Original quantitative research

Obesity and healthy aging: social, functional and mental well-being among older Canadians

Deepa P. Rao, PhD (1); Parth Patel, MPH (1,2); Karen C. Roberts, MSc (1); Wendy Thompson, MSc (1)

Abstract

Introduction: Canadians are living longer than before, and a large proportion of them are living with obesity. The present study sought to describe how older participants in the Canadian Longitudinal Study on Aging (CLSA) who are living with obesity are aging, through an examination of measures of social, functional and mental well-being.

Methods: We used data from the first wave of the CLSA for people aged 55 to 85 years in this study. We used descriptive statistics to describe characteristics of this population and adjusted generalized logistic models to assess measures of social, functional and mental well-being among obese participants (body mass index ≥ 30 kg/m²) relative to non-obese participants. Findings are presented separately for females and males.

Results: More than half of the participants reported living with a low personal income (less than $50 000); females were particularly affected. Less than half of the participants were obese; those who were had higher odds of multimorbidity than those who were not living with obesity (among those aged 55–64 years: odds ratio [OR] 2.7, 95% CI: 2.0–3.5 males; OR 2.8, 95% CI: 2.2–2.5 females). Low social participation was associated with obesity among older female participants, but not males. Physical functioning issues and impairments in activities of daily living were strongly associated with obesity for both females and males. While happiness and life satisfaction were not associated with obesity status, older females living with obesity reported negative impressions of whether their aging was healthy.

Conclusion: The odds of multimorbidity were higher among participants who were obese, relative to those who were not. Obese female participants tended to have a negative perception of whether they were aging healthily and had lower odds of involvement in social activities, while both sexes reported impairments in functional health. The associations we observed, independent of multimorbidity in older age, highlight areas for healthy aging initiatives may be merited.

Keywords: obesity, healthy aging, mental health, social participation, multimorbidity, happiness

Introduction

Canadians are living longer than in previous generations: the proportion of Canadians aged 65 years and older is expected to be 1 in 5 by 2024.1 Healthy aging constitutes more than just longevity, however; an individual’s quality of life (QOL) has a bearing on the years spent living in good health. So, while average Canadians may live longer, they might not necessarily be living well.2 The majority of seniors in Canada are overweight or obese,3 the latter being a known risk factor for a number of chronic conditions4,5 and a factor that can exacerbate age-related declines in physical function and frailty.6 Furthermore, even though perceived weight does not always agree with actual weight, the former has been associated with measures of self-rated health and life satisfaction that vary based on sex.7 Therefore, understanding the role that obesity may play in successful aging among older Canadians is important.

There is, however, an obesity paradox among the elderly: high body mass index (BMI) appears to provide a survival advantage and have a lower association with mortality, while low BMI is often associated with higher mortality relative to normal weight.8 The risks of excess weight among the elderly are complex and there are added considerations such as fat redistribution with age, competing mortalities, and risks associated with weight redistribution.

Author references:

1. Public Health Agency of Canada, Ottawa, Ontario, Canada
2. Dalla Lana School of Public Health, University of Toronto, Toronto, Canada

Correspondence: Deepa P. Rao, Public Health Agency of Canada, 785 Carling Avenue, Office 707B1, Ottawa, ON K1A 0K9; Tel: 613-867-8303; Fax: 613-941-2057; Email: deepa.rao@canada.ca
change that all contribute to the unique perspective on obesity treatment and prevention for this age group. The clinical definition of obesity is based on BMI, but there are other metrics of excess weight that may be more applicable to this age group. Metrics that better reflect fat distribution, such as waist circumference, may be able to provide an indication of health risk where BMI cannot. In regard to healthy aging, weight management in the elderly is geared towards improving physical function (minimizing muscle and bone loss) and health-related QOL.

While there is no uniform definition for successful aging, it can be interpreted as maintaining physical, social and mental well-being with age. QOL in older individuals is largely determined by these factors, and by the ability to maintain autonomy and independence. Fewer chronic conditions, strong social supports, high independent functioning and life satisfaction are among the many indicators of successful aging. Within this holistic understanding, social, functional and mental well-being, in combination with fewer chronic conditions and lower levels of mental illness, can be examined together to provide an objective indication of successful aging.

Recent estimates suggest that roughly 15% of Canadians aged 20 years and older are living with two or more chronic diseases (multimorbidity), and that these rates increase with age. Accordingly, there is growing interest in research on attitudes in later life that contribute to living well. Current trends also suggest that obesity and its related illnesses will persist as the “baby boomer” population approaches retirement. Given this trend, it is prudent to better understand the role obesity may play in successful aging in Canada. Consequently, this study aimed to profile indicators of social, functional and mental health among older Canadians living with obesity, in spite of their multiple chronic conditions.

Methods

Data source

This study was conducted using cross-sectional data from the first wave of the Canadian Longitudinal Study on Aging (CLSA). Participants (n = 21,241) were recruited from Statistics Canada’s Canadian Community Health Survey (CCHS)—Healthy Aging focus survey (n = 3923); (2) the provincial health care registration databases (n = 3810); and (3) through random digit dialling (n = 13,508). All participants were asked survey questions using the computer-assisted telephone interviewing (CATI) technique between 2010 and 2014. The sampling frames excluded residents of the three Canadian territories, persons living on federal First Nations Reserves, full-time members of the Canadian Armed Forces, individuals living in long-term care institutions, and individuals unable to communicate in English or French. A detailed background and methodology on CLSA are available elsewhere. The study population was restricted to individuals between the ages of 55 and 85 years (N = 15,345).

Variables

Socioeconomic characteristics

We ascertained annual individual income levels based on self-reported total personal income from all sources and recoded them as a binary variable (≤ $50,000 vs. ≥ $50,000). We derived home residence status, which was used as a subjective measure of financial well-being, from a combination of the dwelling within which the individual resided, and their ownership status. Individuals who lived in seniors’ housing, old-age facilities and hotels were identified as not residing in their own home, and individuals who lived in other independent venues (house or apartment) but who also indicated that they did not own their residence were also considered not to live in their own home. Individuals who responded that they lived in a house or apartment and that they owned their home were identified as living in their own home.

Behavioural characteristics

Current smoking status was identified based on self-report (current smoker vs. current nonsmoker [former smoker or never smoker]), as was level of usual alcohol consumption (≥ 4 alcoholic beverages per week vs. < 4).

Health characteristics

We derived BMI from self-reported height and weight and calculated it as weight (kg) divided by height squared (m²). Obesity was identified as BMI ≥ 30 kg/m², and non-obesity (including normal weight and overweight) was identified as BMI < 30 kg/m². We derived multimorbidity from self-reported diagnosis with two or more of the following conditions: arthritis, respiratory conditions (asthma or chronic obstructive pulmonary disease), diabetes, heart disease (including angina, heart attack, and peripheral vascular disease), stroke (including cerebrovascular event and transient ischemic attack), neurological conditions (Alzheimer’s or Parkinson’s disease), cancer, or mental health disorders (mood or anxiety). Respondents were identified with these conditions if they responded yes to the respective question of whether they had ever been told by a doctor that they had the condition.

Social health

Participants were asked how often in the past 12 months (at least once a day, at least once a week, at least once a month, at least once a year, never) they participated in eight different activities: (1) family- or friendship-based activities outside the household; (2) church or religious activities; (3) sports or physical activities that you do with other people; (4) educational and cultural activities involving other people; (5) service club or fraternal organization activities; (6) neighborhood, community or professional association activities; (7) volunteer or charity work; or (8) other recreational activities involving other people. Based on their responses, participation in community and social activities was recoded as participating in community or social activities at least once a week versus less frequently. Questions were taken from the Medical Outcomes Study Social Support Survey for these measures, which have been shown to be valid and reliable in older females.

Functional health

We determined physical functioning based on responses to 14 questions. For each of the 14 scenarios asked, such as whether an individual experienced physical difficulty extending an arm above their head, we coded individuals as having functional limitations if they experienced limitations with 3 or more of the proposed scenarios. Impairments to activities of daily living were recoded based on responses using the Older Americans Resources and Services Multidimensional Assessment scale, which has been validated previously. Ordinal response options were recoded as either “no impairment” or “mild to total impairment.”
Mental health and well-being
We determined mental health status based on self-report of a mood or anxiety disorder diagnosed by a physician. Various measures were used for mental well-being. We identified happiness as feeling happy 3 or more days per week versus fewer. While this measure is not a substitute for specific mental health assessment, it has been validated as a useful one to measure general mental health.28 Self-reported measures of happiness have been shown to associate with lower mortality, which may be mediated by physical activity and comorbidity, in the elderly.29 Life satisfaction was derived from reports of feeling slightly satisfied or better with life versus neutral or dissatisfied. These measures (self-rated mental health and self-rated healthy aging) were each coded as binary variables based on self-report responses of “fair” or “poor” versus “good,” “very good” or “excellent,” respectively.

Analysis
We used descriptive analyses to examine socioeconomic, behavioural and health characteristics among older Canadian participants (restricted to those aged 55 to 85 years). We used chi-square analyses to compare characteristics across age-groups, and by sex. Logistic regression models were constructed to examine the association between obesity (compared to non-obesity) and multimorbidity, functional health, social health, mental health and mental well-being. We tested potential confounders individually for inclusion in a logistic regression model assessing the odds of multimorbidity based on obesity status, and the level of significance was set at p-value < .01. Accordingly, we used the following confounding variables: income level, alcohol consumption and current smoking behaviour. Education level and marital status were also tested but were not found to be significant. We included multimorbidity in the models to control for its association with obesity. Odds ratios (ORs) and 95% CIs are presented. The overall response rate was 10% for the CLSA-Tracking Component sample, and although trimmed sampling weights were used to account for the complex and multiple sampling frames in the CLSA, results are described for the CLSA sample and not generalizable to the Canadian population.30

Results
With each successive age group, the number of individuals represented through weighting techniques diminished by a factor of two (weighted N_{55-64} = 4 090 454; weighted N_{65-74} = 2 599 404; and weighted N_{75-85} = 1 664 872). The prevalence and distribution of socioeconomic, behavioural and health characteristics are described in Table 1. Roughly half of male participants aged 55 to 64 years had a personal income of greater than $50 000, with this value decreasing significantly in older age groups. Less than a third of female participants aged 55 to 64 years had a personal income greater than $50 000, significantly fewer than the proportion of males. We observed significant decreases in older age groups. We observed significant differences in residence ownership between the sexes, as well as across age groups, with proportions showing that many older participants lived in their own home.

With respect to health, the proportion of current smokers was lower in older age groups for each sex. While smoking behaviours were not significantly different between the sexes at age 55 to 64 years, more females than males aged 75 to 85 years reported smoking (p < .01). The consumption of 4 or more alcoholic beverages per week differed significantly between the sexes, and also decreased significantly with increasing age groups. Obesity was significantly higher among males and decreased with age, until age 75 to 85, where more females lived with obesity than males, despite their own age-related decreases. Finally, significantly more females than males reported having multimorbidity at ages 55 to 64, with differences disappearing by ages 75 to 85 years (Table 1). Across all age groups, and for both sexes, multimorbidity was strongly associated with obesity (Table 2). We observed differences between the sexes in younger age groups (p < .01), but not among those aged 75 to 85 years (p = .8).

Reduced social participation among male participants was not associated with obesity. However, among female participants aged 55 to 64 and 75 to 80, it was (OR 0.5, 95% CI: 0.4–0.7), and OR 0.5, 95% CI: 0.3–0.8, respectively; Table 3). While social participation among individuals living with obesity did not vary significantly between the sexes, there were significant differences across age groups for females (p < .01). Reduced physical functioning was strongly associated with obesity for both males and females, with differences between the sexes being significant only among those aged 65 to 74 years old. The strength of this association between reduced physical functioning and obesity increased with age for both sexes. Similarly, impairments in activities of daily life were significantly associated with obesity for both sexes, with the strength of association increasing with age. The difference between sexes was significant across all age group, with females living with obesity reporting more impairments than males living with obesity.

The odds of having a mood or anxiety disorder among those who were obese, relative to those who were not, was significant among females aged 65 to 74 years (OR 0.6, 95% CI: 0.4–0.9); differences between the sexes and across ages were significant as well (p < .01) (Table 4). Measures of happiness and life satisfaction were not significantly associated with obesity status for either sex or for any age group. Self-reported good mental health, however, was significantly lower among females in the 55 to 64 age group who were living with obesity, but this association of mental health with obesity disappeared in older age groups. Self-reported healthy aging was significantly associated with obesity among older Canadian participants—females in all age groups reported strong negative impressions of their aging. Among males, however, this finding was only observed among those aged 55 to 64 years (OR 0.4, 95% CI: 0.2–0.5).

Discussion
Canadians are enjoying a longer life span than ever before, with recent population estimates showing that the number of Canadians aged 65 years and older outnumber those 14 years and below.1 More than half of older Canadians are living with a low personal income, and females are disproportionately affected.11 While studies have suggested that poor financial health is linked with disease,12 we observed that CLSA participants had strong subjective financial well-being. We also found that many drank 4 or more drinks per week in their older age, although the prevalence of current smokers decreased with increasing age. The former finding is not necessarily troubling, since regular alcohol consumption has been associated with increasing QOL and mood,13 although it is still linked to chronic diseases such as cancer.14

The burden of multimorbidity in seniors is well recognized17,35,36 and is a combination

Vol 38, No 12, December 2018

Health Promotion and Chronic Disease Prevention in Canada
Research, Policy and Practice

439
### Table 1: Socioeconomic, behavioural and health characteristics of older respondents to the Canadian Longitudinal Study on Aging, 2014

<table>
<thead>
<tr>
<th>Socioeconomic characteristics</th>
<th>Ages 55–64 years</th>
<th>Males</th>
<th>Females</th>
<th>χ² p-value</th>
<th>Ages 65–74 years</th>
<th>Males</th>
<th>Females</th>
<th>χ² p-value</th>
<th>Ages 75–85 years</th>
<th>Males</th>
<th>Females</th>
<th>χ² p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal income ≥ $50 000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Live in their own home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consume ≥ 4 alcoholic beverages/wk.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obese</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multimorbid (≥2 chronic conditions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy aging characteristics</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Happiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life satisfaction</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy aging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Data source:** Canadian Longitudinal Study on Aging, 2014.

**Abbreviations:** CI, confidence interval; wk., week.

**Note:** For all variables examined, χ² p-value across age groups for each sex were p < .01, with the exceptions in notes b and c, below.

χ² p-values comparing characteristics across sexes for each age group.

Happiness: p = .14 across ages for males, and p = .35 across ages for females.

Healthy aging: p = .01 across ages for females.
TABLE 2  
Odds ratio of multimorbidity among older obese respondents to the Canadian Longitudinal Study on Aging, 2014, by age group and sex

<table>
<thead>
<tr>
<th>Age groups</th>
<th>Males</th>
<th>Females</th>
<th>χ²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
<td></td>
</tr>
<tr>
<td>55–64 years</td>
<td>2.7*</td>
<td>2–3.5</td>
<td>2.8*</td>
<td>2.2–3.5</td>
</tr>
<tr>
<td>65–74 years</td>
<td>2.5*</td>
<td>1.9–3.4</td>
<td>2.7*</td>
<td>2.1–3.6</td>
</tr>
<tr>
<td>75–85 years</td>
<td>2.0*</td>
<td>1.4–2.9</td>
<td>2.1*</td>
<td>1.5–2.9</td>
</tr>
</tbody>
</table>

χ² p-valueab < .01. < .01.

Data source: Canadian Longitudinal Study on Aging, 2014.
Abbreviations: CI, confidence interval; OR, odds ratio.
Notes: Models are controlled for income level, alcohol consumption and current smoking behaviour. Analyses use nonobese Canadians as the referent category.

* χ² p-value between sexes among obese individuals.
* χ² p-value across age groups among obese individuals.
* p < .01.

TABLE 3  
Odds ratios for indicators of social and functional health among older obese respondents to the Canadian Longitudinal Study on Aging, 2014, by age group and sex

<table>
<thead>
<tr>
<th>Social health</th>
<th>Males</th>
<th>Females</th>
<th>χ²</th>
<th>p-value</th>
<th>Males</th>
<th>Females</th>
<th>χ²</th>
<th>p-value</th>
<th>Males</th>
<th>Females</th>
<th>χ²</th>
<th>p-value</th>
<th>Males</th>
<th>Females</th>
<th>χ²</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age groups</td>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
<td></td>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
<td></td>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>OR</td>
<td>95% CI</td>
</tr>
<tr>
<td>Involvement in social activities at least once a week</td>
<td>0.8</td>
<td>0.6–1.1</td>
<td>0.5*</td>
<td>0.4–0.7</td>
<td>.10</td>
<td>1.0</td>
<td>0.7–1.4</td>
<td>0.7</td>
<td>0.5–1.1</td>
<td>.08</td>
<td>0.8</td>
<td>0.5–1.3</td>
<td>0.5*</td>
<td>0.3–0.8</td>
<td>.10</td>
<td>.09</td>
</tr>
<tr>
<td>Functional health</td>
<td>Physical functioning issues</td>
<td>2.2*</td>
<td>1.5–3.1</td>
<td>2.0*</td>
<td>1.5–2.8</td>
<td>.06</td>
<td>1.5</td>
<td>1.0–2.3</td>
<td>3.0*</td>
<td>2.1–4.3</td>
<td>&lt; .01</td>
<td>2.8*</td>
<td>1.8–4.3</td>
<td>1.5*</td>
<td>1.0–2.2</td>
<td>.30</td>
</tr>
<tr>
<td>Impairment(s) in Activities of Daily Living</td>
<td>1.8*</td>
<td>1.1–3.0</td>
<td>2.0*</td>
<td>1.4–2.9</td>
<td>&lt; .01</td>
<td>1.1</td>
<td>0.7–1.9</td>
<td>2.7*</td>
<td>1.8–4.1</td>
<td>&lt; .01</td>
<td>2.1*</td>
<td>1.3–3.3</td>
<td>2.2*</td>
<td>1.6–3.1</td>
<td>&lt; .01</td>
<td>&lt; .01</td>
</tr>
</tbody>
</table>

Data source: Canadian Longitudinal Study on Aging, 2014.
Abbreviations: CI, confidence interval; OR, odds ratio.
Notes: Models are controlled for income level, multimorbidity, alcohol consumption and current smoking behaviour. Analyses use nonobese Canadians as the referent category.

* χ² p-value between sexes among obese individuals.
* χ² p-value across age groups among obese individuals.
* p < .01.
* p < .05.
TABLE 4
Odds ratios for indicators of mental health and well-being among older obese respondents to the Canadian Longitudinal Study on Aging, 2014, by age group and sex

<table>
<thead>
<tr>
<th>Ages 55–64 years</th>
<th>Ages 65–74 years</th>
<th>Ages 75–85 years</th>
<th>χ²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>95% CI</td>
<td>p-value¹</td>
</tr>
<tr>
<td>Mood or anxiety disorder</td>
<td>1.3</td>
<td>0.9–1.9</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>1.0</td>
<td>0.6–1.5</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Good mental health</td>
<td>0.8</td>
<td>0.6–1.2</td>
<td>&lt; .01</td>
</tr>
<tr>
<td>Healthy aging</td>
<td>0.7</td>
<td>0.4–1.2</td>
<td>&lt; .01</td>
</tr>
</tbody>
</table>

Data source: Canadian Longitudinal Study on Aging, 2014.

Abbreviations: CI, confidence interval; OR, odds ratio.

Notes: Models are controlled for income level, multimorbidity, alcohol consumption, and current smoking behaviour. Analyses use nonobese Canadians as the referent category.

¹ χ² p-value between sexes among obese individuals.
² χ² p-value across age groups among obese individuals.
³ p < .01.

Highlights an at-risk demographic that may benefit from healthy aging programs.

Measures of mental health and well-being can vary by age and sex. Anxiety in older age has been shown to have a bidirectional relationship with cognition and with decreases in executive functioning. Measures of mental well-being included those that were evaluative and hedonic. We observed no significant associations of these constructs with obesity in older age, although when we examined these attributes across age groups, chi-square estimates suggested that age is related to life satisfaction among males. Life satisfaction has been previously shown to associate with mortality among men, but not women. Furthermore, these associations were suggested to be partially mediated through adverse health behaviours. So, while adjusting for covariates may have dissipated associations of obesity with life satisfaction, as observed with ORs, the chi-square trends suggest an opportunity to study this evaluative construct among older males. The low perception of good mental health among older females is noteworthy, although this improves with age. Finally, in the context of how retaining a positive outlook can support living well into old age, we found that older participants living with obesity self-identified as not aging with good health. This finding was significant for females in all the age groups examined, and for males in the group aged 55 to 64 years. A negative association of obesity on life satisfaction has been described previously as well, and although this finding was significant among both sexes, Wadsworth et al. found the association to be stronger among females than among males.

Strengths and limitations

The use of a large national survey to examine detailed characteristics of aging is one of the main strengths of this study. However, some limitations must be considered in interpreting our findings. First, BMI was derived based on self-reported measures of height and weight, which may be subject to respondent bias, with some data indicating that misreporting is greatest in the oldest age group. Because of these possible biases, it is difficult to gauge their impact in the context of the multivariable models discussed. Second, given the current literature regarding frailty in older age, it is unclear whether BMI is the most appropriate measurement of obesity or excess body fat for older individuals. Third, the analysis conducted in this study is limited by the information available in the survey. Thus, there may be other important factors that were not included, such as physical activity, nutrition and other environmental factors. The lack of information on physical activity, sedentary time and general time use constrains the interpretation of the obesity–health relationship, particularly given the known associations of physical activity with measures of health in old age. Fourth, although sample weights are generally applied so as to permit an estimation of statistics representative to the Canadian population, the first wave of the CLSA had a low response rate. Therefore, while we have applied sampling weights in our analyses, we describe our results in relation to CLSA participants, and these might not be generalizable to the Canadian population. Finally, we are aware that not all self-reported measures used in this analysis have been validated, such as happiness and healthy aging; therefore, interpretations should be made with caution.

Conclusion

This study provides a baseline analysis of healthy aging among older Canadian CLSA participants living with obesity that may be continued with successive cycles of the CLSA. The finding that these older Canadians’ social and functional health profiles were associated with their obesity, even though other measures of well-being mostly were not, is also concerning as we transition to an era in which healthy aging is becoming a growing concern. These profiles should help to assist efforts geared toward promoting healthy aging for all by providing a picture of how social, functional and mental well-being is impacted by obesity in this age demographic.
Conflicts of interest

None of the authors have conflicts of interest to declare.

Authors’ contributions and statement

All authors were involved in the conceptualization of this study, the interpretation of findings, and in the approval of the final manuscript. PP and DR analyzed the data and drafted the manuscript.

The content and views expressed in this article are those of the authors and do not necessarily reflect those of the Government of Canada.

References


