Chapter 18
Social Capital, Mental Well-Being, and Loneliness in Older People

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18.1 Introduction

As the number of older people increases worldwide, policy and research strategies aiming to maintain older people's health and well-being have received wide attention at national and international levels (FUTURAGE 2011; Walker and Maltby 2012). Policy initiatives, such as Europe 2020, the European Commission's growth strategy (European Commission 2010) that framed the European Innovation Partnership on Active and Healthy Ageing[1] are long-term strategic frameworks for developing sustainable action to support healthy ageing. The purpose of the European Year for Active Ageing and Solidarity between Generations (2012) was to raise awareness of the contribution that older people make to society. It sought to encourage policymakers and relevant stakeholders to take action with the aim of creating better opportunities for positive and active ageing.

Active ageing is commonly defined as the development and maintenance of optimal mental, social, and functional well-being and capacity in older people (WHO 2002). It encourages people to live healthy and active lives and includes aspects such as participation, engagement, health, and security of older people, which fits well into the theories of social capital. Indeed, social capital is increasingly highlighted in health promotion and health research, including its potential ability to promote healthy and active ageing (WHO 2004). An underlying assumption is that social capital is good for mental well-being and research has over the last decades provided evidence that social capital tends to have health benefits (Almedon 2005;

[1] For more information visit http://ec.europa.eu/active-healthy-ageing.

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De Silva et al. 2005; Islam et al. 2006; Kim et al. 2008). However, to some extent research has ignored the significance of social capital for older people and its meaning for mental well-being. In this chapter we consider mental well-being as a positive aspect of mental health as opposed to a negative aspect, such as depression and mental disorders.

Social capital or social resources may benefit individuals' quality of life and well-being in later life (Nyqvist et al. 2013b). With increasing age, it is likely that the role of social capital for active and healthy ageing may also increase in importance as people rely more on interpersonal relations and social networks. Social activities, participation and trust, i.e., social capital, may be more relevant as a means for well-being when retired, due to loss of occupational attachment and work-based social networks. Participating actively in society and building trustful networks may thus promote social inclusion and enable active ageing, which in turn may lead to increased well-being.

In this chapter we will primarily focus on social capital and its meaning for mental well-being in older people. We will present empirical data on social capital and mental well-being such as the absence of loneliness in older people in three European countries. The analysis reveals variations in the pattern of social capital and mental well-being according to welfare regimes, an issue that has not yet been systematically investigated in older people. However, given that there is no "gold standard" of how to define or assess social capital or mental well-being, we start with a theoretical discussion on the concepts of social capital and mental well-being.

18.2 Social Capital

In the literature there are significant theoretical and empirical discussions concerning social capital. According to Kawachi et al. (2008) social capital embraces two distinct approaches, the social network and social cohesion approach. Within the social network approach the amount of various resources within the network constitutes social capital, and resources can be used in finding new jobs, receiving support, and accessing valued resources. This individual social capital approach is emphasized in the work by, for example, Bourdieu (1986) who underlined the amount of various resources within the network as social capital. The social cohesion or collective approach, as presented by Putnam (2000), claims that a society with high levels of participation and trust in others enhances interaction between people and that this is beneficial for individuals living in the neighborhood, community, or society. Within this latter approach social capital is mainly seen as a non-exclusive or public resource, or in other words, individuals can gain the benefits of living in an area with a high level of participation and trust, without necessarily having to participate and be actively engaged themselves. Coordinated actions between individuals enable people to pursue shared objectives that advance the collective welfare of society. For example, areas with high levels of social capital might be more effective at uniting people and ensuring access to health-related services,

support, and amenities which are important for older people. Social capital can thus have benefits for the wider community (Putnam) as well as for obtaining individual ends (Bourdieu). Given its dual focus on individual and/or collective features, analyses of social capital improve our understanding not only of individual resources of well-being but also of the influence of contextual or environmental features.

The social capital concept can also be defined according to its different components (Islam et al. 2006). Putnam (2000) separated two major elements of social capital: structural (e.g., social contacts, social participation) and cognitive (e.g., trust). The structural part describes the basis for generating social capital such as networks, relationships, and institutions that link people and groups together, while the cognitive aspect such as values, trust, confidence, and norms emerge from interacting members and through relations with one another. More broadly, structural and cognitive components of social capital underline the importance of accounting for the quantity as well as quality elements of the concepts. The relationship between the structural and cognitive component is, however, not entirely clear and it has been suggested that participation does not foster trust, as Putnam suggested; rather it is the trustful people who are already engaged socially (Hooghe and Stolle 2003). In empirical research the distinction is of relevance, since it seems that these two aspects influence health and well-being differently. For mental health the quality elements of the concept seem to be explicitly health beneficial (De Silva et al. 2005).

Social capital can also be seen as bonding, bridging, and linking. Putnam (2000) for example, separated two types of horizontal social capital: bonding and bridging. *Bonding social capital* refers to intragroup ties and is exclusive and may be characterized by homogeneity. *Bridging social capital* is more fragile than bonding but also more inclusive of heterogeneous individuals, and is usually seen as a more productive form of social capital at least when it comes to democracy building. Besides bonding and bridging social capital, Woolcock (2001), identified a third form, *linking social capital*, defined as relations between people with unequal wealth, power, and status. Within public health research the distinction between structural and cognitive social capital is common, as well as the distinction between individual and collective social capital, whereas less research has acknowledged the benefits of bonding, bridging, and linking social capital (Almedon 2005; De Silva et al. 2005; Islam et al. 2006; Nyqvist et al. 2013b).

18.3 Mental Well-Being

It is widely agreed that the concept of mental well-being is a complex subjective state that is difficult to define. This can be seen in the interchangeable and frequently concurrent use of the expressions “mental health” and “mental well-being.” It could be said that the constructs of mental health and mental well-being reflect different disciplinary approaches and the perspectives of national and international policy drivers. The World Health Organization’s definition of mental health states that mental health is “*a state of well-being* [our highlight] in which every individual

realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (World Health Organization 2007). Early definitions of mental health focused on subjective well-being consisting of positive and negative affect (Jahoda 1958; Bradburn 1969 in Bishop and Martin 2011, p. 298). Ryff (1989) proposed six theory-guided dimensions of positive psychological functioning, later referred to as "psychological well-being," comprising: self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth. These were shown to be components of people's overall well-being which was related to, but not identical with measures of subjective well-being, i.e., affect balance and life satisfaction (Ryff and Keyes 1995; Keyes et al. 2002). It also seems clear that individual life events affect cognitive and affective well-being, both in terms of magnitude and direction. However, it has been hypothesized that similarities may arise as a result of the level of control involved (Keyes et al. 2010a; Luhmann et al. 2012).

Lehtinen (2008), in a report to the European Union, suggested that mental health is an individual resource which comprises two dimensions: positive mental health (also referred to as psychological well-being) and negative mental health (or mental ill-health). Positive mental health can be conceptualized as a value in itself (Lehtinen 2008) or as including a positive sense of well-being, individual resources, the ability to develop and sustain satisfying personal relationships, and the ability to cope with adversity (Jenkins et al. 2008). This in turn is said to enhance an individual's capacity to contribute to family, social networks, the local community, and society at large (Health Education Authority 1997; Jenkins et al. 2008). Positive mental health can be described as "flourishing," meaning a combination of feeling good about and functioning well in life (Keyes et al. 2010a, b).

In the Foresight Mental Capital and Wellbeing Project, Kirkwood et al. (2008) define mental well-being as "a dynamic state that refers to individuals' ability to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community" (p. 19). Positive mental health is therefore more than the absence of illness or symptoms of mental disorders. Recently, some policy documents have used the expression "mental health and well-being" to denote a dynamic positive state of mind and body, feeling safe and being able to cope with normal stresses in life, and connect with people, communities, and the wider environment (see for example: Department of Health 2009; World Health Organization 2011). None of these definitions are age specific. However, the National Institute for Health and Clinical Excellence (NICE 2008) guidance on the promotion of the mental well-being of older people, which has been adopted by NHS Health Scotland (2010), defines mental well-being as a dimension of mental health which includes life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support.

The range of conceptualizations of mental well-being shows that despite some overlap between them, each of them includes additional and specific dimensions. This dissimilarity is reflected in the debate around the measurement of mental well-being.

Some authors have developed specific tools for the measurement of mental well-being (e.g., Stewart-Brown et al. 2009; Lamers et al. 2011), others have suggested the use of specific scales from existing validated measures (e.g., SF-36, WHO-5, GHQ-12, OPQOK; Bech et al. 2003; Hu et al. 2007; Lavikainen et al. 2006; Bowling 2009). Loneliness, or the absence of loneliness, is frequently used in association with measures of mental health in older people to denote quality of life or mental well-being (O'Luanaigh and Lawlor 2008). This will be addressed next.

18.4 Loneliness

Loneliness is often considered to be a problem of growing older. Although loneliness can be experienced at any age, older people are at greater risk of enduring loneliness because of a reduction in personal and external resources available to them (Dykstra 2009). It has been shown that about 50 % of the oldest old report serious or moderate loneliness, and that between 30 and 40 % of older people in the UK and other European countries are sometimes or often lonely (Victor et al. 2009), and this figure has remained fairly constant for the past 40 years. With the increase in the numbers of people aged 60+, the actual numbers of older people experiencing loneliness are also increasing.

Loneliness has been described as a mismatch between one's desired level of companionship and the relationships one has (Scharf and De Jong Gierveld 2008). Older people are at higher risk of health problems, such as mobility problems and sensory impairment, as well as decreasing social networks through the loss of spouse, close family members and friends, which puts them at risk of loneliness. In addition, residential relocation is common, moving from a family home to an institution, suggesting a change in informal relations. All these factors are associated with an increased risk of becoming lonely. Loneliness is associated with a wide range of physical and mental health problems and with a reduction in quality of life (Bowling and Gabriel 2007). Known risk factors include loss and bereavement, widowhood, perceived and actual poor health, lack of resources, living alone, and time spent alone (Scharf and De Jong Gierveld 2008).

Loneliness can occur as a result of one event, such as the loss of one's partner, or it can be chronic and made worse by the transition into old age. Research has shown that loneliness contributes more strongly to the variance in both physical and mental health than, for example, perceived social support (Stephens et al. 2011). There is now strong evidence that loneliness is directly associated with depression (O'Luanaigh and Lawlor 2008), reduced self-rated health (Nummela et al. 2011), and increased mortality (Steptoe et al. 2013) in older people. The risk of suicide increases in older people who are lonely and depressed (Koponen et al. 2007). In England, local authorities are expected to monitor loneliness in older people as part of the Adults Social Care Outcomes Framework (DoH 2012) as it is seen as a major threat to health.

18.5 Social Capital and Loneliness in Older People: A European Context

For the purpose of this chapter, we ran a series of analyses based on the European Social Survey (ESS) data from year 2010. The main aim of the ESS is to provide high quality data over time about behavior patterns, attitudes, and values of Europe's various populations. It consists of an effective sample size of 1,500 face-to-face interviews per country obtained by using random probability methods.[2]

Here we restrict the analyses to Finland, Poland, and Spain and to people aged 50 and over.[3] These countries represent three different welfare regime types (Esping-Andersen 1990; Ferrera 1996; Rostila 2013) that differ with regard to their institutional characteristics. Finland has often been categorized as member of the "universal" or "social democratic welfare state," whereas Poland and Spain can be said to be part of the "post-socialist" and "Mediterranean" welfare systems, respectively. The universal welfare state is characterized by higher levels of welfare provisions mainly based on universal social benefits, compared with the Mediterranean welfare regime with lower levels of social protection and the post-socialist regimes with a rather developed social security system with, however, low benefits.

We used these countries to study the association between social capital and health among older people in order to assess (1) if social capital and loneliness varies between the countries and (2) if loneliness consequences of structural and cognitive aspects of social capital vary. We used correlation and logistic regression analyses. Design weights were applied to the values presented in the tables.

From the ESS we selected social contacts, i.e., structural social capital, through the question: "how often do you meet socially with friends, relatives or work colleagues?" The response alternatives were "low" (never, less than once a month), "moderate" (once a month, several times a month), and "high" (once a week, several times a week, every day). Interpersonal trust or the cognitive aspect of social capital was measured with the question: "would you say that most people can be trusted, or that you cannot be too careful when dealing with people?" The original response categories, which ranged from 0 (you cannot be too careful) to 10 (most people can be trusted) were divided into three: low (0–3), moderate (4–7), and high (7–10) trust.

Loneliness was used as an outcome variable and was measured with the question: "how much of the time during past week you felt lonely?" The response alternatives were "none or almost none of the time," "some of the time," "most of the time," and "almost all of the time." The response alternatives "most of the time" and "almost all of the time" were collapsed into one category in Table 18.1.

The analyses were also adjusted for relevant sociodemographic variables such as gender, education, marital status, and income. Marital status included the

[2] For further details of ESS sampling methodology and survey design, see http://www.europeansocialsurvey.org/.

[3] These countries have also been analyzed within the COURAGE in Europe project (http://www.courageproject.eu/).

Table 18.1 Distribution (%) of socio-demographic indicators, social capital indicators, and loneliness by country

	Finland	Poland	Spain
	N=944	*N*=734	*N*=752
Gender			
Men	51.8	55.6	54.1
Women	48.2	44.4	45.9
Age			
50–64	53.6	61.3	53.8
65+	46.4	38.7	46.2
Marital status			
In a relationship	64.7	64.6	69.7
Single	35.3	35.4	30.3
Educational level			
Primary	41.1	55.3	74.4
Secondary	24.3	26.9	7.8
Tertiary	34.5	17.8	17.8
Income			
Coping on income	87.2	59.9	75.5
Not coping	12.8	40.1	24.5
Social contacts			
Low	6.4	23.5	8.6
Moderate	31.5	46.4	19.5
High	62.1	30.1	71.8
Interpersonal trust			
Low	8.6	41.3	24.9
Moderate	55.5	46.6	65.7
High	35.9	12.1	9.4
Experienced loneliness			
All or almost all of the time	4.0	14.9	10.3
Some of the time	20.1	20.6	29.0
None or almost none of the time	75.9	64.5	60.7

Source: European Social Survey, 2010, weighted data

response alternatives: “in a relationship” (legally married, in a legally registered civil union), and “single” (“separated,” “widowed/civil partner died,” and “none of these”). Education was measured with a question about the highest level of education achieved and included three categories: primary (less than lower secondary; lower secondary), secondary (upper secondary, post-secondary), and tertiary (lower and higher tertiary). Income was assessed with feeling about current household income and the original response alternatives were divided into two: “coping on income” (living comfortably on present income, coping on present income) and “not coping on income” (difficult on present income, very difficult on present income). The analyses were also adjusted for gender and two age groups, 50–64 and 65 years and over.

18.5.1 Social Capital and Loneliness in Finland, Poland, and Spain

Table 18.1 suggests differences between Finland, Poland, and Spain when it comes to informal social contacts and trust. High social contact was found in 62 % of the Finnish sample and 72 % of the Spanish, whereas only 30 % in the Polish. High trust was also found in Finland (36 %). In contrast, the rates of low trust were high in Poland (41 %) as well as Spain (25 %). The findings corroborate previous research suggesting that the level of social capital in terms of contacts and trust is high in northern European countries (van Oorschot 2006; Rostila 2013) and that older people from the Mediterranean countries have larger family networks and social contacts than other European countries (Litwin 2010). On the other hand, studies suggest that post-socialist countries such as Poland experience lower levels of social capital (see Rostila 2013), which was also found here. The reason why the northern European countries, including Finland, repeatedly score high on social capital is not fully understood. However, it has been suggested that high level of social equality in the Scandinavian countries reduces social capital inequalities on a national level (Kumlin and Rothstein 2005; Pichler and Wallace 2007). In other words, when inequality increases, trust and social participation decreases.

The loneliness pattern follows a divide that has been seen in other studies (Sundström et al. 2009; Yang and Victor 2011), so that older people in northern Europe report lower levels of loneliness than those in southern Europe such as Spain. The highest levels of loneliness were, however, found in Poland. It has been suggested that the value systems and ideology of individualism in the Scandinavian countries may lower the levels of experienced loneliness. While living alone is more typical in northern Europe, feelings of loneliness are also lower as compared to the more collectivistic societies of southern Europe (Jylhä and Jokela 1990). In the next analyses, experienced loneliness is dichotomized into lonely (all or almost all of the time; some of the time) and not lonely (none or almost none of the time). We analyzed the likelihood of not being lonely rather than being lonely.

The results in Table 18.2 show that the distribution by loneliness varied among older people in Finland, Poland, and Spain with respect to social contacts. Interestingly, in Poland, older people with moderate social contacts showed less loneliness as opposed to the high social contact groups in Finland and Spain. Significant differences in loneliness were found in Poland in terms of interpersonal trust so that the absence of loneliness was more commonly reported in high trusting respondents.

Finally, Table 18.3 shows the association between social capital and loneliness in Finland, Poland, and Spain, respectively, when controlling for different background variables. Older people with high social contacts were more likely to report the absence of loneliness in Finland and Spain when compared to those with low social contacts, although this was not seen in Poland. The results also reveal a positive correlation between moderate trust and loneliness in the Polish sample, however not in the Spanish or Finnish samples. The empirical findings thus suggest an association between social capital and loneliness among older people in Finland, Poland, and Spain.

Table 18.2 The prevalence (%) of the absence of loneliness by country and the social capital variables

	Finland	Poland	Spain
	n = 712	*n* = 463	*n* = 459
Social contacts			
Low	63.3	56.8	47.7
Moderate	75.3	70.2	57.1
High	77.5	62.1	63.7
p	0.049	0.008	0.024
Interpersonal trust			
Low	74.1	56.6	56.1
Moderate	74.4	69.6	61.8
High	78.5	71.3	68.6
p	0.304	0.001	0.159

Source: European Social Survey, 2010, weighted data
Note: Absence of loneliness (none or almost none of the time)

Table 18.3 Odds ratios (OR) and 95 % confidence intervals (CI) for the absence of loneliness in Finland, Poland, and Spain

	Finland		Poland		Spain	
	OR[a]	(95 % CI)	OR[a]	(95 % CI)	OR[a]	(95 % CI)
Gender: male	0.91	(0.65–1.28)	1.11	(0.91–1.89)	1.38	(0.99–1.92)
Age group: 50–64	0.99	(0.70–1.40)	1.31	(0.91–1.89)	0.89	(0.64–1.25)
Marital status: in a relationship	**3.41**	(2.44–4.80)	**4.02**	(2.75–5.86)	**4.51**	(3.16–6.44)
Education						
Secondary	1.27	(0.84–1.92)	0.87	(0.58–1.33)	1.02	(0.55–1.87)
Tertiary	**1.63**	(1.09–2.42)	1.27	(0.75–2.17)	1.24	(0.79–1.94)
Income: coping on income	**2.64**	(1.71–4.06)	**2.47**	(1.71–3.57)	1.38	(0.95–2.01)
Social contacts						
Moderate	1.82	(0.97–3.44)	1.37	(0.89–2.13)	1.23	(0.66–2.31)
High	**2.29**	(1.24–4.22)	1.07	(0.67–1.71)	**1.88**	(1.08–3.28)
Interpersonal trust						
Moderate	0.71	(0.40–1.28)	**1.60**	(1.11–2.32)	1.05	(0.72–1.53)
High	0.71	(0.49–1.66)	1.72	(0.95–3.12)	1.45	(0.77–2.73)
Valid *N*	934		712		732	
2 log Likelihood	920.33		769.415		893.608	
Cox & Snell R^2	0.110		0.190		0.135	
Nagelkerke R^2	0.165		0.262		0.183	

Source: European Social Survey, 2010, weighted data
Note: A *bold* figure indicates a statistically significant difference ($p < 0.05$); Reference categories: gender "female"; age group "65+"; marital status "single"; education "primary"; income "not coping"; social contacts "low"; interpersonal trust "low"; absence of loneliness (none or almost none of the time)

However, the association differs between the countries whether structural or cognitive aspects of the concept were analyzed, implying that the meaning of social capital for loneliness and well-being may vary depending on the society in which one lives.

Before we conclude and discuss the ability of social capital to promote well-being in older people, it is important to note some limitations with our analyses based on the ESS data. We included only three European countries here to illustrate differences in social capital and loneliness between older people in Europe. Although more countries are preferable, our results are in line with previous research on social capital and health and well-being based on more European countries (Poortinga 2006; van Oorschot 2006; Yang and Victor 2011). In order to understand how much of the differences in loneliness can be explained by differences among individuals and how much of the variation stems from differences among the countries, different types of statistical analyses are needed such as fixed effect analyses or multilevel analyses.

Further, responses to loneliness may be sensitive to cultural environment, and different nationalities may interpret questions on well-being differently. Given the cross-sectional design of the data, we cannot draw conclusions about causality. We assume that social capital has a positive influence on the absence of loneliness, although a reversed causality is also likely. We did not control for health status in our analyses. Older people with good health may remain socially active and more trustful because of their good health status, which may influence the level of loneliness. Finally, the measure of social capital is not fully validated, although similar types of indicators have been used previously (e.g., Islam et al. 2006).

18.6 Discussion and Conclusions

This chapter started with an overview of the concepts of social capital, mental well-being, and loneliness. The impact of social capital on loneliness was highlighted by analyzing ESS data for Finland, Poland, and Spain. In this final discussion, we acknowledge that social capital offers a way to insert a social aspect into debates on active and healthy ageing for various groups of older people.

Social capital has attracted interest in both policy and academic literature because it has been recognized that the quality of social relationships contributes to health and well-being. An important aspect of the study of social capital is its dual focus on individual as well as collective features, suggesting that social capital can be used as an individual resource to reach personal goals such as access to emotional support, resources, and well-being. In addition, social capital can be seen as a collectively produced resource that is generated within a neighborhood, community, or society to advance collective welfare of society. This suggests that interventions to strengthen social capital need to focus on both access to resources within social networks (e.g., bring together groups normally divided along age, ethnicity, gender) as well as macro-level social and health policies (e.g., facilitate the development on nongovernmental organizations) (see WHO 2004).

In this chapter we focused on the absence of loneliness that is theoretically linked to mental well-being as a positive aspect of mental health rather than negative aspects such as mental disorders and depression. Loneliness is related to reduced quality of life, depressive symptoms, cognitive decline and increased mortality, and policies which aim to reduce loneliness are important for public health. Our chapter underscored that social capital has health beneficial qualities but that the meaning of social capital for well-being could differ depending on welfare state context, an issue that has been extensively discussed in relation to self-rated health (Rostila 2013). A recent systematic review showed that social capital has been associated with various mental well-being outcomes among older people (Nyqvist et al. 2013b). However, to date, research has failed to assess the relationship within a broader institutional or political context such as welfare state regimes. Our initial analyses in this chapter, showing social capital as well as loneliness differences between European countries, suggest that this is an issue that should be more thoroughly investigated in the future.

Active ageing is not only a matter of "productive ageing" and working longer, it is also, as we have seen in this chapter, a matter of social inclusion, participation, trust, and engagement which tend to have health beneficial qualities. Interventions that enhance health and mental well-being in the wider older population are important if social policy objectives of healthy ageing are to be accomplished. An important part of achieving active and healthy ageing is ensuring equality regarding social capital resources. Within health research much focus has been on establishing the association between social capital and health. Social capital is, however, an unevenly distributed resource between groups of older people (e.g., urban–rural older people; older people living at home or in institutional settings (Nyqvist et al. 2013a)) or even between nations, as seen in this chapter. The best-known consequences of social capital are health and well-being. There are far fewer propositions on how to generate social capital. For example, human capital such as education and skills is correlated with social capital, and policies focusing on education and training could also generate social capital and influence the level of well-being. In the literature, there is an emerging consensus that the welfare state could stimulate social capital (Rostila 2013), so that more welfare investment contributes to the social capital of the inhabitants. In countries with higher levels of welfare provisions, older people supposedly will have the time (due to retirement policies) and financial resources (due to welfare support and pensions) to actively take part in organizational activities and to socially connect with family, friends, and neighbors.

To conclude, the findings from this chapter suggest that there are differences in social capital and loneliness between older people living in Finland, Poland, and Spain. The level of loneliness tends to be lower with higher levels of social capital, although this association differed between the studied countries. Social capital as a resource can operate at different levels (micro, meso, and macro) as a promoting factor for health and well-being. The focus throughout the chapter has been on older people, who constitute a very heterogeneous group with regard to health, economic resources, age, gender, living environment, and social capital, and these differences need to be acknowledged when strengthening active and healthy ageing.

Based on the findings presented in this chapter, we conclude that social capital cannot be overlooked in research or by policymakers when considering different ways of improving well-being for various groups of older people in Europe.

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