



A life-cycle approach to the analysis of the relationship between social capital and health in Britain

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ABSTRACT

I examine to what extent social capital can promote individual well-being in the form of good physical and mental health. Our analysis is based on multiple waves of data from the National Child Development Survey and the British Cohort Study, two large cohort studies following the lives of children who were born in Britain in one particular week in 1958 and 1970. I use waves that are comparable across the surveys in childhood and adulthood to explore the association between aspects of social capital and several measures of health when adopting a life-cycle approach. The findings suggest that individuals with high levels of social capital generally fare better than individuals with lower levels of social capital and that such associations are robust to the inclusion of controls such as physical and mental health in childhood and circumstances of the family of origin.

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Introduction

In *Bowling Alone*, Robert Putnam famously stated that social capital is as important as smoking as a cause of ill health and therefore individuals can enjoy similar health improvements by quitting smoking, exercising regularly or joining groups and associations: “if you smoke and belong to no groups, it’s a toss up statistically whether you should stop smoking or start joining” (Putnam, 2000, p 331).

A large body of research backs Putnam’s claim on the association between social capital and health. Individuals with high levels of social capital have lower mortality rates and are less likely to suffer from cardiovascular disease and stroke than similar individuals with low levels of social capital (see Kawachi, Subramanian, & Kim, 2008 for an extensive review of the literature). New evidence is also emerging on the positive association between social capital and both mental health (Almedom, 2005; De Silva, McKenzie, Harpham, & Huttly, 2005; Henderson & Whiteford, 2003; Kawachi & Berkman, 2001; McKenzie, Whiteley, & Weich, 2002) and happiness levels (Borgonovi, 2008).

Policy-makers are becoming increasingly interested in research claiming that social capital enables individuals to improve their

well-being because it represents the possibility of promoting positive outcomes cheaply and effectively without the need of traditional public service delivery. For example, the review chaired by Michael Marmot *Fair Society, Healthy Lives* that was commissioned by the British Department of Health to gather evidence on the determinants of health inequalities in England, recommended the promotion of social capital as a policy that would help reduce disparities and promote health and well-being (Marmot, 2010). Critics, however, point out that it is still unclear whether observed associations are causal and to what extent government action can successfully foster social capital directly. Moreover, promoting health by diverting scarce resources from the provision of services to the promotion of social capital may exacerbate social inequalities in health and result in a culture that blames individuals for their own illnesses and diseases (Lynch, Davey Smith, Kaplan, & House, 2000; McKinlay, 1993; Szreter & Woolcock, 2004).

Apart from rare exceptions, most of the existing evidence on the role of social capital in promoting health in Britain is based on cross-sectional data. This means that such evidence only describes associations rather than the effect of social capital on health because it does not take into account important issues such as unobserved individual heterogeneity and reverse causality (Henderson & Whiteford, 2003; Szreter & Woolcock, 2004). Cross-sectional studies based on data from the United Kingdom generally estimate significant correlations between different indicators of individual level social capital and health status (see for example Poortinga,

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2006). Findings based on longitudinal data however find no relationship, or only a weak relationship, between changes in levels of social capital and health developments (Pevalin & Rose, 2002). Such differences suggest that cross-sectional estimates of the social capital-health link might be biased.

Because data that could allow us to fully account for potential biases in estimates of the relationship between individual social capital and health such as natural or randomised experiments (see the Moving to Opportunity as an example of a suitable data source in the United States) are not available, we focus our analysis of the association between social capital and health in Britain on a particular source of bias: the potential heterogeneity stemming from differences across individuals in childhood experiences. We hypothesise that such differences could shape both individual propensities to have high levels of social capital and to be in good physical, emotional and mental health. In our study we adopt a life-cycle approach and examine the association between childhood experiences such as health status and family and social environment, social capital and health indicators and assess whether the relationship between social capital and health is robust to the inclusion of detailed controls for circumstances in various stages of childhood.

Evidence indicates that several risk factors for poor health are rooted in people's experiences in the early years and that individuals exposed to severe adversity during their early years are at an increased risk of developing negative outcomes later in life (Burgess, Propper, & Rigg, 2004; Davey Smith, Hart, Blane, Gillis, Hawthorne, 1997; Duncan & Brooks-Gunn, 1997; Lynch, Kaplan, Shema, 1997). A life course approach to the study of health recognises the importance of circumstances in all stages of life, but also that the timing of events and the accumulation of risk factors over time and in different domains may be crucial in establishing whether exposure to risk will translate into poor outcomes (Ben-Shlomo & Kuh, 2002; Lynch & Davey Smith, 2005). Moreover, even though early events significantly influence health outcomes in adulthood, positive experiences over the life course can offset the negative effects of exposure to risk factors (Yaquub, 2002).

Social capital and health

Social capital may benefit individuals in several distinct ways. First, it may increase the diffusion of information on behaviours that improve health and promote the adoption of healthy lifestyles. Second, it may provide opportunities for psychosocial support, which reduces stress and improves health (Kawachi & Berkman, 2001). Finally, in the presence of social capital, individuals may be more likely to organise to fight budget cuts and request more and better resources for their communities (Kawachi & Berkman, 2000).

We examine various indicators of individual level social capital to capture the different pathways through which different forms of social capital could potentially influence health (Kawachi & Berkman, 2000; McKenzie, 2006). The literature distinguishes two main forms of social capital: horizontal social capital and vertical, or linking, social capital. Horizontal social capital results from ties that exist among individuals or groups of equals, while vertical social capital stems from relations between individuals with different power, resources and social positions. Horizontal social capital, in the form of participation in formal social networks and levels of interpersonal trust, may influence health status by decreasing transaction costs and increasing access to material resources and to health related information (Stephens, Rimal, & Flora, 2004; Viswanath, Randolph Steele, & Finnegan, 2006). Moreover horizontal social capital provides sources of social support by establishing networks individuals can rely on in case of need and by so doing may foster individual well-being (Berkman & Glass, 2000; Seeman, 1996). Vertical social capital on the other

hand may affect people's health primarily because it allows for the effective mobilisation of political institutions and will (Szreter & Woolcock, 2004), but also because it expresses people's sense of mutual responsibility and support (Coleman, 1990; Putnam, 1993) and their trust in institutions (Szreter & Woolcock, 2004).

In line with the WHO definition of health as a state of complete physical, mental and social well-being, we take a holistic approach and examine indicators of physical, psychological and emotional health. We also include indicators to characterise behaviours that have a significant impact on individuals' health and that represent major challenges for policy-makers such as alcohol abuse and obesity.

Data and methods

Sample

Our analyses are based on data from the National Child Development Survey (NCDS) and the 1970 British Cohort Study (BCS). These ongoing surveys contain information on all individuals who were born in Britain in one specific week in 1958 (NCDS) and in 1970 (BCS), with initial sample sizes of approximately 17,500 individuals each. Cohort members were surveyed shortly after birth, as young-sters, teenagers, young adults and adults. We use data from waves that are comparable across the two surveys including birth (NCDS₁₉₅₈ and BCS₁₉₇₀), young childhood (age 7 NCDS₁₉₆₅ and age 5 BCS₁₉₇₅), late childhood (age 11 NCDS₁₉₆₉ and age 10 BCS₁₉₈₀), age 33/34 (NCDS₁₉₉₁ and BCS₂₀₀₄) and age 46 for NCDS (NCDS₂₀₀₄). Childhood waves are based on interviews with cohort members' parents, teachers and doctors to assess the background and environment where children grew up. Adulthood waves are based on interviews with cohort members, cohort members' spouses and children and cover a wide range of outcomes and life circumstances. In 2004, the NCDS study contains fewer indicators of social capital than in 2000 and was conducted using phone interviews instead of face-to-face interviews as NCDS₁₉₉₁ and BCS₂₀₀₄ and therefore presents problems of comparability with previous waves and lower quality data.

We exploit significant overlaps between the two cohort studies to develop a set of common indicators. A description of variables used in the study can be found in Tables 1, 2 and 3.

Health measures

We recode self-reported health status to obtain a dichotomous indicator taking value 0 when cohort members report good or very good health and 1 when their health is fair or poor. Self-reported health is an important predictor of mortality (Idler & Benyamini, 1997) and of the onset of disability and stress levels (Farmer & Ferraro, 1997) and has high levels of validity and consistency (Franks, Gold, & Fiscella, 2003; Van Doorslaer & Gerdtham, 2003). We construct a variable that takes value 1 if cohort members report suffering from any limiting and long-standing illness and value 0 if they do not.

We use two indicators of unhealthy behaviours: obesity and alcohol abuse. Obesity represents an important risk factor for chronic diseases such as stroke, heart disease, diabetes and some forms of cancer (World Health Organization, 2002). Individuals who abuse alcoholic drinks are at a higher risk of suffering from cancer, liver cirrhosis, lung disease, cardiovascular problems, mental and behavioural disorders, and from experiencing injuries and accidents (see Huerta & Borgonovi, 2010 for a review).

We use information on cohort members' weight and height to calculate the body mass index (BMI) and categorise cohort members with a BMI over 30 as obese. Following Britain's Department of Health recommendations on sensible alcohol consumption, we

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