 or latest available year

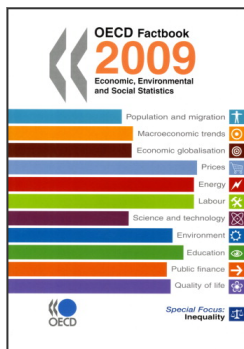


### Suicides rates and subjective life satisfaction

Suicides rates (2004 or latest available year) and life satisfaction (2008 or latest available year)



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