



## The subjective wellbeing profile of the ‘pretiree’ demographic: A cross-sectional study



Julie A. Pasco<sup>a,b,c,d,\*</sup>, Kara L. Holloway<sup>a</sup>, Amanda L. Stuart<sup>a</sup>, Lana J. Williams<sup>a</sup>, Sharon L. Brennan-Olsen<sup>b,e,f,g</sup>, Michael Berk<sup>a,c,h</sup>

<sup>a</sup> Deakin University, Geelong, Australia

<sup>b</sup> Department of Medicine-Western Health, Melbourne Medical School, The University of Melbourne, St Albans, Australia

<sup>c</sup> Barwon Health, Geelong, Australia

<sup>d</sup> Department of Epidemiology and Preventive Medicine, Monash University, Melbourne, Australia

<sup>e</sup> Australian Institute for Musculoskeletal Science (AIMSS), The University of Melbourne and Western Health, St Albans, Australia

<sup>f</sup> Institute for Health and Ageing, Australian Catholic University, Melbourne, Australia

<sup>g</sup> Australian Health Policy Collaboration, Melbourne, Australia

<sup>h</sup> Orygen, The Centre of Excellence in Youth Mental Health, the Department of Psychiatry and the Florey Institute of Neuroscience and Mental Health, The University of Melbourne, Melbourne, Australia

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### ABSTRACT

**Objectives:** Pretirees are a demographic interposed between the latter stages of working life and old age. We aimed to characterise subjective wellbeing and lifestyle behaviours for individuals aged in their late-fifties and sixties.

**Study design:** Cross-sectional study of 233 men and 229 women aged 55–69 yr from the Geelong Osteoporosis Study.

**Main outcome measures:** Subjective wellbeing assessed using the World Health Organization Quality of Life questionnaire (WHOQOL-BREF, Australia). Scores below published population norms for Australia for WHOQOL domains (physical, psychological, social, environmental) were considered low.

**Results:** For men, low WHOQOL scores were evident for 78 (33.5%) of participants regarding physical health, 94 (40.3%) for psychological wellbeing, 89 (38.2%) for social relationships, and 99 (42.5%) for the environment; the respective figures for women were 110 (48.0%), 124 (54.1%), 84 (36.7%), and 95 (41.5%). While there were few smokers (men 10.8%; women 6.5%), 42.5% of men and 17.7% of women exceeded recommended alcohol levels; 6.4% of men and 15.2% of women met the recommendation to consume each day at least two portions of fruit and five of vegetables. In multivariable models, being active was consistently associated with high WHOQOL scores, and low socioeconomic status with low WHOQOL scores. Pain and polypharmacy were associated with increased likelihood of poor scores for physical health, living with a partner increased the likelihood of good social relationships, and body mass index, employment, sleep, and alcohol and fruit/vegetable intakes were associated with WHOQOL scores in at least one domain.

**Conclusions:** There is an opportunity for targeting health promotion to pretirees, particularly in socially disadvantaged regions, in order to optimise transition into old age. Our data highlight lifestyle interventions without which many pretirees might progress to old age at increased risk of diminished wellbeing.

### 1. Introduction

In contemporary societies, the early-elderly, spanning from the mid-fifties to late-sixties, is an important yet unrecognised life stage. Interposed between work and old age, the pretirees are a rapidly growing demographic. What happens in the pretiree period powerfully

influences the divergent paths of health or unhealthy ageing, setting the stage for targeted preventive interventions.

In the western world, the population is ageing and life expectancy is increasing. In the fifty years since 1964, the number of people in Australia aged 65 years and over rose from 948,100 to 3.4 million, which represents an increase in the proportion of the total population

\* Corresponding author at: Epi-Centre for Healthy Ageing, IMPACT Strategic Research Centre, School of Medicine, Deakin University, PO Box 281 (Barwon Health), Geelong, VIC, Australia.

E-mail address: [juliep@barwonhealth.org.au](mailto:juliep@barwonhealth.org.au) (J.A. Pasco).

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from 0.8% to 15% [1]. In response to the growing number of older people in the population and increases in longevity, attention needs to shift from the quantity to the quality of life.

Analysis of longitudinal data from the Household, Income and Labour Dynamics in Australia (HILDA) Survey conducted in Australia 2001–2010, suggested that the combined indirect effect of education, which considered income, employment, marriage, children and health, contributed to overall life satisfaction [2]. In another Australian study, data from 2008 suggested that psychological life satisfaction can be enriched by improving individuals' connectedness to community [3]. A survey of adults in the USA conducted in the same year, revealed that life appraisal had a U-shaped age profile that increased steadily after a nadir early in the sixth decade of age and that older people were generally happier and less stressed than their younger counterparts [4]. Emerging from this nadir, the pretiree life-transition stage represents a period of change that provides opportunities for targeting multiple behavioural and social factors.

There is evidence to suggest that people of retirement age are amenable to interventions that promote healthy lifestyles [5,6]. It seems imperative that practical health promotion interventions target this age group in order to enhance wellbeing and optimise the transition into old age. Subjective wellbeing is a complex multidimensional construct of inter-related aspects of physical health, psychological state, social relationships and the environment [7]. The objective of this study was to characterise subjective wellbeing and lifestyle behaviours for men and women aged between 55 and 69 years, participating in a population-based health study.

## 2. Methods

Participants were assessed as part of the most recent follow-up phases of the Geelong Osteoporosis Study (GOS) [8]. This prospective cohort study follows cohorts of men and women selected at random from electoral rolls for the Barwon Statistical Division, a geographically distinct area surrounding the regional city of Geelong in south-eastern Australia. At baseline, age-stratified samples of 1540 men and 1494 women were assessed 2001–2006 and 1993–1997, respectively. The cohorts are re-assessed every few years and the current analysis uses cross-sectional data collected at follow-up assessments for men 2007–2011 and women 2011–2014. Details of study design, participation and non-participation have been described elsewhere [8]. For this study we focused on men and women aged 55–69 years. From a pool of 449 men and 406 women who were assessed at baseline and would have been in our target age-group of 55–69 years at follow-up, 13 men and 14 women had died, 10 men and 20 women had left the region, 27 men and 21 women had lost contact and 264 men and 218 women had declined. Among 351 men and 292 women assessed at follow-up, 118 men and 63 women were excluded, as they provided insufficient data for this analysis, leaving 233 men and 229 women [9]. Written, informed consent was obtained from all participants. This study was approved by the Barwon Health Human Research Ethics Committee.

### 2.1. Data

Subjective wellbeing was measured using the Australian version of the World Health Organization Quality of Life questionnaire (WHOQOL-BREF) [7]. The WHOQOL-BREF assesses quality life in four specific domains, namely physical health (incorporating activities of daily living, medications, energy, mobility, pain, sleep and work capacity), psychological wellbeing (incorporating body image, positive and negative feelings, self-esteem and spirituality, memory), social relationships (incorporating personal relationships, social support and sexual activity) and environment (incorporating financial resources, security, home environment, recreation/leisure activities, physical environment and transport). Participants provided responses to items in

the WHOQOL-BREF, based on their experience during the preceding two weeks. Each item was scored on a 5-point scale ranging from “not at all” (score = 1) to “completely” (score = 5). After reversing scores for negative items, domain scores were totalled and expressed as percentile scores, ranging from zero to 100.

Body weight and height were measured to the nearest 0.1 kg and 0.001 m, respectively, and body mass index (BMI) calculated as weight/height<sup>2</sup>. Based on World Health Organization (WHO) criteria, underweight was identified as BMI < 18.5 kg/m<sup>2</sup>, normal weight as 18.5–24.9 kg/m<sup>2</sup>, overweight as BMI 25.0–29.9 kg/m<sup>2</sup> and obesity as BMI ≥ 30.0 kg/m<sup>2</sup> [10]. As there were few individuals with BMI < 18.5 kg/m<sup>2</sup>, underweight was combined with the normal weight category for analyses.

Self-reported details of current employment, marital status, the number of children, health behaviours and medication use were documented by questionnaire. Employment included full-time and part-time work, self-employment and working for an employer. Marital status was described as living with a partner (included married, de facto relationship) or not (included single, separated, divorced, widowed). The number of children referred to parity, reported number of children and/or listing of children's years of birth. Habitual physical activity was categorised as very-active, active, sedentary, limited, inactive or chair/bedridden (descriptors were included in the questionnaire [8] but are not shown here) and for this analysis, these categories were collapsed into three groups of very-active, active and inactive (includes sedentary, limited activity, chair/bedridden). The estimated number of hours sleep each night ranging from 6 to 9 h were considered normal sleep duration and values above and below this range were pooled. Pain (overall) during the past week was estimated using a Visual Analogue Scale (0–10, 10 = severe) and deemed present if score ≥ 5. Intakes of food and alcohol were captured via a food frequency questionnaire developed by the Cancer Council (Victoria) [11]. Mean energy intake was expressed in megajoules per day MJ/d, mean alcohol consumption in grams per day (g/d) and amounts exceeding 20 g/d were considered above recommended levels [12]. Self-reported medication use was categorised according to the Australian index of medications (<http://www.mims.com.au/index.php/about-mims/about-mims-overview>), known as MIMS (an acronym derived from the original publication, Monthly Index of Medical Specialties). Medication use numbering three or more is referred to as polypharmacy. Supplements include vitamins, minerals, herbs and tonics.

Socioeconomic status (SES) was ascertained using Socio-Economic Index For Areas index scores based on 2006 census data for men and 2011 for women census data from the Australian Bureau of Statistics. We used these data to derive an Index of Relative Socio-Economic Advantage and Disadvantage (IRSAD) that was categorised into quintiles, according to cut-points for the study region. IRSAD accounts for high and low area-based income and occupation types including unskilled employment to professional positions, among other variables. A low IRSAD score represents a more disadvantaged area and a high score a more advantaged area. To avoid small numbers, quintiles 1 and 2 were collapsed into a low SES group, quintile 3 was the mid SES group and quintiles 4 and 5 were collapsed into a high SES group.

### 2.2. Statistics

Intergroup differences for continuous data were compared using Student's *t*-test for parametric and Mann-Whitney test for non-parametric data. For men and women (separately), low WHOQOL-BREF scores in each of the four domains were those below adult population norms derived from Australian data, namely 73.5 for the domain of physical health, 70.6 for psychological wellbeing, 71.5 for social relationships and 75.1 for the environmental domain [13]. Missing data were noted for the following: WHOQOL social domain (4 women), environmental domain (1 woman), physical activity (2 women), BMI (6 men, 3 women), pain (1 woman), sleep (1 woman) and, where relevant,

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