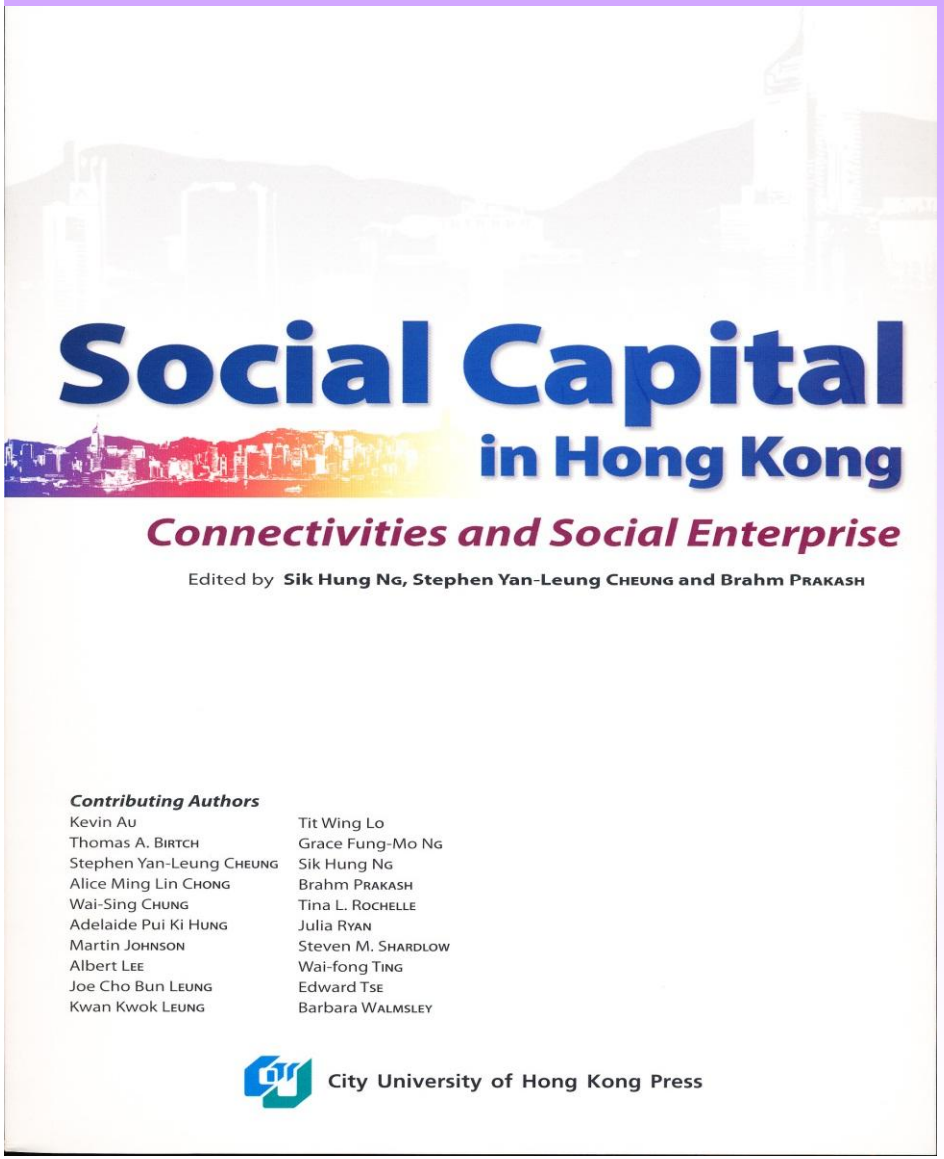
Building Social Capitals to Improve Health of Population



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The Health Action Model (HAM) initially devised by Professor Keith Tones in the early 1970s identifies major psychological, social and environmental influences on individuals adopting and sustaining health or illness related actions.

It needs to shift from experts telling people what to do, to an approach that equips people with knowledge and skills to make their own decision. **Empowerment** process helps people to take control of their health.

There are four interacting systems that determine the likelihood of a given individual developing an intention to adopt a particular course of health- or illness-related action:

- beliefs
- motivation
- normative influences
- the self

Tones BK (1981). *Affective education and health.*
In J. Cowley, K. David and T Williams (eds),
Health Education in Schools. London : Harper and Row.

- The health of the nation is determined by how the four interacting systems work together. Social scientists had explored the concept of social capital to explain the difference between societies.
- Social capital has been defined as those features of social organization — such as the extent of interpersonal trust between citizens, norms of reciprocity, and density of civic associations — that facilitate cooperation for mutual benefit.
- It constitutes the 'glue' that holds the community together.
- Literature review has documented two components of social capital, a cognitive component including "norms, values, beliefs and attitudes" and a structural component referring to social network or civic engagement (Islam et al, 2006).

Islam MK, Merlo J, Kawachi I, Lindstrom M, Gerdtham UG (2006). Social capital and health: Does egalitarian matter? A literature review. *International Journal for Equity in Health*, 5.3

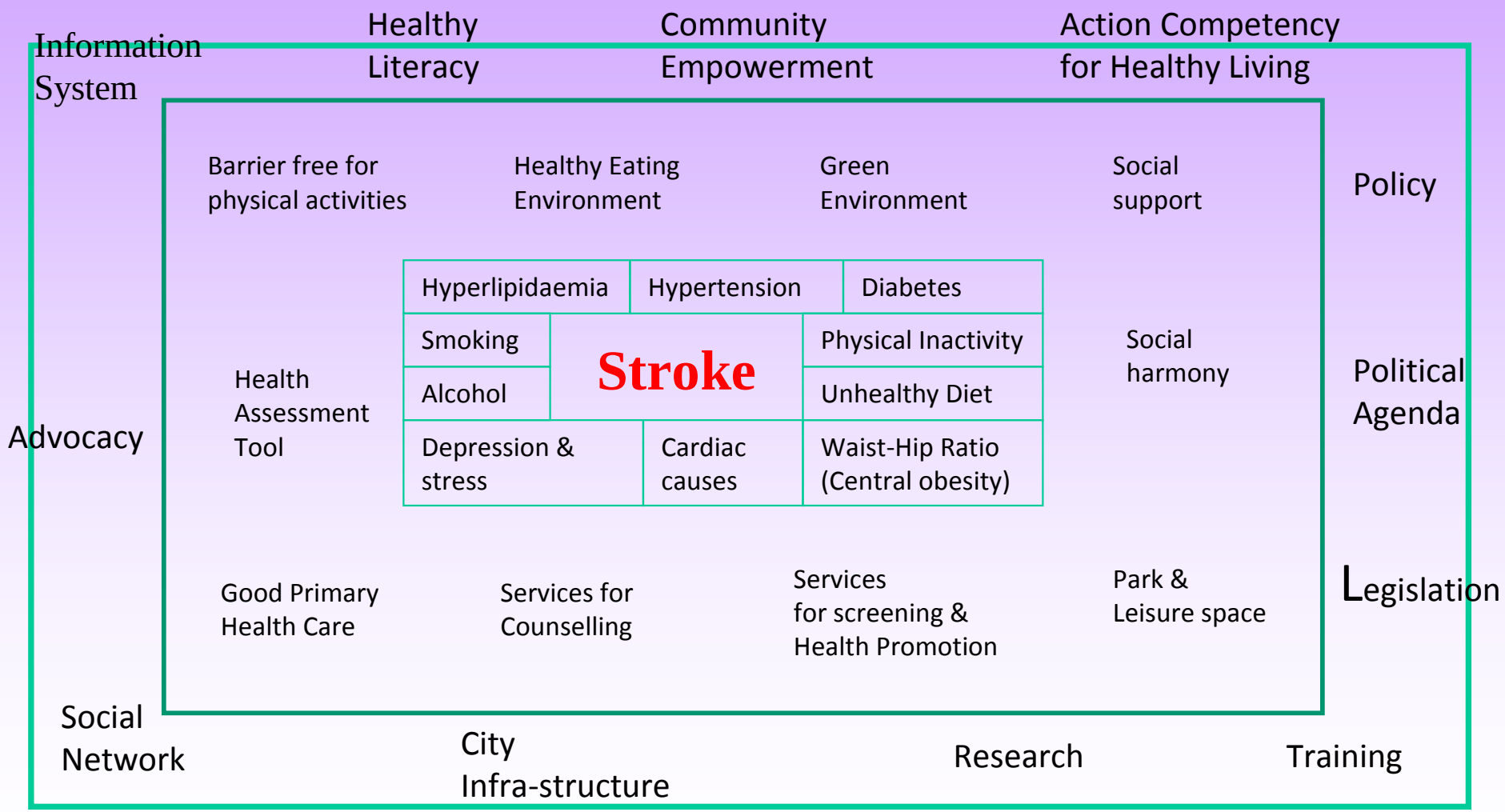
Building Social Capital to combat Triple burden of Health

- **'Second wave' epidemic of cardiovascular disease is flowing through developing countries as result of changing lifestyles. Death and disability will rank from Coronary Heart Disease and Cerebro-vascular Accident will rank number 1 and 4 respectively.**

Murray and Loppz: The Global burden of disease. WHO 1996.

- **Emerging new and old communicable diseases (SARS, Avian Flu, food poisoning) as result of ecological change, urbanization, globalization, population movement, changing living environment, changes of farming**
- **Rapid economic growth and urbanization, knowledge based economy, advancement of technology, changes of family structure, loss of neighbourhood relationship, lack of time for communication and inter-personal interaction would put individual vulnerable to mental distress as resources for emotional support are depriving**

Impact of City Structure and Governance on a leading chronic illness © Prof Albert Lee 2010



Inter stroke study. Top 10 risk factors, Lancet 2010

Is current health care system empowering patients to improve their health literacy in self management?

Do health professionals have the skills to empower patents for self management?

– Substantial proportion of patients still expect their health to be responsibility of medical team rather than their own control

– Most health care professionals are trained in the acute medical model of care with treatment provided by medical team and little contribution to outcome from patient's perspectives

– Ample of evidence showing that *if the professionals remain in control*, *the outcome are worse* (Kaplan RM, Chadwick MV, Schimmel LE. *Diabetes Care* 1985;8:152-5.)

– The "contract" between patient and carers in chronic disease management is markedly different from acute situations. It needs to be explicit, negotiated and modified in response to various life and disease events.

– The predominant role of the professional is to meet the medical agenda to improve outcome (glycaemic control, blood pressure). Although technical targets are important, they are unlikely to be satisfied if psycho-social aspects are not addressed.

– Admission to hospitals, exercise demands to review results of investigations would erode patient's feelings of self-control.

Lee A. Siu CF, Leung KT, Chan C, Lau L, Wong KK. General Practice and Social Service Partnership for Better Clinical Outcomes, Patient Self Efficacy and Lifestyle Behaviours of Diabetic Care: Randomised Control Trial of a Chronic Care Model. *Postgraduate Medical Journal* 2011, In Press.

- Proportion of subjects with normal HbA1c increased from 4.5% at baseline to 28.6% at week 24 for experimental group, P<0.001 but only slight improvement from 3.9% to 11.8% in control group, P=0.13.
- Proportion of subjects removing skin when eating poultry increased from 67.1% at baseline to 81% at week 26, P= 0.03 and no change for control group.
- Repeated measure of analysis of variance showed changes in DM self efficacy scale with significant interaction demonstrating marked improvement in experimental group.
- Similar effect was observed for BMI.

香港復康會
The Hong Kong Society for Rehabilitation
社區復康網絡
Community Rehabilitation Network

香港中文大學
The Chinese University of Hong Kong
健康教育及促進健康中心
Centre for Health Education and Health Promotion

New public health initiatives in fighting against SARS

- The quote from Kass in 1977 stated, “The terror of unknown is seldom better displayed by the response of a population to the appearance of an epidemic, particularly when the epidemic strikes without cause.” This described the fears surrounding the newly recognized legionnaires’ disease, and the same would apply to SARS.
- **The biggest challenge for public health practice is that some of the most important public health measures are to be taken OUTSIDE the health sector by those with responsibility for economic and social policy, such as politicians, educators, industrialists and economists.**
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Hygiene Charter

- As a public health discipline, there is no better dictum “prevention is better than cure” in the SARS crisis and control of infectious disease.

- The public should take this opportunity to equip themselves the skills in maintaining good standard of hygiene and advancement of health education knowledge. Effective public health practice needs to involve the community at large and encourage people to be involved in all decision-making processes relating to health.

EVIDENCE BASED PUBLIC HEALTH POLICY AND PRACTICE

How would schools step up public health measures to control spread of SARS?

A Lee, F F K Cheng, H Yuen, M Ho, and the Hong Kong Healthy Schools Support Group*

Poverty and social disadvantage are strongly associated with mental disorders.

(Duarte et al, *Int J Psy. Med* 2003; 35: 203-22; Earls F. Child Adolesc Psychiatr clinic N Am 2001; 10: 693-709).

The risk of exposure to adversity increase such as inadequate nutrition, violence, poor education, social isolation.

Genetic and biological factors interact with family and school environmental to modify risk of mental disorders. (Eley et al. Mol Psychiatry 2004; 9: 908-15)

Protection can mitigate the risk factors for health compromising behaviors

- sense of connection
- low levels of conflict
- social environment encourages free emotional expression
- parents and friends model health behaviour
- school with zero-tolerance policy toward bullying
- promotion of atmosphere addressing individual needs and interests
- involvement in community activities
- religious observance

Birmaher B et al. *J Am Acad Adolesc Psychiatry* 1996; 35: 1427-35.

Greening L et al, *Suicide Life Threat Behav* 2002; 32: 404-17

Most important factor for building resilience in young people is to enable parents to provide adequate psychosocial stimulation during early childhood. “Giving young people a good start in life is to help parents.”

Walker SP et al. *BMJ* 2006; 333: 472-

Social capital has been claimed to be important for the enhancement of government performance and the functioning of democracy, for the prevention of crime and delinquency and, more recently, for the maintenance of population health.

Kawachi et al used US data aggregated at the state level and reported strong cross-sectional correlations between indicators of social capital and mortality rates.

In that study, social capital was measured by responses to the General Social Surveys about the degree of mistrust, levels of perceived reciprocity, and per capita membership in voluntary associations of all kinds

Each indicator of social capital was strikingly correlated with lower mortality rates, even after adjustment for state median income and poverty rates.

Kawachi et al (1999). Social Capital and Self-Rated Health: A Contextual Analysis, *Am J Public Health*, 89(9): 1187-1193

Research dating back to Durkheim's study of the causes of suicide has shown that social integration can enhance population well-being.

Epidemiologic investigations of social ties have found that individuals lacking social connections have 2 to 3 times the risk of dying from all causes compared with well-connected individuals.

An important distinction must be drawn between social integration measured as an individual characteristic (which is how most epidemiologic studies have measured social networks) and social integration measured as a collective characteristic (which is how social capital is conceptualized).

Social capital may influence the health behaviours of neighbourhood residents by :

- promoting more rapid diffusion of health information
- increasing the likelihood that healthy norms of behaviour are adopted (e.g., physical activity)
- exerting social control over deviant health-related behaviour.

The theory of the diffusion of innovations suggests that innovative behaviours (e.g., use of preventive services) diffuse much more rapidly in communities that are cohesive and in which members know and trust one another.

Neighbourhood social capital might influence the health of individuals via psychosocial processes, by providing affective support and acting as the source of self-esteem and mutual respect.

Variations in the availability of psychosocial resources at the community level may help to explain that socially isolated individuals residing in cohesive communities do not appear to have the same ill health consequences as those living in less cohesive communities.

What should be the effective intervention for health improvement and building human and social capital

Health could not be improved simply by provision of health services focusing on particular diseases or organs.

The supply of primary health care services has been shown to be the independent factor associated with positive health outcomes while other socio-demographic variables are controlled.

Apart from availability of quality primary health care, the services need to be widely accessible particularly the disadvantaged group and universal approach might not fully address the questions of inequity.

The ‘Healthy Setting’ approach ensures that ethos of the setting and all the activities are mutually supportive and combine synergistically to improve health and well being of those who live or work on receive care there.

It integrates health promotion into all aspects of the setting including all those coming into contact with that setting.

This will help to bring those disadvantaged groups into contact of essential primary health care service.

Healthy setting shifts away from specific health behaviour change towards creating the conditions that are supportive of health and well being.

It shifts the focus from risk factors to organizational change so sustainability of the system can be ensured.

Primary health care and healthy setting can cut across different levels interacting with each other, and interconnectedness of individuals, families and peers with comprehensive and integrated primary care system and healthy setting approach.

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The WHO Commission on Social Determinants of Health (CSDH, 2008)

recognised the importance of the urban setting as a social determinant of health.

Its Knowledge Network on Urban Settings (KNUS, 2008) recommended a broad spectrum of interventions, including:

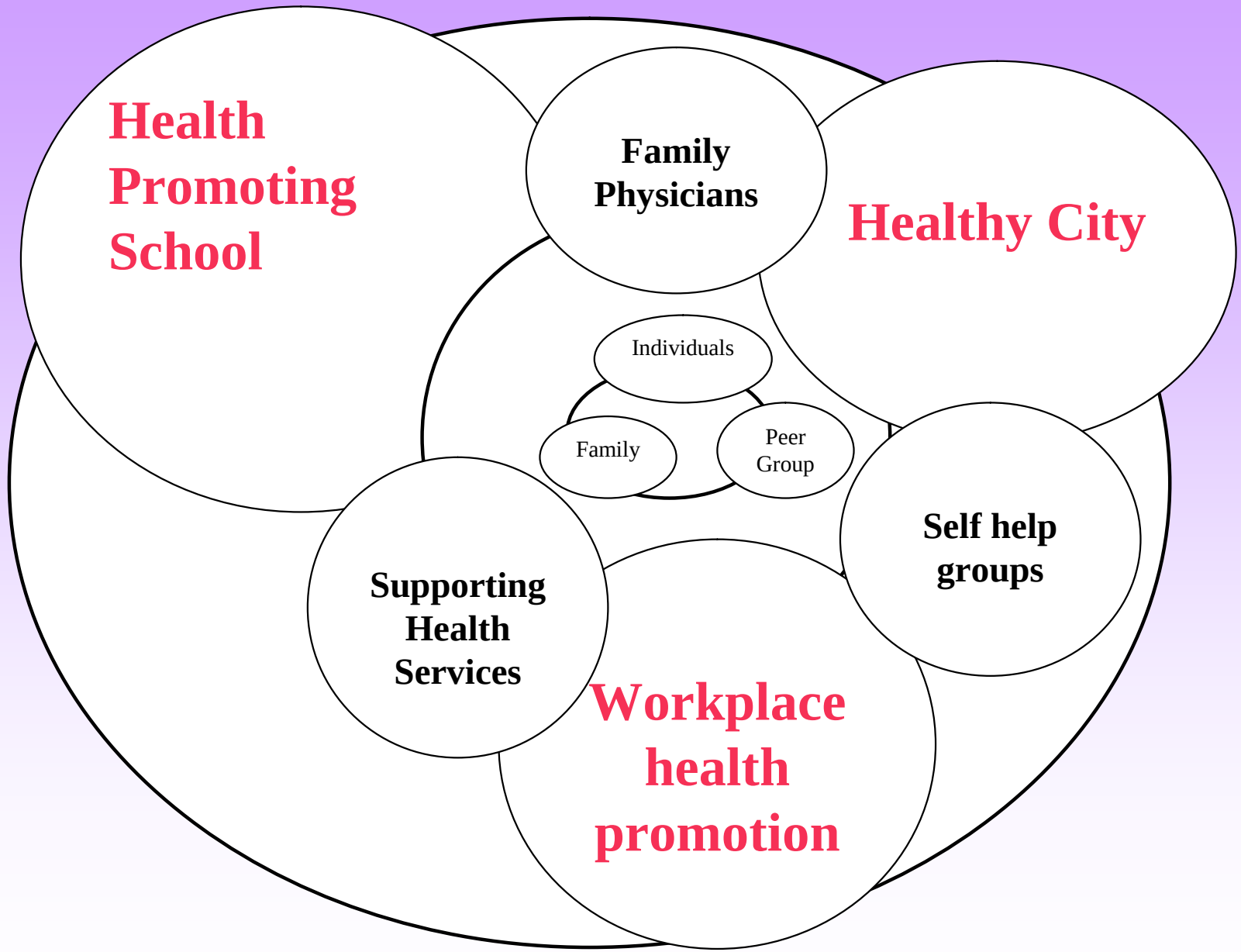
- building social cohesion,
- improving environments for health,
- accessible primary health care for all,
- healthy settings as vehicles,
- proactive and coordinated urban planning, and good urban governance.

Our cities, our health, our future: Acting on social determinants for health equity in urban settings. Report of the Knowledge Network on Urban Settings, WHO Commission on Social Determinants of Health. WHO Centre for Health Development, Kobe, Japan – 2007.
http://www.who.int/social_determinants/resources/knus_report_16jul07.pdf

First Meeting of the Knowledge Network on Urban Settings (KNUS), WHO Commission on Social Determinants of Health

7−9/2/ 2006, Kobe, Japan

Lee A., Kiyu A., Milman HM., Jara J. Improving Health and Building Human Capital through an effective primary care system. *Journal of Urban Health* 2007; 84(supp1): 75-85



Thank You! Merci! 多謝！

Let health professionals all around the world to address the ways ahead for the international collaboration to promote better health of our citizens