Prevalence of self-reported overweight-obesity and its association with socioeconomic and health factors among older Mexican adults

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Abstract

Objective: To investigate the prevalence of obesity and its association with socioeconomic factors and comorbidities in a population-based study. Material and Methods: Data were examined from 4,605 persons ages 60 and older that participated in the 2001 Mexican Health and Aging Study, conducted in rural and urban communities in Mexico. The prevalence of obesity (according to self-reported weight and height) was obtained, stratified by age, and logistic regression was used to study cross-sectional associations between obesity and socioeconomic factors. Results: Of the population studied, 20.9% were classified as obese and the prevalence diminishes with age. Overall, women were more likely than men to be obese. Lower educational level was associated with lower risk of overweight. In both men and women, obesity was more common between subjects with hypertension (OR 1.38 and 1.71, respectively) and long-distance walk limitation (OR 2.08 and 2.21, respectively). Conclusion. In older Mexican adults, hypertension and long-distance walk limitation were independent associated factors for higher prevalence of obesity.

Key words: obesity; elderly; socioeconomic factors; health factors; Mexico

Resumen

Objetivo: Estudiar la prevalencia de obesidad y su asociación con factores socioeconómicos y comorbilidades. Material y métodos: Se analizaron los datos de 4,605 personas de 60 años y más que participaron en el Estudio Nacional sobre Salud y Envejecimiento en México 2001 (ENASEM 2001) en zonas rurales y urbanas. La prevalencia de obesidad (peso y talla autorreportados) se obtuvo estratificada por edad y mediante una regresión logística se asoció con factores socioeconómicos. Resultados: 20.9% se clasificaron como obesos y la prevalencia disminuyó con la edad. En general las mujeres tuvieron mayor probabilidad de ser obesas. Una baja escolaridad se asoció con menor riesgo de sobrepeso. En hombres y mujeres la obesidad se asoció con hipertensión (RM 1.38 y 1.71 respectivamente) y con dificultad para caminar (RM 2.08 y 2.21 respectivamente). Conclusión: En la población de edad avanzada en México la hipertensión y la dificultad para caminar son factores independientes de mayor prevalencia de obesidad.

Palabras clave: obesidad; anciano; factores socioeconómicos; salud; México
Obesidad es un serio problema de salud pública que está aumentando en países desarrollados y en desarrollo. Un gran número de personas se vuelven sobrepeso o obesas a medida que envejecen, lo que se asocia con una disminución en la actividad física y el metabolismo basal, y un reajuste de la grasa a la zona abdominal.1

Se han encontrado varios estudios que la asociación entre obesidad y mortalidad es menor en mayores de edad; no obstante, la morbilidad aumenta con el índice de masa corporal.2,3

El índice de masa corporal (IMC) se calcula dividiendo el peso (kilogramos) por el cuadrado de la altura (métro). Basándose en el peso y la altura reportados, el IMC se obtuvo en 2001 para la población de México y se excluyeron los datos en los que faltaban datos.17 La MHAS es un estudio transversal, población-basado realizado en comunidades rurales y urbanas de México en 2001. Datos de 7 170 personas mayores de 60 años de edad se incluyeron. De este grupo, 4,905 indicaron un peso y altura que fueron verificados por Avila-Funes (2004), quien concluyó que es un método válido que se puede utilizar para estimar el IMC de forma precisa en el adulto mayor mexicano.18

El consentimiento informado se obtuvo para todos los sujetos de acuerdo con el “Declaración de Helsinki sobre los Principios Éticos en la Investigación Médica Involucrando a los sujetosHuman Subjects”.17

Basado en el reporte autoinformado de peso y altura, el IMC se calculó dividiendo el peso corporal (kilogramos) por el cuadrado de la altura (metro). Usando este índice, los pacientes se agruparon de acuerdo con el IMC según la Organización Mundial de la Salud.19

El estudio incluyó la morbilidad y mortalidad en la población de adultos mayores de América Latina. El objetivo de este estudio fue investigar la prevalencia de obesidad y sus asociaciones independientes con factores socioeconómicos y comorbilidades tales como hipertensión, infarto de miocardio e hipoglucemia en un estudio de población grande.

Material y Métodos

El estudio de 2001 Mexican Health and Aging Study (MHAS) base de datos fue analizado. El MHAS es un estudio transversal, población-basado realizado en comunidades rurales y urbanas de México en 2001. Datos de 7 170 personas mayores de 60 años de edad se incluyeron. De este grupo, 4,905 indicaron un peso y altura que fueron verificados por Avila-Funes (2004), quien concluyó que es un método válido que se puede utilizar para estimar el IMC de forma precisa en el adulto mayor mexicano.18

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Statistical Analysis

Resultados son presentados como porcentajes. Para la comparaación de variables, el test de Pearson x2 fue utilizado.
Using stepwise logistic regression analyses, predictors of overweight and obesity relative to normal weight were examined. Analyses were stratified by gender. A p value < 0.05 was considered significant. The SPSS Inc. (Version 10.0) statistical program was used for the statistical analysis.

Results

Out of 4,605 persons studied, 2,392 (51.9%) were men and 2,213 (48.1%) were women. Normal weight was present in 35.8%, overweight in 43.3%, and obesity in 20.9% of the total population studied. Figure 1 shows the distribution of normal weight, overweight and obesity among men and women stratified by age and gender. Women were more likely to be obese compared to men (24.8 vs. 17.3%). In both men and women, prevalence of overweight and obesity were low in the oldest age groups.

All socioeconomic and health variables included in this study have significant differences when compared by gender, with the exception of age, education level, respiratory disease, stroke and current smokers.

Table I shows demographic and socioeconomic characteristics stratified by gender in subjects with normal weight, overweight and obesity. There is a statistically significant lower occurrence of single men classified as overweight and obese compared with normal weight. People with a low educational level have a lower occurrence of obesity compared with those with a higher level of education.

<table>
<thead>
<tr>
<th>Variables</th>
<th>Normal</th>
<th>Men</th>
<th>Women</th>
<th>Respective</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N = 875</td>
<td>N = 1102</td>
<td>N = 415</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>60 - 64</td>
<td>29.5</td>
<td>32.9</td>
<td>39.3</td>
<td></td>
</tr>
<tr>
<td>65 - 69</td>
<td>25.1</td>
<td>28.2</td>
<td>31.8</td>
<td></td>
</tr>
<tr>
<td>70 - 74</td>
<td>20.1</td>
<td>18.6</td>
<td>16.4</td>
<td></td>
</tr>
<tr>
<td>75 - 79</td>
<td>14.3</td>
<td>12.4</td>
<td>8.7</td>
<td></td>
</tr>
<tr>
<td>&gt; 80</td>
<td>11.0</td>
<td>7.8</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Marital Status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>25.1</td>
<td>20.9</td>
<td>18.3</td>
<td></td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; primary</td>
<td>66.2</td>
<td>59.3</td>
<td>65.6</td>
<td></td>
</tr>
<tr>
<td>Self-rated economic status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair/poor</td>
<td>82.0</td>
<td>76.3</td>
<td>81.2</td>
<td></td>
</tr>
</tbody>
</table>

* Data expressed as percentages

\[^{*}\] \( p < .01 \)

\[^{5}\] \( p < .001 \)

\[^{2}\] \( p < .05 \)
lower prevalence of overweight. In subjects classified as overweight, there were fewer men who self-rated their socioeconomic status as poor.

Table II shows health characteristics stratified by gender in subjects with normal weight, overweight and obesity. In women, a self-rated health status of poor and arthritis were associated with obesity. Hypertension, diabetes mellitus, comorbidity, and long-distance walk limitation were more frequent in subjects classified as obese compared with normal. In men, there was a higher occurrence of myocardial infarction and a lower occurrence of bowel disease associated with overweight. Current smokers had a statistically significant lower prevalence of obesity and overweight in both genders. Alcohol consumption was associated with risk of overweight.

Results from logistic regression analysis, with adjusted odds ratio for the relationship between studied variables and overweight or obesity, are presented in Table III. Overall, women were more likely than men to be obese (OR 1.47). Lower educational level was significantly associated with lower risk of overweight (among men and women, OR 0.80 and 0.67, respectively). Among men, poor economic self-perception and bowel disease were inversely associated with overweight and obesity, respectively. In the total population, obesity was associated with a higher risk of myocardial infarction (OR 1.61), but in the analysis stratified by gender there was no significant association. In both men and women, obesity was more common between subjects with hypertension (OR 1.38 and 1.71, respectively) and long-distance walk limitation (physically inactive) (OR 2.08 and 2.21, respectively). Age and tobacco use were inversely associated with obesity in men (OR 0.50 and 0.61, respectively) and with overweight in women (OR 0.76 and 0.66, respectively). The other variables were not significantly associated with the risk of overweight or obesity.

**Conclusion**

The prevalence of obesity and overweight according to age and gender found in the present study was similar to that which was found in the Mexican National Health Survey, in which the occurrence of obesity starts to decline from the 60 to 69 years age group to the age group 80 years and older, probably caused by population sur-
In this study, it was found that a lower educational level was associated with a lower prevalence of overweight in women and men, and a poor self-rated socioeconomic status in men. This is in concordance with Stunkard, who stated that in developing countries, people from lower educational levels and with a lower socioeconomic status may have difficulties getting access to sufficient food in order to become fat. On the other hand, in developed countries, people with a lower socioeconomic status have a higher prevalence of overweight and obesity because they have access to food but less knowledge about nutrition and poor physical activity.

It is important to take into account the great differences that exist in the health and nutrition of the Mexican population. People who live in cities generally present similar characteristics to those in developed countries (a greater prevalence of obesity and a tendency to be sedentary), and those living in rural areas tend to be thinner, their alimentation is mainly based on grains and vegetables and they have greater physical activity.

On the other hand, in the present study, the economic situation was defined based on self-perception and not on investigating the actual situation based on a set of socioeconomic variables. Therefore, the comprehensive investigation of the relation between socioeconomic conditions and obesity is considered to be important.

Hypertension and long-distance walk limitation were independently associated with obesity in men and women. These results are consistent with several studies that show that high BMI (past or current) is associated with a greater risk of self-reported functional limitation (especially mobility) among older persons. Subjects with a BMI ranking between 23 and 27 had about three times less chance of being ADL dependent in five years. Risk of loss of mobility is significantly associated with high BMI (>80th percentile) compared with moderate (21st-80th percentiles) BMI. Several studies have also shown that BMI and fat mass are positively related to disability, limitation in activities of daily living, walking upstairs, walking on flat surfaces, pulmonary disease, diabetes, and arthritis.

In men, we found that smoking was inversely related to obesity, which is in accordance with Garrison et al. 1983 who state that smoking is clearly related to body size: lean individuals are more likely to be smokers than are those of normal or excess weight. Cigarette smoking appears to reduce body fat in a number of ways, including a reduction in caloric intake and an increased level of energy expenditure. Smoking cessation

### Table III

**Logistic regression analyses of overweight and obesity with associated variables. Mexican Health and Aging Study 2001**

<table>
<thead>
<tr>
<th>Variables</th>
<th>Total (OR 95%CI)</th>
<th>Men (N=2392) (OR 95%CI)</th>
<th>Women (2213) (OR 95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Overweight</td>
<td>Obesity</td>
<td>Overweight</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (years)</td>
<td>0.66 (0.55-0.81)</td>
<td>0.50 (0.39-0.64)</td>
<td>0.76 (0.58-0.99)</td>
</tr>
<tr>
<td>Educational level</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt; primary</td>
<td>0.81 (0.67-0.97)</td>
<td>0.80 (0.64-0.99)</td>
<td>0.67 (0.48-0.95)</td>
</tr>
<tr>
<td>Self-rated economic status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fair/poor</td>
<td>0.70 (0.55-0.87)</td>
<td>0.69 (0.53-0.91)</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>1.45 (1.5-1.84)</td>
<td>1.38 (1.04-1.83)</td>
<td>1.71 (1.14-2.58)</td>
</tr>
<tr>
<td>Myocardial infarction</td>
<td>1.61 (1.05-2.47)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowel disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-distance walk limitation</td>
<td>1.94 (1.52-2.47)</td>
<td>2.08 (1.53-2.82)</td>
<td>2.21 (1.47-3.32)</td>
</tr>
<tr>
<td>Currently smokes</td>
<td>0.72 (0.56-0.94)</td>
<td>0.61 (0.44-0.84)</td>
<td>0.66 (0.46-0.97)</td>
</tr>
</tbody>
</table>

* p < .01  † p < .001  ‡ p < .05
is also related to body size. Studies of mortality generally found that current smokers are leaner and have higher mortality than nonsmokers or past smokers.

Diabetes and arthritis-two diseases most commonly associated with excess weight-were not significantly associated with overweight or obesity. These results could be explained because subjects who are prone to the complications of overweight and obesity may have already died, leaving those who are more resistant to its effects.24

In this study, we found an effect of obesity on myocardial infarction in the total population, but this effect disappears in the gender-stratified analysis. The evidence of the effect of overweight and obesity in the incidence of cardiovascular disease is contradictory in some cases or not consistent in the literature.25

Data from weight and height were obtained from self-reports and could be underestimated or overestimated, especially in people 75 years and older; in the literature, however, we found that several studies have consistent findings of high correlations of self-reported height and weight with measured height and weight.26

Another aspect to consider about self-reporting is that people with a low educational level and or with cognitive decline would be underestimated.

In addition, measuring height and weight in older adults, taking into account their physical (scoliosis, lordosis, arthritis, amputations) and functional conditions (balance problems, walking limitations, dementias, protrated condition), represents a problem.

In conclusion, some evidence was found of an association between overweight and obesity and some common health and sociodemographic conditions in the elderly; however, it is important to conduct longitudinal studies in order to discover the effect of BMI and other nutritional status indicators, such as body composition, on this population health group. This information can be useful for nutritionists and physicians who work with elderly people, in terms of making decisions as to whether or not to recommend losing weight.

References