Asia-Pacific Social Science Review

Volume 19 | Issue 3 Article 13

9-30-2019

Community Social Capital and Health Status and Health Seeking Behaviors Among the Elderly

Mary Joyce D. Bernardo
Central Luzon State University, Philippines

Melanie P. Tolentino
Central Luzon State University, Philippines, meltolentino_21@yahoo.com

Recommended Citation
Bernardo, Mary Joyce D. and Tolentino, Melanie P. (2019) "Community Social Capital and Health Status and Health Seeking Behaviors Among the Elderly," *Asia-Pacific Social Science Review*: Vol. 19: Iss. 3, Article 13.
DOI: https://doi.org/10.59588/2350-8329.1247
Available at: https://animorepository.dlsu.edu.ph/apssr/vol19/iss3/13

Asia-Pacific Social Science Review 19(3) 2019, pp. 155–166

RESEARCH ARTICLE

Community Social Capital and Health Status and Health Seeking Behaviors Among the Elderly

Mary Joyce D. Bernardo and Melanie P. Tolentino*
Central Luzon State University, Philippines
*meltolentino_21@yahoo.com

Abstract: Social capital is becoming a well-studied social construct that establishes its relevance in uplifting the well-being and health of diverse social categories. A survey was conducted among 120 individuals aged 60 years and above who were randomly selected from the list of senior citizens in Quezon, Nueva Ecija, Philippines. In this study, the social capital of the elderly population in a rural community and its relation to their health status and health-seeking behaviors is examined. The social capital of the elderly is determined based on the following five domains—general trust, social support, social networks, social participation, and close ties. Their health status is based on a self-rated evaluation of: being free from chronic diseases in the last three months, being capable of performing daily activities, having lucid memory, and having life satisfaction. Their health-seeking behaviors are described in terms of frequency in which they rely on self-care, medical professionals, traditional medicines, familial, and non-familial support system. Results from the correlation and multiple regression analyses suggest that the elderly describe themselves as most healthy in that they are capable of performing daily activities, whereas they describe themselves as least healthy in that they experience chronic diseases in the last three months. Self-care, which includes having a healthy diet, exercise, and fun, is their top health-seeking behavior, but it should be noted that having close ties and social participation tend to determine better self-care among the elderly. Although accessing medical professionals is uncommon among the elderly, the findings indicate that the said health-seeking behavior tends to become more frequent with increasing social support. Results are relevant for identifying social innovations in the context of networks and social support that they may promote better health among the elderly in rural communities.

Keywords: community social capital, elderly, health status, health-seeking behaviors, Philippines

Community social capital is a key determinant of health outcomes in various social categories. Specific measures of community social capital, such as generalized trust and social support (Kim, 2016), social networks, and social participation (Forsman, 2012), help improve and maintain the mental health of the older adult population. Self-reported general health and subjective well-being are also positively influenced by increased levels of social participation and networks (Giordano & Lindstrom, 2009; Viswanath, Steele, & Finnegan, 2006; Yip et al., 2007). Social capital is significant not only in terms of health status but even in practices that people devise to achieve better health. In the study of Bakshi, Mallick, and Ulubasoglu (2015), social capital has a strong positive influence on health-seeking behaviors and hygienic practices among poor households in the rural region of Bangladesh. Trust is also positively related to health-seeking behaviors among

children in an urban neighborhood in Western Cape, South Africa (Mwase, 2015). Considering the said benefits of community social capital in health aspects, it is a pressing concern to examine its relationship to health status and health-seeking behaviors among the elderly.

The older adult population experience life events are characterized with decreased physical and mental capacity, vulnerability to chronic diseases, and even social isolation and loneliness (World Health Organization, 2018; Tomaka, Thompson, & Palacios, 2006). Despite these limitations as results of the gradual aging process, longer life brings opportunities for older adults and societies. Additional years enrich education and new pathways that contribute to further social and economic growth of their families and communities if their health is addressed with needed attention (World Health Organization, 2018). Hence, this study is important to know how community social capital may encourage better health practices and outcomes among the elderly in rural communities. The older adult population in rural communities is the focus because the scarcity of healthcare-related services and social isolation are more prevalent in rural areas (Wang, 2001; Rosenthal & Fox, 2000). Besides, the Philippines should begin exploring innovations that will help in the betterment of the health of the elderly. The country is beginning to age. There is 8.2% in the present population who are aged 60 years old and above and this will become 14% between 2030 and 2035 according to the Commission on Population and Development (Galvez, 2019).

Hence, to address the critical concern on elderly and to determine social innovation on health through social support and social ties, this study sought to examine the relationships of community social capital and health status, and health seeking behaviors of the elderly in a rural community in the Philippines. Specifically, the levels of community social capital, self-rated health status, and health-seeking behaviors are determined; then, the determinants of health status and health-seeking behaviors of the elderly are examined using socio-demographic characteristics and community social capital as predictors.

Community Social Capital

Community social capital is a particular form of social capital, and it comprises the informal content of institutions that aim to contribute to the common good (Durston, 1999). According to Putnam (1993), active engagement in civic affairs and functions and the presence of social support are key in building community social capital. This social construct is accumulated into two process components—community characteristics and individual relationships with other community members (Israel, Beaulieu, & Hartless, 2001). However, this study focuses on the individual or elder's relationships among other adults and even youth. Domains of community social capital in this study are general trust, social support, social networks, social participation, and close ties, which are all measured based on the mean score of responses to questions using 5-point Likert scale.

The generalized trust was measured using three questions: (1) Would you say that most people can be trusted? (2) Would you say that most of the time, people try to be helpful? and (3) Do you think that most people would try to take advantage of you if they got the chance?" (Survey Research Center-Political Behavior Program, 2014).

Social support comes from various sources that include family, friends, romantic partners, pets, community ties, and coworkers (Taylor, 2011). Social support from family members and friends is natural; however, it is said to be formal in nature when it comes from healthcare specialist or community organizations (Hogan, Linden, & Najarian, 2002). In this study, social support was measured by asking the respondents according to the help (including emotional, financial, and instrumental) they gain from their kin and non-kin members. The questions were: (1) How often do you receive emotional support from your kin members? (2) How often do you receive financial support from your kin members? (3) How often do you receive help on household chores from your kin or non-kin members? and (4) How often do you get to talk about your problems with other people?

A social network is a social structure composed of groups of actors with dyadic ties and interactions (Wasserman & Faust, 1994). This domain was measured by the frequency of visits, communications, and dependability of people in their immediate environment.

Social participation is the extent to which a person participates in a broad range of social roles and relationships (Avison, Mcleod, & Pescosolido, 2007). This was measured based on their responses

to questions about participation in community organizations, civic functions, and in the community or religious celebrations.

Lastly, close ties are the close interaction of individuals in a micro-level setting that includes family members and friends. This was measured using questions with themes about intimate communications and shared activities with family and friends near or far from the elders.

Self-Rated Health Status

Several studies prove that subjective or self-rated health assessments are valid indicators of health status among middle-aged populations (Miilunpalo, Vuori, Oja, Pasanen, & Urponen, 1997). A review of community studies by Idler and Benyamini (1997) had determined that self-rated health is a valid predictor of mortality. Self-rated health reports reflect individual feedback about one's wellness or illness (Bailis, Segall, & Chipperfield, 2003). In this study, it was determined to use the following four-item questions: (1) How was your health for the past three months? (2) How capable are you in doing daily living activities? (3) How good is your memory? and (4) How satisfied are you in your life situation? (Boone & Boone, 2012).

Health-Seeking Behaviors

Health seeking behaviors are attitudes, values, and practices in the use of health resources (Pang, Marsh, Silverstein, & Cody, 2003). Health seeking behaviors are not rooted solely in the individual; these behaviors are also dynamic, collective, and interactive relative to household behavior and community norms, hence, connected to the concept of community social capital (MacKian, Bedri, & Lovel, 2004; Ihaji, Gerald, & Ogwuche, 2014). This study described health-seeking behaviors by asking the respondents the following questions: (1) How often do you do self-care? (2) How often do you consult in medical professionals? (3) How often do you rely on traditional treatment? and (4) How often do you seek advice from your family or friends regarding your health?

Methods

This study was conducted in the rural community of Quezon, Nueva Ecija, Philippines. It is a fourth class municipality with a total area of 68.53 km^2 ("Quezon, Province of Nueva Ecija", n.d.). In 2016, there were 2,357 older adults aged 60 years old and above or 5.73% of the municipality's population (Engineering Department, 2015). Interestingly, 2,331 of those elderly are registered and involved in various organizations in Quezon, Nueva Ecija (C. Fernando, personal communication, April 11, 2019).

The population of the elderly aged 60 years and above in the municipality of Quezon is 2,357. To usher the random sampling procedure, the 16 barangays or communities in the municipality were clustered into two: within the town proper and in the outskirts of municipality. Two communities were picked from each cluster that make four rural communities as the subset. A list of elders, 60 years old and above and have a membership to community organizations, was devised from the four communities. From this, 120 respondents were randomly selected.

This study collected data through a structured survey questionnaire. Through a formal letter, we informed the president of the Federation of Senior Citizens-Quezon Chapter regarding the survey and asked for assistance in identifying the senior citizens in the municipality. Upon the completion of the sample list, we went house to house for the self-administered survey. Each survey questionnaire has an attached informed consent subject to the approval of the elderly who was selected as respondent. The respondents were guided and given enough time to answer the survey questionnaire. After the collection, the data were encoded and processed using SPSS 21.

The data were analyzed using descriptive statistics. The socio-demographic characteristics of the elders, levels of community social capital, self-rated health status, and health-seeking behaviors were analyzed using mean, standard deviation, and frequency count. The relationships of socio-demographic characteristics, self-rated health status, and health-seeking behaviors were determined using Pearson correlation. Finally, the determinants of self-rated health status and health-seeking behaviors of the elderly were examined using multiple regression analysis.

Results

Characteristics of the Elderly

There were 120 elderly respondents in this study (see Table 1). Majority of the respondents are male

Table 1

Sociodemographic Characteristics of the Elderly

Socio-Demographic Characteristics		Frequency (n=120)	Percentage (%)
Sex	Female	54	45.0
	Male	66	55.0
Age	60-65	41	34.2
	66-70	35	29.2
	71-75	21	17.5
	76-80	14	11.7
	81-above	9	7.5
Civil Status	Single	6	5.0
	Married	75	62.5
	Divorced	0	0
	Separated	5	4.2
	Widowed	34	28.3
No. of Children	None	8	6.7
	1-3	50	41.7
	4-6	40	33.3
	7-8	11	9.2
	9-over	11	9.2
No. of Household member	None	8	6.7
	1-2	32	26.7
	3-5	44	36.7
	6-8	25	20.8
	9-above	11	9.2
Monthly Income	below-1,000	24	20.0
	1,001-4,000	66	55.0
	5,001-10,000	8	6.7
	10,001-15,000	9	7.5
	15,001-above	13	10.8
Educational Attainment	None	1	.8
	Elementary school	63	52.5
	High/secondary school	25	20.8
	Technical/vocational	1	.8
	College	29	24.2
	Graduate Studies	1	.8
Employment Status	Currently employed	8	6.7
	Unemployed	79	65.8
	Retiree	16	13.3
	Self-employed	17	14.2
Place of Residency	Outside municipality center	53	44.2
	Within/near center of municipality	67	55.8

and are married. Many of the elderly have one to three children and have three to five household members. A great majority of elderly have a monthly income ranging PhP1,001 to PhP4,000, have elementary education and live wit hin or near the center of the municipality.

Level of Community Social Capital of the Elderly

The level of community social capital of the elderly was measured through the five domains, namely: general trust, social support, social networks, social participation, and close ties (see Table 2). Among all of these domains, social participation generated a high level of community social capital with a mean of 3.82 (SD = 1.12). Overall, the level of community social capital of the elderly is moderate, which has a mean of 3.11 (SD=0.81).

Self-Rated Health Status of the Elderly

The self-rated health status of the elderly is high (M=3.60; SD=1.24). All the domains of health status in this study have high ratings (see Table 3) except for being free from chronic diseases in the last three months (M=3.32; SD=1.12). The elderly are highly capable of daily living activities. Aside from doing household chores, they can also travel on their own, do farm works, and other activities. However, there are times when they cannot perform hard tasks because of

Table 2

Level of Community Social Capital of the Elderly

Community Social Capital	Mean	SD	Qualitative
General Trust	2.93	0.61	Moderate
Social Support	2.79	0.78	Moderate
Social Networks	3.01	0.77	Moderate
Social Participation	3.82	1.12	High
Close Ties	3.02	0.76	Moderate
Overall	3.11	0.81	Moderate

Legend: 1.00 – 1.79 Very Low; 1.80 – 2.59 Low; 2.60 - 3.39 Moderate; 3.40 – 4.19 High; 4.20 – 5.00 Very High

Table 3

Self-Rated Health Status of the Elderly

Health Status	Mean	SD	Qualitative
Free from chronic diseases for the last 3 months	3.32	1.123	Moderate
Capable of daily living activities	3.73	1.282	High
Lucid memory	3.70	1.248	High
Satisfaction in life	3.67	1.324	High
Total	3.60	1.244	High

Legend: 1.00 – 1.79 Very Low; 1.80 – 2.59 Low; 2.60 - 3.39 Moderate; 3.40 – 4.19 High; 4.20 – 5.00 Very High

some ailments like arthritis and high blood pressure. This is connected to their moderate rating to the status of being free from chronic diseases in the last three months. On the other hand, the elderly still have lucid memory; they can answer questions regarding their past experiences and remember the names of their grandchildren and other people.

Health-Seeking Behaviors

As shown in Table 4, the elderly have moderate health-seeking behaviors (M=2.63; SD=1.14). Self-care is the only highly practiced way to achieve and maintain health among the elderly (M=3.88; SD=0.830); the rest are practiced in moderation.

The high self-rating of health among the elderly might be relative to their high preference to take care of themselves. They regularly eat healthy and nutritious foods, and they exercise such as walking, jogging, and stretching every morning. They also spend time to have fun with their family and friends. Whenever they are sick, they try to treat it as soon as possible. The most common ways of treating their ailments are self-medication, traditional treatment, and asking advice or help from their kin members. The elderly prefer to self-medicate whenever they have fleeting sicknesses such as cough and headache, but also consult medical professionals every time they have chronic diseases. In some cases, the elderly still believes in traditional treatment, and there are some elderly who do it by themselves. They also take into consideration what their family says about their health.

Correlation of Socio-Demographic Characteristics, Community Social Capital, Health Status, and Health Seeking Behavior Among the Elderly

As shown in Table 5, educational attainment of the elderly and close ties with their family and friends have the strongest positive relationship with p = .001 (r = .311). Their age and their general trust are moderately and positively correlated with p = .040 (r = .188). At the same time, the number of household member and social support such as emotional, financial, and help from household members are also moderately and positively related with p = .040 (r = .188).

In terms of health status, having a lucid memory is positively correlated with a social network (p = .015; r = .222). It is important for the elderly to communicate with their family and friends, including those living far in their homes to avoid memory loss.

The following domains of community social capital have strong to very strong significant positive relationships to specific health seeking behaviors: social support and self-medication (p = .009; r = .236); general trust (p = .001; r = .292), social network (p = .004; r = .261), social participation (p = .003; r = .270), and close ties (p = .000; r = .393) with self-care. Social support is strongly and positively related to the elderly's consultation to medical professional with p=.003 (r = .271), but the latter is moderately and positively correlated to social network (p = .014; r = .224) and close ties (p = .024; r = .206). Social support is also strongly and positively correlated to

Table 4

Health-Seeking Behaviors Among the Elderly

Health Seeking Behaviors	Mean	SD	Qualitative
Self-medication	2.25	1.416	Moderate
Self-care	3.88	0.830	High
Medical professional	2.57	1.083	Moderate
Traditional treatment	2.13	1.089	Moderate
Seek health advice/help from kin	2.33	1.304	Moderate
Total	2.63	1.144	Moderate

Legend: 1.00 – 1.79 Very Low; 1.80 – 2.59 Low; 2.60 - 3.39 Moderate; 3.40 – 4.19 High; 4.20 – 5.00 Very High

Table 5

Correlation Analysis of Socio-Demographic Characteristics, Community Social Capital, Health Status, and Health Seeking Behaviors of the Elderly

	General Trust	Social Support	Social Network	Social Participation	Close Ties
Age	.188*	.003	-.050	-.022	.018
	.040	.973	.587	.808	.844
Number of Household Member	-.004	.188*	-.106	-.096	-.055
	.963	.040	.248	.298	.548
Educational Attainment	.012	.099	.096	-.102	.311**
	.899	.282	.297	.270	.001
Lucid Memory	-.053	.138	.222*	.018	.069
	.562	.132	.015	.847	.454
Self-Medication	.024	.236**	-.076	-.062	.059
	.792	.009	.409	.502	.519
Self-Care	.292**	.125	.261**	.270**	.393**
	.001	.174	.004	.003	.000
Medical Professional	.061	.271**	.224*	-.016	.206*
	.510	.003	.014	.866	.024
Traditional Treatment	.013	.323**	.119	.066	-.062
	.885	.000	.194	.471	.502
Advice from Kin Member	-.006	.218*	.068	.028	.118
	.948	.017	.462	.759	.198

**.Correlation is significant at the 0.01 level (2-tailed).

*.Correlation is significant at the 0.05 level (2-tailed).

the elderly's seeking of traditional treatment (p = .000; r = .323), but it is moderately related to the elderly's seeking of health advice from kin members (p = .017; r = .218).

Regression Analysis of Community Social Capital and Self-Rated Health Status

Among the domains of community social capital and health status of the elderly, only social networks and lucid memory have a very strong positive relationship (p=.001). This shows that an increase in social networks (such as the number of interconnected relatives and friends who frequently see and talk with the elderly at least once a month, number of relatives and friends they feel at ease talking with, and having dyads or groups that they can count on whenever a need for help arises) indicates higher level of lucid memory among the elderly by 0.450. Also, the age of the elderly has a very strong but negative predicting level of memory (p = .002). This implies that an increase in age leads to a lower level of memory by -.260. This result explains only 20% of the variation in memory as the capacity of all elderly in this study (R^2 = .221; Adjusted R^2 = .201)

Regression Analysis of Community Social Capital and Health Seeking Behaviors Among the Elderly

Among the domains of community social capital, only close ties of the elderly have very strong predictive power on the level of self-care among the elderly (p = .000). This indicates that an increase in having close ties, such as the frequency of having visited by relatives and friends, talking and doing different activities with their relatives and friends, leads to a higher level of self-care of the elderly by 0.427 points. This result explains only 15% of the variation in the level of self-care of all the elderly in the study (R^2 = .155; Adjusted R^2 = .147).

Social support consistently has a strong to very strong relationship to the rest of the health-seeking behaviors of the elderly. This domain of community social capital increases the practice of the elderly in addressing concerns through self-medication by .431. This result explains only 5% of the variation in the level of consulting in medical professional of all elderly in the study (R^2 = .056; Adjusted R^2 = .048).

Social support also strongly encourages the health-seeking behavior through consultation with medical professional among the elderly (.003). This shows that higher social support infers a higher level of consultation with the medical professional of the elderly by 0.378 points. This result explains only 7% of the variation in the level of consulting in medical professional of all elderly in the study (R^2 = .073; Adjusted R^2 = .066).

Social support also has a very strong significance in predicting the level of health-seeking behavior in terms of traditional treatment among the elderly (p = .000). It implies that higher social support the elderly receives from the family and friends denotes a higher level of beliefs in going for a traditional treatment by a point of 0.453. This result explains only 10% of the variation in the level of beliefs in going for a traditional treatment of the elderly in the study (R^2 = .104; Adjusted R^2 = .096).

Lastly, social support and age of the elderly strongly and moderately influence health-seeking behavior of consulting their kin for health advice (p=.016 and p=.043, respectively). It implies that the higher the social support, the more frequent the elderly asks their kin members regarding their health (0.366). The age of the elderly is also a positive predictor of the said health-seeking behavior (p = 0.43). This denotes that the older the adults, the more frequent they ask for health advice from their kin (0.188 points). This result explains only less than 9% of the variation in the frequency of asking kin members regarding the health of the elderly in the study (R^2 = .119; Adjusted R^2 = .089).

Discussion

Community Social Capital: A Wanting Among the Elderly

The domains of community social capital in this study comprise Putnam's definition: close ties with family and friends, collective resources such as generalized trust, structural resources such as networks and social participation, and subjective resource in the form of social support (Coll-Planas, 2016). Results show that the elderly living in rural communities in a fourth class municipality in the Philippines have a moderate level of community social capital.

Social participation is the only domain of community social capital that is of high level. The elderly have a high level of social participation in various community organizations; most of them (76.7%) are members of

Table 6

Regression Analysis of Community Social Capital and Memory

Predictors	Output	B	Sig.	R^2	Adjusted R^2
Age	Lucid memory	-.260	.002**	.221	.201
Social Networks		.450	.001**		

n = 120

Legend: * $p < 0.05$ level; ** $p < 0.01$ level

Table 7

Regression Analysis of Community Social Capital and Health Seeking Behaviors Among the Elderly

Predictor	Output	B	Sig.	R^2	Adjusted R^2
Close Ties	Self-Care	.427	.000**	.155	.147
Social support	Self-medication	.431	.009**	.056	.048
Social support	Consultation to medical professional	.378	.003**	.073	.066
Social support	Traditional treatment	.453	.000**	.104	.096
Social support Age	Seeking health advice from kin	.366 .188	.016* .043*	.119	.089

n = 120

Legend: * $p < 0.05$ level; ** $p < 0.01$ level

the Senior Citizens Federation, Knights of Columbus, and others. They often participate in national and local elections, in community fiestas or religious activities, in dance and musical parties for adults in their communities, in watching Zarzuela, in preparing special dishes for an open house, and in *Pabasa ng Pasyon* (singing of the Passion of the Christ) during the Lenten seasons.

However, all the other domains, namely, close ties, generalized trust, social network, and social support, have moderate levels. In terms of close ties, the elderly sometimes have visitors and at times are engaged in conversations. However, this interaction is usually with their friends rather than their family members living away from home. Hobbies and recreational activities are also sometimes shared with friends and family. Consequently, in social networks, the elderly have only three to five interconnected kin and non-kin whom they have contact once a month through personal or voice/video call. The elderly have three to five kin or non-kin whom they feel comfortable sharing their personal concerns and whom they can call whenever they need help. The elderly are neutral about trusting people in their communities, about people trying to be helpful, and about the idea that people will take advantage of them if they got the chance. In terms of social support, the elderly sometimes receive emotional and financial support from their kin members. It also means that whenever they have a problem or they are struggling, their family and friends are sometimes, but not always, at their side. Occasionally, they also get help from kin members on household chores. Moreover, the elderly, at times, share their problems with family and friends.

The results indicate that community social capital is a resource wanting among the elderly. This is a concern following the argument that social capital, specifically in community level, is a relevant source of many health outcomes among older adults. The presence of family members and friends, participation in community activities and organizations, and contact with informal ties in the community are important resources that aid in the emotional and practical needs of the elderly (Gray, 2009). In fact, a study among the elderly population in Japan concluded that the low level of community social capital is associated with the experience of psychological distress (Kobayashi, Suzuki, Noguchi, Kawachi, & Takao, 2015). Enhancing community social capital of the elderly benefits all parties as this enables older individuals to have productive, independent, and fulfilled lives (Coll-Planas, 2016; Cannuscio, Block, & Kawachi, 2003).

Determinants of Health Status and Health Seeking Behaviors Among the Elderly

Findings in this study reveal that the elderly highly rated themselves in health status in the aspects of cognitive functions, daily living abilities, and satisfaction in life. However, they are not free from chronic diseases in the last three months. Despite this, their health-seeking behavior is also wanting. They occasionally practice the use of health resources, specifically, self-medication, consultation with a

medical professional, traditional medicine, and seeking advice from kin. Self-care is the only health-seeking behavior that they often do. Interestingly, health-seeking behavior rooted in the individual effort of the elderly is high, but behaviors that require collective and dynamic efforts from informal ties are lacking (MacKian et al., 2004; Ihaji et al., 2014).

Social network is the only domain of social capital that determines an aspect in the health status of the elderly, that is, cognitive function or having lucid memory. This finding supports the studies that social capital, in general, promote cognition among people with or without mild cognitive impairment and reduce agitation among people with dementia (Low et al., as cited in Coll-Planas, 2016). Among elderly women, larger social networks have a protective influence on their cognitive function (Crooks, Lubben, Petitti, Little, & Chiu, 2008). Findings of this study are further supported by Wang, Karp, Winblad, and Fratiglioni (2002) in that rich social network decreases the risk of developing dementia. Social interaction and physical and mental activities are factors that stimulate cognitive functions of the elderly.

The elderly's close ties with kin and non-kin within the community encourage them to increase the frequency of self-care practices. Social support is another community social capital domain that consistently influences health-seeking behaviors, including self-medication, consultation with a medical professional, traditional medicine, and seeking health advice from kin. Social support is in the form of being in contact with others through religious activities and engaging in clubs (Gray, 2009); these measures are expanded in this study to more specific community activities where the elderly sometimes participate in. This finding is relevant and supported by Cannuscio et al. (2003) because the elderly are vulnerable at losing social ties as they age; hence, they will be more dependent to social resources within their community for such social support. Kin and non-kin assistance and daily interaction within the neighborhood prevent the elderly from being isolated in their homes, rather they actively participate in community life and seek health resources available in the community whenever the need arises. Consequently, this involvement of older adults in the community life as they partake in the social support from the neighborhood brings benefit to the young population. The elderly, in return, become an essential part of the community social capital. The elderly serve as role models for the young, contributing to the socialization of the young to learn values and right conduct (Tolentino & Arcinas, 2018).

Although there is growing research interest in community social capital in health outcomes, there is dearth literature that delves into the influence of community social capital to health-seeking behavior. Some of the factors include the lack of standard measures of community social capital, such as clear distinctions of bridging, bonding, and linking social capital. Moreover, most studies dealing with the health aspect of the elderly focus on their health care access but limited to specific informal practices of seeking health resources. Nevertheless, it is important to note that social support—a subjective component of community social capital, according to Putnam—is a consistent determinant of the informal health-seeking behaviors indicated in this study.

Conclusion

Our findings confirm the beneficial effect of community social capital to the health status and health-seeking behaviors among the elderly in rural communities in the Philippines. However, this overall finding must be taken with caution due to the possible limitations of the measures of community social capital used in this study. Nevertheless, the wanting status of the level of community social capital of the elderly in this study supports the arguments in the literature that older population tend to lose their important social ties as they age. With great consideration to the positive influences of social network, close ties, and social participation to the cognitive functions and health-seeking behaviors, social innovations promoting health and practices that seek health resources among the elderly must invest in the following: increase the quantity and quality of social network, encourage social participation of elderly in community-based activities, and create a consistent close ties with family members and neighbors.

Declaration of ownership

This report is our original work.

Conflict of interest

None.

Ethical clearance

The study was approved by the institution.

References

Avison, W., McLeod, J., & Pescosolido, B. (2007). *Mental health, social mirror*. New York: Springer.

Bailis, D. S., Segall, A., Chipperfield, J. G. (2003). Two views of self-rated general health status. *Social Science and Medicine, 56,* 203–217.

Bakshi, R. K., Mallick, D., & Ulubasoglu, M. A. (2015). Social capital and hygiene practices among the extreme poor in rural Bangladesh. *The Journal of Development Studies, 51*(12), 1603–1618. doi: 10.1080/00220388.2015.1068291

Boone, D., & Boone, H. (2012). Analyzing Likert data. *Journal of Extension*, *50*(2). Retrieved from https://www.joe.org/joe/2012april/tt2.php.

Cannuscio, C., Block, J., & Kawachi, I. (2003). Social capital and successful ageing: The role of senior housing. *Annals of Internal Medicine, 139*(5 part 2), 395–399.

Coll-Planas, L. (2016). Promoting social capital in an ageing society: A win-win proposition? *Gaceta Sanitaria, 30*(5), 323–325. doi: 10.1016/j.gaceta.2016.03.018

Crooks, V. C., Lubben, J., Petitti, D. B., Little, D., & Chiu, V. (2008). Social network, cognitive function, and dementia incidence among elderly. *American Journal of Public Health, 98*(7), 1221–1227.

Durston, J. (1999). Building community social capital. *CEPAL Review No. 69*, 103–118.

Engineering Department. (2015). *Projected Population of Municipality of Quezon 2015-2020.* Quezon, Nueva Ecija: Engineering Department.

Fernando, C. (2019, April 11). Personal interview.

Forsman, A. K. (2012). *The importance of social capital in later life: Mental health promotion and mental disorder prevention among older adults* (Unpublished doctoral dissertation). Nordic School of Public Health NHV, Gothenburg, Sweden.

Galvez, D. (2019, January 21). Philippines to have 'aging population' between 2030 and 2035 – CPD. *Inquirer.net.* Retrieved from https://newsinfo.inquirer.net/1075493/philippines-to-have-aging-population-between-2030-and-2035-cpd

Giordano, G., & Lindstrom, M. (2009). The impact of changes in different aspects of social capital and material conditions on self-rated health over time: A longitudinal cohort study. *Social Science & Medicine*, *70*(5), 700–710. doi: 10.1016/j.socscimed.2009.10.044

Gray, A. (2009). The social capital of older people. *Ageing & Society, 29*(1), 5–31. doi: 10.1017/S0144686X08007617

Hogan, B., Linden, W., & Najarian, B. (2002). Social support interventions: Do they work? *Clinical Psychology Review*, *22*(3), 381–440. doi:10.1016/s0272-7358(01)00102-7

Idler, E. L., & Benyamini, Y. (1997). Self-rated health and mortality: A review of twenty seven community studies. *Journal of Health and Social Behavior, 38*(1), 21–37.

Ihaji, E., Gerald, E., & Ogwuche, C. (2014). Educational level, sex and church affiliation on health seeking behaviour among prisoners in Makurdi metropolis of Benue state. *Journal of Educational Policy and Entrepreneurial Research, 1*(2), 311–316.

Israel, G., Beaulieu, L., & Hartless, G. (2001). The influence of family and community social capital on educational achievement. *Rural Sociology, 66*(1), 43–68.

Kim, H. H. (2016). Examining the social capital measures associated with mental health among the Korean adult population. *Asia Pacific Social Science Review, 16(2),* 39–47.

Kobayashi, T., Suzuki, E., Noguchi, M., Kawachi, I., & Takao, S. (2015). Community-level social capital and psychological distress among the elderly in Japan: A population-based study. *PLoS ONE, 10*(11), 1–11. doi:10.1371/journal.pone.0142629

Mackian, S., Bedri, N., & Lovel, H. (2004). Up the garden path and over the edge: Where might health-seeking behavior take us? *Health Policy and Planning, 19*(3), 137–146. doi: 10.1093/heapol/czh017

Miilunpalo, S., Vuori, I., Oja, P., Pasanen, M., & Urponen, H. (1997). Self-rated health status as a health measure: The predictive value of self-reported health status on the use of physician services and on mortality in the working-age population. *Journal of Clinical Epidemiology, 50*(5), 517–528. doi: 10.1016/S0895-4356(97)0045-0

Mwase, I. (2015). *Social capital and household health-seeking behaviour for children in the context of urban neighborhood: the case of Khayelitsha in Western Cape, South Africa* (Unpublished master's thesis). University of Cape Town. Retrieved from https://open.uct.ac.za/bitstream/handle/11427/13806/thesis_hsf_2015_mwase_i_saac.pdf?sequence=1

Pang, E. C., Marsh, M. J., Silverstein, M., & Cody, M. (2003). Health seeking behaviors of elderly Chinese American: Shifts in expectations. *The Gerontologist, 43*(6), 864–874.

Putnam, R. D. (1993). The prosperous community: Social capital and the public life. *American Prospect, 13,* 35–42.

Quezon, Province of Nueva Ecija. (n.d.). Retrieved August 21, 2019, from PhilAtlas website: https://www.philatlas.com/luzon/r03/nueva-ecija/quezon.html.

Rosenthal, T. C., & Fox, C. (2000). Access to health care for the rural elderly. *JAMA, 284*(16), 2034–2036. doi: 10.1001/jama.284.16.2034

Survey Research Center, Political Behavior Program. (2014). *ANES 1964 time series study.* Ann Arbor, MI: Inter-University Consortium for Political and Social Research. doi: 10.3886/ICPSR35109.v1

Taylor, S. (2011). Social support: A review. In H. S. Friedman (Ed.), *The Oxford handbook of health psychology* (pp. 189–214). New York, NY, US: Oxford University Press.

Tolentino, M. P. & Arcinas, M. M. (2018). Social capital of left-behind children: Determinants and association with school performance. *Asia Pacific Social Science Review, 18*(2), 16–33.

Tomaka, J., Thompson, S., & Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Aging and Health, 18*(3), 350–384.

Viswanath, K., Steele, W., & Finnegan, J. (2006). Social capital and health: Civic engagement, community size, and recall of health messages. *American Journal of Public Health, 96*, 1456–1460.

Wang, J. J. (2001). Prevalence and correlates of depressive symptoms in the elderly of rural communities in southern Taiwan. *The Journal of Nursing Research, 9*(3), 1–12.

Wang, H., Karp, A., Winblad, B., & Fratiglioni, L. (2002). Late-life engagement in social and leisure activities is associated with a decreased risk of dementia: A longitudinal study from the Kungsholmen Project. *American Journal of Epidemiology, 155*(12), 1081-1087. doi: 10.1093/aje/155.12.1081.

Wasserman, S., & Faust, K. (1994). *Social network analysis: Methods and applications*. Cambridge, New York: Cambridge University Press.

World Health Organization. (2018, February 5). Ageing and health. Retrieved from https://www.who.int/news-room/fact-sheets/detail/ageing-and-health

Yip, W., Subramanian, S., Mitchell, A., Lee, D., Wang, J., & Kawachi, I. (2007). Does social capital enhance health and well-being? Evidence from rural China. *Social Science and Medicine, 64*(1), 35–49. doi: 10.1016/j.socscimed.2006.08.027