Health & Place 42 (2016) 111–119

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

Older adult social participation and its relationship with health: Rural-urban differences

Eric M. Vogelsang

Department of Sociology, California State University-San Bernardino, 5500 University Parkway, San Bernardino, CA 92407-2397, United States

ARTICLE INFO

Keywords:
Social participation
Self-rated health
Rural-urban differences
Older adults
Counties

ABSTRACT

In an aging world, there is increased need to identify places and characteristics of places that promote health among older adults. This study examines whether there are rural-urban differences in older adult social participation and its relationship with health. Using the 2003 and 2011 waves of the Wisconsin Longitudinal Study (n=3006), I find that older adults living in rural counties are less socially active than their counterparts in more-urban counties. I also find that relationships between social participation and health vary by the type of activity and rural-urban context.

1. Introduction

As the proportion of older adults around the world has grown and is projected to increase further, global organizations have stressed the importance of ensuring that seniors live in "enabling environments" and "age-friendly communities" (Plouffe and Kalache, 2010; United Nations Population Fund, 2012). Two important components of these environments are a positive social setting and opportunities for social participation, since research has generally found associations between social participation and positive older-adult health outcomes (Menec et al., 2011). Indeed, these relationships have been identified across numerous contexts, including North America (Gilmour, 2012; Glass et al., 1999), East Asia (Hsu, 2007; Kondo et al., 2007), and Europe (Bennett, 2005; Sirven and Debrand, 2008). Unfortunately, much less is known about how older adult social participation varies across space (Clarke and Nieuwenhuijsen, 2009). In particular, researchers have just begun to study how social environments differ between rural-urban contexts; and the implications this may have for older adults living in these places (Levasseur et al., 2015).

This paper has two objectives. The first is to investigate whether and how social participation among older adults varies between rural and urban settings. The second goal is to identify whether *the relationships* between social participation and health differ between these contexts. The two goals work in concert since the implications of the former depend on results found in the latter. For example, community center use may be more common in urban counties (goal 1), but not associated with well-being (goal 2). If so, this may indicate that certain structural differences between urban and rural places have limited health consequences. Conversely, suppose that older adults living in rural areas meet friends less often than those living in urban areas (goal 1); and these gatherings are associated with better health (goal 2). This would highlight one way in which older adults living in rural locations are being "left behind" by differential social environments.

2. Background

2.1. Social participation and older adult health

Numerous studies have established positive relationships between social participation and improved health outcomes (Kim et al., 2008). While less plentiful, there is increasing evidence suggesting that these associations are even stronger among older adults (Morrow-Howell and Gehlert, 2012). One reason this may be the case is that a majority of seniors are no longer working. That is, retirement not only results in the loss of a primary outlet for social interaction, it also is often accompanied by more free time in which to join social groups. In addition, the benefits of physical movement related to regular group activities may be particularly important for older adults looking to delay functional decline (Hamar et al., 2013). Lastly, a greater life purpose that some of these activities may bring could compensate for the loss of family or friends that have died or moved away (Bath and Deeg, 2005).

Robert Putnam's *Bowling Alone* (2000) is often credited as motivating research that highlights possible implications of a disconnected society. It also brought widespread attention to what he described as a multi-decade decline in social capital throughout the United States—particularly as it related to community engagement and

E-mail address: eric.vogelsang@csusb.edu.

http://dx.doi.org/10.1016/j.healthplace.2016.09.010
Received 5 May 2016; Received in revised form 8 September 2016; Accepted 19 September 2016

social participation. Putnam hypothesized that this decline was associated with a number of negative consequences, including more deleterious health outcomes for those living in places that are not as socially and civically connected (Elgar et al., 2011). Although *Bowling Alone* did not specifically focus on older adults, it details how the United States' "Greatest Generation"—which was entirely 65-plus by 2010—represents the U.S.'s last "cohort of joiners" (i.e., relatively high levels of community and civic engagement) (Brand and Burgard, 2008; Putnam, 2000). Despite its salient contributions, *Bowling Alone* contains a number of theoretical and empirical limitations. For one, Putnam often relied on social capital at the state-level to explain negative social consequences, even though there is likely a high degree of within-state heterogeneity. In particular, a significant portion of the variability in social capital between states is likely accounted for by *rural-urban differences* in social capital within states (Durlauf, 2002). Secondly, Putnam's research makes it difficult to make even basic causal claims. For example, relationships between social participation and health may be attributable to the fact that healthy individuals likely have a greater ability to be socially active.

Both *Bowling Alone* and the broader literature linking older adult health to place are frequently unclear as to which activities form various aspects of social capital (Poulsen et al., 2011). To address this ambiguity, the present manuscript explicitly focuses on *social participation*. While there is no consensus on its definition, prior work overwhelmingly points to "involvement with activities that provide an interaction with others in the community" (Levasseur et al., 2010). In addition to necessitating a group component, this description stresses the importance of community and, thus, the local—local friends, local places and local groups. Interestingly, research linking social participation to health does not always explicitly focus on "social participation", per se. Instead, it often investigates relationships between health and *specific activities* that are widely considered elements of social participation under this definition—such as group exercise (Rubenstein et al., 2000), religious participation (Hill et al., 2014), and volunteer work (Fried et al., 2004; Hanlon et al., 2014). This is notable since mechanisms linking social participation to health likely depend on the type of activity. For example, exercise groups may improve health through strength training; religious participation by providing a sense of purpose; and volunteering by a combination of physical, psychological, and cognitive pathways.

2.2. Rural-urban differences

There is growing evidence that suggests older adult health differs between those living in rural and urban locations (Burholt and Dobbs, 2012; Therrien and Desrosiers, 2010). As a likely correlate of healthy aging, identifying and understanding geographic variation in older-adult social participation may be one way to explain these disparities (Annear et al., 2014). On one hand, older adults living in rural places are often idealized as possessing stronger ties to their communities and retaining high-quality relationships with friends for decades (Keating, 2008). In addition, there is evidence suggesting older adults are increasingly volunteering and positively transforming rural communities that are facing numerous structural challenges (Hanlon et al., 2014; Joseph and Skinner, 2012). Conversely, seniors living in these same places may experience greater isolation, have access to fewer senior-focused amenities, and face transportation challenges that, in turn, could be associated with lower rates of social participation (Eby et al., 2008; Nyqvist et al., 2013).

Prior research investigating possible rural-urban differences in social participation—whether or not it focuses on older adults—is limited and provides mixed conclusions. For example, two different studies of older adults in Quebec found little evidence that social participation varied between metropolitan, urban and rural locations (Levasseur et al., 2015; Therrien and Desrosiers, 2010). That said, the results obtained by Levasseur and colleagues provide evidence that the environmental determinants of senior participation (e.g., proximity of resources, transportation options) do systematically differ between rural and urban contexts. Conversely, a study of Chinese adults found that those living in urban counties report greater social participation than those in rural counties (Meng and Chen, 2014); although it is unclear which activities these differences were attributable to. Similarly, one U.S. study found that structural disadvantage—including lower social capital, broadly—was more common in U.S. rural counties, when compared to urban ones (Monnat and Beeler Pickett, 2011).

Despite increasing interest in whether social participation or health varies between rural or urban settings, there has been inadequate consideration as to whether *relationships* between social participation and older adult health differ between these places. On one hand, there may not be obvious reasons to expect that an association between exercise and health differs by residential location. On the other hand, relationships between religious participation and health, for example, could conceivably vary across rural-urban contexts if rural older adults possess distinct practices or beliefs that are linked to health (Mitchell and Weatherly, 2000). For one region in Finland, Nummela et al. (2009) found that being in roughly the top half of social participation scores was associated with better health when living in urban and rural places; but not in suburban locations. Similarly, a study of Canadian older women found that social capital had stronger relationships with health for urban residents; when compared to their rural counterparts (Wanless et al., 2010). One limitation of both studies is that that it is unclear whether these relationships depended on or differed by particular social activities. In addition, the cross-sectional nature of these studies limit the ability to draw many conclusions with respect to the direction of causality. This is particularly notable since longitudinal studies tying social participation to health—particularly those focusing on older adults—are scarce and have been mostly set in Northern Europe (Murayama et al., 2012).

2.3. Social participation and activity spaces

Social participation emphasizes the "local" community, and there are three compelling reasons to conceptualize activity spaces at administrative areas larger than a census tract or town; such as counties, districts, or regional municipalities (Perchoux et al., 2013). One, these units capture greater metropolitan areas that often share resources and amenities relevant for social participation. In other words, many social activities (e.g., going to a museum, being involved with a senior center, joining a team sports club) are often centered within a larger contextual sphere that benefits individuals across numerous neighborhoods.

Two, research has begun to question the appropriateness of neighborhoods to adequately capture activity spaces. In particular, the literature on "neighborhood effects" assumes that *living* in a particular census tract has associations with particular outcomes. This may be problematic, however, if individuals have little connection to the social environment within their neighborhood or are primarily engaged in activities outside their neighborhood. For example, research by Milton et al. (2015) and Jones and Pebley (2014) suggests that neighborhoods and census tracts did not adequately capture activity spaces of English older adults and Los Angeles residents, respectively. Conceptualizing activity places as covering a larger area than a neighborhood may be even more important in rural places, where "local" friends could live miles from home, and long drives to activities may be normative.

Three, counties and districts generally share a political history and environment that shape the characteristics of older adults living there; including the administration of infrastructure-related improvements (Gerstorf et al., 2010; McLaughlin et al., 2001). In other words, they can capture local conditions and represent areas relevant for social planning (Monnat and Beeler Pickett, 2011).