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Healthy and active ageing: Social capital in health promotion

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Abstract

Objectives: This paper examines the context of health promotion actions that are focused on/contributing to strengthening social capital by increasing community participation, reciprocal trust and support as the means to achieve better health and more active ageing.
Method: The methodology employed was a literature review/research synthesis, and a thematic analysis.
Results: Four core themes emerged from the analysis: a) active ageing; b) the relationship between social capital and ageing; c) the importance of social capital in health promotion; and d) policy implications. The role of social capital in health promotion stresses empowerment, intergenerational support, the building of social trust, and the need to tackle loneliness among older adults. The importance of community/social participation emerged from the literature review as a key contributor to the maintenance and promotion of a healthier ageing population.
Conclusion: Supporting long-term social capital building within communities can lead to improved public health and well-being for an ageing population.

Keywords

Active ageing, healthy ageing, networks, older adults, social capital, trust

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Introduction

There has been a rapid increase in the global ageing population of 2.6% per year. By 2050, nearly one-third of the global population is expected to be above the age of 60 years.[1] The United Nations (UN) has therefore stressed that further knowledge is needed to assist policy-makers in making the necessary policy changes to tackle the economic and social challenges arising from population ageing.[1] The present paper focuses on the ways in which healthy and active ageing can be facilitated through health promotion interventions explicitly organised around the concept of social capital.

According to the World Health Organization (WHO), health promotion aims to influence the determinants of health with the aim of improving population health, reducing health inequalities, endorsing human rights and building social capital.[2] As stated in the Ottawa Charter for Health Promotion,[3] two of the core health promotion actions are: (a) the creation of supportive environments and (b) the strengthening of community actions. Both actions adopt a socioecological approach, and are based on equity and the enhancement of social support, participation, and empowerment of the individual towards health issues.[3]

In addition, WHO considers participation to be one of the three pillars – along with health and security – for building policies towards active ageing.[4] Community empowerment is an essential element of any health promotion initiative.[5] Participation and trust are core concepts of the notion of social capital that relate to community empowerment.[6] According to Howard et al.,[7] links exist between health outcomes, social capital and health promotion actions for social change. In terms of health outcomes and health promotion, social capital can be used as a means for promoting health and well-being through social change and the fairer allocation of resources. If social capital is built in a substantive way among ageing populations, then this may potentially have a major impact.[8]

Against this background, the overall aim of this paper is to examine the context of health promotion actions focused on/contributing to the strengthening social capital by increasing community participation, reciprocal trust and support, as the means to achieve better health and more active ageing among populations. The specific research questions underpinning the present study were:

a) What is already known about the implementation of social capital for promoting healthy ageing?
b) How can social capital contribute to future health promotion policies and practices that aim for healthier and more active ageing populations?

Background

According to WHO's definition, health is 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[9] According to the definition of healthy ageing employed in the present paper, healthy ageing is the process of adapting and compensating for the decline of physical and cognitive health, with the aim of a person achieving the best possible levels of function and participation (physical, social, etc) in his or her everyday life.[10] The UN recognises that there is correlation between disability and ageing. According to a 2003 report, 63% of persons with disabilities were above the age of 45.[11]

Although the 'settings approach' for health promotion – implemented in schools, workplaces, health care facilities, and clinical and/or community settings – has been enthusiastically supported for many years by health promotion practitioners,[12] it has been claimed to rest on shaky social

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scientific foundations. The latter views settings as something more than just 'vessels', arguing instead for the use of an ecological and critical approach to settings for health promotion.[13] Applying an ecological approach to health promotion through a 'settings approach' may ensure prolonged health benefits for older people, since it may reduce the density of chronic diseases into a shorter period of time, and improve individuals' overall quality of life.[14] A settings approach to a community of older persons may also challenge prejudicial perceptions of older people as being burden to the economy and society, and move towards viewing older persons as respect worthy and valuable members of the community.[14]

The major theorists of social capital include Bourdieu, Coleman and Putnam, who, although viewing social capital from different perspectives, all agree that social networks are (i) key contributors to social capital, and (ii) can lead to cooperation with positive outcomes. Bourdieu[15] specifically views social capital as the collective of resources which associate with persons' networks of formal or informal relationships. For Coleman, social capital encompasses prospects of reciprocity, trust, shared values, norms and obligations.[16] According to Putnam,[6] social capital may be defined as a public good comprising trust, ties and norms, and as a 'moral resource' which, unlike other types of capital (human, financial, etc), is not the private property of individuals and is based on social activities.

Although the theoretical boundaries of the notion of social capital are still under discussion, it can provide a means for organising and planning community health promotion.[17] Social capital offers a different lens for viewing community health partnerships, and may also offer a framework for the evaluation of the processes and effectiveness of community interventions.[18] While some have seen a risk of enhancing social inequalities through the implementation of social capital-based health promotion initiatives,[19] a recent systematic review of studies published between 1990 and 2011 found positive associations between elements of social capital and aspects of mental well-being among older adults.[20]

Methods

Scientific journals were searched to find articles that explored issues relevant to ageing, social capital and health promotion. Online sources were searched, and in particular, the following 15 electronic sources were accessed: PubMed; Elsevier ScienceDirect; BMJ Journals Online; ISI Web of Knowledge (v.4.10) (including SCI-EXPANDED, Social Sciences Citation Index (SSCI), Arts & Humanities Citation Index (A&HCI)); SAGE Journals online; ProQuest; The Cochrane Library; Blackwell-Wiley; Applied Social Sciences Index & Abstracts (ASSIA); Oxford Journals; Expanded Academic ASAP; Emerald; SpringerLink; Journal Storage (JSTOR); and Cambridge Journals Online.

The inclusion criteria adopted for the electronic literature search were: articles that in their abstract/title included the keywords 'health' AND 'promotion' AND 'social' AND 'capital' AND 'ag(e)ing'; articles published between January 2001 and March 2011 in the English language; only articles published in scientific journals (commentaries, reviews and original research); and with an abstract in which there was information relevant to the research questions of the present study. During the search, editorials and letters were excluded. During the initial screening process of articles, all titles and abstracts were examined and ones that did not meet the abovementioned criteria were excluded.

The literature review/research synthesis on the content of papers employed thematic analysis. The full text of included papers was read and text segments, in the form of phrases or paragraphs relevant to and matching (fully or partially) the objectives of the present study, were extracted. The meaning of each of these text segments was classified by theme. Latent-level analysis was

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conducted according to which text segments were allocated to themes on the basis of the dominant meaningful concept within them.[21] For example, a text segment referring to 'the use of the reminiscence method in research of focus groups of older adults and young persons' was fitted under the theme of 'Intergenerational support/interaction', which describes the main features of the text segment, despite the fact that the exact words of the theme chosen were not found in this passage. The core themes presented were not pre-determined but emerged inductively in the course of the analysis through a bottom-up approach.

Results

The online search yielded 26 citations, of which only six were eligible for inclusion in the analysis (Figure 1). Table 1 presents information on the six articles included regarding their objectives, methods of data collection, sample and context, social capital indicators used, and health promotion activities reported on.

In total, 17 themes were identified. These were further grouped into four core themes as shown in Table 2.

Core theme 1: Active ageing

Defining active ageing. Active ageing refers to the process of empowering older adults towards self-actualisation, self-confidence, and independent and dignified living, based on one's own personal values as well as being able to stand up for their own rights and freedom.[25] WHO acknowledges the dual burden of disease in the form of disability and care for members of the ageing population, and also dependency due to chronic disease, as an important financial cost not only on the health care system, but also for the older adult and his or her family.[25] Overall, in order for older adults to achieve positive health, quality of life and wellbeing, an active approach to ageing is advocated.[22]

Ageing and participation. This theme refers to enjoyable recreational, occupational and psychosocial activities adapted to the older persons' individual preferences, interests and capacities.[25] Low levels of income, loneliness, widowhood and ill health are all identified as barriers to participation among older adults.[22]

Facilitators or barriers to active ageing. This theme refers to factors that facilitate or hinder active ageing. Two types of barriers can be identified. First, older adults' participation may be hindered by lack of money, living alone and mobility problems, a poor sense of belonging, lack of optimism, trust and poor mental health.[22] Second, negative stereotypes exist towards members of the older generation. Intergenerational activities may soothe some aspects of this negativity and prejudice.[27] With regard to facilitators, the literature points both to the value both of social- and health-related factors. Community-level actions for the prevention of chronic diseases are valuable for older adults.[25] In addition, it is important to take steps to enhance participation, to facilitate prevention and to allow for intergenerational solidarity.[25] Although only a small number of studies show the effects of intergenerational support on health, life satisfaction and well-being among older adults, the available evidence signals how intergenerational activities can improve the health status of older adults.[23,27]

Core theme 2: The relationship between social capital and ageing

Socioeconomic inequalities and health. Theories of social capital may be used to understand the relationship between social inequality, poverty and area of residence, health and well-being.[26] Social

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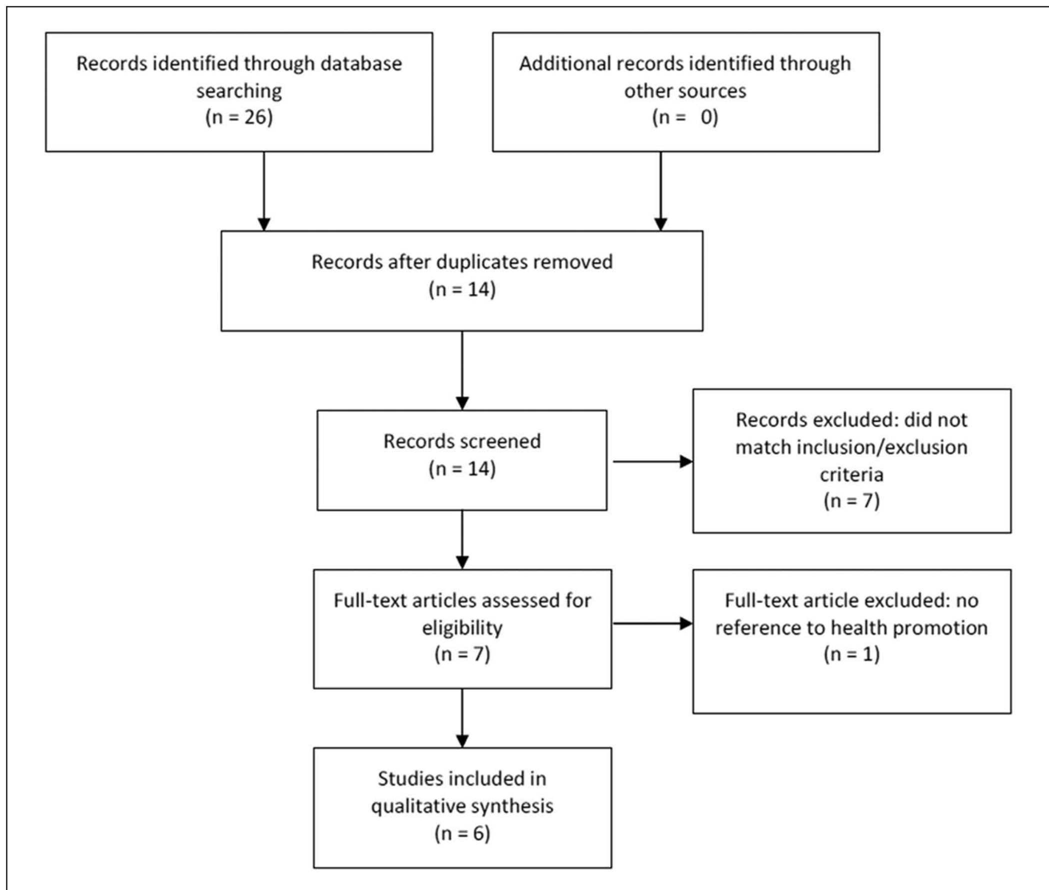

Figure 1. Process of inclusion of studies in the literature review/research synthesis.

inequalities linked to social isolation and loneliness pose threats to health and well-being.[24] Income inequality and poverty are frequently associated with ill health and, in particular, mental health problems.[24] Low levels of community-level social capital may be associated with higher levels of depression, although the detailed nature of the association has yet to be clarified.[24]

Community participation/social cohesion. Community participation can be viewed both as a determinant and an indicator of social capital, and is linked to self-rated health.[22] In order to be effective, mental health promotion programmes with an emphasis on participation need to be appropriate to the target group.

Religiosity. Religiosity, especially among women, has been associated with good mental health.[24] Participation in religion may provide a coping strategy for loneliness and a shield from stress.[24] Membership in voluntary or religious organisations is associated with better self-rated health.[26] Nevertheless, extreme religious communities can cause negative religiosity since they impose on their followers forced social restrictions and moral practice.[24]

Social trust. Among members of the ageing population, good subjective health has been found to be associated with active social participation and trust.[26]

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Table 1. List of selected studies.

First author, year of publication	Objective of the study	Method of data collection	Sample and context	Social capital indicators used	Health promotion activities reported
Berry, 2008[22]	To (1) explore whether residents of a socioeconomically disadvantaged rural Australian region could be grouped according to their patterns of community participation, (2) prepare descriptive profiles of these groupings, (3) report on differences in social cohesion and psychological distress between groupings, and (4) comment on the policy implications of the groupings.	Quantitative study; completion of anonymous postal survey. Measures included: (1) frequency of 14 types of participation, (2) thoughts and feelings about each type, and (3) five aspects of social cohesion.	Participants were 963 community members, aged 19–97, randomly selected from a socioeconomically disadvantaged coastal Australian region (Eurobodalla Shire in southern coastal New South Wales, Australia).	Social capital indicators were used as part of the Community Participation Questionnaire, and personal social cohesion was measured and defined as respondents' altruistic values, sense of belonging, generalised reciprocity, social trust and optimism.	Grouping and description of members of a socioeconomically disadvantaged rural region based on community participation, social cohesion and psychological distress; reflection on policy implications.
	To describe a new program (Experience Corps) which establishes new, productive roles for older adults in public elementary schools; these roles are explicitly designed to boost the social capital available through the mobilisation of a critical mass of seniors. This article (1) describes the scientific basis for this health promotion intervention,	In essence, the Experience Corps program involves the recruitment, training, and deployment of a critical mass of older adults who volunteer their time and experience in underserved elementary schools to improve the lives and academic achievements of children. The intervention is hypothesised to operate at three nested levels:	Experience Corps volunteers are predominantly African American (96%) and high-school educated or less (82%) and have incomes of less than $15,000 (69%). Participants entered the program with varying levels of health and functional status. Experience Corps volunteers reported 2.5 chronic	Social capital is the guiding theoretical concept at the school level. The deployment of a critical mass of older adults in carefully designed roles is hypothesised to lead to improvements in four primary outcomes: (1) aggregate academic achievement (standardised assessments), (2)	Description of conceptual framework of a model of health promotion for older adults to remain socially engaged and productive.

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Table 1. (Continued)

First author, year of publication	Objective of the study	Method of data collection	Sample and context	Social capital indicators used	Health promotion activities reported
Glass, 2004[23]	(2) explains how it simultaneously harnesses the social capital of an aging society and seeks to 'compress' its morbidity, (3) describes the core design features of Experience Corps, and (4) provides details about the operational aspects of the program that support generativity and social capital.	individuals, schools and the broader community. At the individual level, it proposes a model based on Erikson's concept of generativity to explain how and why Experience Corps works. At the level of schools, it proposes a parallel model based on social capital. Experience Corps is a volunteer service program designed to improve the lives of urban children and to yield health improvement for older persons.	conditions, and most (62%) reported some difficulty climbing stairs. The programme had been expanded and had been currently operating in 18 cities in a network coordinated through civic ventures.	overall school climate, (3) teacher retention and (4) community/parental involvement in schools. The program was designed to have an impact on the entire school through three elements: (1) critical mass, (2) school-level roles performed outside classrooms and (3) adult volunteers who become conduits to the resources and concerns of the broader community. By deploying volunteers in critical mass, each becomes an agent of social capital.	
Lauder, 2006[24]	The aims of the study were to (i) investigate age and loneliness, (ii) investigate the association between religiosity and loneliness and (iii) and explore the relationship between social capital and loneliness.	The study employed survey methods of a randomly selected sample of people living in Central Queensland, Australia. Data were collected by computer-assisted telephone	The sample comprised 1289 subjects with a mean age of 46.25 years (SD 15.61) of whom 50.1% were female (*n* = 645) and 49.9% male (*n* = 643).	Social capital was operationalised through items selected from the Social Capital Module of the General Household Survey (General Household Survey 2000). In the General Household	Investigation of age and loneliness, religiosity and loneliness, social capital and loneliness.

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Table 1. (Continued)

First author, year of publication	Objective of the study	Method of data collection	Sample and context	Social capital indicators used	Health promotion activities reported
	interview methods. In participating households, one person was selected as the respondent for the 30-minute interview.			Survey indicators of social capital are neighbourliness, civic engagement, social support, social networks and perceptions of the local area.	
Mendoza-Núñez, 2009[25]	To show our experience in the development and implementation of a model for chronic disease prevention and control in old age at the community level under the active ageing paradigm.	Formation of 40 gerontological promoters (GPs) from among the older adults themselves, following a specific healthy ageing model proposed. The pillars of this model were: gerontological health care; gerontological orientation for families, and gerontological social development.	A longitudinal study would be carried out in a sample of 400 urban and rural-dwelling older adults residing in Hidalgo State, Mexico, during five years, with a significance level of 0.05, a power of 80% and an expected difference in chronic diseases incidence of 50% between the pre-intervention and post-intervention. Taking into account a drop-out rate of 30%, a minimum of 280 participants would be needed in the cohort.	Social networks were formed among older adults based on self-care, mutual help and self-promotion principles. Specific workshop community gerontology topics used (among many others): social-support nets; leisure and aging; and age-related social changes.	Presentation of experience on the development and implementation of an active-ageing community-based framework for prevention, control and empowerment of older adults regarding chronic diseases, which constitutes basic social capital for chronic disease prevention and control in old age.

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Table 1. (Continued)

First author, year of publication	Objective of the study	Method of data collection	Sample and context	Social capital indicators used	Health promotion activities reported
Nummela, 2009[26]	To investigate associations between self-rated health and indicators of social capital (trust, various social contacts, social participation and access to help) among ageing people living in urban and rural areas in Finland.	A postal survey was conducted in 2002 among men and women born in 1926–1930, 1936–1940, or 1946–1950 and dwelling in 14 municipalities in the Päijät-Häme hospital district in Finland.	2815 participants represented 66% of the original stratified (by age, gender and municipality) sample.	Trust; social contacts with relatives and family members (outside households); frequency of contacts with close friends or close relatives; participation; access to help from other persons.	Investigation of associations between self-rated health and indicators of social capital among ageing population.
de Souza, 2003[27]	To evaluate a pilot intergenerational reminiscence project from the participants' viewpoint (before and after the programme) and to improve the contribution of ageing and adolescent populations in building up social capital.	Qualitative study; focus groups. During the data collection process an interview guide was used including eight questions (i.e. 'What have you learnt from the project?', 'What is your opinion about the project?', 'How did the participation in the project influence your health?', etc.)	84 students aged 13–19, divided into nine focus groups, plus 26 older adults aged 60+, divided into three focus groups. Focus groups' sessions took place from November 1999 to April 2000 at Taguatinga, Brazil.	No specific social capital indicators were used for data collection in this study	Evaluation of pilot project for promoting well-being of ageing and adolescent populations through intergenerational activity and improvement of the contribution of these age groups in building social capital.

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Table 2. Themes emerging from the analysis.

Core theme 1: Active ageing
Defining active ageing
Ageing and participation
Facilitators or barriers to active ageing
Core theme 2: The relationship between social capital and ageing
Socioeconomic inequalities and health
Community participation/social cohesion
Religiosity
Social trust
Social networks
Social support/loneliness
Core theme 3: The importance of social capital in health promotion
Enhancing community/social participation
Disease prevention/health care
Self-actualisation/self-care/mutual help
Family education
Intergenerational support/interaction
Core theme 4: Policy implications
Challenges for the design and implementation of policies
Community participation-based health promotion
Active ageing-based health promotion

Social networks. Social networks (a core component of social capital), allow for communication at personal, community and institutional levels. They facilitate the retention of an individual's social identity and enable access to support, both emotional and practical.[25] Communities with high levels of social capital have high levels of social networking, mutual reciprocity and participation in organisations/groups.[24] Among older adults, lack of social networks has been linked to poor subjective health, while volunteers and people who regularly participate in associations and clubs have been found to report higher levels of well-being and better subjective health status.[26]

Social support/loneliness. Loneliness is associated with poorer self-rated health through its impact on health behaviour, stress and other factors.[24] According to Lauder et al.,[24] a key factor in tackling loneliness is the existence of sufficient forms of social engagement and interaction to meet the need for human closeness. For example, older women who have good friendship networks have been found to have higher levels of self-rated health.[24]

Core theme 3: The importance of social capital in health promotion

Enhancing community/social participation. In a study by Mendoza-Núñez et al.,[25] a programme on active ageing for the prevention of chronic diseases among older adults at the community level focused on building networks of mutual support between older adults. Another example of an effective multi-level social model of health promotion for older adults is provided by the Experience Corps programme, which aimed to strengthen the social capital of older adults through involvement in elementary school settings.[23]

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Disease prevention/health care. Mendoza-Núñez et al.[25] used mutual-help group coordinators performing actions of self-care to boost older adults' psychological and social well-being in an attempt to prevent the most common diseases within an ageing population (e.g. diabetes mellitus, osteoporosis, dementia). Lauder et al.[24] emphasised the role that community-based nurses can play in improving health and well-being by facilitating the building of effective social networks and thereby enhancing social capital.

Self-actualisation/self-care/mutual help. Self-actualisation among older people is a vital component of active ageing and can be enhanced by self-care and mutual support.[25]

Family education. Family support can be an important resource for health promotion among an ageing population. One study used general practitioners to train members of the older person's family on how to provide basic care to older relatives, thereby contributing to ill-health prevention.[25]

Intergenerational support/interaction. As indicated earlier, interaction between members of different generations can have a beneficial impact on ageing populations.[23] In the qualitative study by de Souza,[27] intergenerational interaction programmes were found to enhance trust and reciprocity, which are core components of social capital.

Core theme 4: Policy implications

Challenges for the design and implementation of policies. The recent decrease in birth rates after the 'baby-boom' era in many industrialised countries has led to an increase in the older population and creates financial and social challenges for the future.[23] Even in developing countries such as Brazil there are major challenges to be faced. Here, economic and social change is reported to have increased the dysfunction of mechanisms that facilitate social integration, and has increased socioeconomic inequality.[27] Problems for the development of interventions for ageing populations include low levels of participation among older adults in training programmes, and the high cost of intensive interventions.[23] The prevention and delay of disability and disease in older adults may lead to reduced ill health, nevertheless. However, few research and model-based attempts have been made in this direction.[25] On the other hand, programmes have been recently implemented which may be useful for policy-makers or planners who want to create organizations and institutions that facilitate intergenerational communication and interaction for the benefit of ageing populations.[23]

Community participation-based health promotion. Berry[22] suggested that increasing community participation can be a relatively inexpensive and cost-efficient way to address issues related to individual trust and loneliness. Loneliness is an issue related to the lack of perceived support, thus, policy-makers could modify public health interventions and services towards tackling loneliness.[24] Further training for community nurses, especially regarding mental health interventions, could be important in this regard.[24] Overall, in terms of health promotion, there is need for multilevel interventions, considering both the relations within the social context and individual behaviour.[25]

Active ageing-based health promotion. The current approach to ageing which disregards older adults' potential for social and economic development and considers them as burden should be substituted by an active ageing model which enables older persons' empowerment through self-care and in this way aims to prevent ill health.[25] Towards this goal, community care frameworks need to focus on social support and education if they are to have a significant impact on the quality of life and cost

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benefit of older adults.[25] Active ageing implies a three-dimensional approach: as a paradigm, as a policy framework and as action at the community level.[25] Living longer and healthier also implies facing new challenges in terms of the societal involvement of older adults, who have the opportunity to 'give back' to society and remain productive longer; for example, through their paid or voluntary work for the community, and through household and care work for family members.[23]

Discussion

Based on this literature review/research synthesis, a variety of themes relevant to issues of health promotion, social capital and ageing have emerged. In particular, core themes stress the importance of a) active ageing; b) the relationship between social capital and ageing; c) the importance of social capital in health promotion; and d) policy implications. In particular, the findings presented here stress the importance of social/community participation for better health, and point to aspects of health promotion relevant to healthy and active ageing.

The papers reviewed suggest that social capital may have a significant role to play in promoting healthy ageing through community participation, although detail is lacking on the precise form that initiatives need to take. Based on findings from the papers reviewed, the following tentative suggestions can be made, however. Social capital may be enhanced among the elderly through the following actions: community/social participation by older adults; individual empowerment through self-care; intergenerational and mutual support; the enhancement of social cohesion as a buffer to loneliness; by religious involvement which in some circumstances may increase emotional and mental health; through family education which helps build social trust and social networks around older persons; and through social capital building by nurses involved in disease prevention and control.

The policy implications for health promotion initiatives relevant to ageing and social capital mainly concern the promotion of 'active ageing' in line with the commitments of the European Innovation Partnership on Active and Healthy Ageing, which aims to increase the average healthy lifespan by two years by 2020.[28] The work of this initiative aims to enhance older persons' social development by facilitating social participation and by providing older people with the opportunity to 'give back' to society by remaining productive in volunteering or paid employment. The need for partnership and multi-disciplinary action throughout health promotion initiatives aiming at promoting active ageing was also evident from the literature review.

Several challenges need to be overcome, however, when implementing health promotion initiatives targeting older people. These include public prejudice regarding the usefulness of health promotion strategies implemented in later life; the idea of older people being a burden (rather than an asset) to society; the limited participation of older persons in such training programmes to date; and the cost of such intensive interventions. At a theoretical and research level, there is a need to overcome a certain vagueness in notions of social capital and its methodological operation and evaluation, in addition to undertaking more research on the prevention of disease and the reduction of disability for older populations.

With respect to limitations, given the small number of papers available in the literature, this review does not present a comprehensive overview of the topic, since more research is needed at an international level. In addition, all the studies reviewed were found to endorse health promotion initiatives for ageing which incorporate social capital theory or component(s) of it. No reference in any of the studies was found to documented disadvantages of health promotion initiatives based on social capital. The inclusion of such negative references, if they exist, would be helpful in identifying the advantages and disadvantages of such an approach and the circumstances in which it is best applied.

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Further research might usefully explore the contribution of social capital to addressing the determinants of health, disability and ageing utilising the International Classification of Functioning, Disability and Health[29] (ICF)'s biopsychosocial model (BPS) for health promotion strategies and research projects and a social ecological approach. Education aiming at building a more positive public perception of ageing should be undertaken since the public prejudice that exists towards older persons seems to hinder the process towards enhancing their health, quality of life and well-being. Such an initiative could contribute at the same time towards the fuller inclusion of persons with disabilities and their families in the community, which is important for social capital building.

Conclusion

From the current analysis it appears that supporting long-term social capital building within communities may lead towards better health and well-being among the ageing population. In the current context of economic crisis, health promotion interventions based on social capital can provide an inexpensive solution for policy-makers, and at the same time provide a holistic means of tackling the forthcoming economic and social changes due to the increase of the ageing population worldwide. Within the present analysis, a wide spectrum of known aspects of the role of social capital in health promotion has been covered. However, further research on the applicability of such initiatives at a practical level should be undertaken to establish the value of this approach in improving the health of specific ageing populations, along with the resolution of theoretical and measurement issues surrounding the notion of social capital and health.

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Conflict of interest

None declared.

Ethical approval

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