Social Connectedness and Health Amongst Older Adults

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Abstract

Australia is experiencing a “structural ageing” of its population; by 2044 approximately 25% of adults will be aged 65 years and over, leading to a corresponding increase in need for aged health and community care provisions. Older adults have been shown to be more vulnerable to social isolation than the rest of the populace. Socially isolated older adults have more ill health and less well being than those who are socially connected. Social connection appears to provide a protective effect against ill health and mortality in the aged. It is likely that those who are socially connected will, therefore, have less need to access health and community care services than those who are socially isolated. Based on a qualitative study of older adults within a local Melbourne municipality, I argue that increasing social connectedness amongst the elderly could have important beneficial impacts, not only on health, but also on government budgetary requirements and service allocations and, at a social capital level, on all of society. I also argue that, to date, programs that promote social connectedness amongst older adults are limited in their ability to access those who are truly socially isolated.

Introduction

This paper considers issues of social connection amongst older adults arising from a study of a local Melbourne municipality. First a brief differentiation between the effects of the two concepts, social isolation and social connection is given, along with a discussion of their differing impacts on health and wellbeing. Second, the social capital thesis is postulated as providing an explanatory basis for why social connection should be promoted in today’s society. Finally, results from my study into social connectedness and the elderly are provided as evidence that truly isolated older adults are not being accessed by existing social connection programs. If, as Putnam argues, social connectedness is one of the “most powerful determinants of our wellbeing” (Putnam, 2000a: 326), then this finding raises important questions for the social capital thesis in particular and for community life in general.

Research has shown that social isolation amongst older adults is a problem of growing concern (see Findlay 2003). Older adults who have limited or no contact with others,
and who perceive those contacts to be inadequate in some way, are considered to be socially isolated (Findlay 2003: 648). Older adults are more vulnerable to loneliness and social isolation than the rest of the population (World Health Organization (WHO) 2002: 28) due, in part, to a loss of physical mobility, a lack of transport options and the loss of life partners and friends (Findlay and Cartwright 2002: 6-7; McKinnon 2003: 10; Strang and Pearson 2000: 2). Older adults who are socially isolated have been shown to be more depressed, more disabled, to be in poorer health and to have less well-being than those who are socially connected (WHO 2002: 28; WHO 2003: 22). Indeed, a recent meta review of existing empirical research undertaken by the National Heart Foundation of Australia identified social isolation and a lack of quality social support as independent psychosocial risk factors for the occurrence of coronary heart disease across various age groups (Bunker et al. 2003: 272). Prevalence rates for social isolation vary, with a recent review estimating the rate in Britain at between two and 20% of people aged 65 years and over (Victor et al. 2000: 410). Research in Australia suggests that, in the veteran community at least, approximately 10% are socially isolated, with a further 12% at risk of social isolation (Gardner et al. 1999: 5).

Socially connected adults, on the other hand, have a greater chance of successfully recovering from a heart attack and have lower rates of coronary heart disease (WHO 2003: 22) than socially isolated individuals. Social connection, that is, social participation, social support and social networks have been shown to contribute to seniors’ overall health and wellbeing (National Advisory Council on Ageing 1993: 3). For instance, in a study of elderly Americans, Glass et al. (1999) found that participation in social activities such as social groups, playing cards, games or bingo, visiting cinemas and so on, lowered the risk of mortality in adults aged 65 years and older (1999: 278,480). Moreover, a recent longitudinal study found that, in Australian adults aged 70+ years, involvement in social networks with friends and confidants, excluding family, provided “significant protective effects against mortality over a 10 year follow-up period” (Giles et al. 2005: 577).
Why is social isolation / social connection an issue?

Increases in life expectancy and a sustained decline in fertility have led to a “structural ageing” of Australia’s population (Australian Bureau of Statistics (ABS) 1999: [3]). In 2001, 12.4% of the population of Australia was aged 65 years and over; by 2044-45 this figure is estimated to be almost 25% (Productivity Commission 2005: 339). This so-called “greying” of the population is of particular concern to all levels of government because of the perceived dependency of this age group (WHO 2002: 9) and the corresponding blow-out in costs associated with an increased need for aged health services and community care programs (ABS 1999: [1,5]). The predicted increase in future need, will place significant pressure on Australian governmental budgeting arrangements, service provisions, and personnel, program and infrastructure allocations (Productivity Commission 2005: 293,299). This will be especially relevant at the local government level, where many programs and services associated with aged and community care are implemented (Australian Local Government Association 2005: 16-20; Productivity Commission 2005: 293,299).1

The anticipated increase in the elderly population means, potentially, a subsequent increase in the number and proportion of socially isolated individuals, who, given the foregoing evidence, will be more vulnerable to ill health than the rest of the population. This increase in older citizens in poor health will only serve to augment the strain on aged health services and community care programs. In contrast, empirical studies show that socially connected older adults have better health and wellbeing and, by implication, may have less need to access health and community care services than those who are socially isolated. Consequently, it seems both socially and fiscally advantageous to ensure that older adults within local communities are socially connected. This is in line with the World Health Organization’s pronouncement that policies and programs that promote social connection “are as important as those that improve physical health status” (WHO 2002: 12).

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1 Explaining the provision of services for the elderly in Australia is difficult. It is complicated by the fact that aged care and health care services are funded as separate entities and by differing levels of contributions from all three levels of government.

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“Social Capital” - a framework for social connectedness

At an individual level, promoting social connectedness amongst older adults has obvious health benefits and, at a macro level, may well have beneficial financial and policy implications. However, at a community level the advantage of encouraging social connection amongst older adults has not been made altogether clear. A framework that may help contextualize the intricacies and benefits of social connectedness is the theory that social capital is related to our health and wellbeing. Social capital refers primarily to connections and relations among individuals, with the central premise being that social networks have value (Putnam 2000a: 18-19).

Putnam describes social capital as “features of social organization, such as networks, norms and trust that facilitate coordination and cooperation for mutual benefit” (Putnam 1993: [1]).

School performance, public health, crime rates, clinical depression, tax compliance, philanthropy, race relations, community development, census returns, teen suicide, economic productivity, campaign finance, even simple human happiness – all are demonstrably affected by how (and whether) we connect with our family and friends and neighbours and co-workers. (Putnam 2000b)

Further, Putnam sees social capital as being composed of two dimensions: bridging or bonding. Bridging capital is “inclusive”, it promotes broader identities and a more outward looking focus; whereas bonding capital is “exclusive” and has a tendency to reinforce identities and promote homogeneous groups with strong boundaries (Putnam 2000a: 22).

Social capital is both productive and cumulative so that, as people work together building connections and trust, they create a network of links that benefit communities and result in the increased possibility of collective action (ABS 2002: 4). Behaviours such as singing in the local choir, saying hello to someone in the street, voting, being involved in the local computer club, gossiping with neighbours, reading newspapers and so on, are all examples of “civic engagement” and, as such, can be seen to create social capital solidarity and collaboration at a community level (Putnam 1993: [2-3]; Putnam 2000a: 93). To illustrate, in the USA, strong correlations have been found between high levels of social capital and neighbourhood vitality, lower crime rates, and tolerance for others (Putnam 2000a: 308-309,356). Putnam has cautioned,
however, that social capital can have a downside, whereby it can be used negatively by “power elites” for antisocial purposes, such as “sectarianism, ethnocentrism (and) corruption” (Putnam, 2000a: 22).

In keeping with the findings reported earlier, Putnam asserts that social connectedness has been proven “beyond reasonable doubt” to be one of the “most powerful determinants of our wellbeing” (Putnam 2000a: 326). A series of longitudinal studies in the USA showed that “people who are socially disconnected are between two and five times more likely to die from all causes, compared with matched individuals who have close ties with family, friends and the community” (Berkman and Glass 2000; cited in Putnam 2000a: 327). Furthermore, in a study that used survey data from approximately 170,000 people in the USA, a strong relationship between poor health and low social capital was found, even when individual risk factors were accounted for (Kawachi et al. 1999: 1187). However, the reasons why social networks and social cohesion are beneficial for health have yet to be elucidated (Putnam 2000a: 327,331), although it has been postulated that social capital may act as a trigger to arouse the immune system to fight off disease and stress (Putnam 2000a: 327).

These results mirror those found earlier for older adults. Thus the social capital thesis appears to offer an empirical association as to why health outcomes in older adults are bound up with social connectedness. The emphasis on social networks and social involvement helps create a sense of social cohesion which bolsters and sustains social capital and which has, in turn, flow-on effects on community health outcomes. These results have implications for ensuring that social connection initiatives for older adults are provided in an ongoing community context.

**Local governments and social isolation / connection**

Local governments have a relationship with local communities that is missing from other tiers of Government (Commonwealth of Australia 2003: 8). Further, the Australian Local Government Association maintains that local government is a “key player in public health and community welfare” (ALGA 2005a: [5]) and the Municipal Association of Victoria claims that local government is increasingly being identified as “responsible for community care” (MAV 2004: 4).
Given the proposition that socially connected older adults need fewer health and community care services, local area governments have a vested interest in sponsoring social connection amongst the aged. In addition, the evidence that social connection fosters and promotes social capital which, in turn, influences health and wellbeing, cannot be ignored. It seems especially appropriate then that local governments, which are in a unique position to advocate on behalf of the community, implement programs to actively encourage social connection and thereby, social capital. However, much of the local government research to date has focused on social isolation in older adults rather than social connection per se (see for example: Knox City Council 2002 The Social Isolation Pilot Project). The work that this paper is based on was undertaken in an attempt to address this lack.

Despite the gap in the research, programs designed to promote social connection and alleviate social isolation in the aged do exist. However, ongoing research by Cattan and her colleagues suggests that, thus far, these programs have evolved to “meet the needs of current participants”, thereby excluding truly isolated individuals (Cattan et al. 2003: 20). This limitation will need to be borne in mind, as it poses significant problems for the development and implementation of programs in this area in the future.

**The study**

This study was undertaken as an Honours project investigating social connectedness amongst older adults from a local Melbourne municipality. This paper reports qualitative findings from in-depth interviews with older adults. Eight social club organizers (who were also older adults) and eight older adults were interviewed (16 in total). Of the 16 respondents, 10 were females (62.5%) and six were male (37.5%). Ages ranged from 65 – 92 years and the median age was 75 years. Questions were asked about various aspects of social connection and social isolation. The interviews were analysed thematically.

The study had two objectives. The first objective was to determine whether existing programs and initiatives within the municipality helped promote social connection
amongst older adults. Furthermore, as research by Cattan et al. (2003) suggests that services provided for socially isolated older adults do not actually get through to those in most need, an additional objective was to ascertain whether socially isolated older adults were actually being accessed by these programs.

**Older adults’ social club organizers**

Members of this target group were older adults who were involved in various organizing capacities as volunteers at older adults’ social and activity groups. They were all on the Committee of Management as President, Secretary, Treasurer, and so on. These social activity groups sponsor a variety of structured weekly events, such as cards, craft, indoor bowling, dancing, bingo and day trips. New group members are recruited primarily via word-of-mouth referrals from existing social club members or sometimes through advertisements in local newspapers. Initial contact with new members is usually by a telephone call and is sometimes followed up by a home visit. This is undertaken by a committee member who is often designated as the “Welfare / Welcoming Officer”.

Results from the interview data suggest that some clubs make a concerted effort to welcome new members, and to actively promote an atmosphere of inclusiveness. They generate social connectedness through the group activities, either large or small, and through shared interests and peer support. In these clubs, many of the organizers endeavour to connect with isolated people in their surrounding neighbourhoods, in an effort to encourage them to be involved:

> I visit many people in my area to ask them to come along (to the club)..... I don’t like to think that older people might be stuck at home and might never leave the house; it makes me sad. [Nick, Social Club Organizer]

Other clubs are cliquey and inadvertently (or otherwise) create an atmosphere of exclusion, as evidenced by waning numbers. In these cases, club officials maintain a power structure reminiscent of in-group and out-group dynamics (Tajfel 1982 cited in Taylor et al. 2000: 190) and are far more restrained in their attitudes to those whom they know to be isolated. For instance, many of these social club organizers consider those who are truly socially isolated as “too much hard work” or “too much trouble”. This means they are not really interested in helping to recruit new members from this
subsection of the population, or in going out of their way to help them, as this quote attests: “We don’t like to push them; if they want to come, they’ll come” [Rudy, Social Club Organizer].

These results fit neatly into the social capital thesis which sees social capital as composed of two dimensions: bridging or bonding. Social groups that were welcoming to newcomers and promoted an atmosphere of “inclusiveness”, could be classed as being high in bridging capital; whereas those social groups that were not so welcoming and could, at times, be “exclusionary”, could be viewed as high in bonding capital (see Putnam 2000a: 22).

Older adults

This group of respondents were drawn from two sub-groups: (i) older adults who were active members of social activity groups; or (ii) older adults who were not taking part in any social activity groups. Results suggest that those older adults who are involved are usually involved in more than one group. Many learn about social activity groups via word-of-mouth, that is, from their friends or neighbours and most had received a phone call or a personal visit from a designated club officer, such as the “Welfare/Welcoming” Officer, before attending for the first time. Once involved, older adults became socially connected through involvement in social activities, befriending others and giving and receiving social support, particularly those involved in “inclusive” groups. Programs and activities provide older adults with a feeling of connection to their peers and to the wider community:

I feel that I have made many friends through my club. I see those friends outside of the club. I think it is very important to be connected to friends and the community, and being part of a club has made it possible for me. [Frank, Older Adult]

Our club always visits people when they are sick in hospital. It makes you feel good. It's good to have someone else, not just from your family, to have someone your own age..... you can rely on them if you need them. [Jenny, Older Adult]

Whilst some older adults were willing to help those who were socially isolated to become connected others, however, would not go out of their way to help. Reflecting
the results obtained from the social organizers, it seems these older adults feared the commitment of helping others on an ongoing basis, reiterating the sentiments stated above that it was “too much hard work” or “too much trouble”.

Nevertheless, for the most part, social club organizers and social club participants found socially isolated older adults in the community extremely difficult to identify. There is no registry of isolated older adults, nor any way of determining who is socially isolated except through sporadic referrals from families, friends or neighbours and, in most cases, health care workers. Furthermore, privacy laws constrain direct contact with an isolated older person without first obtaining permission from the person themselves. This creates an invidious “Catch 22” situation and can leave many people who could benefit from increased social contact and participation, unconnected. Whilst the objective of privacy laws may well be to enhance trust within the community, in this instance, they only served to maintain social isolation in the aged by inhibiting social connectedness.

Conclusion

The results presented in this paper are necessarily brief. Nevertheless, they provide some answers to the research objectives. A number of local government initiatives aimed at promoting social connection in the aged do appear to be effective. Those older adults who are involved in social activity groups report feeling connected to their peers and to the wider community. However, the majority of the people involved in these programs are not the socially isolated individuals that the programs were originally designed for. This has previously been established by Cattan et al. and my small study supports her findings (2003: 20). I was able to demonstrate that socially isolated older adults – those who were most in need of social connection – were difficult to access due to structural and social impediments. Accordingly, programs that specifically target this cohort are needed, together with a greater awareness in the wider community of the negative implications of social isolation in older adults.

Social connection in the aged provides a powerful protective effect against ill health and an equally protective effect against mortality. In general, older adults who are
socially connected may have less need to access health and community services. Given this, and the anticipated blow-out in aged and community care costs, it makes sense for Governments, at all levels, to promote any program or method that enhances social connection amongst the aged. Further, the social capital thesis suggests that increasing social connectedness at a community level, is beneficial for all of society.

References


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