

The Relationship among Subjective Health Status, Wisdom, and Self-care Agency in Korean Older Adults

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Purpose: This study identified the relationships among subjective health status, wisdom, and self-care agency of Korean older adults. **Methods:** The participants were 274 older adults from Daegu, aged over 65 years. Data were collected by visiting two social welfare centers, two senior welfare centers, and nine senior centers in Daegu from January 18 to February 5, 2013. Data were analyzed through one-way ANOVA, independent t-test, Pearson's correlation, and stepwise multiple linear regression using the IBM SPSS/WIN 19.0 statistical program. **Results:** A significant positive correlation was found among older adults' subjective health status, wisdom, and self-care agency. Self-care agency was affected by wisdom (47%, $\beta=.55$), the physical component summary (18%, $\beta=.31$) and mental component summary (1%, $\beta=.12$) of subjective health status, and the absence of disease (2%, $\beta=.13$). **Conclusion:** This study suggests that nursing interventions to promote self-care agency in older adults should be developed based on the characteristics of their subjective health status and wisdom.

Key Words: Self-care, Health status, Aged

INTRODUCTION

In Korea, 11.8% of the population comprised of the older adults aged 65 years or above in 2012 and it is expected to reach 24.3% by 2030[1]. As older adults age, their bodily function weakens and they are at a higher risk of contracting diseases. Additionally, they are at a higher risk of suffering from chronic diseases than younger generations are due to the loss of social and financial capability[2]. A higher incidence of health issues caused by the deterioration of physical, mental, and social function, with the simultaneous increase in various desires and changes in their roles in the family structure, demands that older adults to take care of themselves. Therefore, today, the importance of self-care is emphasized even more. Self-care agency is crucial as it determines an individual's ability to take care of one's own

needs[3]. Further more, fully exercising self-care agency improves one's performance of self-care and helps one maintain a healthy life by reducing the duration of functional disorders[4].

Self-care agency is influenced by personal awareness and attitude toward health status[3]. Since the perceived subjective health status of the older adults indicates the overall conditions that reflect comprehensive characteristics of physical, mental, and social health, it may predict the actual health status more accurately[5].

A positive evaluation of older adults' own health status is a critical factor affecting self-care agency, which is vital for fulfilling daily activities while maintaining physical independence[3]. In addition, it affects their health-promoting activities[6], facilitates adjustment to old age [7], and influences their quality of life[8].

Meanwhile as compared to older adults' education

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levels in the past several decades in today's society older adults have a higher level of education. They are interested in leading a successful life in old age, which includes adjusting to the aging process by maximizing their individual potential and living a healthy life by recovering their physical function and maintaining independence, rather than just surviving[9]. Therefore, with reference to its positive and significant capacity, wisdom has been given much attention as a predictor of successful aging[10]. Wisdom is experience-based knowledge and the thoughtful discretion to utilize and apply such knowledge. It contributes to solving various crises and tasks that a person faces[11], helps with adjustment[12], and has a positive effect on one's satisfaction with health and life[13,14].

Self-care agency is manifested in a variety of ways based on a person's developmental stage and health status. Indeed, knowledge and experience play an important role in on self-care[3]. Earlier studies identified that wise older adults have good health behaviors and habits such as eating regularly, avoiding smoking or drinking, high sleeping satisfaction, and exercising moderately. Therefore, wisdom was reported to have an effect on successful aging[15].

Searching for a strategy to maintain and improve their independent life and autonomy by evaluating self-care agency is essential to guarantee a healthy quality of life for older adults, and leads to successful aging[16]. An older adults' subjective health status and wisdom are expected to influence self-care agency. Therefore, it is necessary to conduct a study that examines the relationships among subjective health status, wisdom, and self-care agency.

Previous studies on older adults' subjective health status and self-care agency include the examination of the relationship between health status and self-care capacity [17], as well as that between self-esteem, health status, and self-care[18]. Although there was a study on the correlation between wisdom and subjective health status [14,19], only few studies have dealt with the correlation between wisdom and self-care agency. Therefore, this study aimed to identify the relationships among older adults' subjective health status, wisdom, and self-care agency and to verify these factors influence on self-care agency.

The purpose of this study is: (1) to identify the degrees of subjective health status, wisdom, and self-care agency in older adults. (2) to identify the differences in self-care agency based on the older adults' general characteristics. (3) to identify the relationships among older

adults' subjective health status, wisdom, and self-care agency. (4) to verify variables influence on self-care agency.

METHODS

1. Research Design

This was a descriptive study that aimed to identify the relationships among older adults' subjective health status, wisdom, and self-care agency as well as the factors that influence their self-care agency.

2. Participants

Participants of this study included older adults in Daegu, Korea, aged over 65 years who have often visited social welfare centers, senior welfare centers, or senior centers while living in their homes. The participants did not have any problems in communicating or any cognitive disabilities in performing daily activities. The participants understood the purpose of this study and provided written consent to participate voluntarily in the study. The sample size for this study was determined by using the G*Power 3.1. When the significance level was set at 0.05, test power at 90%, and effect size at 0.4 for the Z-test, an estimated sample size of 222 older adults was revealed. Finally, considering the response rate and insincere responses 300 was chosen as the actual sample size.

3. Ethical Considerations

Ethical protection of personal information was ensured, and the present study was approved by the Institutional Review Board of Daegu Catholic University Medical Center (IRB Protocol No; CR-13-001-RES-001-R). During the research period, the guidelines of the Institutional Review Board were followed. The survey was conducted after obtaining the prior consent from the director of each organization for data collection. The purpose of this study was explained to the participants. Before conducting the survey, the participants signed a written consent form that stated that they could withdraw their participation at anytime, that the collected data would be used for research purposes only, that the anonymity and autonomy of the participants would be guaranteed, and that the ethical process to protect the participants would be upheld. The survey participants were rewarded with a small gift for their participation.

4. Measurement Instruments

1) Subjective health status

The Korean version of the Medical Outcomes Study Short Form-36 (MOS SF-36 version 2) was used with permission from Quality Metric Incorporated (License Number: QM017057). The tool consists of 36 questions. The Physical Component Summary consists of 10 questions on physical function, 4 on limited roles due to physical health problems, 2 on bodily pain, and 5 on general health. The Mental Component Summary consists of 4 questions on vitality, 2 on social function, 3 on limited role due to emotional problems, 5 on mental health, and 1 on change in health status. The question on change in health status evaluates the participants' current health in comparison with the health status of the previous year. Except for this category, 8 sub-scales were used for the final analysis[20]. In order to ensure accurate calculation of the test score, the Quality Metric Health Outcomes (TM) Scoring Software 4.5, which was provided by Quality Metric Incorporated, was used. The Likert scale for each question varied (3, 5, and 6 points). Based on the scale used for each question, a different weighted value was assigned, such that a higher score in the area of mental health is indicative of better health, with fewer limitations in physical, mental, and social function. The Cronbach's α was .84~.95 in the study in which the tool was developed. In this study, the Cronbach's α of both the physical and mental health areas was .96.

2) Wisdom

The wisdom measurement tool for Korean older adults was used with permission from the developer[21]. This tool consists of 27 questions: 11 on empathetic emotion, 9 on self-reflection, and 7 on experience of overcoming adversity in life. Each question is evaluated on a 4-point Likert scale, ranging from "strongly disagree"(1 point) to "strongly agree"(4 points). One question was reversely scored. The possible score ranges from 27 to 108 points, and the higher the score is, the higher is the wisdom level perceived by the older adults. The Cronbach's α in this study was .94 while in the original study, it was .92.

3) Self-care Agency

This study used the self-care agency measurement tool comprising 34 questions, which So[22] had revised based on the 40-item Self-As-Carer Inventory by Geden and Taylor[23]. The sub-scale include 11 questions on

the cognitive orientation of self-care, 9 on physical skill, 5 on decision-making and judgment process, 4 on information seeking behavior, 2 on the perception of self-regulation, and 3 on attention of self-management. Each question is rated on a 6-point Likert scale (1="strongly disagree", to 6="strongly agree"). The possible score ranges from 34 to 204 points, where higher scores are indicative of higher self-care agency. The Cronbach's α in the study in which the original tool was developed was .96, that in So[22] study was .92, and that in the present study was .97.

5. Data Collection Methods

Data were collected from January 18, 2013 to February 5, 2013 at 2 social welfare centers, 2 senior social welfare centers, and 9 senior centers in Daegu. The participants who understood the goal of this study and agreed to participate were asked to fill out a questionnaire that was intended to be used in a one-to-one interview. For older adults who had difficulty in writing due to the deterioration in vision, the researcher read the questions and noted down their responses. The survey took about 20 minutes for each participant. A total of 300 questionnaires were distributed, and 274 responses (91%) were used for the final analysis, after excluding 26 responses that were insufficient.

6. Data Analysis

The collected data were analyzed using the IBM SPSS/WIN Ver 19.0, as follows:

- The participants' general characteristics, subjective health status, wisdom, and self-care agency were examined using frequency, percentage, means, standard deviation, and range.
- The differences in subjective health status, wisdom, and self-care agency based on the participants' general characteristics were analyzed using the independent t-test and one-way ANOVA. Scheffé test were performed as a post-hoc test.
- The relationships among the participants' subjective health status, wisdom, and self-care agency were analyzed with Pearson's correlation coefficients.
- The explanatory power of the participants' subjective health status and wisdom to predict self-care agency was analyzed using a stepwise multiple linear regression analysis.

RESULTS

1. Participants' General Characteristics

The total number of participants was 274; 158 (57.66%) women and 116 (42.34%) men. The age of the participants ranged from 65 to 89 years: 140 (51.09%) participants were in their 70s and 81 (29.56%) were in their 60s. With regard to their educational level, 119 (43.43%) participants were uneducated and 89 (32.48%) had received elementary school education. Further, 139 (50.73%) participants were single and 135 (49.27%) had spouse. With regard to household types, 104 (37.96%) participants lived in a married-couple household, and 83 (30.29%) lived in a single household. Additionally, 237 (86.50%) people did not have jobs and 37 (13.50%) had jobs. With regard to their economic status, 118 (43.07%) participants were in the middle class and 109 (39.78%) of them were in the lower class. Further, 163 (59.49%) participants were socially active and 111 (40.51%) were

socially inactive. With regard to the current health status, 183 (66.79%) participants had diseases and 91 (33.21%) participants did not have diseases (Table 1).

2. The Degrees of Subjective Health Status, Wisdom and Self-care Agency

The mean subjective health status score was 47.13 ± 8.82 for the Physical Component Summary and 48.05 ± 10.86 for the Mental Component Summary. The average score for each physical health sub-category was as follows: 49.51 ± 10.72 for bodily pain, 47.21 ± 10.21 for limited role due to physical health problems, 44.75 ± 11.03 for physical function, and 43.46 ± 12.23 for general health. The average score for each mental health subcategory was as follows: 49.56 ± 13.08 for vitality, 47.09 ± 13.90 for mental health, 45.81 ± 11.25 for social function, and 45.55 ± 11.37 for limited role due to emotional problems.

The mean wisdom score was 75.19 ± 16.37 out of the total possible 108. The average score for each sub-cat-

Table 1. The Differences in Self-care Agency according to the General Characteristics of the Participants (N=274)

Characteristics	Categories	n (%)	M±SD	t or F (p)
Gender	Male	116 (42.34)	129.32±31.31	1.79 (.182)
	Female	158 (57.66)	134.63±33.27	
Age (year)	65~69a	81 (29.56)	139.06±32.13	12.75 ($< .001$) a, b > c
	70~79b	140 (51.09)	135.79±32.30	
	≥80c	53 (19.34)	113.17±26.30	
Education level	Uneducated ^a	119 (43.43)	126.38±30.49	7.35 ($< .001$) a, b < d a < c
	Elementary ^b	89 (32.48)	129.18±34.24	
	Middle school ^c	41 (14.96)	143.90±28.87	
	Over high school ^d	25 (9.12)	153.48±29.18	
Spouse	Yes	135 (49.27)	140.29±31.62	16.65 ($< .001$)
	No	139 (50.73)	124.71±31.60	
Household type	Alone ^a	83 (30.29)	124.42±29.68	5.83 ($< .001$) a < b
	A couple ^b	104 (37.96)	140.63±32.46	
	With unmarried children ^c	16 (5.84)	115.56±37.18	
	With married children ^d	64 (23.36)	136.47±31.33	
	With the other partner ^e	7 (2.55)	105.43±18.58	
Job	Yes	37 (13.50)	140.30±28.64	2.55 (.111)
	No	237 (86.50)	131.15±32.95	
Economic status	Beneficiary of basic livelihood ^a	17 (6.20)	108.00±28.22	22.24 ($< .001$) a, b < c, d
	Low class ^b	109 (39.78)	118.53±28.70	
	Middle class ^c	118 (43.07)	144.01±30.15	
	High class ^d	30 (10.95)	150.80±28.27	
Social activity	Participation	111 (40.51)	144.50±30.78	28.57 ($< .001$)
	None participation	163 (59.49)	124.13±31.10	
Disease	Yes	183 (66.79)	128.40±31.57	8.51 (.004)
	No	91 (33.21)	140.40±33.04	

egory was as follows: 2.89 ± 0.62 for empathetic emotion, 2.75 ± 0.70 for experience of overcoming adversity in life, and 2.70 ± 0.67 for self-reflection.

The mean self-care agency score was 132.38 ± 32.50 out of the total possible 204. The average score for each sub-category was as follows: 3.93 ± 1.02 for the cognitive orientation, 3.89 ± 1.25 for the perception of self-regulation, 3.85 ± 0.99 for physical skill, 3.82 ± 1.16 for decision-making and judgment process, 3.79 ± 1.02 for information seeking behavior, and 3.12 ± 0.85 for attention of self-management (Table 2).

3. Differences in Self-care Agency Based on the Participants' General Characteristics

Analysis of participants' self-care agency with reference to their general characteristics indicated significant differences in the following: age ($F=12.75, p<.001$), educational level ($F=7.35, p<.001$), spouse status ($t=16.65, p<.001$), living situations ($F=5.83, p<.001$), economic status ($F=22.24, p<.001$), participation in social activities ($t=28.57, p<.001$), and presence of disease ($t=8.51, p=.004$).

With regard to self-care agency, older adults aged 65 to 69 years (139.06 ± 32.13) and those aged 70 to 79 years (135.79 ± 32.30) scored higher than those aged 80 years

or above (113.17 ± 26.30). The older adults who had received education at least up to high school (153.48 ± 29.18) scored higher than those with no formal education (126.38 ± 30.49) and those with elementary school education (129.18 ± 34.24). Similarly, older adults with middle school education (143.90 ± 28.87) scored higher than those with no formal education. With regard to spouse status, older adults with a spouse (140.29 ± 31.62) scored higher than those who were single (124.71 ± 31.60). Additionally, those who lived with their spouse (140.63 ± 32.46) scored higher than those who lived alone (124.42 ± 29.68). With regard to economic status, the high class older adults (150.80 ± 28.27) as well as those from the middle class (144.01 ± 30.15) scored higher than the beneficiaries of basic livelihood (108.00 ± 28.22) or those in the lower class (118.53 ± 28.70). The older adults who participated in social activities (144.50 ± 30.78) scored higher than those who did not (124.13 ± 31.10). The older adults with no current disease (140.40 ± 33.04) scored higher than those with a disease (128.40 ± 31.57) (Table 1).

4. Correlation among Participants' Subjective Health Status, Wisdom, and Self-care Agency

An analysis of the relationships among subjective health status and self-care agency indicated a positive

Table 2. The Degrees of Subjective Health Status, Wisdom and Self-care Agency in the Participants (N=274)

Variables	M±SD	Possible range	Observed range
PCS on the subjective health status	47.13±8.82	0~100	30.00~60.14
Physical functioning	44.75±11.03		21.18~57.54
Role-physical	47.21±10.21		21.23~57.16
Bodily pain	49.51±10.72		26.52~62.00
General health	43.46±12.23		18.95~66.50
MCS on the subjective health status	48.05±10.86	0~100	30.00~62.73
Vitality	49.56±13.08		22.89~70.42
Social functioning	45.81±11.25		17.23~57.34
Role-emotional	45.55±11.37		14.39~56.17
Mental health	47.09±13.90		11.63~63.95
Wisdom	75.19±16.37	27~108	40~104
Empathic emotion	2.89±0.62	1~4	1.36~3.91
Self-reflection	2.70±0.67	1~4	1.22~3.89
Experience of overcoming adversity in life	2.75±0.70	1~4	1.29~4.00
Self-care Agency	132.38±32.50	34~204	62~191
Cognitive orientation	3.93±1.02	1~6	1.73~5.73
Physical skill	3.85±0.99	1~6	1.56~5.67
Decision-making and judgment process	3.82±1.16	1~6	1.40~6.00
Information seeking behavior	3.79±1.02	1~6	1.00~6.00
Perception to self-regulation	3.89±1.25	1~6	1.00~6.00
Attention of self-management	3.12±0.85	1~6	1.00~4.50

PCS=Physical component summary; MCS=Mental component summary.

correlation in the Physical Component Summary, with $r=.64$ ($p<.001$) and the Mental Component Summary, with $r=.61$ ($p<.001$). Thus, the better the physical and mental health condition of the older adults, the higher was their self-care agency. In addition, wisdom and self-care agency were positively correlated, with $r=.69$ ($p<.001$), indicating that older adults with higher levels of wisdom had higher self-care agency (Table 3).

5. The Effect of Subjective Health Status and Wisdom on Self-care Agency

To examine the explanatory power of subjective health status and wisdom with reference to the participants' self-care agency, a stepwise multiple linear regression analysis were used. Subjective health status and wisdom were entered as the independent variables. Further, among the general characteristics of the participants, the factors that showed significant differences in the level of self-care agency (age, education level, marital status, household type, financial status, participation in social activities, and presence of illness) were entered as the independent variables. The variables that were in the nominal scale were treated as dummy variables for analysis. The multicollinearity, independency, normality, and equivariance were tested before the regression analysis was performed. Findings indicated that the tolerance limit was 0.35~0.83, and the Variance Inflation

Factor was 1.21~2.88, which did not exceed the cut-off limit of 10. With reference to auto correction for errors the Durbin-Watson statistic was close to 2 (1.49) and there was no systematic correlation between errors. Thus, the normal distribution of errors could be tested and the goodness-of-fit of the chosen model could be verified ($F=144.67$, $p<.001$).

The result of the multiple regression analysis showed that the areas of the Physical Component Summary ($\beta=.31$, $p<.001$) and those of the Mental Component Summary ($\beta=.12$, $p=.050$) in subjective health status, wisdom ($\beta=.55$, $p<.001$), and absence of disease ($\beta=.13$, $p=.001$) had a significant effect on participants' self-care agency. Out of all the predictors, wisdom manifested a 47% explanatory power, while the same was 18% for the areas of the Physical Component Summary, 2% for absence of disease, and 1% for the areas of the Mental Component summary, all of which amounted to a significant explanatory power (68%) to predict self-care agency (Table 4).

DISCUSSION

The mean of self-care agency score was 132.38 ± 32.50 , which is similar to the result of Oh's study on older adults[4]. Further, younger older adults had higher self-care agency, which is similar to the result of the study by Park[17]. Biological aging is believed to be related to the evident decrease in the performance level of daily activities and increase in the rate of contracting chronic diseases with advancement of age. In addition, older adults who had a spouse or lived with a spouse exhibited high self-care agency. This result is similar to Shin's[2] study results, which reported that the higher the support from their spouse and family members, the higher was the self-esteem and self-care agency of older adults.

The present study revealed that older adults who

Table 3. Correlations among Subjective Health Status, Wisdom, and Self-care Agency in the Participants ($N=274$)

Variables	Self-care agency	PCS	MCS
	r (p)	r (p)	r (p)
PCS	.64 (<.001)		
MCS	.61 (<.001)	.79 (<.001)	
Wisdom	.69 (<.001)	.37 (<.001)	.39 (<.001)

Table 4. The Effect of Subjective Health Status and Wisdom on Self-care Agency

($N=274$)

Variables	B	SE	β	t	p	Adj. R^2
(Constant)	-24.23	6.84		3.54	<.001	
Wisdom	1.10	0.08	.55	14.07	<.001	.47
PCS	1.16	0.21	.31	5.43	<.001	.18
Disease (No) [†]	8.69	2.60	.13	3.34	.001	.02
MCS	0.35	0.17	.12	1.97	.050	.01
Adj. $R^2=.68$, $F=144.67$, $p<.001$.						

[†]Dummy variables.

graduated from middle or high school scored higher than those who had graduated from elementary school or had no formal education. The older adults with a higher economic status or those who participated in social activities scored high. The results related to education are similar to those of the study by Oh[4]. It is considered that education level affects the knowledge and awareness of diseases symptoms, and the higher older adults' educational level is, the more capable they are in utilizing self-care and health-related information, which leads to a higher self-care agency. In addition, the results on economic status are similar to the results of the study by Park[17] and Kim et al.,[16]. It is believed that older adults with a higher economic status can cope with the changes in their health more effectively because they have better access to medical services, less financial burden, and more opportunities and resources in life. It leads to higher self-care agency. The findings on socially active older adults are similar to Oh[4] and Park's[17] study results that reported that older adults who actively engage in social activities, fellowships, or exercise have a higher self-care agency than those who do not. This may be because the older adults can share their self-care experiences and learn from each other through social relationships. This was supported by Shim's[24] study results that showed that social support and health promoting behaviors were positively correlated.

The present study identified that older adults' subjective health status and self-care agency were positively correlated. This is supported by Park's[17] study that used the same tools to assess subjective health status and self-care agency as the present study, and that showed that the healthier the older adults were, the higher was their self-care agency. In addition, Kim's[18] study reported a positive correlation between older adults' health status and self-care in urban and rural areas, which shows that the physical and mental health status of older adults are closely connected to self-care agency.

In the present study, wisdom was identified to have a positive correlation to the self-care agency of the elderly. This finding was supported by Ardelt's[14] study, which revealed that wisdom was positively related to subjective health of the elderly and to their overall sense of wellness in old age. In addition, Sung's[15] study, which used the same measurement tools for wisdom as the present study, supports that the elderly older adults whose daily health behavior habits were good and who evaluated their health status favorably were identified to

have a higher level of wisdom. Similarly, Kim et al.'s[16] study also supports the result of the present study as it reported that older adults' performance of daily activities had a positive correlation to their self-care agency. With regard to the effect of wisdom on self-care agency, the direct relation is difficult to observe because few studies have explored this topic; however, according to Webster's[19] study, wisdom was identified to have a positive correlation with ego integrity, sense of creativity, and health status. Similarly, Lee et al.,[25] study identified that ego integrity was positively correlated with health behavior, which partially supports the results of the present study.

Among the participants' general characteristics, presence of disease was identified as the only factor that significantly affected their self-care agency. Further, subjective health status and wisdom were identified to significantly affect self-care agency. Together, participants' presence of disease, subjective health status, and wisdom were identified to have 68% explanatory power to predict their self-care agency.

Shin's[2] study analyzed that the subjective or objective health status of the older adults affected their self-care agency. In addition, Park's[17] study identified that the explanatory power of participant's age, employment status, education, and health status to predict self-care agency was 55%, thus partially supporting the result of the present study. On the other hand, this study identified the presence of illness as a factor affecting self-care agency. However, its explanatory power was merely 2%. In contrast, Park[17] and Shin's[2] study did not identify this as a significant contributing factor. More chronic diseases, more pain were associated with Activities of Daily Living of older adults[26]. Indeed, this finding is similar to that of the present study. Based on this, older adults' illness is considered to affect their overall life as well as self-care agency. Future studies need to expand the scope of the study sample and test self-care agency based on the severity and duration of illness.

In the present study, wisdom had the highest explanatory power to predict self-care agency. This reflects the fact that, in old age, wisdom is more closely related to self-care agency than are other variables. Considering that wisdom is the ability to solve life's conflicts and issues and help make crucial decisions[11], the result of this study indicates that older adults need to fully extend their wisdom in order to improve their self-care agency.

Through awareness and discernment of life, older

adults understand and accept life and achieve self-esteem and ego integrity. In order for them to gain wisdom, it is vital to achieve ego integrity[27]. Therefore, programs such as writing an autobiography and recollection, which promote self-acceptance and ego integrity among older adults can be used as nursing interventions for gaining and practicing wisdom. In addition, in the process of developing and applying a nursing intervention program that promotes self-care agency, it is necessary to encourage older adults to exercise wisdom and consider the individual differences in the same.

The results of this study indicated that the subjective health status, wisdom, and self-care agency of the older adults were significantly correlated. This study identified subjective health status and wisdom as variables that affect self-care agency. Therefore, this study is significant in that it identified wisdom as a new variable that accounts for self-care agency in older adults. It succeeded in providing evidence that the subjective health status and wisdom of older adults who lived at home affected their self-care agency. The results of this study can be used as basic data to establish strategies to improve self-care agency by considering the individual differences and diversity in older adults' wisdom.

CONCLUSION

This study examined the relationship among subjective health status, wisdom, and self-care agency in the older adults, and identified the explanatory power of these variables. The study results indicated that the areas of physical and mental health, and wisdom were positively correlated with self-care agency. This indicated that the higher the health status was with reference to the physical and mental condition of the older adults, the higher was their self-care agency. Similarly, the higher their wisdom level was, the higher was the self-care agency. Thus, wisdom, subjective health status, and absence of illness were identified as variables affecting older adults' self-care agency. These variables had a 68% explanatory power in predicting self-care agency. Therefore, assisting older adults to maximize self-care agency by identifying their subjective health status and wisdom can be an effective strategy to improve the quality of their life by maintaining and enhancing their health.

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