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Original Research

Comparing levels of social capital in three northern post-industrial UK cities

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ABSTRACT

Objectives: A high level of 'excess' mortality (i.e. that seemingly not explained by deprivation) has been shown for Scotland compared to England & Wales and, in particular, for its largest city, Glasgow, compared to the similarly deprived postindustrial English cities of Liverpool and Manchester. The excess has been observed across all social classes, but, for premature mortality, has been shown to be highest in comparison of those of lowest socioeconomic status (SES). Many theories have been proposed to explain this phenomenon. One such suggestion relates to potential differences in social capital between the cities, given the previously evidenced links between social capital and mortality. The aim of this study was to ascertain whether any aspects of social capital differed between the cities and whether, therefore, this might be a plausible explanation for some of the excess mortality observed in Glasgow.

Study design: Cross-sectional study.

Methods: A representative survey of Glasgow, Liverpool and Manchester was undertaken in 2011. Social capital was measured using an expanded version of the Office for National Statistics (ONS) core 'Social Capital Harmonised Question Set'. Differences between the cities in five sets of social capital topics (views about the local area, civic participation, social networks and support, social participation, and reciprocity and trust) were explored by means of a series of multivariate regression models, while controlling for differences in the characteristics (age, gender, SES, ethnicity etc.) of the samples.

Results: Some, but not all, aspects of social capital were lower among the Glasgow sample compared to those in Liverpool and Manchester. A number of these differences were greatest among those of higher, rather than lower, SES. Levels of social participation, trust and (some measures of) reciprocity were lower in Glasgow, particularly in comparison with Liverpool. However, assessment of any potential impact of these differences is limited by the cross-sectional nature of the data.

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Conclusions: The analyses suggest it is at least possible that differences in some aspects of social capital could play some part in explaining Glasgow's excess mortality, especially among particular sections of its population (e.g. those of higher SES). However, in the absence of more detailed longitudinal data, this remains speculative.

Introduction

Despite the well-established and profound links between poverty and poor health, a considerable amount of recent research has shown high levels of 'excess' mortality (i.e. higher mortality seemingly not explained by differences in socio-economic deprivation) in Scotland compared to England & Wales,[1–4] and, in particular, in its largest city, Glasgow, compared to the similar postindustrial English cities of Liverpool and Manchester. Research published in 2010 showed the deprivation profiles of these three cities to be virtually identical: yet despite this, premature mortality in Glasgow was 30% higher than in the English cities, with deaths at all ages around 15% higher.[5,6] This excess was seen among both males and females, in all adult age groups, and in comparisons of both deprived and non-deprived areas. For deaths at all ages the excess was similar across all neighbourhood types; however, for premature deaths it was shown to be greater in comparisons of more, rather than less, deprived areas, potentially suggesting differences in the underlying causes of the excess between sub-sections of the population.[5]

A considerable number of theories have been proposed to explain Glasgow's excess mortality compared to the English cities.[7,8] One such suggestion is that levels of social capital may be lower in the Scottish city.

The theory of social capital is complex. It entails different dimensions (e.g. structural, cognitive[9–12]) and types (e.g. bonding, bridging[13]), and it has been defined in many different ways and by many different commentators,[13–16] albeit that most definitions overlap to large degrees. Perhaps the most frequently used definition is that of Putnam,[13,17] who defines it as the 'features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit'. Although by no means exempt from criticism particularly relating to: how it is measured;[18–22] whether it is an individual or collective (e.g. of a community) attribute;[9,14,23,24] and its potential negative effects (e.g. negative aspects of bonding capital such as criminal gang activity among disenfranchised groups[13] or negative peer effects for risky health behaviours among the young,[25] or exclusion of outsiders from closely controlled social networks[14]), there is, however, a considerable amount of convincing evidence of the beneficial impact of social capital on health. For example, significant associations between higher social capital and lower mortality have been shown in the USA,[26–29] postcommunist Eastern Europe,[30–33] Finland,[34] Australia,[35] and Latin America and the Caribbean,[36] and a recent review concluded that 'both individual social capital and area/workplace social capital had positive effects on health outcomes, regardless of study design, setting, follow-up period, or type of health outcome'.[37]

A number of different mechanisms have been suggested as means by which social capital may impact on population health. Some commentators have argued that at the city or state level (as opposed to the neighbourhood level), greater social capital impacts on health via political processes: it is argued that social participation (e.g. in voluntary groups, churches) nurtures skills that can lead to political engagement and activity, and greater political activity across the social gradient results in political decisions more beneficial for the least advantaged members of society:[26,38–41] 'who participates in politics matters for political outcomes, and in turn the resulting policies have an important influence on the opportunities available to the poor to lead a healthy life'.[26] Other suggested mechanisms include: social and psychological support processes (i.e. greater social support in times of need, and 'psychosocial processes … providing affective support and acting as [a] source of self-esteem and mutual respect'); more positive health behaviours (influenced both by informal social control [preventing damaging behaviours such as alcohol and drug abuse], and by an increased likelihood of healthy behaviours such as physical activity being adopted); and provision of access to services and amenities (i.e. as more socially cohesive communities can safeguard relevant services under threat through effective local action).[42]

With regard to social participation in particular, volunteering has been shown to be independently associated with better health outcomes: a recent systematic review suggested better outcomes related to depression, life satisfaction, and well-being, with some links to lower all-cause mortality.[43]

Although lower social capital has been deemed a possible contributory explanation for Glasgow's excess mortality compared to the English cities,[7,8] comparable data have not previously been available to enable this to be assessed. This paper aims to describe the patterning of social capital across the three cities to inform public health efforts to understand the excess mortality in Glasgow.

Methods

Population survey

A population survey of Glasgow, Liverpool and Manchester was carried out in 2011. Full details of survey design and implementation are available elsewhere.[44,45] Briefly, a stratified clustered random probability sample design was employed, from which face-to-face household interviews