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Exploring Health Information Sharing Behavior Among Chinese Older Adults: A Social Support Perspective

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ABSTRACT
This study investigated the determinants of health information sharing behaviors of Chinese older adults living in rural areas. Drawing upon a widely used categorization of social support, we tested the effect of social embeddedness and perceived social support on health information sharing behavior, which is conceptualized as a type of enacted social support—informational support. Data were collected between June and August 2014 from 387 older Chinese adults aged 60–79 years in Linxi County of northern China. The results of hierarchical ordinary least squares regression analyses revealed that Chinese older adults’ perceived social support from families and social embeddedness were positively associated with health information sharing behavior, net of the influence of social demographic controls and health information seeking and scanning behaviors. Furthermore, health information sharing behavior was also found to be positively associated with health information seeking and scanning behaviors. Overall, this study enriched the existing literature on health information sharing behavior by taking a social support perspective. A number of practical implications were also discussed.

Introduction
An essential component of health information exchange is health information sharing behavior, which has emerged as a promising research area in health communication. Despite the proliferation of research on health information seeking behavior (HISB), health information sharing behavior remains under-researched. In recent years, health communication scholars and practitioners have recognized the importance of using the Internet to disseminate health information to older adults and increasing their access to online health information (Flynn, Smith, & Freese, 2006; Morrell, 2001). However, health information exchange among older adults occurring in interpersonal context has been largely overlooked in health communication research.

Communication is a life-span phenomenon (Nussbaum, Pecchioni, Robinson, & Thompson, 2000). It is important to recognize the uniqueness of older adults’ communication behaviors. Compared to other age groups, older adults confront age-related communication barriers such as memory difficulties and cognitive decline, which influence their communication competence (Sparks & Nussbaum, 2008). Recent scholars on computer-mediated communication (CMC) have turned their attention to improving the effectiveness of communication among older adults (Brathwaite, Waldron, & Finn, 1999; Lin, Neafsey, & Strickler, 2009; Weatherall, 2000). Though information on Internet could benefit older adults in a variety of ways, older adults in developing countries such as China are still left behind by new information technologies. In China, only 15.6% older adults are Internet users (CNNIC, 2017), compared with 51% in the United States (Pew Research Center, 2018). With declining communication skills, older adults are particularly in need of a supportive and stimulating interpersonal environment (Ryan & Butler, 1996). Little research have been conducted to examine the complex aspects of interpersonal relationships, such as giving and receiving social support, among older adults (Wright, 2000).

Health information sharing behavior as provision of informational social support
This study employs the theoretical perspective of social support to explore the social and behavioral determinants of health information sharing behavior of Chinese older adults, who are aged 60 or older. Social support has been one of the most frequently studied psychosocial concepts in the area of health communication (Thoits, 1995). As contended by Albrecht and Goldsmith (2003), supportive communication is “a necessary condition for the quality of life and for healthful living” (p. 263). In the present research, we adopt Barrera’s (1986) conceptualization of social support as a meta-construct, which has three dimensions: social embeddedness, perceived social support, and enacted social support (Barrera, 1986). Building on Barrera’s (1986) work, in this study we conceptualize health information sharing behavior as a type of enacted support—informational support. Previous work on social support exchange highlights the reciprocal nature of social support: when people perceive there are abundant social support available to them, they tend to give back (Gleason, Iida, Shrout, & Bolger, 2008). In addition, the size and quality of one’s social network also determine the extent to which one can provide...
informational support to others. Drawing upon a review of social support literature, we explore whether and how social embeddedness and perceived social support may be related to health information sharing behavior.

Information is flowing around all the time, between person and person, media and audience, organization and individual. The dynamics of information transmission involves a recursive interaction between information provider and information receiver. In a social information environment, individuals on the receiving end of information transmission often send information out. Notably, information-receiving not only encompasses passive information exposure, but also purposeful or nonpurposeful information acquisition. Individuals differ in terms of the amount of information they received and possess varying levels of health knowledge, hence different abilities to distribute health information to others. Those people who acquired more information may be more likely to share information as they possess more information. This study is designed to assess the role of passive and active information acquisition, which are represented by health information scanning and health information seeking, in predicting health information sharing behavior.

**The context of the current research**

The current study is situated in the context of China, which has a rapidly aging population. By the end of 2014, the aging population (individuals aged 60 and over) in China reached 212 million, accounting for 15.5% of the total population in China (Aging Population, 2015). Of the total aging population, more than half live in rural areas (Zimmer & Kwong, 2004). The rising out-of-pocket medical costs significantly impede Chinese older adults’ access to healthcare and create vast health disparities between urban and rural areas (Flaherty et al., 2007). This study focuses specifically on a population living in rural China, many of whom were underserved by the healthcare system. For older adults who live in rural areas, information social networks and lay experts may be particularly important when there is difficulty in accessing healthcare services (Wathen & Harris, 2006). Since health information could have positive effect on individuals’ health (e.g., increasing health knowledge, raising the awareness of health issues, prompting behavioral change) (Cotten & Gupta, 2004; Ransom, Jacobsen, Schmidt, & Andrykowski, 2005), health information exchange through interpersonal communication is a viable healthcare activity for Chinese older adults to improve health, especially for those who live in rural areas. To our knowledge, there has been no empirical study yet specifically on the health information behaviors of older adults in rural China. Understanding their health information behaviors from a social support perspective will add valuable insights to existing research.

**Health information sharing behavior as enacted social support**

Social support is conceptualized by Shumaker and Brownell (1984) as “an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the wellbeing of the recipient” (p. 13). In the 1980s, scholars started to recognize social support as a multi-faceted construct (Barrera, 1986; Wethington & Kessler, 1986). According to Barrera (1986), social support includes three dimensions: social embeddedness, perceived social support, and enacted social support. Social embeddedness, which represents the structural aspect of social support, expresses both quantity and quality of interpersonal relationships, including both direct (e.g., families) and indirect (e.g., friend’s friend) linkages (Streeter & Franklin, 1992). Perceived social support, also called subjective social support, refers to one’s subjective perception of how much support is available within one’s social network. Enacted social support, defined as the actions that people perform to help others (Barrera, 1986), is often represented in the form of behavioral assistance, such as money transfer, informational exchange, the provision of guidance and feedback, services, and lay referrals (Shumaker & Brownell, 1984).

Social support is essentially a communication behavior (Albrecht & Adelman, 1987; Goldberg & Cullen, 1985). As such, social support consists in a transactional, symbolic process that involves two or more individuals exerting influences on each other’s affective, cognitive, or behavioral states (Albrecht & Adelman, 1987). In this study, we define health information sharing behavior as the purposive transmission of health information to others. We regard it as a type of supportive communication intended to benefit others, and to build or consolidate desirable social relationships. As such, health information sharing can be perceived as the behavioral content of a form of enacted support (House, 1987). Compared to other types of health information behaviors such as seeking and scanning, which are primarily for self-benefit, health information sharing behavior incorporates more social and altruistic elements. From the perspective of social support, health information sharing is an act of distributing informational resources within one’s social networks. While existing studies have mostly focused on health information seeking behavior of older adults (Czaja, Sharit, Hernandez, Nair, & Loewenstein, 2010; Gollop, 1997; Manafo & Wong, 2012; Tennant et al., 2015), this study takes on the question of what factors underlie the health information sharing behaviors among older adults in China.

**Health information seeking, scanning, and sharing**

Information has to be obtained by individuals before being distributed to others. Health information sharing presumes prior information acquisition. Existing research has differentiated two types of information acquisition behaviors (Niederdeppe et al., 2007; Shim, Kelly, & Hornik, 2006), health information seeking which represents active information acquisition, and health information scanning which means passive information encounter. Individuals may actively search information about a particular health concern, but they also acquire health information merely via minimal attention to information they are exposed to in myriad ways (Ruppel, 2016). The health knowledge repertoire built by health information seeking and/or scanning is a prerequisite for health information sharing behavior.
Information seeking behavior not only serves informative purposes but also social purposes (O’Brien, Freund, & Westman, 2014). The information acquired from information seeking activities is a necessary resource to foster social interactions and maintain social relationships. Therefore, individuals’ information sharing and seeking behavior should correlate if information is the object of the activity and it validates their social status (Clarke, 1973). There is a paucity of literature on the relationship between health information seeking and sharing. One study found that information seeking behavior and social motivation were positively associated with information sharing behavior about climate change (Yang, Kahlor, & Griffin, 2014).

Information scanning refers to the information acquisition mode that happens less purposefully (Niederdeppe et al., 2007). Health information scanning has been shown to predict subsequent health behaviors, such as cancer screening behaviors and preventative behaviors (Hornik et al., 2013; Shim et al., 2006), but whether and how it may be related to health information sharing is less clear. In current research, we include both active and passive information acquisition in our model to explore the behavioral predictors of health information sharing. Based on the prior research, we will examine the following hypothesis and research question:

H1: Health information seeking is positively related to health information sharing behavior among Chinese older adults.

RQ1: Is health information scanning related to health information sharing among Chinese older adults?

The reciprocal nature of social support exchange

As mentioned earlier, the process of giving and receiving support is guided by the norm of reciprocity (Berkman & Glass, 2000). Both social exchanges theories and equity theory offer explanations for the social support exchange processes. According to social exchange theories, the exchange of social and mental resources serves as a fundamental form of interaction (Blau, 1964; Emerson, 1962). Central to social exchange theories is the concept of reciprocity. Individuals who receive favor or help from others are supposed to reciprocate sufficiently based on moral norms. It is considered as socially inappropriate not to provide social support reciprocally once an individual receives social support from others.

Equity theory offers another theoretical foundation for social support exchange. Equity theory focuses on how to maintain a balanced relationship for long-term relationship survival (Hayes, 2013). The underlying assumption of equity theory is that individuals have a sense of reciprocity when they receive support or help from others. Researchers have provided evidence for the effect of reciprocity on information sharing. For instance, Oh (2012) found that reciprocity was an important motivation for people to share health information in Yahoo! Answers, which a social Q&A site.

The flow of social support in one’s social network also manifests the norm of reciprocity. Prior research has demonstrated a positive relationship between received social support and the provision of social support (Gleason et al., 2008). Furthermore, the cognitive evaluation of the availability of social support is also shown to be associated with enacted support (Lakey et al., 2002; Melrose, 2015; Swickert, Rosentretter, Hittner, & Mushrush, 2002). A meta-analysis of 23 studies has revealed that perceived social support is positively associated with received social support (Haber, Cohen, Lucas, & Baltes, 2007).

In a collectivist culture such as China, the norm of reciprocity may be particularly important to social relationships (Buchan, Croson, & Dawes, 2002). People in a collectivist culture perceive individual action as an important contribution to their group well-being (Earley, 1989). Provision of informational support in such a context could serve the purpose of keeping a harmonious social environment. In an organizational setting, people from Taiwan (a collectivist culture), compared to those from Australia (an individualistic culture), reported a stronger sense of collective responsibility to share information for the good of the company (Chow, Harrison, McKinnon, & Wu, 1999). Kim, Kreps, and Shin (2015) demonstrated that strong social support from family members and friends had a positive impact on disseminating health information among Korean Americans. Taken together, these findings suggest that the norm of reciprocity does have a strong influence on information sharing in a collectivist culture. In this study, we propose that perceived social support is positively associated with informational support, which is represented by health information sharing behavior in the context of this study. Specifically, we propose the following hypothesis.

H3: Perceived social support is positively related to health information sharing behavior among Chinese older adults.

Prior studies showed that various dimensions of social embeddedness, including network size, quality of relationship, and density, were associated with information sharing behavior. Social network research has suggested that social embeddedness could influence information sharing via trust (Reagans & McEvily, 2003; Uzzi, 1996; Uzzi & Lancaster, 2003). Greater trust as fostered by social embeddedness could facilitate the exchange of information and invite the agent who received the social support to reciprocate (Uzzi, 1996). One study found that the extentiveness of social networks among organizational members was positively associated with knowledge sharing (Chow & Chan, 2008). Based on previous research, we postulate the following hypothesis:

H4: Social embeddedness is positively related to health information sharing behavior among Chinese older adults.

Method

Data and sample

The data employed in this study were collected between by the authors June and August 2014 by face-to-face interviews as part of the 2014 Filial Piety and Health Survey (2014 FPHS)
with a sample of 432 older adults in Linxi County, a traditionally agricultural county located in the Inner Mongolia Autonomous Region of northern China. Older residents (aged 60 years and older) account for 16.29% of Linxi Country’s total population of 240,906 as of 2013. The sample was drawn from 7 community centers serving 45 neighborhoods of the two subdistricts (the equivalent of a township) of the county seat and a town.

Although we employed a convenience sampling method to reach participants, the 2014 FPHS sample is roughly comparable to the China National 2010 Census in terms of the sex and education composition. For example, for Chinese aged 60 to 79 living in townships, 50.54% were female and 17.12% had no formal education. In the 2014 FPHS sample, 55.32% were female and 20.83% had no formal education.

Descriptive statistics for the participants and the main variables are shown in Table 1. The mean age of the participants is 66.24 (SD = 4.99), with 44.7% being male and 55.3% being female. The household income of most participants (91%) was below or equal to ¥ 60,000 (approximately $9,090). Specifically, about 27.8% had incomes less than ¥10,000, 32.2% between ¥10,001 and ¥30,000, and 31.0% more than ¥60,000.

### Table 1. Descriptive Statistics of variables analyzed (N = 387).

<table>
<thead>
<tr>
<th>Variables</th>
<th>Range</th>
<th>M (SD)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age in years</td>
<td>60–79</td>
<td>66.24(4.99)</td>
<td>55.3</td>
</tr>
<tr>
<td>Female (vs. male)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than ¥10,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¥10,001–¥30,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>¥3,0001–¥60,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than ¥60,000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information seeking</td>
<td>1–5</td>
<td>1.79(0.72)</td>
<td></td>
</tr>
<tr>
<td>Information scanning</td>
<td>1–5</td>
<td>1.99(1.08)</td>
<td></td>
</tr>
<tr>
<td>Social embeddedness</td>
<td>1–9</td>
<td>4.77(2.24)</td>
<td></td>
</tr>
<tr>
<td>Perceived social support from friends</td>
<td>1.75–7</td>
<td>4.94(1.39)</td>
<td></td>
</tr>
<tr>
<td>Perceived social support from families</td>
<td>2–7</td>
<td>5.74(0.67)</td>
<td></td>
</tr>
<tr>
<td>Information Sharing</td>
<td>1–5</td>
<td>2.94(1.08)</td>
<td></td>
</tr>
</tbody>
</table>

Multi-item measures were first subject to exploratory factor analysis (EFA). For the scales reported below, apart from perceived social support having two subscales, EFAs showed a one-factor structure for all the other scales, and then we proceeded to calculate scale reliability and create the scales by combining the items.

**Health information sharing behavior** was measured by two items. Respondents were asked, “When you see some good health tips or advice on TV, online, or on the newspaper, how often do you share them with others?” and “When you see some useful health information that is particular relevant to certain people you know (such as friends, family, colleagues, neighbors, etc.), how often do you pass it on to these people?” (1 = never, 5 = very often). Eisinga, Grotenhuis, and Pelzer (2013) suggested that the most appropriate reliability for a two-item scale is the Spearman-Brown coefficient that together with standardized coefficient alpha. The two items were averaged (α = .93, Rpb = .93, M = 2.94, SD = 1.08).

**Health information scanning behavior** was measured by the five items used in Shim et al. (2006) study. Respondents were asked how much attention they pay to information about health or medical topics on the following media: television, radio, newspaper, magazine, or the Internet, respectively (1 = not at all, 5 = a lot). Responses were summed to create the health information scanning index (α = .75, M = 1.99, SD = 1.08).

**Health information seeking behavior** was assessed by a four-item scale, ranging from 1 (never) to 5 (very often). Respondents were asked to estimate how often they seek health information “for yourself,” “for others you know,” “when you want to make sure you understand certain things well,” and “to double check whether certain information is right or wrong.” The current scale was developed based on previous health information seeking scales (e.g., Health Information National Trends Survey, 2013; Cotten & Gupta, 2004) (α = .96, M = 1.79, SD = .72).

**Social embeddedness** was measured using a six-item scale specifically created for the current study. The previous social embeddedness scale was created in the context of Western
culture (Kaniasty, Norms, & Murrell, 1990) and thus not suited for the current study. The social embeddedness scale developed for this study encompassed both the size and the quality of one’s social network based on prior research (Streeter & Franklin, 1992). Sample items include “Looking back over the last 12 months, how many friends and siblings do you see or hear from at least once a month?” “Suppose you were in a financial strain and you had to borrow some money for emergency, how many friends and siblings do you have to ask to borrow you some money?” and “Looking back over the last 12 months, how many friends and siblings do you have with whom you feel close to such that you could call on them for help when in need?” Respondents were asked to estimate the number of persons who they can rely on for the aforementioned questions, from 0 (none) to 8 (more than seven). An additive index of these items was created (α = .91, M = 4.77, SD = 2.24).

Perceived social support from family and friends was measured by a 12-item multidimensional scale developed by Zimet, Dahlem, Zimet, and Farley (1988). The result of exploratory factor analysis (EFA) reveals that the scale has two dimensions: perceived social support from families and friend social support from friends. The Cronbach’s alpha coefficient indicated that the two subscales were internally consistent: friend support (α = .89, M = 4.94, SD = 1.39) and family support (α = .87, M = 5.74, SD = .67). Two sample items include in the family and friend support subscale are “My family really tried to help me” and “I have friends with whom I can share my joys and sorrows.” Responses range from 1 (strongly disagree) to 7 (strongly agree).

### Analysis

Hierarchical ordinary least squares (OLS) regression analysis was employed to examine the proposed hypotheses and research questions. Demographic variables, including age in years, gender, level of education, and annual household income, were entered as the first block. Two health information acquisition variables, including health information seeking behavior and health information scanning behavior were then added. Perceived social support from friends, perceived social support from families, and social embeddedness were added as the final block. Data were analyzed using SPSS 22.

### Results

Table 2 shows the results of the OLS regression analysis. We did not detect any multicollinearity or normality problems in the regression models. The Variance Inflation Factor (VIF) value of all dependent variables entered in the regression model were smaller than 2, showing no evidence of multicollinearity. Q-Q plot was employed to test normality of residuals. The points in the residual plot were randomly dispersed on the horizontal axis. From the final model, it can be seen that health information seeking was positively related to health information sharing behavior (β = .37, p < .001), supporting H1. In response to RQ1, health information scanning was significantly associated with health information sharing (β = .16, p < .01). Taken together, respondents who frequently engaged in health information seeking or scanning activities were more likely to share health information with others. Overall, health information seeking and scanning accounted for 25% of the variance in health information sharing behavior.

<table>
<thead>
<tr>
<th>Variable</th>
<th>Model 1</th>
<th>Model 2</th>
<th>Model 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income</td>
<td>.16</td>
<td>.02</td>
<td>.01</td>
</tr>
<tr>
<td>Information behaviors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Information seeking</td>
<td>.36</td>
<td>.16</td>
<td>.37</td>
</tr>
<tr>
<td>Information scanning</td>
<td>.19</td>
<td>.08</td>
<td>.02</td>
</tr>
<tr>
<td>Social support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perceived social support from friends</td>
<td>-.02</td>
<td>-.08**</td>
<td>-.23**</td>
</tr>
<tr>
<td>Perceived social support from families</td>
<td>.15</td>
<td>.08**</td>
<td>.05</td>
</tr>
<tr>
<td>Social embeddedness</td>
<td>.23</td>
<td>.02</td>
<td>.03</td>
</tr>
<tr>
<td>Model R value</td>
<td>6.87***</td>
<td>27.14***</td>
<td>20.58***</td>
</tr>
<tr>
<td>R squared</td>
<td>.04</td>
<td>.25</td>
<td>.28</td>
</tr>
</tbody>
</table>

Note: Standard errors in parentheses.

*p < .05 **p < .01 ***p < .001

### Discussion

The health information sharing behaviors of older adults has not received much attention from health communication scholars. This study, designed to fill that gap, examined what factors were related to older adults’ health information sharing behavior using a sample of 387 Chinese people aged 60 to 79. Our data showed that older adults in China, a group of people most in need of health information, also played the role of disseminating health information to certain extent. Specifically, using a social support perspective, our study focused on how two types of social support (perceived support from families and friends and social embeddedness) and information acquisition behaviors (information seeking and scanning) were related to health information sharing.
behavior. Our findings revealed that social embeddedness and perceived social support from families were positively associated with health information sharing behavior. Health information scanning and health information seeking were both positively associated with health information sharing behavior.

This study contributes to the current literature by identifying the social and behavioral determinants of health information sharing behaviors of Chinese older adults. Drawing on the insights from social support research, this study conceptualizes health information sharing behavior as a type of enacted social support. We found that the higher level of perceived social support from families, the more likely older adults were willing to share health information to others. However, the perceived social support from friends was not significantly associated with health information sharing. It is likely that for older adults in China, the reciprocal relationships between family members are stronger than the relationships between friends when it comes to providing health information. The results of the present study are consistent with previous research: Information sharing behavior is driven by social motivations (Bakshy, Rosenn, Marlow, & Adamic, 2012; Chu & Kim, 2011). In rural China where older adults have lower access to health services, the provision of informational support serves as an important way of maintaining and consolidating social relationships among older adults. The findings of this study echo the previous research, which suggested that Chinese older adults were under strong pressure to provide more social support, particularly instrumental support, to people in their social networks (Liu, Liang, & Gu, 1995). This study also expands the understanding of health information sharing behavior from a cultural perspective. It demonstrates that social motivation could be an important factor that influence information transmission in collectivist culture, which is characterized by obligatory reciprocity (Ting-Toomey, 1986). The positive influence of social embeddedness on health information sharing indicated that older adults in rural China who had more people that they can emotionally and physically rely on were more likely to provide health information other people in their social networks.

Our study also demonstrated that health information scanning and health information seeking, respectively, accounted for a substantial amount of variance of health information sharing behavior. Results suggest that those older adults who frequently engage in health information scanning and seeking activities should be more knowledgeable about health issues and thus have a health information repertoire that enables them to share information. This study also echoes the call of the emerging research to make conceptual distinction between health information scanning and seeking behavior (Shim et al., 2006). We found that the passive, repeated health information acquisition makes a unique contribution in predicting health information sharing behavior. These findings provide new insights on the social functions of health information scanning and seeking behavior.

There are a number of practical implications of this study. First, it is important to improve the social connectedness of older adults. Expanding older adults’ social network not only could enhance their subjective well-beings (Cornwell & Waite, 2009; Pinquart & Sörensen, 2000), but also increases their likelihood to provide informational support to others in their social networks. Compared to health information received from mass media, health information transmitted in social networks is advantageous to older adults since “social relations make information credible and interpretable, imbuing it with qualities and value beyond what is at hand” (Uzzi, 1996, p. 678). In particular, public health professionals should make an effort to identify socially isolated older adults, especially those who do not have children. Health interventions can be strategically designed to improve their social connectedness and foster social cohesion through activities such as organizing community-based social activity programs (e.g., hiking, dancing). On the other hand, as the findings showed that the participants with more social connections shared more health information, therefore it is reasonable to expect that their information dissemination ability is stronger. We highlight the importance of identifying influencers or so-called “opinion leaders” who have large social networks. Such older adults are conveyors of health messages and can transmit information from their communities back to the agencies that implement health programs (Valente & Pumpuang, 2007). Health professionals should improve influencers’ access to high-quality health information and their communication skills.

The findings of this study expand the literature on rural older adults’ health information behaviors by using a sample of Chinese rural older adults, a majority of whom are underserved by the current healthcare system. Given that older adults in rural China are economically and psychologically disadvantaged at using new technologies, health practitioners should consider health information exchange through interpersonal communication as a viable way to promote their health and wellness. Compared to their urban counterparts, rural Chinese older adults were found to be less likely to use structured forms of healthcare, such as visits to doctor’s offices and clinics (He, Sengupta, Zhang, & Guo., 2007). Previous research revealed that facilitating social support exchange had positive effects on older adults’ well-being in the context of rural China (Liu et al., 1995; Yip et al., 2007). Health communication interventions that encourage older adults to undertake the role of providing health information to their peers could serve as a good strategy for health prevention and promotion for Chinese rural elderly. The results of this study underscore the importance of incorporating health information sharing behavior into the broader practices of building social support networks for Chinese older adults.

Another key implication drawn from our findings is that health information seeking and sharing forms the social dynamics of information transmission among Chinese older adults. Providing health information that can be easily accessible, comprehensible, and actionable to Chinese older adults not only increases their self-care ability, but also can potentially encourage them to share health information more actively. Dissemination of such quality information should be a collaborative effort that engages older adults, people in their social networks, public health professionals, and society.
This study has a few limitations. Although our sample is quite similar to Chinese aged 60 to 79 living in townships in terms of sex and education composition revealed in the 2010 Census, as mentioned previously, the findings of this study are not generalizable. Future research using national representative sample is needed to test whether our findings would be replicated for the purpose of generalizability. Moreover, it should be pointed out that the mean scores of health information scanning and health information seeking were both below midpoint of the scales, suggesting that a large number of participants in this sample did not scan or seek health information frequently. Therefore, our findings may not be able to generalize to those who did not scan or seek health information at all. Since our main research interest is to explore the social determinants of health information sharing behavior, the findings still add valuable contribution to the understanding of health information sharing behavior. Furthermore, the distinction between online and offline health information sharing behavior was not made in this study. Prospective studies may examine how health information sharing behaviors of older adults vary in different communication channels. We also did not distinguish between reactive information sharing, which is information transmission in response to someone’s request, and proactive information sharing, which is active information transmission without someone’s requests (Liang, 2015). Our measure of health information sharing behavior is more concerned with proactive information sharing, whereas reactive information sharing has been largely overlooked.

A number of important issues may be addressed in future studies. First of all, future research may investigate the behavioral outcomes of health information sharing behavior, such as medical decision-making and preventive behaviors. Apart from the positive outcomes, future studies might also examine the negative outcomes of health information sharing. For example, in some circumstances, informational support such as advice may be perceived as being intrusive or offensive (Goldsmith & Fitch, 1997). Moreover, to better understand the determinants of health information sharing behavior, it would be insightful to add mediating and moderating variables in the analysis. For instance, health literacy may moderate the relationship between health information seeking and health information sharing. Lastly, because the sociocultural context could influence how social support is related to specific behaviors (Brashers, Goldsmith, & Hsieh, 2002), future research may compare how social support influence health information sharing behavior between older adults in collectivist culture and individualistic culture.

In conclusion, this study offers a theoretical contribution to the literature of health information sharing behavior by incorporating a social support perspective. Practically, this study highlights the important role of older adults in disseminating health information and the potential of using health information exchange as a viable way for self-care of Chinese older adults who have difficulties in accessing healthcare facilities. Overall, this research extends the scope of health information sharing behavior research and paves the way for future research in this area.

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**References**


