ABSTRACT

Objective Inequalities exist between the 23-valent pneumococcal polysaccharide vaccination (PPSV23) rate in each municipality among Japanese older adults. Exploring individual-level and community-level intervenable factors is necessary to improve the vaccination rates. We examined the associations between community-level and individual-level social capital and the PPSV23 vaccination among older Japanese adults using multilevel Poisson regression analyses.

Design Cross-sectional study.

Setting We used data from the Japan Gerontological Evaluation Study, conducted between 3 October 2016 and 10 January 2017 in 631 districts, 39 municipalities and 18 prefectures.

Participants The target population comprised persons aged 65 years or older who are physically and cognitively independent (that is, not certified as needing long-term care). Further, 180021 older adults from 39 Japanese municipalities were enrolled.

Primary outcome measure The primary outcome was the PPSV23 vaccination among the Japanese older adults aged 65 years or older who did not have physical or cognitive disabilities.

Results After adjusting for municipality-, community-, individual-levels effects with multiple imputation, 137075 individuals who participated in one/more of the civic participation (participation of social groups), social cohesion (social tie), or reciprocity (mutual exchange of social support) were significantly associated with more vaccinations than those without the three social capitals among the 137075 older adults (13.0% (95% CI 11.0% to 14.9%), 5.0% (95% CI 2.4% to 7.6%) or 33.9% (95% CI 23.6% to 44.2%) increase, respectively, p<0.001 for all). The rich (≥+1 SD) community-level civic participation was significantly associated with 3.4% increase (95% CI 0.02% to 6.78%, p<0.05) of the PPSV23 vaccination among the older adults compared to those with the poor or standard one.

Conclusions Older adults with one/more of the three social capitals at the both levels received more PPSV23 vaccinations than those without those social capitals. Therefore, fostering of those social capitals may improve the inequality of the PPSV23 vaccination rate among older adults in each municipality.

INTRODUCTION

It was estimated that lower respiratory infectious illnesses including pneumonia caused 1080958 deaths in older adults aged >70 years worldwide in 2016. Streptococcus pneumoniae was the leading cause of morbidity and mortality of the illnesses globally, contributing to 1189937 deaths, which were more than all other etiologies combined in 2016. The adult pneumonia study group—Japan estimated that 69.4% of adult pneumonia was occurring in older adults aged ≥65 years annually in Japan and S. pneumoniae was the leading bacterial etiological agent as related to 530000 adult pneumonia cases in multicentre prospective surveillance conducted from September 2011 to January 2013.

The 23-valent pneumococcal polysaccharide vaccination (PPSV23) and the 13-valent pneumococcal conjugate vaccine are effective for preventing pneumonia caused by S. pneumoniae strains in older adults aged ≥65 years. The following epidemiological determinants have been reported to be associated with coverage of the PPSV23 or the both vaccinations: age, sex, education, income, marital status, household structure, self-rated health, health literacy, smoking, general practitioner, high-risk diseases for pneumonia including diabetes, heart diseases, chronic respiratory
diseases,6 7 out-of-pocket amounts after subtracting the subsidy of municipalities from the vaccination costs.11 12

In Japan, the PPSV23 vaccination (PNEUMOVAX NP, MSD) has been incorporated into a national immunisation programme for adults aged ≥65 years since October 2014. Public subsidies for the PPSV23 vaccination are available in most developed countries, including Japan.13 In almost all the municipalities in Japan, PPSV23 vaccination payment is partly subsidised by the municipality and the remaining out-of-pocket cost is undertaken by the individual.14

Recently, Naito and colleagues estimated that the 5-years cumulative vaccination coverage was 49% across Japan in 2018 since the PPSV23 vaccination was started in 2014 as the national immunisation programme.15 The immunisation programme is intended for older adults who aged ≥65 years, and those who aged 60–64 and have extremely restricted daily activity due to a disorder in their heart/kidney/respiratory function or immune function because of HIV infection. However, Murakami et al reported that there was the remarkable inequality in the PPSV23 vaccination rate (median, 5/95 percentiles of the vaccination rate: 41.8%, 13.6%, and 62.5%) in 1010 Japanese municipalities.16 Murakami’s group also reported that the out-of-pocket cost and the number of direct mail notifications from a municipality were negatively and positively associated, respectively, with the municipality-level PPSV23 vaccination rate.11 Murakami’s reports suggest that municipality-provided subsidies and implementations can improve the PPSV23 vaccination rate among the older adults at the municipality level11. However, municipalities may not be able to subsidize or implement the tools for encouraging the PPSV23 vaccination depending on circumstances (e.g. financial reason). Therefore, it is important to pursue individual-level or community-level intervenable factors for improving the vaccination rate among older adults.

Social capital is one such factor that has undergone multilevel analyses to examine the contextual effects of group-level social capital in many studies in the field of public health.16–19 A few reports show associations between individual-, group, or community-level social capital and paediatric vaccinations.20 21 However, to the best of our knowledge, no study has yet assessed associations between individual-, community-level social capital, and vaccination among older adults. Fostering social capital may improve the inequality in PSSV23 vaccination rate among older adults if social capital is related to the vaccination among them.

We analysed associations between the individual and community-level social capital measures including civic participation (social participation), social cohesion (social tie) and reciprocity (mutual exchange of social support). The three social capital measures have been developed and validated as an instrument to measure community-level social capital based on data derived from older community dwellers in Japan.17 Besides, the three measures at the two-levels have been most frequently shown to be associated with health-related outcomes among Japanese older adults aged ≥65 years.16 17 22–27 So, we evaluated whether the three measures of social capital were associated with the PPSV23 vaccination adjusting with municipality, community- and individual level effects among community-dwelling older adults aged ≥65 years.

**METHODS**

**Study population**

This study had a cross-sectional design and used data from the Japan Gerontological Evaluation Study (JAGES). The JAGES was designed to describe the health status and social determinants of people who are physically and cognitively independent (not certified as needing long-term care). We used the 2016 wave of JAGES, a cross-sectional dataset obtained from self-reported questionnaires mailed to community-dwelling individuals in 39 municipalities. In the 2016 wave, 196, 438 of 279, 661 individuals (70.2%) responded to the survey. After excluding data from older adults who had been certified as needed the long-term care at the survey, those who aged <65 years, and those who did not answer any question at all, the number of participants in the JAGES2016 data attributed to 180,021. The questionnaires comprised basic items and eight optional modules. We used data concerning the basic items that included questions about PPSV23 vaccination and three social capital measures. The data were nested in 631 communities essentially based on elementary or junior high school district because a school district reflects a geographical scale wherein older Japanese people can move on foot or bike,17 and the communities were further nested in the 39 municipalities.

**PPSV23 vaccination**

The outcome variable was the PPSV23 vaccination in the last 5 years. This was assessed by asking the respondents, ‘Did you get a pneumococcal vaccination in the last 5 years? They chose from the following options: (1) no, (2) yes, I used my municipality’s subsidy and (3) Yes, but I did not use my municipality’s subsidy. We considered the no.2 and 3 as those who received the PPSV23 vaccination.

**Measurements of individual- and community-level social capital**

To assess community-level social capital, each response was aggregated to the elementary or junior high school district. These school districts can be interpreted as units at the community level for the following reasons: First, the district represents a geographical area wherein people can walk easily from home, interact with each other on a daily basis, and organise community activities.17 Second, previous studies used the district as a unit for the community level to assess the effect of community-level social capital on health outcomes among community-dwelling older adults.16 17 28 The value of the aggregated responses was scaled so that the effect of a one-unit increase or decrease can be interpreted as the effect of an 1 SD increase or decrease.
Civic participation, social cohesion and reciprocity were evaluated as measurements of individual- and community-level social capital. Civic participation was assessed as participation in the following five social groups: sports groups/clubs, volunteer groups, hobby activity groups, study/cultural groups and groups that conduct activities to teach skills/pass on experiences to others. Individual-level civic participation was scored ‘1’ if respondents participated in any of the five social groups once a month or more often and scored ‘0’ if respondents participated in these social groups less than once a month. Community-level civic participation was determined by summing the participation proportions of the five social groups in each community. Social cohesion was assessed with the following questions: ‘Do you think people living in your area can be trusted in general?’; ‘Do you think most people in your community aid others?’; and ‘How strong is your attachment to your place of residence?’. Individual-level social cohesion was scored ‘1’ if respondents answered ‘very’ or ‘moderately’ to at least one of the three questions and scored ‘0’ if respondents did not answer ‘very’ or ‘moderately’ to any of the questions. Community-level social cohesion was determined by summing the proportions of those who answered ‘very’ or ‘moderately’ to the questions in each community. Reciprocity was assessed with questions related to emotional or instrumental social support as follows: ‘Do you have someone who listens to your concerns and complaints?’; ‘Do you listen to someone’s concerns and complaints?’ and ‘Do you have someone who looks after you when you are sick for a few days?’. Individual-level reciprocity was scored ‘1’ if respondents answered ‘any one or more’ to any of the questions and scored ‘0’ if respondents answered ‘nobody’ to all of the three questions. Community-level reciprocity was determined by summing the proportions of those who answered ‘any one or more’ to the questions in each community.

Covariates
Age was categorised into two groups: 65–74 years and ≥75 years. Educational attainment was categorised into five groups: <6 years (less than elementary school course completion), 6–9 years (elementary school course completion to middle/completion of junior-high school), 10–12 years (junior high school completion to middle/completion of high school), ≥13 years (middle/completion of university course, or more) and others that varied from these four categories. Equivalised income was calculated by standardising household gross income divided by the square root of the number of household members and was categorised into five groups: <¥0.5 million, ¥0.50–¥0.99 million, ¥1.00–¥1.99 million, ¥2.00–¥3.99 million and ≥¥4.00 million. Marital status was classified into five groups: married, widowed, divorced, never married and others. Household structure was assessed by asking the respondents ‘Who do you live with?’ and ‘How strong is your attachment to your place of residence?’. The responses were categorised into six households: living alone, living with a spouse, living with offspring, living with a spouse and offspring, living in a three-generation household, and the others. The first five categorisations mirrored the five major households among adults aged ≥65 years in Japan. The longest job that have ever had was assessed by asking the responders ‘What is the type of the occupation that you have taken the longest in your life?’ and they were asked to choose from the following options: professional/technical, managerial, clerical, sales/service, skilled labour, agriculture, forestry/fisheries, self-employment other than agriculture/forestry/fisheries, the other, I have never had a job.

Statistical analyses
We created the Directed Acyclic Graph (DAG) to identify a Minimal Sufficient Adjustment Sets (MSAS) of the potential confounders for estimating the total effects of social capital on the PPSV23 vaccination. We used an on-line tool, DAGitty V.3.0 (http://www.dagitty.net) to create the DAG. The DAG analysis revealed that the MSAS for estimating the effects were age, sex, education, income, marital status, household structure and municipality (figure 1). The data consisting of the 180021 participants had missing in most of the characteristics including the PPSV23 vaccination, three social capitals, sex, educational attainment, equivalised income, marital status (online supplemental table 1). For handling the missing data, we performed multiple imputation (MI) among 180021 participants including the PPSV23 vaccination, the three social capital measures, and all the MSAS except for the community and municipality dummy variables, age, and household structure. There was no missing data in the age, household structure, and municipality dummy variables. The community dummy variable had missing data, however, we did not impute the variable with the MI because the numbers for each community were assigned for convenience only, and there was no relationship between the numbers and the characteristics of the regions, and no regular distribution among them to enable MI. We generated five imputed datasets with MI by Chained Equations method. To meet the assumption that data were missing at random and improve the quality of the imputed values, we included the longest jobs that have ever had and the community dummy variable as auxiliary variables associated with missing data and the PPSV23 vaccination. We confirmed that the two auxiliary variables did not bias on estimating the effects of social capital on the vaccination even if those were included in the estimation (figure 1).

χ² test was performed for categorical data. A multilevel Poisson regression model with a random intercept was used to calculate a coefficient and 95% CI as the effect of community- and individual-level social capital measure on the PPSV23 vaccination. Unadjusted coefficient and 95% CI were calculated in multivariate Poisson regression with a fixed
Open access

intercept and no covariate adjustment. Only the PPSV23 vaccination variable with quantitative variables after the MI was converted to a binary variable for the Poisson regression analyses. The imputed values <1 were converted to 0, and 1 or more converted to 1. The other imputed variables were not converted for the regression analyses at all. Coefficients and 95% CI were adjusted with the MSAS and the auxiliary variables were also input in the model as the Stef. van Buuren’s recommendation.31 We estimated the effect to social capital on the PSSV23 vaccination from each imputed dataset with combining the results by using Rubin’s rules.32 We performed a sensitivity analysis with the complete data set without missing data in the multilevel Poisson regression same as performed in the imputed data sets. All p values were two tailed and the significance was set at 5%. P values lower than 0.05 were considered statistically significant. We used Stata V.14.1 (Lightstone) for all analyses.

Respondents were informed that participation was voluntary and that returning the self-administered questionnaire would be deemed as consent to participate.

**RESULTS**

Table 1 shows the individual- and community-level characteristics of the 180021 older adults who received PPSV23 vaccination and those who did not the vaccination with the MI data sets. A greater percentage of older adults who had individual-level civic participation, social cohesion or reciprocity received the vaccination compared with those without the social capitals. A greater percentage of older adults who had the rich (≥1 SD) of the community-level civic participation or social cohesion received the vaccination compared with the standard (<−1SD, <+1 SD) or poor (≤−1SD) of the two social capitals. A greater percentage of the older adults with the standard community-level reciprocity received the vaccination compared with the other two. A greater percentage of adults who were women, aged ≥75 years, had

Figure 1 The DAG for estimating effects of social capital on the PPSV23 vaccination. The DAG shows the outcome (the PPSV23 vaccination), the exposure (social capital), the ancestors of the outcome and exposure including the MSAS and the auxiliary variables (white coloured) and ancestors of the outcome (grey coloured). The MSAS consists of age, sex, education, household structure, income, marital status and municipality. The auxiliary variables consist of the longest job and community.® 1 16 17 24 25 35-41 DAG, Directed Acyclic Graph; MSAS, Minimal Sufficient Adjustment Sets; PPSV23, 23-valent Pneumococcal Polysaccharide Vaccination. IADL, Instrumental Activities of Daily Living

**Patient and public involvement**

No patients were involved in the development of the research question, study design, or data interpretation in this study.
Table 1  Basic characteristics of the community-dwelling older adults aged 65 years and over (N=180 021)

| Individual-level social capital variables | PPSV23 |        |        |        |        |        |
|-------------------------------------------|--------|--------|--------|--------|--------|--------|
|                                           | No     | SD†    | Yes    | %      | SD    | P value*|
| Civic participation                       |        |        |        |        |        |        |
| No participation                          | 69876  | 60.9   |        | 42.3   | 44878  | 39.1   | 24.9   |
| Any participation                         | 36167  | 55.4   | 37.5   | 29100  | 44.6   |        |        |
| Social cohesion                           |        |        |        |        |        |        |
| Not cohesive                              | 16980  | 63.3   | 29.0   | 9847   | 36.7   |        |        |
| Cohesive                                  | 89063  | 58.1   | 34.2   | 64131  | 41.9   |        |        |
| Reciprocity                               |        |        |        |        |        |        |
| No support                                | 4701   | 68.2   | 16.9   | 2196   | 31.8   |        |        |
| Any support                               | 101342 | 58.5   | 43.3   | 71782  | 41.5   |        |        |

| Community-level social capital variables  |        |        |        |        |        |        |
| Civic participation                       |        |        |        |        |        |        |
| >-1SD, <+1SD                              | 80633  | 58.7   | 775.8  | 56800  | 41.3   | 440.9  |
| ≥+1SD                                    | 8387   | 55.6   | 110.0  | 6703   | 44.4   | 72.2   |
| ≤-1SD                                    | 17063  | 62.1   | 790.0  | 10435  | 37.9   | 397.6  |
| Social cohesion                           |        |        |        |        |        |        |
| >-1SD, <+1SD                              | 79353  | 58.9   | 589.9  | 55314  | 41.1   | 235.0  |
| ≥+1SD                                    | 14267  | 58.5   | 320.5  | 10125  | 41.5   | 139.0  |
| ≤-1SD                                    | 12453  | 59.4   | 275.8  | 8509   | 40.6   | 95.5   |
| Reciprocity                               |        |        |        |        |        |        |
| >-1SD, <+1SD                              | 84383  | 58.5   | 267.7  | 59871  | 41.5   | 143.1  |
| ≥+1SD                                    | 12667  | 59.4   | 291.9  | 8666   | 40.6   | 141.6  |
| ≤-1SD                                    | 9023   | 62.5   | 241.9  | 5411   | 37.5   | 80.5   |

| The other covariates                      |        |        |        |        |        |        |
| Age groups, years                         |        |        |        |        |        |        |
| 65–74                                     | 65681  | 65.0   | -‡     | 35350  | 35.0   | 35.0   |
| ≥75                                       | 40362  | 51.1   | -     | 38628  | 48.9   | -      |
| Sex                                       |        |        |        |        |        |        |
| Male                                      | 49720  | 60.4   | 19.9   | 32556  | 39.6   | 21.1   |
| Female                                    | 56323  | 57.6   | 18.8   | 41422  | 42.4   | 20.2   |
| Educational attainment, years             |        |        |        |        |        |        |
| <6                                        | 1291   | 63.8   | 8.0    | 731    | 36.2   | 6.6    |
| 6–9                                       | 35225  | 60.1   | 27.1   | 23351  | 39.9   | 16.2   |
| 10–12                                     | 42368  | 58.2   | 35.5   | 30407  | 41.8   | 31.7   |
| ≥13                                       | 26486  | 58.2   | 5.4    | 19040  | 41.8   | 12.0   |
| Others                                    | 673    | 60.0   | 2.1    | 449    | 40.0   | 1.6    |
| Equivalised income, million yen           |        |        |        |        |        |        |
| <0.5                                      | 6395   | 58.0   | 48.3   | 4630   | 42.0   | 23.6   |
| 0.50–0.99                                 | 17478  | 58.7   | 61.1   | 12316  | 41.3   | 37.8   |
| 1.00–1.99                                 | 37084  | 58.5   | 79.9   | 26294  | 41.5   | 77.6   |
| 2.00–3.99                                 | 31736  | 59.6   | 48.4   | 21530  | 40.4   | 87.7   |
| ≥4.00                                     | 13350  | 59.2   | 75.3   | 9209   | 40.8   | 39.8   |
| Marital status                            |        |        |        |        |        |        |
| Married                                   | 75883  | 58.7   | 11.3   | 53399  | 41.3   | 20.0   |
| Widowed                                   | 20052  | 55.6   | 7.7    | 16007  | 44.4   | 18.0   |
| Divorced                                  | 5464   | 67.7   | 8.3    | 2606   | 32.3   | 7.8    |
| Never married                             | 3740   | 70.9   | 1.2    | 1538   | 29.1   | 3.6    |
| Other                                     | 904    | 67.9   | 0.8    | 428    | 32.1   | 5.7    |
| Household structure                       |        |        |        |        |        |        |
| Living with a spouse                      | 44598  | 58.1   | -      | 32148  | 41.9   | -      |
| By alone                                  | 10952  | 61.0   | -      | 7014   | 39.0   | -      |
| Living with offspring                     | 8048   | 59.7   | -      | 5441   | 40.3   | -      |
| Living with a spouse and offspring        | 15802  | 61.3   | -      | 9981   | 38.7   | -      |
| Living in three-generation household      | 11529  | 55.1   | -      | 9406   | 44.9   | -      |
| The other house structures                | 15115  | 60.2   | -      | 9987   | 39.8   | -      |

Continued
higher education, lower equivalised income or widowed received the vaccination compared with those in the other categories. A greater percentage of older adults who lived in a three-generation household received the vaccination than those in the other household structures. A greater percentage of older adults who had ever had clerical or never had a job received the PPSV23 vaccination compared with those who had the other job.

Table 2 shows the associations between individual-, community-level social capital and PPSV23 vaccination among the 137,075 community-dwelling older adults after adjusting for all the MSAS and inputting the auxiliary variables. The individual-level civic participation, social cohesion, or reciprocity was significantly associated with 13.0% (95% CI 11.0% to 14.9%), 5.0% (95% CI 2.4% to 7.6%) or 33.9% increase (95% CI 23.6% to 44.2%) of the PPSV23 vaccination among the older adults, respectively. The rich (≥+1 SD) community-level civic participation was associated with 3.4% increase (95% CI 0.02% to 6.78%) of the PPSV23 vaccination among the older adults, although the other two community-level social capital were not significantly associated with the vaccination. We performed a sensitivity analysis with the complete data set and the results were almost same as the one with the imputed data set (online supplemental table 2). However, the two estimates were consistent in that community-level social participation was significantly associated with the vaccination.

**DISCUSSION**

Inequalities have been shown to exist between the PPSV23 vaccination rate among the older adults. We analysed associations between individual-, community-level social capital and the PPSV23 vaccination among community-dwelling older adults aged ≥65 years. After adjusting for all the covariates and inputting the auxiliary variables in the imputed data sets, our analyses showed that one or more individual-level civic participation, social cohesion or reciprocity was significantly associated with a greater likelihood of vaccination among the older adults than those with the lack of these social capitals (table 2). The rich community-level civic participation was associated with more vaccination than the standard or poor social capital among older adults (table 2). These results suggest that older adults with the higher individual-level civic participation, social cohesion or reciprocity receive the PPSV23 vaccination greater than those without these social capitals, and that older adults living in districts with the rich community-level civic participation receive more vaccinations than those living in districts with the standard or poor community-level social capital.

Several groups reported an association between municipality-provided subsidies and the PPSV23 vaccination as ecological studies at the municipality or nation level.
In contrast, this study was conducted to assess the associations between social capital and the PPSV23 vaccination among Japanese adults aged ≥65 at individual, community and municipality-levels. After adjusting for all the covariates, the individual-level civic participation, social cohesion, reciprocity and community-level civic participation were significantly associated with the PPSV23 vaccination than in the lack of these social capitals (table 2). Our results suggest that fostering individual- and community-level civic participation may improve the inequality of the vaccination among older adults. Thereby, recommending a policy to mitigate the inequality of PPSV23 vaccination in municipalities among Japanese older adults.

A few reports show associations between social capital and influenza vaccination among older adults. However, these studies solely assessed associations between individual-level social capital and vaccination. Contrasting, we assessed associations between multilevel (community and individual) social capital and PPSV23 vaccination among older adults (table 2). Our results suggest that both of the individual- and community-level social capitals were associated with the PPSV23 vaccination among older adults. Moreover, our study indicates the importance of such multilevel analyses. However, it is unclear why the three social capitals were associated with higher vaccination receipt, and how the three social capitals were associated with the PPSV23 vaccination among older adults. Future studies should address this issue.

Nawa and Fujiwara recently reported associations between individual and community-level social cohesion and the second dose of measles vaccination among Japanese children. Our results showed that the individual-level social cohesion but not community level’s one was significantly associated with PPSV23 vaccination among older adults (table 2). This suggests that the social cohesion had an effect on the two vaccinations similarly but at different levels.

The present study has two strengths. First, to our best knowledge, this is the first study to show associations between the PPSV23 vaccination and individual- or community-level social capital among older adults aged 65 years, although there have been a few studies that showed associations between paediatric vaccinations, individual- and community-level social capital, or associations between influenza

---

Table 2: Coefficients and 95% CI of associations between the PPSV23 vaccination and individual-level and community-level social capital among the community-dwelling older adults (N=137,075)

| Individual-level social capital variables | Unadjusted coefficient | Unadjusted 95% CI | Adjusted coefficient | Adjusted 95% CI |
|-------------------------------------------|-----------------------|------------------|---------------------|----------------|
| Civic participation                       |                       |                  |                     |                |
| No participation                          | Reference             |                  |                     |                |
| ≥1 participation                          | 0.136***              | 0.120 to 0.152   | 0.130***            | 0.110 to 0.149 |
| Social cohesion                           |                       |                  |                     |                |
| No social cohesion                        | Reference             |                  |                     |                |
| ≥1 social cohesion                        | 0.089***              | 0.066 to 0.112   | 0.050***            | 0.024 to 0.076 |
| Reciprocity                               |                       |                  |                     |                |
| No reciprocity                            | Reference             |                  |                     |                |
| ≥1 reciprocity                            | 0.457***              | 0.372 to 0.542   | 0.339***            | 0.236 to 0.442 |

| Community-level social capital variables | Unadjusted coefficient | Unadjusted 95% CI | Adjusted coefficient | Adjusted 95% CI |
|------------------------------------------|-----------------------|------------------|---------------------|----------------|
| Civic participation                       |                       |                  |                     |                |
| Less than 1 SD difference                |                       |                  |                     |                |
| ≥1 SD                                    | 0.062***              | 0.033 to 0.091   | 0.034*              | 0.0002 to 0.068 |
| ≤−1 SD                                   | −0.082***             | −0.106 to −0.057 | −0.007              | −0.040 to 0.026 |
| Social cohesion                           |                       |                  |                     |                |
| Less than 1 SD difference                |                       |                  |                     |                |
| ≥1 SD                                    | 0.025*                | 0.00004 to 0.049 | −0.022              | −0.049 to 0.006 |
| ≤−1 SD                                   | 0.042**               | 0.017 to 0.067   | 0.001               | −0.029 to 0.031 |
| Reciprocity                               |                       |                  |                     |                |
| Less than 1 SD difference                |                       |                  |                     |                |
| ≥1 SD                                    | −0.041***             | −0.068 to −0.013 | −0.004              | −0.031 to 0.023 |
| ≤−1 SD                                   | −0.101***             | −0.101 to −0.710 | −0.008              | −0.043 to 0.027 |

The coefficients and 95% CIs were calculated in multivariate Poisson regression with random intercepts and adjusted with the MSAS (age group, sex, educational attainment, equivalised income, marital status, household structure and municipality) together with auxiliary variables (the longest jobs that have ever had and community dummy variable). The municipality and community dummy variables were included in the regression model as the random intercepts (municipality variable: level 3 and community variable: level 2). Unadjusted coefficient and 95% CIs were calculated in multivariate Poisson regression with a fixed intercept and no adjustment. We estimated the effect of social capital on the PPSV23 vaccination from each imputed dataset with combining the results by using Rubin's rules. The significant associations are shown in bold.

*P<0.05; **p<0.01; ***p<0.001.

MSAS, Minimal Sufficient Adjustment Sets; PPSV23, 23-Valent Pneumococcal polysaccharide Vaccination.
vaccination and only individual-level social capital among older adults.\textsuperscript{33, 34} Second, our result suggests that the individual- and community-level social capital may be one of intervenable factors which can ameliorate the inequality of the PPSV23 vaccination rates among a large population of community-dwelling older adults.

There are some limitations to our study. First, we only analysed the epidemiological association between social capital and PPSV23 vaccination among older adults; we did not determine causal pathways owing to cross-sectional nature of the data at the survey. Second, our findings cannot be generalised to people who had been certified as needed as the long-term care because the participants were limited to those who were physically and cognitively independent. Third, a recall bias may have occurred in the survey for the PPSV23 vaccination. The question asked participants the vaccination status in the last 5 years, which they might not have remembered the vaccination if they had got it several years before the survey. The impact of this potential bias is unknown. Forth, we could not analyse the associations between individual-, community-level, social capital and the PSSV23 vaccination among the community-dwelling older adults who information of the school district was missing because we did not perform the MI for the community-dummy variable (see statistical analysis in the ‘Methods’ section).

**CONCLUSION**

Individual- and community-level intervenable factors are necessary to improve the inequality of the PPSV23 vaccination among older adults. We assessed associations between individual-, community-level social capitals and the PSSV23 vaccination among community-dwelling older adults aged ≥65 years. Our results show that civic participation, social cohesion or reciprocity at the individual level was associated with the vaccination, and that the rich civic participation at community-level was associated with more vaccinations among older adults living in communities than those in communities with the standard or poor social capital. Our findings suggest that older adults with individual- or community-level social capitals receive more vaccinations than those without such social capitals. Therefore, fostering social capital is recommended as a policy to ameliorate the inequality of PPSV23 vaccination among older adults in Japanese municipalities.

**Author affiliations**

\begin{itemize}
  \item 1Division of International Health, Niigata University Graduate School of Medical and Dental Science, Niigata, Japan
  \item 2Department of Active Aging (donated by Tokamachi city, Niigata Japan), Niigata University Graduate School of Medical and Dental Sciences Biological Functions and Medical Control, Niigata, Japan
  \item 3Department of Social Preventive Medical Sciences, Center for Preventive Medical Sciences, Chiba University, Chiba, Japan
  \item 4Department of Gerontology and Evaluation Study, Center for Gerontology and Social Science, National Center for Geriatrics and Gerontology, Oshu, Aichi, Japan
\end{itemize}

**Acknowledgements**

We deeply appreciate all the participants of the survey. We thank the other members of the JAGES project for their constructive suggestions for this manuscript. This work was supported by the Japan Science and Technology Agency-Supported Programme on Open Innovation Platform with Enterprises, Research Institute and Academia (grant number JPMJOP1831; development issue number five). We would like to thank Editage (www.editage.com) for English language editing.

**Contributors**

KIS had the idea for the study, performed the statistical analysis and drafted the manuscript as the principal author. YS designed the questionnaires to ask respondents the PPSV23 vaccination status, participated in acquiring the data and in designing the study, helped to develop the idea of the study and critically revised the manuscript. KK is the principal investigator of the JAGES project, helped to develop the idea of the study, participated in acquiring the data and in designing the study, and critically revised the manuscript. All authors have read and approved the final manuscript.

**Funding**

This study used data from the Japan Gerontological Evaluation Study (JAGES). This study was supported by Grant-in-Aid for Scientific Research (15H01972, 15H04781, 15H05059, 15K03417, 15K03982, 15K16181, 15K17232, 15K18174, 15K19241, 15K21266, 15K0071, 15K16907, 16H05556, 16K09122, 16K09013, 18K02025, 18K02264, 18K01343, 18K01269, 18K01695, 18K01633, 18K17256, 18K17281, 16K19247, 16K19267, 16K21461, 16K21465, 16K00104, 17K04305, 17K04357, 17K04306, 25255052, 25313027, 26285138, 26460828, 26780328, 18H03018, 18H04071, 18H03047, 18H00953, 18H00955, 19K00057, 19H03915, 19H03915, 19H03860, 19K04785, 19K10641, 19K11657, 19K19818, 19K19455, 19K24060, 19K20099, 20H00557) from JSPS (Japan Society for the Promotion of Science); Health Labour Sciences Research Grants (H26-Chouju-Ippan-006, H27-Ninchisyou-Ippan-001 H28- Chouju-Ippan-002, H28-Ninchisyou-Ippan-002, H29-Chikyu-Ippan-Ippan-001, H30-Jynkindanido-Ippan-004, 18H04071, 19K1012, 19K2001) from the Ministry of Health, Labour and Welfare, Japan; the Research and Development Grants for Longevity Science from the Japan Agency for Medical Research and development (AMED) (JP17dk0110027, JP18dk0110027, JP18dk0110027, JP18dk01110002, JP18dk0110009, JP20dk0110034, JP20dk0110037, the Research Funding for Longevity Sciences from National Centre for Geriatrics and Gerontology (24-17, 24-23, 24-92, 30-30, 30-22, 20-19); Open Innovation Platform with Enterprises, Research Institute and Academia (OPERA, JPMJOP1831) from the Japan Science and Technology (JST); a grant from the Japan Foundation For Ageing And Health (J09KF00804), a grant from Innovative Research Programme on Suicide Countermeasures(1-4), a grant from Sasakawa Sports Foundation (N/A); a grant from Japan Health Promotion & Fitness Foundation (N/A); a grant from Chiba Foundation for Health Promotion & Disease Prevention (N/A); the 8020 Research Grant for fiscal 2019 from the 8020 Promotion Foundation (adopted number: 19-2-06), a grant from Nimi University (1915010), and grants from Meiji Yasuda Life Foundation for Health Promotion & Disease Prevention (N/A), the Japan Science and Technology (JST); a grant from Innovative Research Programme on Suicide Countermeasures(1-4), a grant from Sasakawa Sports Foundation (N/A); a grant from Japan Health Promotion & Fitness Foundation (N/A); a grant from Chiba Foundation for Health Promotion & Disease Prevention (N/A); the 8020 Research Grant for fiscal 2019 from the 8020 Promotion Foundation (adopted number: 19-2-06), a grant from Nimi University (1915010), and grants from Meiji Yasuda Life Foundation of Health and Welfare (N/A).

**Disclaimer**

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of the respective funding organisations.

**Competing interests** None declared.

**Patient consent for publication** Not required.

**Ethics approval** The ethics committee at Nihon Fukushi University approved the protocol and informed consent procedure for the present study (No. 10–05). This study conformed to the principles embodied in the Declaration of Helsinki.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** All data used are from the JAGES study and are not third-party data. All enquiries are to be addressed at the JAGES data management committee via e-mail: dataadmin.ml@jages.net. All JAGES datasets have ethical or legal restrictions for public deposition due to inclusion of sensitive information from the human participants. Following the regulation of local governments which cooperated on our survey, the JAGES data management committee has imposed the restrictions upon the data.

**Supplemental material** This content has been supplied by the author(s). It has not been vetted by BMJ Publishing Group Limited (BMJ) and may not have been peer-reviewed. Any opinions or recommendations discussed are solely those of the author(s) and are not endorsed by BMJ. BMJ disclaims all liability and responsibility arising from any reliance placed on the content. Where the content includes any translated material, BMJ does not warrant the accuracy and reliability of the translations (including but not limited to local regulations, clinical guidelines, terminology, drug names and drug dosages), and is not responsible for any error and/or omissions arising from translation and adaptation or otherwise.

**Open access** This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is
Iwai-Saito, K., & et al. BMJ Open 2021;11:e043723. doi:10.1136/bmjopen-2020-043723

REFERENCES

1. GBD 2016 Lower Respiratory Infections Collaborators. Estimates of the global, regional, and national morbidity, mortality, and aetiology of lower respiratory infections in 195 countries, 1990-2016: a systematic analysis for the global burden of disease study 2016. Lancet Respir Med 2018;6:115-130.

2. Morimoto K, Suzuki M, Ishifuji T, et al. The burden and etiology of community-onset pneumonia in the aging Japanese population: a multicenter prospective study. PLoS One 2015;10:e012247.

3. Villa-Corcoles A, Ochoa-Gonzar O, Hospital I, et al. Protective effects of the 23-valent pneumococcal polysaccharide vaccine in the elderly population: the EVAN-65 study. Clin Infect Dis 2006;43:860-8.

4. Bonten MJM, Huijs SM, Bolkenbaas M, et al. Polysaccharide conjugate vaccine against pneumococcal pneumonia in adults. N Engl J Med 2010;362:114-25.

5. McDermott-Marx C, Tak C, Peltigara T, et al. Impact of a guideline-based best practice alert on pneumococcal vaccination rates in adults in a primary care setting. BMC Health Serv Res 2019;19:474.

6. Chen C-H, Wu M-S, Wu I-C. Vaccination coverage and associated factors for receipt of the 23-valent pneumococcal polysaccharide vaccine in Taiwan: a nation-wide community-based study. Medicine 2018;97:e9773.

7. Ho HJ, Tan Y-R, Cook AR, et al. Increasing influenza and pneumococcal vaccination uptake in seniors using point-of-care informational interventions in primary care in Singapore: a pragmatic, cluster-randomized crossover trial. Am J Public Health 2019;109:1776-83.

8. Jain A, van Hoek AJ, Boccia D, et al. Lower vaccine uptake amongst older individuals living alone: a systematic review and meta-analysis of the determinants of vaccine uptake. Vaccine 2020;38:5607-17.

9. Ang LW, Cutter J, James L, et al. Epidemiological characteristics associated with uptake of pneumococcal vaccine among older adults living in the community in Singapore: results from the National health surveillance survey 2013. Scand J Public Health 2018;46:175-81.

10. Murakami Y, Kanazu S, Petigara T, et al. Factors associated with PPSV23 vaccine coverage rates among older adults in Japan: a nationwide community-based survey. BMJ Open 2019;9:e030197.

11. Fau-Oukbo HS, Fau-Hoshi YM, Kondo MS-L. Demand for pneumococcal vaccination under subsidy program for the elderly in Japan. 2012(1472-9683)(Electronic).

12. Wu LA, Kanitz E, Crumly J, et al. Adult immunization policies in Japan: A longitudinal cohort study. Vaccine 2017;35:2315-26.

13. Wat J, Shu V, Hohmeier KC, et al. Pneumococcal vaccination in older adults: an initial analysis of social determinants of health and vaccine uptake. Vaccine 2020;38:5607-17.

14. Kang H, Shu V, Hohmeier KC, et al. Pneumococcal vaccination in older adults: an initial analysis of social determinants of health and vaccine uptake. Vaccine 2020;38:5607-17.

15. Kondo N, Kondo M, Aida J, et al. Community social capital and the onset of functional disability among older adults in Japan: a multilevel longitudinal study using Japan Gerontological evaluation study data. BMJ Open 2019;9:e029279.

16. Fujihara S, Tsujii T, Miyaguchi Y, et al. Does community-level social capital predict decline in instrumental activities of daily living? A JAGES prospective cohort study. Int J Environ Res Public Health 2019;16:828.

17. Arimia Y, Saito J, Saito M, et al. Social capital and the improvement in functional ability among older people in Japan: a multilevel survival analysis using JAGES data. Int J Environ Res Public Health 2019;16:1310.

18. Koyama S, Aida J, Saito M, et al. Community social capital and tooth loss in Japanese older people: a longitudinal cohort study. BMJ Open 2016;6:e010768.

19. Yamaguchi M, Inoue Y, Shinozaki T, et al. Community social capital and depressive symptoms among older people in Japan: a multilevel longitudinal study. J Epidemiol 2019;29:363-9.

20. Ministry of health. I., w., Japan, comprehensive survey of living conditions, 2017. Available: https://www.mhlw.go.jp/toukei/saikin/hw/kotosya/k-kotosya1217/02.pdf.

21. Royston P, White I. Multiple Imputation by Chained Equations (MICE): Implementation in Stata. J Stat Softw 2011;45:1-20.

22. Van Buuren S, Oudshoorn K. Flexible multivariate imputation by MICE. TNO: Leiden, 1999.

23. Rubin DB. The calculation of posterior distributions by data augmentation: Comment: A noniterative sampling/importance resampling alternative to the data augmentation algorithm for creating a few imputations when fractions of missing information are modest: the Sir algorithm. J Am Stat Assoc 1987;82:543-6.

24. Chung Y-C, Huang Y-L, Tseng K-C, et al. Social capital and health-promotive behavior intentions in an influenza pandemic. PLoS One 2015;10:e0122970.

25. Chiatti C, Barbadoro P, Lamara G, et al. Influenza vaccine uptake among community-dwelling Italian elderly: results from a large cross-sectional study. BMC Public Health 2011;11:207.

26. Saikia P, T, S., T., Nagamine Y, et al. Socio-Economic status and dementia onset among older Japanese: a 6-year prospective cohort study from the Japan Gerontological evaluation study. Int J Geriatr Psychiatry 2019;34:1642-50.

27. Pasgaard AA, Mæhlisen MH, Overgaard C, et al. Social capital and frequent attenders in general practice: a register-based cohort study. BMC Public Health 2019;19:310.

28. La EM, Tranlham T, Kurosky SK, et al. An analysis of factors associated with influenza, pneumococcal, Tdap, and herpes zoster vaccine uptake in the US adult population and corresponding inter-state variability. Hum Vaccin Immunother 2018;14:430-41.

29. Torres A, Blasi F, Dantas N, et al. Which individuals are at increased risk of pneumococcal disease and why? Impact of COPD, asthma, smoking, diabetes, and/or chronic heart disease on community-acquired pneumonia and invasive pneumococcal disease. Thorax 2015;70:984-9.

30. Yamamoto T, Kondo K, Aida J, et al. Association between the longest job and oral health: Japan Gerontological evaluation study project cross-sectional study. BMC Oral Health 2014;14:7.

31. Ichida Y, Kondo K, Hirai H, et al. Social capital, income inequality and self-rated health in Chita Peninsula, Japan: a multilevel analysis of older people in 25 communities. Soc Sci Med 2006;62:489-99.

32. Joung IM, Stronks K, van de Mheen H, et al. Health behaviours explain part of the differences in self reported health associated with partner/marital status in the Netherlands. J Epidemiol Community Health 1995;49:482-8.