



Social capital, income inequality and the social gradient in self-rated health in Latin America: A fixed effects analysis



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ABSTRACT

Latin America is the most unequal region in the world. The current sustainable development agenda increased attention to health inequity and its determinants in the region. Our aim is to investigate the social gradient in health in Latin America and assess the effects of social capital and income inequality on it. We used cross-sectional data from the World Values Survey and the World Bank. Our sample included 10,426 respondents in eight Latin American countries. Self-rated health was used as the outcome. Education level was the socioeconomic position indicator. We measured social capital by associational membership, civic participation, generalized trust, and neighborhood trust indicators at both individual and country levels. Income inequality was operationalized using the Gini index at country-level. We employed fixed effects logistic regressions and cross-level interactions to assess the impact of social capital and income inequality on the health gradient, controlling for country heterogeneity. Education level was independently associated with self-rated health, representing a clear social gradient in health, favoring individuals in higher socioeconomic positions. Generalized and neighborhood trust at country-level moderated the effect on the association between socioeconomic position and health, yet favoring individuals in lower socioeconomic positions, especially in lower inequality countries, despite their lower individual social capital. Our findings suggest that collective rather than individual social capital can impact the social gradient in health in Latin America, explaining health inequalities.

1. Introduction

Socioeconomic inequality in Latin American countries (LAC) is the highest in the world (UNDP, 2010), and recently with the post-2015 sustainable development agenda, addressing health inequity in LAC has become a greater concern (Becerra-Posada, 2015). The Pan American Health Organization (PAHO) advocates health equity as essential to the sustainable development in the region and recommends universal access to health and universal health coverage along with health-in-all approach to tackle the issue (PAHO, 2014a, b). Additionally, in May 2016, PAHO launched a high-level commission on health inequity in the Americas, focusing on gathering evidence in the region aiming to propose targeted recommendations to address the problem (PAHO, 2016).

Despite improvements to the overall health in LAC in the past 30 years, resulting in a marked increase in life expectancy and a decline in child mortality, the unfair distribution of health between and within countries remained (Barreto et al., 2012; PAHO, 2012), independent of the indicator used to assess the social gradient: e.g., income (Belon

et al., 2012; Restrepo-Mendez et al., 2015), education (Belon et al., 2012; Haebeler et al., 2015; Hertel-Fernandez et al., 2007), or ethnicity/skin color (Chiavegatto et al., 2014; Lima-Costa et al., 2015; Perreira and Telles, 2014). The analyses of several socioeconomic position (SEP) indicators reflects multiple mechanisms implicated in the power distribution and in the social stratification in the region, which are further influenced by broader contextual health determinants, such as social capital and income inequality.

In the past two decades LAC experienced steep economic growth, declining income inequality, and growing social investments (Tsounta & Osueke, 2014), yet little is known about the impact this development has had on the social gradient in health and the social capital's role. Additionally, the investigation of which sociodemographic groups are mostly affected by income inequality and social capital could assist in clarifying the mechanisms behind the social gradient in health (Subramanian and Kawachi, 2004).

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1.1. Aims

The overall aim of this study is to investigate the moderating effects of social capital and income inequality on the social gradient in self-rated health in LAC. Specific aims are: to verify the association between socioeconomic disparities and self-rated health, controlling for the country-level heterogeneity, and to address to what extent social capital (both individual and collective) and income inequality modifies this association.

1.2. Theoretical framework

In recent decades, social capital has often been debated when addressing health disparities within and between populations (Kawachi et al., 2008a). Here, we conceptualize social capital as both individual and collective assets (Kawachi et al., 2008a). This view accounts for differences in processes on each level and suggests that individuals can benefit from their own social capital as well as societies can profit from the collective surplus generated by the coordinated actions of its individuals.

According to Rostila's (2013) resource-based approach—which builds on several social capital theories (e.g., Bourdieu (1986); Coleman (1988); Portes (1998); Putnam (2000); Putnam et al. (1993); Szreter and Woolcock (2004)), social capital is generated in trustful and reciprocal social relations that result in social resources, for individuals and for societies. The sources of both individual and collective social capital are the same, but the resources generated and the mechanisms to health differ depending on them being individual or collective (Eriksson, 2010; Rostila, 2013). At individual-level those resources could be informational, emotional, instrumental or appraisal supports (Berkman and Glass, 2000). At collective-level (i.e. country-level in our paper), resources are non-exclusive and targeted to achieve a common goal (Putnam et al., 1993), and it could lead to instrumental returns, e.g. better government performance, or expressive returns, e.g. social inclusion (Rostila, 2013).

Social capital—at both individual and collective—is further differentiated as structural or cognitive. Structural social capital refers to the basis and composition of and the participation in networks and institutions, while cognitive social capital refers to perceptions of norms, values, and attitudes such as trust and reciprocity (Harpham et al., 2002; Krishna and Shrader, 2000). While Putnam (2000) and Putnam et al. (1993) conceptualized social capital based on the strong and positive association between structural and cognitive factors, others found no correlation (Lindström, 2004). It is argued that structural and cognitive dimensions have their own independent pathways to health (Giordano and Lindstrom, 2010; Rostila, 2013), through for instance social support (Berkman and Glass, 2000) and psychosocial mechanisms (Marmot, 2006; Wilkinson and Pickett, 2009), respectively.

In general, both collective and individual social capitals are consistently associated with better health outcomes in high-income countries (Kawachi et al., 2008b). Studies about social capital and health in LAC are relatively scarce (Pattussi et al., 2006), yet higher social capital seems to relate with better health outcomes in the region (Hurtado et al., 2011; Kripper and Sapag, 2009; Pattussi et al., 2016; Sapag and Kawachi, 2010). The question is if social capital benefits individuals equally within a society and also between societies.

A possible hypothesis is that SEP affects social capital's effects on health (Uphoff et al., 2013). Considering the SEP effects on health as a result of the “status syndrome”, in which the relative disadvantages and social comparisons generate long-term stress (Marmot, 2006; Wilkinson and Pickett, 2009), social capital could for instance help individuals to mitigate that stress, through different social resources (Uphoff et al., 2013; Wilkinson and Marmot, 2003). Some studies suggested this buffering effect of social capital on the social gradient in health (Gorman and Sivaganesan, 2007; Uphoff et al., 2013), while most of the evidence supported a dependency relationship between economic, cultural and

social capitals, i.e. individuals in higher SEP have higher individual social capital (Ahnquist et al., 2012; Bourdieu, 1986; Uphoff et al., 2013). Furthermore, in high collective social capital settings, lower individual social capital was found to be even more deleterious to health than in less affluent settings (Campos-Matos et al., 2016; Uphoff et al., 2013).

Social capital effects on health are also assumed to be dependent of the income inequality levels (Islam et al., 2006; Kawachi et al., 2008b; Szreter and Woolcock, 2004). A systematic review suggested that social capital have a greater impact on health where inequality is higher (Islam et al., 2006), where the provision of safety nets is lower and the social capital relevance possibly greater (Kawachi et al., 2008b). Several mechanisms have been proposed to explain the association between income inequality and health: (i) based on neo-materialistic interpretations in which the societal provision of and individual access to material resources explains the association (Lynch, 2000); (ii) through the stress of social comparisons of a severe “status syndrome” in a society marked by pronounced social stratification (Marmot, 2006; Wilkinson and Pickett, 2009) and; (iii) by eroding social capital, leading to social exclusion, social isolation and hostility (Kawachi et al., 1997; Wilkinson, 1996). Although these mechanisms are proposed as independent and incompatible, according to Szreter and Woolcock (2004) social capital bridge these arguments, integrating state and civil society; neo-materialistic and psychosocial interpretations.

2. Methods

2.1. Study population

We used cross-sectional data from publicly available sources, i.e. from the World Values Survey (WVS)—wave 6 (2010–2014)—and from the World Bank world development indicators database. WVS conducted population surveys, in a stratified probabilistic sample of adults (18 + years), including rural and urban areas, using a common domiciliary face-to-face questionnaire, in the countries' native language. Individual data weights were applied aiming at better representative samples of the adult population in each country, and sampling and survey procedures were consistent among countries included in the study (WVS, 2016).

The WVS collected data in the following countries in LAC between 2010 and 2014: Argentina, Brazil, Chile, Colombia, Ecuador, Mexico, Peru and Uruguay. We removed respondents if they had missing data on the outcome ($n = 14$). Our sample, thus, included 10,426 respondents in 8 countries.

2.2. Measures

The outcome variable, self-rated health (SRH) was measured using the WVS question “All in all, how would you describe your state of health these days?” which had 4 possible answers: poor, fair, good or very good. We dichotomized the variable into “poor” (poor or fair) and “good” (good or very good), in accordance with previous studies (Kawachi et al., 2008b). The outcome of interest is good SRH. SRH is a validated measure of objective health, consistently associated with overall mortality and morbidity (DeSalvo et al., 2006; Theme et al., 2008).

We used education as a SEP indicator, as it reflects long-term influences of early life circumstances and also adulthood resources, for instance income and employment (Galobardes et al., 2006). Education level was categorized as lower (up to incomplete secondary school), middle (complete secondary school) and higher (higher education, incomplete and complete).

Social capital was measured at individual and collective levels. We selected 43 questions from the WVS that we judged relevant to the social capital concept based on the literature and according to the structural and cognitive social capital constructs (see Table 1). We

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