

Editorial

Promoting social capital in an ageing society: a win-win proposition?



Promoviendo capital social en una sociedad que envejece: ¿una propuesta win-win?

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In health care and public health, benefits should have enough weight to make costs and adverse effects bearable. Whereas, a win-win proposition guarantees a favourable outcome for everyone involved. In this editorial, I argue whether promoting social capital in an ageing society could be a paradigmatic win-win proposition from a public health perspective, while considering the Spanish context. Therefore, I discuss the state of the art of social capital interventions targeting older people on health outcomes, adverse effects, costs, beneficiaries and practices.

Ageing as opportunity

Ageing is commonly seen as a problem and a deficit perspective sustains ageism thus hiding older people's potential at a social, economic and political level. On the contrary, the Active Ageing paradigm states ageing to be a success, stresses the relevance of the social environment on resilience throughout life and pushes the policy response towards a healthy, inclusive and resilient ageing process in a supportive environment.^{1,2}

Likewise, public health has increased its attention on ageing reinforcing a shift towards a strengths-based and salutogenic approach.

Social capital as a health resource?

Several definitions of social capital exist. Putnam's definition³, the most common in health research, was adapted to ageing emphasizing the interaction between individuals at the micro level.⁴ Thus, social capital was operationalized as an umbrella concept, comprising individual (family and friends) and collective social resources (neighbourhoods), as well as structural (social networks, social contacts and participation) and subjective aspects (social support and sense of belonging).

Growing evidence from observational studies suggests that social capital is associated with better mental and physical health, a lower risk for dementia, disability and mortality. These effects are comparable to well-established factors like tobacco cessation and physical activity.^{5,6} However, little information exists from intervention studies on the modifiability of these social aspects and their health impact. Isolated studies have achieved significant effects on physical and emotional health, cognition, and use of health resources,^{7,8} while others have not.⁹ Even the evidence on social support groups for dementia caregivers is not yet clear.¹⁰ Therefore,

the effectiveness of social capital interventions on health outcomes is limited but promising.

The risk of adverse effects

Involvement in social networks also produces adverse effects. Responding to the needs of network members can be stressful, especially for women with low socioeconomic resources.^{11,12} Highly unequal mutual support in dyadic relationships may trigger demoralization and depression, especially among women who give more support than they receive.¹¹ Moreover, getting social support from the extended family may produce a sense of indebtedness and obligation to conform and follow advice.¹³ In older age friendships, the disruption of expectations about how friends should be (e.g., balanced relationship) causes strain.¹⁴

However, the harmful effects of social interventions are understudied and underestimated and specially here a gender perspective is needed.

From a global perspective, social capital interventions tackle one of the determinants of health inequalities and thus they could reduce them. However, selection bias may work against specific subgroups and potentially reinforce inequalities.

Costs

Regarding cost-effectiveness, the most promising evidence comes from a Finnish trial aimed at alleviating loneliness by creating "circles of friends". Besides lowering mortality and improving other health outcomes, it significantly lowered health care costs during the 2-year follow-up.⁷ In another trial based on peer support among widows, the experimental group slightly improved against slightly higher costs.¹⁵ Therefore, the service would be acceptable depending on the willingness to pay per QALY gained. Further research should help to distinguish which specific subgroups could benefit the most considering the diversity of interventions and contexts.

Who wins?

Interestingly, Linda Fried, author of the most used definition of frailty,¹⁶ conducted the Experience Corps trial on promoting older people's volunteering in public schools applying a generativity perspective.^{17–19} It aims to prevent disability by increasing cognitive, physical and social activity through meaningful roles. In this win-win intervention teachers also receive support, and children from socio-economically disadvantaged areas are reinforced in academic achievement and classroom behaviour, with a view to encouraging success throughout life.

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A similar intervention, specifically an intergenerational programme based on reminiscence, was conducted also in schools from a socio-economically deprived city but in Brazil.²⁰ Positive effects were found among adolescents and older adults but compliance was very low among the oldest group.

Caregivers are some of the main beneficiaries of peer support groups. Moreover, peer support programmes also target patients with chronic diseases to achieve better self-management and healthier lifestyles. Regarding mental health, people suffering from loneliness and depression benefit from increasing their participation in groups or from receiving one-to-one support.²¹ Interventions based on social interaction have been successful at promoting cognition among people with and without mild cognitive impairment and at reducing agitation among nursing home residents with dementia with an effect size comparable to risperidone.²²

In short, social capital interventions may benefit a wide range of older people, family members, carers and people from other generations. Indirectly, health and social care professionals would also benefit from them.

But who is missing? Selection bias is a big challenge to be considered: social capital interventions (e.g., group-based or involving information and communication technologies) do not appeal to everybody. Moreover, they require time availability, thus they may exclude people with caring responsibilities within the family, especially women. Likewise, older people, especially women and those who are frail and impaired, are often excluded from participation mechanisms.

Social capital, ageing and health in practice

Context is highly relevant in social capital. Therefore, context-specific research and evaluation are required. In familistic countries like Spain, more social support is provided but loneliness is also more prevalent than in individualistic countries from Northern Europe. In the Spanish social and health care system, social capital practices are present, although mostly are not theoretically based, systematically applied, or rigorously evaluated. Support groups are widespread, especially those targeting caregivers to reduce their stressful experience. Some Spanish experiences on social support have been published, e.g., groups for older people,²³ a loneliness study based on primary health care²⁴ and one in a nursing home.²⁵ In Italy, another familistic context, a social support intervention provided by volunteers to older cancer patients receiving chemotherapy successfully increased their quality of life.²⁶

As recommended by the Task Force on Community Preventive Services,²⁷ social support health behaviour interventions, especially peer support, are increasingly implemented to promote healthier lifestyles and better self-management of chronic illnesses. In our context, there is the Programa Pacient Expert Catalunya[®] and a published experience in social interaction and physical exercise targeting women referred by general practitioners.²⁸

Social participation practices are mainly considered as leisure, cultural and political activities not linked to health. However, in recent years, social prescribing has gained attention as a referral scheme that links patients from primary health care with non-medical sources of support like mutual support, befriending and participation opportunities in the community (e.g., arts and creativity, volunteering...²⁹). In Catalonia, it is promoted by the Health Department through the PINSAP and the Programme COMSalut and, in Asturias, by the Observatorio de Salud.

Currently, the on-going randomized clinical trial AEQUALIS³⁰ aims to reduce health inequalities through promoting social capital, health literacy and self-care in socio-economically deprived urban areas around Catalonia. Furthermore, the municipality of

Barcelona is implementing the programme “Escoles de Salut per a gent gran” focused on reducing social isolation in the elderly in the most deprived neighborhoods of the city and it is currently building VINCLES BCN, a service aimed at reducing loneliness by promoting social capital.

Finally, 39 Spanish cities have joined the WHO Global Network of Age-friendly Cities and Communities. This initiative guides the definition and implementation of action plans to engage governments and the overall society in creating inclusive and accessible urban environments, while considering the diversity of cultural and socio-economic contexts for a better ageing from a lifecycle perspective.

What is next?

There is a lack of high quality research in social capital promotion, especially in familistic countries. Therefore, more research but also more evaluation of current practices, from global policy to local programmes, should be conducted to drive a shift towards multilevel interventions and intersectorial health policies.

Research should focus on the effectiveness of social capital interventions on positive and negative health outcomes, including the avoidance or lowering of medication (e.g., in cases of minor depressive symptoms) and their usefulness in changing behaviour.

Efforts should be put into understanding and improving processes. Regarding implementation, fidelity, adherence and tailoring to the personal, cultural and socio-economic context are major issues. Besides, intervention designs require logic models, which integrate theoretical background and assumptions made to achieve changes.³¹ Social capital components are often combined with health education, physical activity, self-management skills, etc. Hence, there is a need to analyse mechanisms of impact and the influences of context.³¹

Flexible designs with individual and group-based components, and remote and face-to-face delivery modes might be better to meet specific needs and reduce selection bias. Moreover, health professionals need to become more aware and be provided with useful resources to act in their daily practice. In this vein, social prescription could become a promising mechanism. However, social prescription is a concept seldom found in the health literature. Therefore, research is needed to understand whether different models would work first on changing professionals' and patients' behaviours embedded in social prescription and, secondly, achieving health outcomes.

Finally, a debate about social capital promotion needs to be opened to understand shared responsibilities and define new roles, since they include but go beyond public health and health care.

Concluding...

Apart from the costs and adverse effects, achieving the potential benefits of social capital faces a major challenge: understanding and managing the complexity of effectively improving existing networks and successfully creating new ones; especially given that the most ambitious goal of social capital-based intervention is to promote a more meaningful life, a more meaningful ageing.

Lastly, social capital research and practice is needed to finally build the third pillar of the biopsychosocial health model, which should reinforce the biological and psychological perspective fulfilling the complexity of health from ill health to salutogenesis.

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