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Social Participation and Health among Ageing People in East-Central Europe

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Abstract: *In this study we examined the health of the ageing population of East-Central Europe. Data derived from the 6th round of the European Social Survey. The aim of our research was to examine the most important factors that determine ageing people's health status. We paid particular attention to the social ties of our target group.*

The European society is an ageing society because of low birth rate and the growing number of aged population due to of the rising of life expectancy at birth (Boncz et al., 2014; Oláh, 2004).

Demographic projections show that in European society the rate of ageing population can reach 36% by the year of 2050 (Hablicsek, 2000). Accordingly, the social policies of the countries have to pay more attention to ageing population. In addition to economic considerations, need to take care of the condition and the quality of their life to provide that the ageing population can live an active and satisfied life (Kovács, 2006). The active and successful ageing is the result of conscious work where the ageing population, after retirement or after they have been left alone by their children, are still able to find the opportunity of active and satisfied life (Füzesi et al., 2013). It is really important to keep an eye on the problem of ageing, because the number of years that the citizens of European societies spend as an ageing population is growing as a result of the rising of life expectancy at birth. As they get older, health condition takes bigger part of their life and largely defines its quality. People's failing health conditions in between the age of 50 and 60 but mostly above 60 set them back more often during their work (Kovács, 2006), as active ageing needs good health condition. According to European statistics, the health of ageing population of Hungary can be 20-25% worse than the European mean?

(Kovács, 2006). In other post-socialist countries (Slovenia, Slovakia, Poland, Czech Republic), the data are also worse than the European average, which is why we decided to show the Hungarian data with other East-Central European post-socialist countries' data.

The health status

In case of health condition we can find disparities in every country, the only difference is in its quantity. In Western Europe the disparities have been decreasing since 1990's, conversely in Hungary (similarly to other post-socialist countries) there was no improvement. That gives a reason to examine the health inequalities of the European society and currently of the post-socialist countries.

During the last decades more and more research dealt with examining the self-rated health (SRH), and its determining factors (Kunst et al., 2005). In Nordic countries if the socio-demographic conditions are disadvantageous, the SRH of the society is still higher than other European societies' because the welfare systems and the health care of these countries is able to relieve the unfavourable effects among people with more difficulties, as proven by Kunst's buffer hypothesis. Also Kunst's researches proved that health inequalities in the Nordic countries are decreasing, unlike in Southern European countries such as Spain and Italy, where an increase of such inequalities can be detected (Kunst et al., 2005).

Health is determined by *socially based* and *individually based* factors. Socially based factors contain the development of the country, and specifically the health care system, while individually based factors are more focused on the person, examining the target person's physical activity is, job, living conditions etc. (Flaskerud & DeLilly, 2012).

According to the causal model of Ross and Wu, the health is determined by several *social* and *psycho-social factors* like work and economic conditions, social-psychological resources (sense of control, social support) or healthy lifestyle (Ross & Wu, 1995).

Moreover, according to the research of Vöörmann and his colleagues, health is created by *neomaterial* (availability of resources both at level of the individual and the household) and p*sychosocial factors* (the importance of the social relationships that are vital for well-being) (Vöörmann & Helemaee, 2013).

During the 1990's Tahin and his colleagues examined of the population of Baranya country, Hungary. This longitudinal study was repeated two more times, in 1996/1997 and in 2003/2004 (Tahin et al., 2000), and as a result they proved the close relationship between education and subjective health status.

Samples for the social determinants of health:
⇨ differences between the health status of men and women
⇨ age
⇨ education (differences in education)
⇨ work conditions, job satisfaction, or higher income providing better health status
⇨ the place of living (capital, city or village)
⇨ marital status (married or single people are healthier) etc.

In addition to the determining material properties, the role of the *psychosocial factors* are also important in health status. According to the research of *Katalin Kovács* and her colleagues, the risk of having anxiety disorder is 2,5 % higher for women than for men, and social connections can provide a protecting factor for adults and hence for ageing people, which may have a positive effect on their health status (Kovács, 2006; Bajsz et al., 2014).
    Samples for psychosocial factors:
> ➢ sense of control (perceived cohesion, perceived control - for adapt to their environment)
> ➢ generalised trust
> ➢ social support
> ➢ social connection, social participation
> ➢ social capital

In our study special attention was paid to the psychosocial factors, more precisely to social participation.

Social capital and social participation

Examination of *social capital* is becoming popular through a growing number of scientific research. Lots of investigations can prove significant connection between health and social capital, but we need to keep an eye on the correlation that, in addition to the individual level, the relation of health and social capital is also defined contextually. However, the research of the connection of these variables is not enough. We need to analyse them with the help of the following environmental factors: social situation, income status, and level of education. The social capital can affect the health condition, but it can apply also the other way around - that is why we need to be careful with the data or examine it with longitudinal research (Han et al., 2012). In our study we considered to social capital at individual level, highlighting person's social participation.
    Health condition of widowed or divorced people is less favourable, and their mortality rate is higher, too (selection or casual mechanism). People with worse health condition show worse remarriage indicators than healthy people. According to casual mechanism, better income status, psychical support and emotional security given by the spouse and also better health behaviour all associate with favourable health conditions for married people. Consequently, such factors act as protective mechanisms (Kovács, 2006).
    According to the buffer hypothesis, people with unfavourable social status but higher social capital can take difficulties easier (Uphoff et al., 2013). According to Shöllgen's model, the negative effect of low social status on health can be improved by favourable psychosocial conditions and social relationships (Schöllgen et al., 2001). Therefore, *social relationships* are particularly important for people with low social status to compensate other shortages that derive from circumstances. Moreover, the research proves that social relationships are particularly important for

ageing people, too. All those people with lower income who live an active social life have better health than those who do not.

Vonneilich's research (2012) proves that social relationships can affect health in a positive way by generating resources which decrease the presence of the elements of harmful lifestyle. An example for this the smoking practice of the spouse does not necessarily mean that the other half of the couple smokes as well.

The well-being of ageing people, even after serious illnesses, is determined by several factors (Molics et al., 2013). Social relationships have a general effect on morbidity chance or recovery. Social ties of ageing „*people have consistently been associated with good health*" (Ellwardt et al., 2014).

Methods

Our data derived from the 6th round of European Social Survey (ESS), the database summarizes the data of 28 European countries data (n=54540). ESS is an academically driven cross-national survey that has been conducted every two years across Europe since 2001[1].

In our study we highlighted the ageing people of post-socialist countries. According to WHO standards, we considered ageing people who are 50 years old or more (Füzesi et al., 2013). WHO considers 50-59-year-old people ageing people who are in an age when they start to recognize the sign of ageing. As post-socialist countries we considered the following countries of East-Central Europe: Hungary, Slovenia, Slovakia, Poland, Czech Republic (N=2549).

Measures
Self-rated health (SRH)

Self-rated and subjective health is a widely accepted measure of health status. It is measured by one question: *How is your health in general? Would you say it is … very good (1), good (2), fair (3), bad (4), or very bad (5)?*

In the analysis we recoded this dependent variable as a two-variable indicator as respondent is healthy (SRH is very good, good) or not (SRH is fair, bad or very bad).

Socioeconomic status

Independent variables in our analysis were *age* (three age group were determined), *gender* (male, female), *education* (low, middle or higher educated), *work status* (paid work, retired, inactive categories), *place of living* (farm, village, suburbs, city, big city), *number of people living particularly in the household, income status, marital status.*

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[1] http://www.europeansocialsurvey.org/about/

Social participation

The social participation was analysed through the following two questions of ESS:
- *How often do you socially meet with friends, relatives or colleagues?* Never (1), less than once a month (2), several times a month (3), once a week (4), several times a week (5), every day (6).
- *How many people do you know you discuss intimate and personal matters with?* (recoded to have or not to have anyone to discuss about personal matters)

Statistical analyses

Statistical analysis contained bivariate analyses (χ^2 test) using IBM SPSS Statistics 20 software. In all of the tests, the level of significant was considered as $\alpha=0.05$.

Results

Table 1 shows the demographic and baseline characteristics of our target group (aged 50 years or more from the post-socialist countries of East-Central Europe). The results showed that in the sample of the survey in East-Central European countries the mean age was 63.95±9.61.

The gender of the target population showed that the major rate of the female population is similar to the European mean.

The reason of the great differences among the education levels of the five countries could be the differences in measuring education in the survey or the selection of samples. Therefore, we could not examine the educational differences between countries.

The data reported that most of the respondents were retired and they lived with somebody, however around 25.2% of them lived alone, which is a significant rate and needs further examination.

The financial status of the ageing population showed that half of them had difficulties. Most of them were widowed and two thirds of them felt unhealthy.

We examined the social participation of ageing people, where we found that 45.8 % of the 50-year-old or older respondents meet friends once a month or less. Furthermore, around 10% of them do not have anyone to discuss personal matters with. These facts turn the attention to the social activity or rather inactivity of the target population, which could be an important factor of the successful ageing.

Figure 1 shows the health status of the target group according to the respondents' self-rated health, where we highlighted the unhealthy categories of response next to the European mean (60%). The Hungarian males and females and the Slovakian, Slovenian, Polish females worse health status than the European mean.

Table 1. Socioeconomic status of the ageing population of East Central European countries

	Hungary	Chech R.	Poland	Slovakia	Slovenia	ECE	Europe
(N)	374	398	1465	228	84	2549	26624
Age							
50-59	37,6	40	40,5	39,1	38,1	39,8	36,6
60-64	44,7	52	41,9	49,7	41,6	44,6	44,9
65-	17,6	8	17,6	11,2	20,4	15,6	18,5
Gender							
Female	57,7	51,3	55,5	62,9	56,8	55,9	57,5
Male	42,3	48,7	44,5	37,1	43,2	44,1	42,4
Education							
Low	30,2	9,4	55,5	19,1	29,5	40,6	35,2
Middle	56,7	79,4	34,4	68,9	60,8	48,5	46,8
Higher	13,2	11,2	10,1	12	9,7	10,9	18
Labour market status							
Paid work	28,6	37,4	31,3	30,7	22,9	31,5	33,4
Retired	62	58,2	64,6	62	68,6	63,1	57,7
Inactive	9,4	4,4	4,1	7,3	8,5	5,4	8,9
Number of people living in household							
Living alone	33,8	32,2	20,7	30,1	17,1	25,2	29,7
Living with somebody	66,2	67,8	79,3	69,9	82,9	74,8	70,3
Place of living							
Big city	25,8	22,9	25	13,6	20,6	23,7	21,4
Suburb	3,2	5,3	4,8	4,8	8,4	4,8	9,7
City	37,3	45,3	32	34,3	20,5	34,6	34,6
Village	32,5	26,3	37,1	47,3	44,8	35,9	30,9
Farm	1,2	0,2	1,1	0	5,7	1	3,3
Income							
Living comfortably	5,6	8,3	5	7,2	26,6	6,5	21,4
Coping on	39,1	45,3	52,4	40	50,6	48,2	43,2
Difficult on	34,5	30,9	37,3	35,8	14,2	35	24,7
Very Difficult on	20,8	15,5	5,3	17	8,6	10,3	10,7
Marital status							
Unmarried	4,9	2,7	6,2	5,5	8,4	5,5	6,5
Married	53,3	56,5	65,5	61,3	64	61,9	58,6
Cohabitation	.	0,1	.	0,2			0,2
Separated	.	.	0,6			0,3	0,5
Divorced	15	17,3	5,7	8,8	7,2	9,2	12,5
Widowed	26,8	23,4	22	24,2	20,3	23,1	21,7
Health (SRH)							
Healthy	33,6	40,6	37,6	39	39,9	37,7	45,6
Not healthy	66,4	59,4	62,4	61	60,1	62,3	54,4
Social participation							
Never	16,2	4	6,2	4,2	3,8	7,1	3,4
Less than one a month	35,3	12,1	21,1	11,1	13,2	20,6	11,9
Once a month	13,6	12,1	21,8	13,3	15,1	18,1	11,4
Several times a month	14,9	25,7	23,1	20,6	21,2	22	22,2
One a week	9,8	19,3	14,7	17,1	21,9	15,1	17
Several times a week	7,9	17,7	8,5	23,7	18,2	11,6	22,6
Every day	2,4	9,1	4,5	10,1	6,5	5,5	11,5
Intimate relationships							
Have	92,5	89	90,9	86,8	90,2	90,5	92,4
Not have	7,5	11	9,1	13,2	9,8	9,5	7,6

Figure 1. Rates of unhealthy people of the ECE countries across the SRH
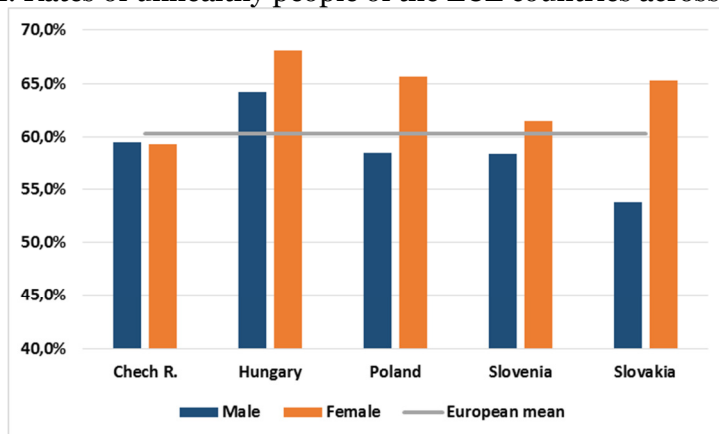
The data in *Table 2* describe the results of χ² tests where we examined baseline data of the 5 post-socialist countries of ECE beside the health status. The results of the χ² test showed that all of the baseline characteristics and social activity factors show significant correlation with health status (SRH) except for the place of living.

Table 2. Result of χ² test of SRH and baseline characteristics

	χ^2	df	p (p<0.05)
Age	161,276	2	0,000
Gender	9,231	1	0,002
Education	92,438	2	0,000
Labour market status	209,798	1	0,000
Number of people living in household	54,717	9	0,000
Place of living	7,99	4	**0,920**
Income	151,931	3	0,000
Marital status	32,495	5	0,000
Social participation	63,911	6	0,000
Intimate relationships	5,708	1	0,000

Table 3. Result of the frequencies of social connections and SRH

%	Not healthy	Healthy
Never	9,150%	3,700%
Less than once a month	23,600%	15,800%
Once a month	17,400%	19,300%
Several times a month	19,500%	26,200%
Once a week	14,800%	15,500%
Several times a week	11,000%	12,400%
Every day	4,550%	7,100%

Table 3 shows that unhealthy people has fewer possibilities to meet friends than other, healthier people. This social inactivity and hence loneliness could result further deterioration in their health status.

50.5% of unhealthy and 38.8% of healthy respondents meet friends, colleagues, relatives once a month or less, which rate is much higher than

the one concerning persons who live alone and for whom it is more difficult to meet other people; therefore, for ageing people it could be a problem to be lonely and socially inactive. Furthermore, only 15.55% of not healthy and 19.5% of healthy ageing adults meet friends, colleagues or relatives several times a week or every day.

Discussion

Based on our findings, social activity of all ECE countries is poorer than the European mean can be detected. Our results are in accordance with earlier studies in which researchers proved the relationships between social activity and health status (Uphoff et al., 2013; Han et al., 2012; Shöllgen, 2011; Vonneilich, 2012).

The results showed that health is closely correlated with health status and the intervention to improve it should concentrate on social activity and social participation, like health intervention in team where people can change their opinions and ideas thanks to each others.

Conclusions

The result have confirmed the relationship between health (SRH) and social activity, which proved that further studies need to investigate better this close relationship. Furthermore, interventions need to improve ageing people's social activity and health status, which could be realized in many areas, for example physical activity, health communication, computer or language trainings.

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