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EDITORIAL

Increasing social participation of older people: are there different barriers for those in poor health? Introduction to the special section

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Background

European populations are ageing and policy makers are concerned with the growing proportion of people becoming dependent on old-age pensions and care, and what this will mean for the sustainability of countries' social welfare systems. Against this background, policies that promote 'active ageing', defined as "the process of optimizing opportunities for physical, social and mental wellbeing throughout the life course in order to extend healthy life expectancy, productivity and quality of life in older age" (WHO 2002) are increasingly being called for. In addition to the societal value proffered by older people's continued engagement in the labour market and in other areas of social participation such as volunteering and caregiving, a growing body of research has shown that participation in such activities can also contribute to better health outcomes for the individual (Glass et al. 1999; Luoh and Herzog 2002; Menec 2003), which in turn contributes to the sustainability of pension and health care systems by reducing demand for their benefits and services. Efforts to increase active ageing should not only focus on promoting individual-level engagement but also on expanding opportunities for older people to remain or become involved. With a view to the emphasis on quality of life and wellbeing in the WHO definition, participation should include all kinds of activities—both the productive ones that were mentioned above and activities that are more 'consumptive' in nature such as leisure time activities and educational activities (Nimrod 2007; Silverstein and Parker 2002).

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Shifting the focus to older people in poor health

A large body of research has focused on the determinants of social participation in the general older population (e.g. Hank 2011; Strain et al. 2002). This research has shown that the various types of social participation can be enhanced by the availability of certain personal and environmental resources. In the case of productive activities, such as labour market participation and volunteering, these resources are often divided into human, social and cultural capital (Wilson and Musick 1997), with one of the main personal resources—and indicators of human capital—responsible for the often observed age-related decline in participation, being one's health status. In light of the importance of the relationship between health and social participation, it is essential to look more closely at health trends in the older population. Are older people nowadays better able to participate until later ages? Most studies show evidence of a rise in the proportion of older people being affected by chronic diseases (e.g. musculoskeletal, cardiovascular or lung disease) (e.g. Crimmins and Beltrán-Sánchez 2011; Galenkamp et al. 2013; Parker and Thorslund 2007). An increase in the prevalence of chronic diseases, together with the rising share of older people in the population, asks for a shift of focus from the 'successful' older people with limited disease or disability to those older individuals who live with multiple chronic diseases. In order to promote their social participation, barriers to remaining or becoming socially active need to be investigated.

Determinants of social participation in older people with and without multimorbidity

One might expect that people with chronic diseases not only participate less but also that people with chronic diseases experience different barriers that keep them from social participation. For example, older people with multiple chronic diseases may as a consequence suffer from functional limitations affecting their mobility and the ease with which they can participate in activities outside the home. Those with multiple chronic diseases may also need to invest more time in managing their conditions, reducing the time they have available for being socially engaged. Despite the increasing salience of the topic, studies that investigate the level of participation and its predictors, and that focus on people in poor health, are scarce. Therefore, papers in this special section focus on this very topic: what are the factors that are associated with social engagement in older people with poor health? Several health indicators can be used to distinguish between good and poor health, for instance self-rated health, physical functioning or the number of chronic diseases. The five studies operationalize poor health as having multiple health problems, i.e. multimorbidity (the occurrence of two or more chronic diseases), or multimorbidity combined with disability. Multimorbidity has proven negative effects on wellbeing and functioning (Marengoni et al. 2011).

To address the multidimensionality of active ageing, five different types of participation are studied that are either more productive or more consumptive in nature: volunteering, informal caregiving, participation in educational activities, participation in social leisure activities and finally, religious participation. The five studies were conducted within the MoPAct project (Mobilising the potential of active ageing in Europe), a four-year project funded by the European Commission under the Seventh Framework Programme (http://mopact.group.shef.ac.uk/). One of the aims of MoPAct is to comprehensively review the social and economic challenges of ageing, among others in the field of health and wellbeing. Four studies used individual-level data from SHARE (Survey of Health, Ageing and Retirement in Europe, Börsch-Supan et al. 2005); one is based on individual-level data from EPOSA (European Project on Osteoarthritis, van der Pas et al. 2013).

Across most types of participation, findings show considerable differences in the level of participation between those with and without multimorbidity, in favour of the group in better health. Regardless, determinants of social participation generally appear to be quite similar between the multimorbidity and non-multimorbidity groups. Many determinants that are found resemble those of previous studies. In both the multimorbid and non-multimorbid groups, and across the different types of participation, factors that are associated with a higher level of participation include a higher socioeconomic status, a larger social network, being active in other types of participation and having better physical and psychological health. If differences are present, they do not always confirm the hypothesis that other resources for social participation compensate for the decline in health in those with multimorbidity: determinants appeared stronger more often in the group without multimorbidity. Depression is recurrently associated with less participation in the group with multimorbidity, indicating that preventing or treating depressive symptoms might be a way to increase the potential of social participation in those with physical health problems. Below we highlight some notable findings that are specific per type of participation.

Principi et al. (2016), examining predictors of volunteering, show that in particular older people with multimorbidity are more likely to be volunteering if they are widowed (rather than married or cohabiting). Previous studies often showed the reverse, but this finding possibly indicates that some people in poor health who lost a relationship compensate for this by volunteering. Principi et al. also show that depressive symptoms are negatively associated with volunteer work particularly for those with multimorbidity or disability.

Determinants of informal caregiving were studied by Schmidt et al. (2016). They conclude that opportunity structures and family structures do not compensate for the effect of multimorbidity on providing care outside the household (to dependent others or to grandchildren). For example, higher education and income, or being married, do not show stronger associations with providing care in those with multimorbidity, compared to those without multimorbidity. With regard to sociodemographic characteristics, they find that women were more likely to provide grandparental care than men, except when they had multimorbidity.

Focusing on educational activities, Golinowska et al. (2016) show that indicators of human capital (e.g. education and income level) are important predictors of participation in formal learning activities. As human capital factors are more difficult to change at older ages than social capital factors, the authors point to the finding that engagement in other social activities might stimulate participation in learning activities.

Participation in social leisure activities proves to be rather high in the six European countries studied by Galenkamp et al. (2016). Interventions may therefore be targeted at the intensity of participation, in particular in those with poor health. People who make use of public transport or of their own car (in particular those with

multimorbidity) have higher levels of participation in social activities. Thus, improving the transportation possibilities for older people may be a way to remove barriers for leisure participation.

Sowa et al. (2016), finally, studied the determinants of religious participation in older Europeans. This is a type of social participation that people with and without multimorbidity participates in at a rather equal level. Within both groups, people with secondary education—but not with higher education—report lower church attendance compared to primary educated people. This study also finds dementia to be a factor that decreases the chance that people participate in church activities. Other types of social participation show rather strong links with church attendance, in particular in the group without multimorbidity.

All papers to some extent address the fact that activities are not done in isolation, by including other types of participation as predictors. In general, being involved in one type of activity increases the chance of being involved in other activities, providing evidence for the hypothesis that similar motivations are responsible for participating in different types of activities (Morrow-Howell 2010), or that network ties reinforce engagement in other activities (Berkman et al. 2000). On the other hand, a large amount of time allocated to a certain activity can inhibit the decision to participate in other activities. This may apply in particular to labour market participation, a factor that is negatively associated with the outcomes volunteering and grandparenting (Schmidt et al. 2016; Principi et al. 2016). Because patterns of complementing or competing activities are probably better predictors of health and wellbeing (Morrow-Howell 2010), future studies should address in particular combinations of activities, and their health effects. A related topic concerns the relatively unexplored field of activity preferences. Compared with healthy individuals, do people with health problems take up or give up some activities earlier than others?

A specific determinant that is addressed in the papers is the role of physical functioning within older people with multimorbidity. The disablement process model (Verbrugge and Jette 1994) considers the level of functioning in the pathway between chronic diseases and participation. Including physical functioning as a determinant for both health groups might imply an overadjustment (as it takes away the differences between the multimorbidity and no multimorbidity groups). However, the papers that did adjust for limitations in physical functioning find rather similar results before and after adjustment. This might imply that other health differences between the multimorbidity groups account for some of the determinants that were found to differ between the groups. More likely, the differences between the multimorbidity groups—at least in factors that are associated with participation—are too small to be affected by the level of functioning.

The studies presented in this special issue provide insight into the correlates of social participation of groups of older people based on their health status. However, further research, ideally employing a longitudinal design and investigating the reasons for ceasing to participate and the consequences of additional health limitations, would be necessary in order to validate and expand on these findings.

Conclusions

The individual studies do provide evidence that health status is related to older people's level of participation in various activities. The challenge is then to enable older people to be active if it is indeed their preference to be socially engaged, despite their health limitations. Nevertheless, based on the results we can also conclude that the level of health should be only a minor factor in designing intervention strategies: little or no substantial differences in predictive factors of social participation were observed. Still, increasing the participation of older people with health problems should remain an important target, not in the least because this might be beneficial for their wellbeing.

References

Berkman LF, Glass T, Brissette I, Seeman TE (2000) From social integration to health: durkheim in the new millennium. Soc Sci Med 51(6):843–857

Börsch-Supan A, Hank K, Jurges H (2005) A new comprehensive and international view on ageing: introducing the survey of health, ageing and retirement in europe. Eur J Ageing 2(4):245–253

Crimmins EM, Beltrán-Sánchez H (2011) Mortality and morbidity trends: is there compression of morbidity? J Gerontol B Psychol Sci Soc Sci 66B(1):75–86

Galenkamp H, Braam AW, Huisman M, Deeg DJH (2013) Seventeen-year time trend in poor self-rated health in older adults: changing contributions of chronic diseases and disability. Eur J Public Health 23:511–517

Galenkamp H, Gagliardi C, Principi A, Golinowska S, Moreira A, Schmidt AE, Winkelmann J, Sowa A, van der Pas S, Deeg DJH (2016) Predictors of social leisure activities in older europeans with and without multimorbidity. Eur J Ageing. doi:10.1007/s10433-016-0375-2

Glass TA, Mendes de Leon C, Marottoli RA, Berkman LF (1999) Population based study of social and productive activities as predictors of survival among elderly americans. BMJ 319(7208):478–483

Golinowska S, Sowa A, Deeg D, Socci M, Principi A, Rodrigues R, Ilinca S, Galenkamp H (2016) Participation in formal learning activities of older europeans in poor and good health. Eur J Ageing. doi:10.1007/s10433-016-0371-6

Hank K (2011) Societal determinants of productive aging: a multilevel analysis across 11 european countries. Eur Sociol Rev 27(4):526–541

Luoh MC, Herzog AR (2002) Individual consequences of volunteer and paid work in old age: health and mortality. J Health Soc Behav 43(4):490–509

Marengoni A, Angleman S, Melis R, Mangialasche F, Karp A, Garmen A, Meinow B, Fratiglioni L (2011) Aging with multimorbidity: a systematic review of the literature. Ageing Res Rev 10(4):430–439

Menec VH (2003) The relation between everyday activities and successful aging: a 6-year longitudinal study. J Gerontol B Psychol Sci Soc Sci 58(2):S74–S82

Morrow-Howell N (2010) Volunteering in later life: research frontiers. J Gerontol B Psychol Sci Soc Sci 65(4):461–469

Nimrod G (2007) Retirees' leisure: activities, benefits, and their contribution to life satisfaction. Leisure Stud 26(1):65–80

Parker MG, Thorslund M (2007) Health trends in the elderly population: getting better and getting worse. Gerontologist 47(2):150–158

Principi A, Galenkamp H, Papa R, Socci M, Suanet B, Schmidt A, Schulmann K, Golinowska S, Sowa A, Deeg DJH (2016) Do predictors of volunteering in older age differ by health status? Eur J Ageing. doi:10.1007/s10433-016-0377-0

Schmidt AE, Ilinca S, Schulmann K, Rodrigues R, Principi A, Barbabella F, Sowa A, Golinowska S, Deeg D, Galenkamp H (2016) Fit for caring: factors associated with informal care provision by older caregivers with and without multimorbidity. Eur J Ageing. doi:10.1007/s10433-016-0373-4

Silverstein M, Parker MG (2002) Leisure activities and quality of life among the oldest old in sweden. Res Aging 24(5):528–547

Sowa A, Golinowska S, Deeg D, Principi A, Casanova G, Schulmann K, Ilinca S, Rodrigues R, Moreira A, Gelenkamp H (2016) Predictors of religious participation of older europeans in good and poor health. Eur J Ageing. doi:10.1007/s10433-016-0367-2

Strain LA, Grabusic CC, Searle MS, Dunn NJ (2002) Continuing and ceasing leisure activities in later life: a longitudinal study. Gerontologist 42(2):217–223

van der Pas S, Castell MV, Cooper C, Denkinger M, Dennison E, Edwards M, Herbolsheimer F, Limongi F, Lips P, Maggi S, Nasell H, Nikolaus T, Otero A, Pedersen N, Peter R, Sanchez-Martinez M, Schaap L, Zambon S, van Schoor N, Deeg D (2013) European project on osteoarthritis: design of a six-cohort study on the personal and societal burden of osteoarthritis in an older european population. BMC Musculoskelet Dis 14(1):138

Verbrugge LM, Jette AM (1994) The disablement process. Soc Sci Med 38(1):1–14

WHO (2002) Active ageing. A policy framework

Wilson J, Musick M (1997) Who cares? Toward an integrated theory of volunteer work. Am Sociol Rev 62(5):694–713