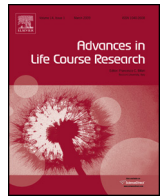




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Are leisure activity and health interconnected after retirement: Educational differences

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ABSTRACT

Objectives: Retirement is a critical life event accompanied by profound changes in life circumstances to which people have to actively adapt. Two important dimensions for the success of adjustment are health and activity. Therefore, we examined developments of physical health and leisure activity over the first 12-years of retirement and their bi-directional interconnections. In this study, we questioned whether all retirees have the same chances for successful aging.

Methods: We used longitudinal data of the German Ageing Survey (DEAS) and identified 2897 retirees. We estimated a bivariate dual change score model simultaneously for retirees who have more and retirees who have less education. Physical health was assessed via the number of self-reported chronic conditions and leisure activity via the number of hobbies engaged in at least monthly.

Results: At the transition into retirement, retirees with less education showed a slightly lower level in health and a distinctly lower level in leisure activity than retirees with more education. These mean level differences persisted over 12 years since an increase of educational difference was neither found for leisure activities nor for physical health. Furthermore, level of activity did not predict changes in physical health. Additionally, only retirees who had less education were sensitive to their levels of health. For those, worse health predicted a reduction in leisure activity.

Discussion: Illness seem to limit leisure activities only for less educated individuals. We discussed these findings under a cumulative inequality perspective. Retirees who have less education are double-jeopardized. They report not only lower levels in health and activity, they are also dependent in their activity on their physical health status. This shows that people have unequal chances for successful aging in retirement.

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1. Introduction

Retirement is a critical life event accompanied by profound changes in life circumstances. The newly retired need to develop new daily activity routines that fulfil their basic needs to be socially integrated and respected (van Solinge & Henkens, 2008). Being active is, on the one hand, beneficial for psychological well-being and health in later life (cf. Adams, Leibbrandt, & Moon, 2011; Huxhold, Fiori, & Windsor, 2013; Rowe & Kahn, 1997). Accordingly, “active aging” in retirement has become a policy target in the European Union (van Dyk, Lessenich, Denninger, & Richter, 2013). On the other hand, previous research has also shown that health affects the development of different kinds of activity, and thereby

active aging (e.g. Anand et al., 2015; Everard, Lach, Fisher, & Baum, 2000; Huxhold et al., 2013; Lennartsson & Silverstein, 2001; Verbrugge & Liu, 2014). Accordingly, health and activity, these two resources for “successful aging” (Rowe & Kahn, 1997), seem to have an intertwined connection and are by no means orthogonal. However, only a few studies to date have included both directions of influence in one analysis. This might be the case because only longitudinal designs are able to dissociate whether these constructs are recursively interconnected (e.g., health influences the level of activities and vice versa) or whether there is only a one-directional relationship between the two (i.e., either health deficits limiting activity or only high levels of activity improving health). The current study fills in this gap and explores the interdependencies of health and activity in the first years after retirement transition.

This study further extends existing knowledge on the interrelation of activities and health in retirement by applying a social inequality perspective. Successful aging has been criticized to follow an “individualistic culture” in which success (and hence

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failure) depends on the individual only (Katz 2015). This would imply that all people have equal chances and risks to (re)structure (in particular after transitioning into retirement) their life in an individually favorable way. In the current study, we question this assertion. We assume that social structure matters in the process of successful aging in general (Dannefer, 1984) and in retirement adjustment in particular. Previous research has shown that older adults with more education are more active (Erlinghagen, 2010; Scherger, Nazroo, & Higgs, 2011; Verbrugge & Liu, 2014) and also healthier (Cullati, Rousseaux, Gabadinho, Courvoisier, & Burton-Jeangros, 2014; Leopold & Engelhardt, 2013; Ross & Mirowsky, 2003; Schöllgen, Huxhold, & Schmiedek, 2012) than older adults with less education. However, education may not only affect levels of health and activity but also their interconnection. To our knowledge, the bi-directional interconnection of health and activity has not yet been investigated from a socially stratified perspective.

The current study examines developments in health and in leisure activity as well as their interconnection after the transition into retirement. Since retirement marks the transition into later life, analyses of this critical adjustment process also contribute to a deeper understanding of successful aging in general. People, who handle their retirement adjustment well, will have better chances of aging well. The adjustment process, however, may be affected in two ways by education. First, retirees with more education may have better access to resources (i.e., they differ in terms of health and activity levels). Second, retirees of different educational classes may differ in the use of resources. This may imply that cross-domain interconnections (i.e., health influencing activities or activities influencing health) differ in accordance with educational class.

2. Theoretical background

2.1. Health and leisure activity in retirement

Two important resources for retirement adjustment are health and leisure activity. Proponents of the dynamic resource investment perspective on retirement argue that both resources are recurrently invested in a dynamic adjustment process to create a new way of living in retirement (cf. Wang, 2012; Wang, Henkens, & van Solinge, 2011).

Health is a particularly important resource since poor health limits mobility and produces stress (Gallo & Matthews, 2003). How retirement affects health is, however, largely unclear. Even though this is a topic that receives much attention in retirement research, “whether retirement affects physical health remains fundamentally unanswered” (Gallo, 2013, p. 326). Studies found no significant effect of retirement on physical health (e.g., Ekerdt, Baden, Bossé, & Dibbs, 1983), showed that the transition was associated with a decline in health (e.g., Behncke, 2009), and also found that retirement improved health (e.g., Mein, Martikainen, Hemingway, Stansfeld, & Marmot, 2003). The most recent studies underline the dynamic nature of the health changes due to retirement. They found a short-term health improvement (mostly for lower SES groups) which seemed to be followed by a long-term health decline (e.g. Jokela et al., 2010; Westerlund et al., 2009).

Leisure activity is also important at retirement since it provides social interactions and stimulation (Huxhold et al., 2013; Ormel, Lindenberg, Steverink, & Verbrugge, 1999). Leisure activity represents voluntary daily routines, which structure life temporally and locally. Even though they are done solely for their own sake, they add meaning and provide intrinsic satisfaction. Accordingly, we assume that leisure activity can serve as a proxy for a more general social engagement. Empirical evidence of how retirement affects activity is heterogeneous. Studies found that

retirement has no influence on non-sports-related leisure activities (e.g. Diehl and Berg, 2006; Slingerland et al., 2007). Other studies found positive effects of retirement for active engagement (e.g. Henkens, van Solinge, & Gallo, 2008; Scherger et al., 2011). And even though Erlinghagen (2010) found a minor increase in volunteering with retirement, he considered it to be less important than the experience of volunteering prior to retirement.

So far, little is known about how health and leisure activity interact in retirement. Huxhold et al. (2013) have shown for elderly that high levels of social leisure activity predicted subsequent development in life satisfaction and health. The interconnection between health and activity depends, however, critically on the specific health facet. Their results suggested that high levels of social leisure activities were beneficial for the development of functional health (i.e., showing less functional impairments over time) in those aged 65 and older. Physical health (i.e., the number of illnesses), in contrast, limited the maintenance of a high level of activities in the same group (cf. Anand et al., 2015). In a similar vein, Verbrugge and Liu (2014) showed that functional health affects various activities differentially. Whereas higher levels of functional impairment reduced walking, housework and shopping, functional health did not affect socializing, club participation and leisure activity.

Summing up, previous research highlights the influence of health and activity for retirement adjustment. This process is crucial for successful aging. However, studies have also shown that health affects activity and activity affects health. Accordingly, development in both constructs in the adjustment to retirement should be studied as a simultaneous and bidirectional process.

2.2. The social structure of adjustment to retirement

One reason for empirical ambiguity in changes of resources with retirement may be that changes in health and leisure activities may depend on the retirees' social class (cf. Dannefer, 1984; Moen, 2004; Wetzel, Huxhold, & Tesch-Römer, 2016). Social class may affect the adjustment process not only in the access to but also in the use of resources.

First, social class indicates access to resources. This assumption has a long standing tradition in sociology and public health research. Ample empirical evidence has demonstrated that socio-economically disadvantaged groups have poorer health (e.g. Ross & Mirowsky, 2003; Schöllgen, Huxhold, & Tesch-Römer, 2010) and that the differences between classes increase over the life course (e.g. Cullati et al., 2014; Lynch & Brown, 2011; Sacker, Clark, Wiggins, & Bartley, 2005; Willson, Shuey, & Elder, 2007). Similarly, a growing number of studies point to socially stratified activity levels (cf. Verbrugge & Liu, 2014, e.g. leisure activities: Anand et al., 2015; Herzog, Franks, Markus, & Holmberg, 1998; and volunteering: Hank, 2011).

Second, social classes also indicate unequal capabilities in the use of resources. For instance, the Reserve Capacity Model (Gallo & Matthews, 2003) predicts higher stressors in lower classes, so that these people have a greater requirement to invest socio-psychological resources in the prevention of decrements in well-being. Empirically, Schöllgen and Colleagues (2012) have shown that only in the group of less educated elderly negative affect does predict development in physical health. In sociology, similar ideas have been expressed in the Capability Approach (Sen, 1985; cf. Anand et al., 2015; Frohlich, Corin, & Potvin, 2001). In this reasoning, not only the access to resources is unequally distributed in societies but also individual capability to put them to use in order to achieve high levels of well-being. Capabilities are affected by individual and social characteristics. One important social characteristic in this regard is education which has been assumed to affect both access and capability of use of resources (Anand et al.,

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