



Does social capital determine health? Empirical evidence from MENA countries



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ABSTRACT

Using data from the World Value Survey (2010–2012) for 18 MENA countries, this paper investigates the causal relationship between social capital and health by applying simultaneous-equations based on structural modeling and IVs regression. Our main findings corroborate the hypothesis of reverse causality between social capital and health i.e. bidirectional causality running from social capital to health and from health to social capital is identified. Furthermore, our empirical findings show that individual-level social capital appears more salient in determining health, while community-level social capital seems less relevant in explaining health differences between individuals. Overall, the present study makes evident that high levels of social capital (i.e. high levels of social participation and high levels of trust) and high individual-level socioeconomic factors (i.e. high levels of income and high levels of education) may generate better health outcomes that policymakers must take into account to improve individual and community health.

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1. Introduction

Over the few last decades, the concept of ‘social capital’ has attracted widespread attention in the public health literature and a growing number of researchers have used this concept to explain individual and community health (e.g., Buonanno, Montolio, & Vanin, 2009; D’Hombres, Rocco, Suhrcke, & McKee, 2010; Folland, 2007; Kawachi & Berkman, 2000; Kawachi, Subramanian, & Kim, 2008; Kim, Baum, Ganz, Subramanian, & Kawachi, 2011; Mellor & Milyo, 2005; Poortinga, 2006a, 2006b; Rocco, Fumagalli, & Suhrcke, 2014; Veenstra, 2005). However, the concept of ‘social capital’ has been analyzed for the first time by Pierre Bourdieu since 1980s to refer to one of the types of resources available to individuals and social groups. According to Bourdieu, social capital is defined as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance or recognition” (Bourdieu, 1986, p. 248).

The concept of ‘social capital’ is further developed and disseminated in the diverse disciplines including health by the Putnam’s work. In broad terms, Putnam defined social capital as the “features of social organization, such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit” (Putnam, 1995, p. 67).

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The literature on social capital provides evidence on the significant role play by social capital, as it contributes mostly to better health outcomes and is generally considered to be the utmost noteworthy factor in determining individual health behavior. It would appear that social environments characterized by high-levels of trust and civic participation tend to produce more individuals with a minimum of public responsibility to each other (Kawachi & Berkman, 2000; Portes, 1998). Such sets of connections appear to be significant factors of social capital through which individual's health may be improved (D'Hombres et al., 2010; Folland, 2007; Kawachi et al., 2008; Poortinga, 2006b). However, as we have observed from the different empirical studies that each concept of social capital may have a specific effect on health outcomes.

In contrast, certain studies based on cross-country investigation have shown that social capital could generate negative consequences (e.g. Kawachi & Berkman, 2000; Kennelly, O'Shea, & Gavey, 2003; Lochner, Kawachi, Brennan, & Buka, 2003; Muntaner, Lynch, & Davey Smith, 2001; Poortinga, 2006b). Such studies make it evident that social capital does not explain health differences between people. It has also found that social capital cannot always generate better health outcomes. In the same direction, Kawachi and Berkman (2000) and Durlauf (2002) suggest that the benefits that social capital produces for one group can disadvantage another. Poortinga (2006b) also suggest that social capital does not consistently benefit individuals who are living in the same society. Similarly, Muntaner et al. (2001), Lindström, Moghaddassi, Bolin, Lindgren, and Merlo (2003) and Brown, Scheffler, Seo, and Reed (2006) have shown that strong associations among individuals would likely lead to increase the risk of certain health outcomes. For instance, strong friendship networks of peers lead to increase the risks of smoking and drinking and further produce higher risk of violent crime and homicide. These findings can be partly explained by the fact that social capital is a contextual variable and that aggregated data can cause some local specifications, that is why the individual track to aggregate social capital may be difficult to identify (Glaeser, Laibson, & Sacerdote, 2002).

Moreover, many multilevel studies have investigated the effect of individual and area-level social capital on health by using 'aggregated' social capital measures (individual level responses). It has shown that there is evidence of the positive impact of multilevel measures of social capital on individual health outcomes. It has also found that social capital impact was more underestimated when multilevel effect is not taken into account (Kawachi, Kennedy, & Glass, 1999; Mohan, Twigg, Barnard, & Jones, 2005; Olsen & Dahl, 2007; Snelgrove, Pikhart, & Stafford, 2009; Subramanian, Kim, & Kawachi, 2002; Sundquist & Yang, 2007; Veenstra, 2005).

The literature reveals that though research on the relationship between social capital and health outcomes using different set of countries, data and estimation techniques are voluminous. However, the association between social capital and health in the context of the Middle East and North Africa (MENA) region is yet not well empirically investigated. Therefore, the main purpose of this study is to investigate empirically this association in MENA region using simultaneous-equation models and instrumental variables (IVs) regression. Specifically, we have raised the question whether the association between social capital and health can reflect reverse causality or there are other factors (i.e. individual factors, social environments characteristics) that are also expected to affect social capital and health.

The paper is organized as follows. Section 2 presents the relevant review of literature on the association between social capital and health. Section 3 discusses the data and the econometric methodology. Section 4 presents the results and discussion. Section 5 concludes by summarizing the main results.

2. Literature review

The relationship between individual and area-level social capital and population health has been the subject of considerable academic research over the past few decades (e.g. Buonananno et al., 2009; D'Hombres et al., 2010; Engström, Mattsson, Järleborg, & Hallqvist, 2008; Folland, 2007; Hamano et al., 2010; Kawachi & Berkman, 2000; Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Kawachi et al., 2008; Kennedy, Kawachi, & Brained, 1998; Kim et al., 2011; Lochner et al., 2003; Mellor & Milyo, 2005; Pollack & von dem Knesebeck, 2004; Poortinga, 2006a, 2006b, 2006c; Richard & Nicolas, 2008; Rocco et al., 2014; Sampson, Raudenbush, & Earls, 1997; Subramanian et al., 2002; Veenstra, 2005; Wilkinson, Kawachi, & Kennedy, 1998). The empirical studies have used different set of countries, data and estimation techniques to investigate the effects of individual and contextual/area-level social capital on population health.

However, to investigating the effects of social capital on mortality in 39 US states, Kawachi et al. (1997) have used four 'aggregated' social capital measures (i.e. social distrust, perceived lack of fairness, perceived helpfulness of others and memberships in groups-taking each one separately). They found that each of the measures was positively associated with mortality and income inequality. Moreover, Sampson et al. (1997) have used a cross-sectional multilevel study based on data from the 1995 Project on Human Development in Chicago Neighborhoods. They used an index of collective efficacy (including mutual trust and social cohesion both at individual and contextual level) as a proxy of social capital, and violent crime and homicide rates as measures of health. They reported that collective efficacy was negatively associated with neighborhood variations in violent crime and homicide rates.

In Russia, Kennedy et al. (1998) have used a cross-sectional data for 40 provinces to test the impact of social capital on mortality rates. The aggregated level social capital measures used are trust in government, civic engagement and social cohesion (i.e. divorce rate, per capita crime rate, conflicts in workplace). These findings suggest that, over the period of the Russian mortality crisis, social capital and cohesion indicators were closely associated with lower mortality rates. Another cross-sectional study was done by Wilkinson et al. (1998) by using the US General Social Surveys (1986–1990) and National Center for Health Statistics (1981–1991) for 39 US states, where social capital was measured by social mistrust and health

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