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Blodgett, Joanna M and Cooper, Rachel and Davis, Daniel HJ and Kuh, Diana and Hardy, Rebecca (2020) Associations between factors across life and balance ability in mid and later life: evidence from a British birth cohort study. *Frontiers in Sports and Active Living*, 2.

Downloaded from: <http://e-space.mmu.ac.uk/625365/>

Version: Accepted Version

Publisher: Frontiers

DOI: <https://doi.org/10.3389/fspor.2020.00028>

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Associations between factors across life and one-legged balance performance in mid and later life: evidence from a British birth cohort study

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9 **Keywords:** balance, ageing, life course, risk factor, epidemiology

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13

14 **Abstract**

15 **Introduction:** Despite its associations with falls, disability and mortality, balance is an under-
16 recognised and frequently overlooked aspect of ageing. Studies investigating associations between
17 factors across life and balance are limited. Understanding the factors related to balance performance
18 could help identify protective factors and appropriate interventions across the life course. This study
19 aimed to: i) identify socioeconomic, anthropometric, behavioural, health and cognitive factors that are
20 associated with one-legged balance performance; and ii) explore how these associations change with
21 age.

22 **Methods:** Data came from 3111 members of the MRC National Survey of Health and Development, a
23 British birth cohort study. Multilevel models examined how one-legged standing balance times
24 (assessed at ages 53, 60-64 and 69) were associated with fifteen factors across life: sex, maternal
25 education (4y), paternal occupation (4y), own education (26y), own occupation (53y) and
26 contemporaneous measures (53, 60-64, 69y) of height, BMI, physical activity, smoking, diabetes,
27 respiratory symptoms, cardiovascular events, knee pain, depression and verbal memory. Age and sex
28 interactions with each variable were assessed.

29 **Results:** Men had 18.8% (95%CI: 13.6, 23.9) longer balance times than women at age 53, although
30 this difference decreased with age (11.8% at age 60-64 and 7.6% at age 69). Disadvantaged
31 socioeconomic position in childhood and adulthood, low educational attainment, less healthy
32 behaviours, poor health status, lower cognition, higher body mass index (BMI) and shorter height were
33 associated with poorer balance at all three ages. For example, at age 53, those from the lowest paternal
34 occupational classes had 29.6% (22.2, 38.8%) worse balance than those from the highest classes.
35 Associations of balance with socioeconomic indicators, cognition and physical activity became smaller
36 with age, while associations with knee pain and depression became larger. There were no sex
37 differences in these associations. In a combined model, the majority of factors remained associated
38 with balance.

39 **Discussion:** This study identified numerous risk factors across life that are associated with one-legged
40 balance performance and highlighted diverse patterns of association with age, suggesting that there are
41 opportunities to intervene in early, mid and later life. A multifactorial approach to intervention, at both
42 societal and individual levels, may have more benefit than focusing on a single risk factor.

43

44 1 Introduction

45 From getting out of bed in the morning to sitting, standing and walking throughout the day, balance is
46 a crucial component of everyday life (1). Poor balance is linked with several adverse health outcomes,
47 perhaps most notably increased falls risk (2), but also with increased risk of disability, fractures,
48 hospitalisation and premature mortality (3-6). Despite the growing awareness of the importance of
49 balance in ageing – as reflected in recent physical activity guidelines (7-9) – the life course
50 epidemiology of balance performance has been under-investigated compared with other measures of
51 physical capability such as grip strength and chair rise performance.

52 In the few studies that have examined factors across life in relation to balance performance, several
53 associations have been found. Across a range of ages, males tend to have better balance performance
54 than females (10-13). Low socioeconomic position (SEP) has been found to have a negative cumulative
55 association with balance performance, with an additive effect of low SEP in childhood and adulthood
56 on risk for poor balance in later life (14, 15). Smoking history (16), low cognitive ability in both
57 childhood and adulthood (17, 18), higher levels of depression (19) and low levels of physical activity
58 (20-22), have also been shown to be associated with poor balance.

59 These previous studies have primarily examined associations between a single risk factor and balance
60 ability at one time point. With the exception of our recent study of the association between childhood
61 cognitive ability and balance performance (17), to our knowledge, no study has examined whether
62 associations change with age. This is a limitation, given that balance is a complex process that relies
63 on sensory input including visual cues, proprioception, vestibular processes as well as muscular
64 strength and cognitive processing (23), and so may be affected by age-related changes, such as
65 increased levels of morbidity and decline in cognitive functioning. In addition, few studies have
66 investigated sex differences in the associations between risk factors and balance ability. This is despite
67 the fact that investigating sex differences in the relationships between different risk factors and balance
68 may help elucidate why men have better average balance performance than women, as the reasons for
69 this are still not fully understood (10, 13, 24-26).

70 Using a British birth cohort study, previously used to study factors associated with balance at a single
71 age (11, 14-18, 20, 21, 27-29), we aimed to investigate associations of socioeconomic, behavioural,
72 health and cognitive risk factors across life with one-legged balance performance over sixteen years
73 and assess if these associations change with age or sex. We hypothesised that positive factors such as
74 high SEP, low BMI, participation in healthy behaviours, absence of poor physical and mental health

75 as well as higher adult cognitive ability would be associated with better balance performance. As
76 physical and mental comorbidities become more common with age, we hypothesised that the
77 associations of health status with balance performance would get stronger with age. Conversely, as
78 health status becomes more important, the relative contributions of SEP were hypothesised to decrease.

79 **2 Methods**

80 **2.1 Sample**

81 The MRC National Survey of Health and Development (NSHD) is an ongoing study of 5362
82 individuals born in England, Scotland or Wales within one week in March 1946. Since 1946, study
83 members have been followed up to 24 times in infancy, across childhood, adolescence, and adulthood,
84 most recently at ages 53 (n=2988), 60–64 (n=2229) and 69 (n=2149) using a combination of
85 questionnaires, interviews and clinical examinations (30). Details of loss to follow-up (e.g. death,
86 emigration, refusal, incapacity) in this sample have been previously described (17). Ethical approval
87 for the most recent data collection wave (2015) was obtained from Queen Square Research Ethics
88 Committee (14/ LO/1073) and Scotland A Research Ethics Committee (14/SS/1009).

89 **2.2 Assessment of balance ability**

90 *One-legged balance performance* was assessed by trained nurses during clinical assessments at ages
91 53, 60-64 and 69 using standardised protocols. Study members were asked to fold their arms and stand
92 on their preferred leg with their eyes closed for as long as possible up to a maximum of 30 seconds. If
93 individuals were unable to perform the test, the reason was recorded. In these analyses, individuals
94 who could not perform the test due to health reasons and those who attempted but could not maintain
95 the balance position were given a score of zero. The final analytical sample consisted of individuals
96 with a balance time at one or more ages (n=3111). The one-legged balance test is considered to be a
97 reliable and valid measure of static balance and has been shown to have high inter-rater and test-retest
98 reliability (31-36). Many studies have consistently demonstrated associations between poor one-
99 legged balance performance and higher risk of falls, disability, poor gait speed, frailty and premature
100 mortality (4, 36-40).

101 **2.3 Assessment of risk factors**

102 We selected a set of risk factors *a priori* that had previously been shown to be associated with balance
103 or other measures of physical capability at a single time point in NSHD and other studies (11, 14-16,
104 18, 20, 21, 27, 41-43)(44).

105 **2.3.1 Socioeconomic indicators**

106 *Paternal occupational class* (at age 4) and *own occupational class* (reported at age 53 years) were
 107 grouped into three categories as distinguished by the Registrar General's Social Classification (45): 1)
 108 I Professional and II Intermediate; 2) III Skilled (non-manual) and III Skilled (manual); and 3) IV
 109 Partly skilled and V Unskilled manual. *Maternal education* was classified into four categories: 1)
 110 Primary only; 2) Primary and further education; 3) Secondary only; 4) Secondary and further
 111 education. Participants reported their highest level of *educational attainment* by age 26, which was
 112 categorised as degree or higher, advanced secondary qualifications generally attained at 18 years (GCE
 113 A level or Burnham B), ordinary secondary qualifications generally attained at 16 years, (e.g. GCE O
 114 level or Burnham C), below ordinary secondary qualifications, or none.

115 **2.3.2 Anthropometric indicators (ages 53, 60-64, 69)**

116 *Height (m)* and *BMI (kg/m²)*, derived from height and weight measurements ascertained by nurses
 117 using standardised protocols, were used (46).

118 **2.3.3 Behavioural risk factors (ages 53, 60-64, 69)**

119 Individuals self-reported their *leisure time physical activity participation* (never, 1-4 times/month, 5+
 120 times/month) and their *smoking status* (never, past smoker, current smoker) (16, 47). Current and past
 121 smokers were defined as those who smoked at least one cigarette a day for 12 months or more.

122 **2.3.4 Health status (ages 53, 60-64, 69)**

123 Current health conditions (yes/no for each) were ascertained using a series of self-reported questions
 124 on *history of diabetes, cardiovascular events, respiratory symptoms and knee pain* (4, 48). *Symptoms*
 125 *of depression and anxiety* were assessed using the 28-item self-reported General Health Questionnaire;
 126 each item was scored from 1 to 4 and summed together (range: 0-84) (49).

127 **2.3.5 Cognitive ability (ages 53, 60-64, 69)**

128 Verbal memory was assessed using a 15-item word list. Each word was presented for two seconds
 129 before individuals were instructed to write down as many words as they could remember. This was
 130 repeated over three identical trials and the number of words recalled during each trial were summed
 131 (range: 0-45). To minimise any practice effects, two word lists were rotated between follow-up
 132 assessments (50).

133 **2.4 Statistical analyses**

134 Sex differences in each risk factor were assessed using t-tests or chi-square tests, as appropriate, and
 135 described by the mean (\pm SD) or proportion (n). Separate multilevel models were used to examine the

136 associations between each risk factor (independent variable) and log transformed balance performance
137 (dependent variable) in the maximal available sample size. Cross-sectional associations were assessed
138 for time-varying covariates (e.g. anthropometric, behavioural, health, cognitive factors), whereas SEP
139 measures were based on reports from one age. Balance times at each age (level 1) were nested within
140 individuals (level 2) and both the intercept and slope were modelled as random effects. As the sample
141 was age-homogenous, age was employed as a linear time metric and was centred at age 53 (intercept);
142 age 63 was utilised as the time integer for age 60-64 (17, 51). Balance times were log-transformed due
143 to the skewed distribution of balance. Non-linearity of the association between each risk factor and
144 balance was assessed using likelihood ratio tests.

145 A variable-by-sex interaction term was estimated, with subsequent models stratified by sex if there was
146 evidence of an interaction. An interaction between age and each risk factor was added to the model to
147 test whether the association between each risk factor and balance changes with age. Age interactions
148 were considered if $p < 0.05$; an alpha of 0.05 was used for both age and sex interactions in order to
149 parsimoniously build each model. Finally, all risk factors and significant interaction terms were
150 included in a combined model. To account for the non-random events of mortality and attrition (not
151 due to death), the model was adjusted for separate binary indicators of both death and attrition (not due
152 to death) between ages 53 and 69. This approach minimises the correlation between non-random loss
153 to follow up and poorer performance on the balance test, thus reducing bias in the other estimates (52,
154 53). All estimates are presented as sympercents (i.e. as % change) to aid interpretation (54). Stata 14
155 was used for all statistical analyses.

156 **3 Results**

157 Characteristics of the sample are described in Table 1. Men were taller than women, had higher adult
158 SEP, higher educational attainment, lower verbal memory and were more likely to have a history of
159 smoking. Men also had a higher prevalence of diabetes and CVD events, although women reported
160 higher prevalence of knee pain and symptoms of anxiety and depression.

161 **3.1 Sex, age and balance**

162 Women had 18.8% (95%CI: 13.6, 23.9%; Table 2, Figure 1) worse balance performance than men at
163 age 53. The interaction between age and sex indicated that for every additional year increase in age,
164 the sex difference in balance decreased by 0.7% (0.3, 1.2%). Thus, at ages 63 and 69 respectively,
165 women had 11.4% (7.6, 15.2%) and 7.0% (2.1, 11.9%) lower balance times than men. Despite the sex
166 differences in balance performance across time, there were no interactions between sex and any of the
167 risk factors investigated.

168 **3.2 Socioeconomic indicators and balance**

169 The results of the likelihood ratio tests for deviations from linearity suggested that all four
170 socioeconomic indicators could be modelled as continuous variables. More disadvantaged SEP for all
171 four indicators – paternal occupation, maternal education, own education, own occupation – was
172 associated with worse balance times (Table 2, Figure 2). For example, more disadvantaged paternal
173 occupational class was associated with 14.8% (11.1, 18.4%; Table 2, Figure 2A) poorer balance time
174 for each subsequent level. The associations with paternal occupational class, maternal education and
175 own educational attainment all became smaller with age (all $p < 0.001$, Table 2, Figure 2), however there
176 was no interaction between own occupational class and age ($p = 0.1$).

177 **3.3 Anthropometric indicators and balance**

178 Height had a quadratic association with balance such that taller individuals had better balance times
179 than shorter individuals although this association plateaued at the tallest heights (see Table 2, Figure
180 3). BMI had an inverse linear association with balance, where every additional kg/m^2 was associated
181 with 2.8% (2.5, 3.1%) poorer balance time (Table 2, Figure 4). There was no evidence of an interaction
182 with age for either height ($p = 0.1$) or BMI ($p = 0.6$) suggesting that the association stayed constant over
183 time (Table 3).

184 **3.4 Health behaviours and balance**

185 Those who participated in leisure time physical activity 1-4 times (23.9% (17.3, 30.5%)) or 5+ times
186 (23.3% (18.0, 28.7%)) per month had better balance times than those who did not participate at age 53
187 (Table 2, Figure 5A). There was no difference in balance between those who participated in leisure
188 time physical activity 1-4 times/month and those who participated 5+ times/month. There was evidence
189 that the association got smaller with age, as shown by the age-interaction for those who participated 1-
190 4 times/month.. Individuals who had a past history of smoking or who were current smokers had worse
191 balance ability than those who had never smoked (6.1% (3.3, 8.9%); Table 2, Figure 5B); there was no
192 evidence that this association changed with age.

193 **3.5 Current health status and balance**

194 Individuals who had a history of diabetes, a history of CVD events or current respiratory symptoms
195 had worse balance performance; these associations remained constant with age (Table 2, Figure 6A-
196 C). Those who reported knee pain had 10.8% (4.6, 17.0%) lower balance times at age 53; this
197 association got larger with age (0.7% per year (0.1, 1.2)) such that those with knee pain at age 69 had
198 21.6% (15.4, 27.8%) poorer balance than those with no knee pain (Table 2, Figure 6D). A one standard

199 deviation increase in depression and anxiety symptoms on the GHQ-28 questionnaire was associated
200 with a 5.2% (2.8, 7.7%, Table 2, Figure 6E) decrease in balance times. This association also increased
201 with age by 0.3% per year (0.04, 0.5%); by age 69, 1 SD increase in GHQ-28 score was associated
202 with a 9.5% (7.0, 11.9%) decrease in balance time.

203 **3.6 Cognitive ability and balance**

204 One standard deviation increase in verbal memory was associated with a 13.4% (11.0, 15.9%; Table
205 2, Figure 7) increase in balance time at age 53. This association got smaller with age (0.5% per year,
206 (0.3, 0.7%), but remained associated with balance at age 69 (5.1%, (2.6, 7.5%)).

207 **3.7 Combined model of all covariates and their association with balance**

208 Table 4 provides the estimates for the combined model of all covariates and the relevant age interaction
209 terms. Notably, being female, having higher BMI, lower maternal education, lower educational
210 attainment, lower own occupational class, not participating in leisure time physical activity, reporting
211 a history of CVD events, higher levels of anxiety and depression and lower verbal memory remained
212 associated with lower balance time. Nearly all age interaction terms weakened and were no longer
213 statistically significant (at the 5% level) in this model, although there remained evidence that the
214 associations with sex and verbal memory decreased with age.

215 **4 Discussion**

216 **4.1 Main findings**

217 We quantified associations between a range of risk factors across life and balance performance at ages
218 53, 60-64 and 69. Individuals with better balance were more likely to be male, have higher SEP in
219 both childhood and adulthood, be taller, have lower BMI, partake in leisure time physical activity and
220 were less likely to smoke. Individuals with better balance were also more likely to be healthier (no
221 history of diabetes or CVD, not currently experiencing respiratory symptoms or knee pain), less likely
222 to be experiencing symptoms of depression and anxiety, and more likely to have higher verbal memory.
223 In a combined model, the majority of risk factors remained independently associated with balance,
224 indicating that the factors across life that are associated with one-legged balance are multifaceted and
225 complex.

226 Sex differences in balance performance were not explained by adjustment for other risk factors.
227 Furthermore, there was no evidence to suggest that the associations between these risk factors and
228 balance differed by sex, although several associations did change with age. Associations of balance

229 performance with sex, socioeconomic indicators, physical activity and verbal memory became smaller
230 with increasing age, while associations with anthropometric indicators, smoking and physical health
231 status stayed constant. Two associations became larger with age; associations of both knee pain and
232 symptoms of anxiety and depression with balance doubled from age 53 to 69.

233 **4.2 Comparison with other studies and explanation of findings**

234 *4.2.1 Socioeconomic indicators*

235 A systematic review and meta-analysis of over 22 000 individuals from 11 separate studies reported
236 that lower childhood SEP (as indicated by parental occupation and education) was associated with
237 inability to balance with eyes open for ≥ 5 seconds (14); adjustment for adult SEP fully attenuated the
238 effect of childhood SEP (paternal occupation used if available). However, maternal education and both
239 indicators of adulthood SEP remained independently associated with balance time in our fully-adjusted
240 model. In addition to differing operationalisations of balance performance (continuous vs binary; eyes
241 closed vs eyes open), a possible explanation for these differing results is that 9 of the 11 studies
242 included in the meta-analysis relied upon retrospective reports of childhood SEP (55). A strength of
243 NSHD is that data on SEP and other risk factors were prospectively ascertained and so not prone to
244 recall bias. As previously shown in relation to cognitive outcomes (56, 57), paternal occupational class
245 and maternal education may have distinctive associations with balance performance; further
246 exploration of these differences are required.

247 While childhood SEP is hypothesised to be associated with balance ability via a complex pathway of
248 health behaviours, education, adult SEP, cognitive ability and/or health conditions, the association
249 remained when these factors were included in the model. Thus, childhood may also represent a
250 sensitive period of development for balance ability, as previously hypothesised when testing
251 associations of childhood cognition and midlife balance performance in NSHD (17). Adult SEP may
252 also be associated with balance through a pathway of current physical and cognitive health or health
253 behaviours. That both childhood and adult SEP indicators remained independently associated with
254 balance suggests that accumulation of low SEP across the life course may be a greater risk factor than
255 low SEP at any one particular life stage.

256 Notably, the relationship between most SEP indicators and balance time weakened with increasing
257 age. This suggests that SEP may be more strongly associated with balance in midlife than at older ages
258 when substantial age-related decline begins and chronic diseases manifest. Nevertheless, the
259 association between the most recent measure of SEP (occupational class at age 53) and balance did not
260 change with age.

261 4.2.2 Anthropometric indicators

262 Higher body mass may influence the stability of an individual and the motor mechanisms involved in
263 the balance process. For example, individuals with higher BMI often require more movement in order
264 to maintain their balance, thus frequently demonstrate high levels of postural sway and reduced balance
265 performance (41, 58). Studies have suggested that body stability is inversely related to the height of
266 the centre of gravity (41) and that shorter individuals are better able to maintain their balance. However,
267 we found that taller individuals had better balance than shorter individuals though this effect appeared
268 to plateau above a certain height.

269 Previous evidence has suggested that sex differences in balance performance disappear when scores
270 are normalised to height (24-26, 59), while other studies have shown that anthropometric factors are
271 major determinants of balance performance in women only (12). However, we found no sex differences
272 in the association of either height or BMI with balance and adjustment for these measures did not
273 explain sex differences (as seen in the combined model). Given that men have higher average strength
274 and mobility compared to women (60-62), further investigation into whether more detailed assessment
275 of body composition (e.g. lean mass, fat mass) explains sex differences is warranted

276 4.2.3 Health behaviours

277 It is well recognised that low levels of physical activity (63-66) and current or past smoking (64, 67)
278 have negative consequences for an individual's physical capability, including their balance
279 performance. Some studies have shown increasing levels of physical activity are associated with better
280 balance (21, 68), while others have shown that there is no difference in health benefit between
281 moderately active and maximally active groups (64). In this study, participation in leisure time physical
282 activity was associated with better balance performance. Although there was little additional benefit
283 for balance beyond 1-4 times per month at age 53, a graded association between increasing levels of
284 physical activity and balance performance emerged by age 69 (see Figure 5A).

285 Individuals who currently smoked had worse balance performance compared with those who were ex-
286 smokers; ex-smokers also had worse balance compared with those who had never smoked. Although
287 not previously examined, this is consistent with increasing severity of poor physical capability seen
288 amongst categories of smoking history (64, 69), suggesting that quitting smoking may have a positive
289 association with balance performance.

290 4.2.4 Current health status

291 The presence of each physical and mental health condition (diabetes, CVD, respiratory symptoms, knee
292 pain, symptoms of anxiety and depression) was associated with poorer balance performance. This is

293 consistent with the literature on how current health impacts an individual's physical capability or
294 functional decline (42, 70, 71). Each health condition likely has a direct biological pathway impacting
295 balance. For example, diabetes is related to both peripheral neuropathy (72) and age-related visual
296 impairment (73, 74) while knee pain can have a direct impact on proprioception and musculoskeletal
297 function (75). Individuals with a history of CVD events or respiratory symptoms often demonstrate
298 shared pathophysiological features common in those with balance impairment including increased
299 postural sway due to physical displacement of breathing (76), decreased blood flow in specific
300 functional areas (77) and decreased musculoskeletal capacity (78). Finally, increased inflammatory
301 markers that are common in arthritis, such as C-reactive protein or nitric oxide (79) are also more
302 common in individuals with depression than those without. In addition to this inflammation pathway,
303 individuals with depression also tend to restrict their physical activity, have reduced motivation to
304 perform well and exhibit psychomotor impedance such as a slowing in musculoskeletal components
305 (80); all of these factors can influence balance performance.

306 The associations of diabetes, CVD and respiratory symptoms with balance performance were constant.
307 However, the associations of knee pain and symptoms of anxiety and depression with balance got
308 stronger at older ages. The constant or increasing associations between health conditions and balance
309 ability with age suggests that overall health becomes relatively more important for balance ability in
310 later life; this could in part explain why the strength of associations with many other risk factors
311 decreased with increasing age.

312 *4.2.5 Cognitive ability*

313 As expected given previous findings in NSHD (17, 18), higher verbal memory was associated with
314 higher levels of balance performance. Cognitive processing of sensory and motor input is an important
315 component of the balancing process (81). Previous evidence in NSHD has shown that childhood
316 cognitive ability is associated with adult balance performance; this is primarily via an adult cognition
317 and education pathway that is independent of most of the other risk factors examined here (17). As
318 suggested above, the decreasing strength of association with age suggests that cognitive ability
319 becomes less important with age, as other factors in the ageing process, in particular health conditions,
320 become more important.

321

322 **4.3 Methodological considerations**

323 A major strength of this paper is the assessment of one-legged balance performance at three ages,
324 which facilitated our novel investigation into whether associations between risk factors and balance
325 change over sixteen years, from mid to later life. A second strength is the comprehensive investigation,
326 in separate and combined models, of the associations between fourteen different factors across life and
327 balance ability. These risk factors were all prospectively ascertained which increases reliability of
328 response and limits recall bias. A third strength was the methods used to include those individuals who
329 had missing balance scores for health reasons or because of death or loss to follow up between ages 53
330 and 69. These combined strengths provided novel evidence on how the associations between these
331 risk factors and balance performance change with age. Finally, the age homogeneity of the sample
332 eliminated any confounding by age that is common when examining physical capability in mid and
333 later life (82, 83).

334 One potential limitation of our study is that we were unable to include participants in analyses if they
335 had been lost to follow up before age 53 (i.e. the age at which balance was first assessed).
336 Characteristics of study members who were lost to follow up before the first clinical assessment at age
337 53 were more likely to be male (84), have lower childhood and adulthood occupational class (30, 84),
338 demonstrate unhealthy behaviours (smoking, physical inactivity) (84), have lower verbal memory (84)
339 and have poorer overall health (30). Participants who were followed up to age 53 but could not be
340 included in analyses due to missing data on risk factors had similar characteristics to those lost to
341 follow-up before age 53. Many of these characteristics (i.e. low SEP, unhealthy behaviours, lower
342 cognition and poorer health) were negatively associated with balance ability, thus it is hypothesized
343 that those with lost to follow up before age 53 or with missing risk factor data may have had poorer
344 balance. This likely resulted in an underestimation of the size and strength of associations.

345 Two further limitations are the assumptions of the model: that the change in balance over time is linear
346 and that all individuals follow the same mean trajectory of decline. Individuals are likely to exhibit
347 heterogenous ageing trajectories as they demonstrate different patterns of change in balance
348 performance with age (e.g. steeper decline, delayed decline, maintenance of balance ability). As there
349 were only three time points for balance, it was not appropriate to test for non-linearity in balance
350 trajectories. Identifying polynomial time terms can help identify the age at which decline begins or
351 accelerates. Further research, with at least four measures of balance performance, should address these
352 differences across time and between individuals. We also need to consider the possibility that other
353 factors not considered in our analyses such as alcohol consumption and medication use may also be
354 important and need to be considered in future research.

355 Although there were multiple comparisons, the risk of Type 2 error remains low as all of the primary
356 associations in Table 2 were significant at $p < 0.001$ and an alpha of 0.05 was intentionally used for
357 interaction terms to ensure a parsimonious model. Finally, the one-legged balance test measures a
358 specific aspect of static balance that does not directly represent the dynamic balance relied upon in
359 everyday situations (85-87) . Further research should consider if associations between the risk factors
360 identified in this study are consistent for tests of dynamic balance or for more sensitive measures of
361 postural sway, as assessed with a force plate.

362 **4.4 Implications and conclusions**

363 We investigated fourteen different factors across life that are associated with balance performance.
364 These findings are important in considering appropriate interventions to minimise balance decline or
365 when identifying high-risk individuals. That multiple risk factors were identified suggests that a
366 multifactorial approach including behavioural, health and cognitive factors (amongst others) may have
367 more benefit than a focus on a single risk factor. As several of these risk factors have different
368 associations with balance at different ages, there may be benefit in targeting different factors at
369 different ages. Knee pain and symptoms of depression and anxiety both appear to become more
370 important with age and may represent important targets for intervention in midlife before their potential
371 association with balance performance increases. While not all of the factors identified (e.g.
372 socioeconomic, height, smoking history) may be easily modified, they are likely to have utility in
373 helping to identify individuals at high risk of future balance difficulties who may require more support
374 than others to maintain balance as they age.

375 In summary, this study identified many anthropometric, behavioural, socioeconomic, health and
376 cognitive risk factors across life that are associated with balance performance. The majority of
377 variables remained independently associated with balance suggesting that the range of risk factors
378 associated with poor balance is diverse and complex. This highlights the importance of considering
379 both type (i.e. multifactorial approach) and timing (i.e. early, mid and later life) of interventions that
380 target balance ability in adulthood.

381 **Conflict of Interest**

382 The authors declare that the research was conducted in the absence of any commercial or financial
383 relationships that could be construed as a potential conflict of interest.

384 **Author Contributions**

385 All authors contributed to the conception and design of the study. JB performed statistical analyses
386 and wrote the first draft of the manuscript. All authors contributed to manuscript revision, read and
387 approved the submitted version.

388

389 **Funding**

390

391 Funding for the MRC NSHD was provided by the Medical Research Council (MC_UU_00019/1
392 Theme 1: Cohorts and Data Collection). JB is supported by the Canadian Institutes of Health
393 Research (FDSA) and the Canadian Centennial Scholarship Fund. RH is Director of CLOSER which
394 is funded by the Economic and Social Research Council (award reference: ES/K000357/1) and was
395 funded by the ESRC and MRC between 2012 and 2017. DK, RH and RC were supported by the UK
396 Medical Research Council MC_UU_12019/1 which provided core funding for the MRC National
397 Survey of Health and Development and by MC_UU_12019/2 and MC_UU_12019/4. DD is funded
398 through a Wellcome Trust fellowship (WT107467).

399

400 **Figure titles:**

401 **Figure 1.** Differences in balance time at ages 53, 60-64 and 69 years by sex

402 **Figure 2.** Differences in balance time at ages 53, 60-64 and 69 years by A. paternal occupational
403 class, B. maternal education, C. own education and D. own occupational class

404 **Figure 3.** Differences in balance time at ages 53, 60-64 and 69 years by height (cm)

405 **Figure 4.** Differences in balance time at ages 53, 60-64 and 69 years by BMI (kg/m²)

406 **Figure 5.** Differences in balance time at ages 53, 60-64 and 69 years by A. leisure time physical activity
407 and B. smoking status

408 **Figure 6.** Differences in balance time at ages 53, 60-64 and 69 years by A. diabetes, B. CVD events,
409 C. respiratory symptoms, D. knee pain and E. symptoms of depression and anxiety

410 **Figure 7.** Differences in balance time at ages 53, 60-64 and 69 years by verbal memory

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Table 1. Characteristics of analytical sample (n=3111), MRC National Survey of Health and Development

	Men (n=1550)	Women (n=1561)	Tests of sex differences (p-value)	
ONE-LEGGED BALANCE TIME (s), median (Q1, Q3), n				
Age 53	5 (3, 10), n= 1421	4 (3, 7), n=1476	<0.001	
Age 60-64	3.57 (2.35, 5.53), n=1055	3.16 (2.16, 4.72), n=1148	<0.001	
Age 69	2.94 (1.84, 4.78), n=1037	2.72 (1.69, 4.15), n=1079	<0.005	
SOCIOECONOMIC INDICATORS, n (%)				
Paternal occupational class				
I Professional/II Intermediate	407 (27.6)	383 (26.0)	0.56	
III Skilled (non-manual or manual)	692 (46.9)	716 (48.7)		
IV Partly skilled/V Unskilled	377 (25.5)	372 (25.3)		
Maternal education				
Secondary and further education	162 (11.74)	169 (12.2)	0.49	
Secondary only	167 (12.1)	153 (11.0)		
Primary and further education	213 (15.4)	193 (13.90)		
Primary only	838 (60.7)	873 (62.9)		
Highest household occupational class				
I Professional/II Intermediate	788 (51.6)	559 (36.1)	<0.001	
III Skilled (non-manual or manual)	578 (37.8)	659 (42.6)		
IV Partly skilled/V Unskilled	162 (10.6)	329 (21.3)		
Educational attainment at age 26				
Degree or higher	212 (14.5)	81 (5.5)	<0.001	
GCE A level or Burnham B	408 (27.9)	343 (23.3)		
GCE O level or Burnham C	211 (14.4)	377 (25.6)		
Sub GCE	92 (6.3)	134 (9.1)		
None attempted	540 (36.9)	537 (36.5)		
ANTHROPOMETRY, mean (SD)				
Height (m)				
Age 53	1.75 (0.07), n=1436	1.62 (0.06), n=1498	<0.001	
Age 60-64	1.75 (0.09), n=1062	1.62 (0.06), n=1159	<0.001	
Age 69	1.73 (0.09), n=1023	1.61 (0.06), n=1077	<0.001	
BMI (kg/m²)				
Age 53	27.4 (4.0), n=1435	27.4 (5.5), n=1486	0.89	
Age 60-64	27.9 (4.1), n=1061	27.9 (5.5), n=1158	0.92	
Age 69	28.2 (4.6), n=1040	28.2 (5.7), n=1081	0.91	
BEHAVIOURAL RISK FACTORS, n (%)				
Leisure time physical activity				
Age 53	None	693 (47.9)	761 (50.4)	0.18
	1-4 times/month	270 (18.7)	245 (16.2)	
	5+ times/month	485 (33.5)	503 (33.3)	
Age 60-64	None	681 (65.2)	716 (62.9)	0.52
	1-4 times/month	137 (13.1)	162 (14.2)	
	5+ times/month	227 (21.7)	261 (22.9)	
Age 69	None	711 (59.9)	777 (61.33)	0.08
	1-4 times/month	135 (11.4)	170 (13.42)	
	5+ times/month	341 (28.7)	320 (25.3)	
Smoking status				
Age 53	Current	343 (23.6)	339 (22.5)	<0.001
	Previous smoker	737 (50.8)	671 (44.5)	
	Never smoker	371 (25.6)	499 (33.1)	
Age 60-64	Current	137 (12.3)	142 (11.8)	<0.001
	Previous smoker	663 (59.5)	629 (52.1)	
	Never smoker	314 (28.2)	436 (36.1)	
Age 69	Current	123 (10.3)	111 (8.8)	<0.001
	Previous smoker	756 (63.5)	723 (57.2)	

Never smoker		311 (26.1)	430 (34.0)	
HEALTH STATUS, n(%)				
Diabetes	Age 53	57 (3.1)	43 (2.4)	0.18
	Age 60-64	129 (10.1)	99 (7.2)	<0.01
	Age 69	175 (13.7)	136 (10.0)	<0.005
CVD events	Age 53	85 (5.8)	48 (3.2)	<0.01
	Age 60-64	131 (11.5)	62 (5.1)	<0.001
	Age 69	193 (17.6)	114 (10.0)	<0.001
Respiratory symptoms	Age 53	292 (19.9)	276 (18.2)	0.22
	Age 60-64	233 (20.1)	224 (18.2)	0.15
	Age 69	264 (24.5)	266 (22.4)	0.23
Knee pain	Age 53	226 (15.5)	310 (20.6)	<0.001
	Age 60-64	216 (20.3)	288 (24.6)	0.01
	Age 69	190 (18.1)	241 (22.1)	0.02
Depression/anxiety	Age 53	15.2 (7.3), n=1051	17.8 (8.9), n=1137	<0.001
	Age 60-64	15.7 (8.6), n=1407	18.9 (10.3), n=1470	<0.001
	Age 69	14.1 (7.5), n=1025	16.2 (8.2), n=1068	<0.001
Verbal memory scores, mean (SD)				
	Age 53	23.0 (6.2), n=1397	24.9 (6.2), n=1473	<0.001
	Age 60-64	23.0 (5.9), n=1023	25.4 (6.1), n=1127	<0.001
	Age 69	21.2 (6.0), n=1005	23.1 (6.0), n=1057	<0.001

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Table 2. Associations between risk factors and balance performance in multilevel models

Risk factors ^a	n participants (n observations)	Mean difference in % balance time at age 53 (intercept)		Age (yr)*covariate interaction	
		Coefficient (%) (95% CI)	<i>p</i> -value	Coefficient (%) (95% CI)	<i>p</i> -value
1: Sex (female vs male (ref))	3111 (obs=7216)	-18.8 (-23.9, -13.6)	<0.001	0.7 (0.3, 1.2)	<0.001
2: Paternal occupational class ^b (per 1 level change)	2947 (obs=6838)	-14.8 (-18.4, -11.1)	<0.001	0.5 (0.2, 0.8)	<0.001
3: Maternal education ^c (per 1 level change)	2768 (obs=6424)	-11.3 (-23.8, -8.8)	<0.001	0.4 (0.2, 0.6)	<0.001
4: Education at age 26 ^d (per 1 level change)	2935 (obs=6830)	-11.1 (-12.9, -9.3)	<0.001	0.3 (0.2, 0.5)	<0.001
5: Own occupational class ^b (per 1 level change)	3075 (obs=7167)	-15.2 (-17.9, -12.6)	<0.001	-	-
6: Height (cm)					
linear term	3090 (obs=7144)	12.5 (6.4, 18.7)	<0.001	-	-
quadratic term		-0.04 (-0.05, -0.02)	<0.001	-	-
7: BMI (kg/m ²)	3083 (obs=7150)	-2.8 (-3.1, -2.5)	<0.001	-	-
8: Leisure time physical activity ^e	3094 (obs=6960)				
1-4 times		23.9 (17.3, 30.5)	<0.001	-0.7 (-1.3, 0.02)	0.04
5+ times		23.3 (18.0, 28.7)	<0.001	-0.4 (-0.9, 0.1)	0.12
9: Smoking ^f (per 1 level change)	3092 (obs=6996)	6.1 (3.3, 8.9)	<0.001	-	-
10: Diabetes ^g	3111 (obs=7214)	18.0 (11.6, 24.4)	<0.001	-	-
11: CVD events ^g	3072 (obs=6895)	19.1 (12.9, 25.4)	<0.001	-	-
12: Respiratory symptoms ^g	3062 (obs=6634)	8.6 (4.5, 12.7)	<0.001	-	-
13: Knee pain ^g	3108 (obs=7173)	10.8 (4.6, 17.0)	<0.001	-0.7 (-1.3, -0.01)	0.02
14: Symptoms of depression/anxiety ^h (per 1 SD)	3071 (obs=7032)	5.3 (2.8, 7.7)	<0.001	0.3 (0.04, 0.5)	<0.02
15: Verbal memory ^h (per 1SD)	3035 (obs=6979)	13.4 (11.0, 15.9)	<0.001	-0.4 (-0.6, 0.2)	<0.05

^a all models adjusted for sex as no evidence of sex interactions (see Table 3)

^b ref: I Professional or II Intermediate

^c ref: Secondary and further education

^d ref: Degree or higher

^e ref: none in last 4 weeks

^f ref: current smoker

^g ref: individuals with no health condition

^h SD estimates at each age are provided in Table 1

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Table 3. Summary of tests of non-linearity, sex interactions and age interactions of all covariates with balance ability

	Description of how variable is modelled	Sex interaction p-value	Age interaction effect on size of association
Sex (female)	n/a ^a	n/a	↓ with age
Socioeconomic indicators			
Paternal occupational class	Continuously	0.9	Effect ↓ with age
Maternal education	Continuously	0.7	Effect ↓ with age
Education	Continuously	0.5	Effect ↓ with age
Own occupational class	Continuously	0.4	Constant with age
Anthropometry			
Height	Quadratic term	0.9	Constant with age
BMI	Linear term only	0.1	Constant with age
Health behaviours			
Leisure time physical activity	Categorically	0.7	Effect ↓ with age
Smoking	Continuously	0.1	Constant with age
Current health status			
History of diabetes	n/a ^a	0.5	Constant with age
History of cardiovascular events	n/a ^a	0.2	Constant with age
Respiratory symptoms	n/a ^a	0.6	Constant with age
Knee pain	n/a ^a	0.8	Effect ↑ with age
Symptoms of anxiety & depression	Linear term only	0.4	Effect ↑ with age
Other			
Verbal memory	Linear term only	0.2	Effect ↓ with age

^aUnable to test non-linearity in dichotomous indicators.

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Table 4. Combined model of all risk factors and all significant age interactions from individual models additionally adjusting⁴²² for death and attrition, n=2465 (obs=5150)

Risk factors ^a	Mean difference in % balance time at age 53 (intercept)		Age (yr)*covariate interaction	
	Coefficient (%) (95% CI)	<i>p</i> -value	Coefficient (%) (95% CI)	<i>p</i> -value
Sex (female)	-21.7 (-28.7, -14.7)	<0.001	0.9 (0.4, 1.3)	<0.001
Paternal occupational class ^b (per 1 level change)	-2.7 (-6.8, 1.5)	0.21	0.3 (-0.1, 0.7)	0.11
Maternal education ^c (per 1 level change)	-3.9 (-6.7, -1.0)	<0.01	0.1 (-0.2, 0.3)	0.51
Education at age 26 ^d (per 1 level change)	-3.8 (-6.2, -1.3)	<0.005	-0.2 (-0.4, 0.02)	0.08
Own occupational class ^b (per 1 level change)	-4.9 (-8.2, -1.7)	<0.005	-	-
Height (m)	linear term	5.0 (-1.6, 11.6)	0.13	-
	quadratic term	-0.02 (-0.04, 0.004)	0.12	-
BMI (kg/m ²)	-2.1 (-2.5, -1.7)	<0.001	-	-
Leisure time physical activity ^e				
1-4 times	9.1 (1.9, 16.3)	<0.001	0.1 (-0.6, 0.8)	0.28
5+ times	5.8 (-0.2, 11.8)		0.3 (-0.3, 0.9)	
Smoking ^f (per 1 level change)	1.4 (-1.6, 4.4)	0.36	-	-
Diabetes ^g	-6.9 (-14.1, 0.5)	0.07	-	-
CVD events ^g	-7.1 (-14.0, -0.3)	0.04	-	-
Respiratory symptoms ^g	-2.5 (-7.0, 2.0)	0.28	-	-
Knee pain ^g	-4.5 (-11.2, 2.1)	0.18	-0.2 (-0.8, 0.4)	0.55
Symptoms of depression/anxiety ^h (per 1 SD)	-3.1 (-5.8, -0.4)	0.02	-0.1 (-0.4, 0.2)	0.46
Verbal memory ^h (per 1SD)	5.9 (2.8, 8.9)	<0.001	-0.4 (-0.7, -0.1)	<0.01

^a all models adjusted for sex as no evidence of sex interactions (see Table 3)

^b ref: I Professional or II Intermediate

^c ref: Secondary and further education

^d ref: Degree or higher

^e ref: none in last 4 weeks

^f ref: current smoker

^g ref: individuals with no health condition

^h SD estimates at each age are provided in Table 1

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