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The role of personal social networks on health inequalities across European regions

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A B S T R A C T

The role of personal social networks on health inequalities is little understood. Theoretically, the characteristics of social network features can contribute to, both, increase and attenuate health inequalities. Few empirical studies that focus on the interaction between socioeconomic position and social networks provide little insight on the topic. Using data from the Survey of Health, Ageing and Retirement in Europe, this study analyses the moderation role of personal social networks on health inequalities in later life among northern, central, and southern European regions. Social advantages of higher socioeconomic individuals are re-enforced by the quality of social connections and the provision of social support. In turn, health inequality is attenuated by marital partnership and participation on social activities that benefits more the health of people at lower socioeconomic positions. Furthermore, results suggest that the influence of social network features on health inequalities is shaped by regions' different policy commitments to familiarization/defamilialization pressures.

1. Background

1.1. Social networks and health inequalities: theoretical pathways

For many years, researchers have been collecting evidence that social ties influence personal health. Personal social networks can influence what we do, how we feel, or the help we can get to cope with life events which have direct and indirect implications for our health and wellbeing (Berkman et al., 2000; Thoits, 2011). Some authors state that these associations are even more relevant among the aged population (Waite and Das, 2010).

Social networks can also influence health inequalities. DiMaggio and Garip (2012) reviewed the literature on how social networks contribute to social inequality. According to the authors, the influence of personal social networks on inequality is particularly important when people make decisions. In this line of reasoning health inequalities are affected by social learning, normative influences, or networks' contingent resources (networks externalities) that tend to promote healthier behaviours especially for individuals in higher socioeconomic positions. Freese and Lutfey (2011), in turn, pointed out how social networks can increase health disparities irrespective of the agency of individuals ("spill over effects"), by affecting differential access to healthier contexts (neighbours, work places), the embodiment of social structures in individual subjectivities (habitus concept), or the differential benefits that social groups derive from institutions that tend to privilege higher socioeconomic groups. The interaction between different kinds of resources related to socioeconomic position is aligned with predictions of the Theory of Cumulative Advantage/Disadvantage. This theory frames the multidimensionality of social inequality in a life-course perspective. Accordingly, people of higher socioeconomic positions are expected to have advantages in multiple social domains throughout their lifetime. Advantages in socioeconomic resources therefore accumulate with advantages related to closer, bigger, and more diverse social networks (Dannefer, 2003).

Bourdieu's understanding of social distinction can also contribute to this topic. In his theory, different interactions of multiple capitals (economic, social, and cultural) are fundamental in the reproduction of social inequality. Social advantage in different fields depends on the activation and interaction of all those types of capital and therefore higher socioeconomic positions tend to convey social advantages across fields or social settings (Bourdieu, 1984; Abel, 2008).

The notion of social capital introduced by Bourdieu grew out from sociology, and then spread to a wider disciplinary domain. This field offers theoretical and empirical arguments that can be connected to the understanding of how social networks contribute to health inequalities. Social networks refer as a specific type of capital –"bonding social capital" – related our peers (e.g. Villalonga-Olives and Kawachi, 2015).

Social capital has been connected to health through different links including: (1) the provision of social and material support; (2) the dissemination of health-enhancing social norms and information; (3) the pressure to control deviant health behaviours; or the (4) efficacy in collective bargaining or other collective strategies to ensure access to

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local services and amenities (Kawachi and Berkman, 2000). Under this perspective social networks influence health throughout resources and power known to be unevenly distributed across social strata. Therefore health inequalities can be reinforced by the differentials in social capital in the personal networks of higher and lower socioeconomic people, neighbourhoods and communities.

In addition, personal social networks have been identified as important dimensions for building resilience to social disadvantage for individuals and communities (e.g. Hildon et al., 2008, Poortinga, 2012). Social networks can plausibly contribute to buffer the negative effects associated with social disadvantage in health and, therefore, contribute to attenuate the differences in health between higher and lower socioeconomic groups. The beneficial effects of social networks on health may be particularly relevant for lower class individuals due to a higher level of exposure to stressful events (Matthews et al., 2010; Uphoff et al., 2013). Social networks can provide connections to more resourceful social groups or contexts positively influencing the health chances of lower socioeconomic individuals (DiMaggio and Garip, 2012).

The role of personal social networks in health inequality has received little attention in scientific literature (Uphoff et al., 2013; Islam et al., 2006). Only a few studies focus on the interaction effects between socioeconomic positions and health and it is difficult to draw general conclusions within the empirical evidence collected, given the lack of uniformity in operationalizing key variables and the somewhat mixed findings. For example, some researchers identified a negative accumulated effect of economic hardship and low social integration on different health indicators suggesting that lower socioeconomic individuals benefit less from social integration (Sun et al., 2009; Ahnquist et al., 2012); yet other studies suggest that social integration can be more relevant for less advantaged social groups, such as the unemployed (Gorman and Sivaganesan, 2007). Gorman and Sivaganesan (2007) conclude that family contacts have a more positive influence on the health of individuals with higher levels of education. Similarly, Sun et al. (2009) found that reciprocity and social support were associated with self-rated health only in the “non-poor” sample, suggesting family and social support exchanges contribute to enhance inequalities. Yet Geckova et al. (2003) found no socioeconomic differences in the influence of perceived social support on health and Huurre et al. (2007) identified the quality of parental relations as a protective factor for depression only for adults from lower socioeconomic backgrounds.

The association between individuals or communities of lower socioeconomic and lower levels social capital has been systematically reported, as well as its negative implications for health (e.g. Elgar et al., 2011). Researchers also have reported important contextual variations in the influence of social networks on health. Some research shows that geography and social policies shape how networks features affect exposure to health risks in very different domains. For example, having family members that smoke increases the risk of second hand smoke exposure more in settings with less restrictive (smoke) norms and policies than in more restrictive settings (e.g. Allem et al., 2015); syringe sharing risk among drug users is shown to be higher among large networks in some residential settings than in others (e.g. Boodram et al., 2015; German et al., 2007; Latkin et al., 2013). Findings also suggest that individual social capital indicators are more influential in settings (neighbourhoods, areas, states) with higher levels of contextual social capital (e.g. Poortinga, 2006; Deindl et al., 2015; Mansyur et al., 2008).

Despite these advances, the role of personal social networks in health inequalities is poorly understood. Concerning both theoretical and empirical research on the topic, studies should attend to: (i) different features of social network influence, since the associations between social networks and health occur via multiple pathways; and (ii) the implications of social context, since macro and micro contextual dimensions shape these associations. However very few studies consider these two dimensions of analysis. This study addresses this gap by assuming a multidimensional operationalization of social networks to account for positive and negative links between social connections and health (and health inequalities). These effects are studied among older adults and in respect to key features that define social networks in later life (Fiori et al., 2006). Additionally, a macro level of analysis is added by comparing results across settings in which social welfare policies ascribe different roles to personal social networks for individuals. The approach contributes to a better understanding of health inequalities and emphasizes the need to adopt contextual reasoning in developing policies to reduce health inequalities.

1.2. Social policy and the role of personal social networks on health inequalities

Socio-political contexts are important components of health inequality, having implications for the definition of social disadvantage and its influence on health. The welfare state regime defines the role of the state in sectors that greatly influence individuals’ health and wellbeing (such as education, health care, social policy) aggregating important macro-contextual features (Eikemo and Bambra, 2008; Olasfsdottir and Beckfield, 2010).

Welfare state regimes differ in the type and the degree of social protection provided, and in the sharing of responsibilities amongst the state, the market, and the family in ensuring population wellbeing. Esping-Andersen, (1990, 1999) identified distinct logics of the organization and stratification of nations, rooted in different historical traditions of political class coalitions. Based on these differences, the author proposed a typology of welfare state regimes that became undeniably influential in social sciences (Arts and Gelissen, 2002). Esping-Andersen, (1990, 1999) considered as defining criteria the states’ role in (i) decommodification (the degree of independence of individuals’ welfare to the labour market), (ii)social stratification, and (iii) in the sharing of responsibilities between the market and families at the provision of welfare services (social protection and social support). With this framework, the author identified three different clusters among Western countries: Liberal, Conservative, and Social Democratic. Esping-Andersen's seminal work introduced a fresh perspective in comparative research, and triggered a wide debate concerning the principles and the methods which should be used in welfare modelling (Arts and Gelissen, 2002). One of the most consistent criticisms of this Three Worlds’ typology concerns the misspecification of the role of the family and personal connections in the provision of welfare. This issue led to the addition of a fourth principle to the framework that considers the level of independence from familial relationships to achieving a reasonable standard of living – i.e. defamiliarization. In more familialistic regimes (lower defamiliarization) the family is the main entity responsible for the support and care of its members, and its role is endorsed by the state through social policy and social norms. In more defamiliarized regimes, in turn, the state promotes independence of individuals from their family caring roles, providing means or services to complement family care.

This added indicator underlines the importance of the type of support alongside the amount of support provided by the state (Bonoli, 1997). Several authors attend to compile and organize cross-country differences according to different arrangements in the availability of social services and different commitments to familiarization and defamilialization pressures (e.g. Ferrera, 1996; Anttonen and Sipilä, 1996; Leitner, 2003; Saraceno, 2008). Table 1 compiles a set of welfare state regime typologies to demonstrate the regional variability of social policies in Europe.

Cross national variation on how social benefits are delivered and organized was carefully considered in Ferrera's approach to welfare state regime types (Ferrera, 1996). The author takes into consideration the rules of access to social security systems, the conditions in the access to social benefits, the regulations of financing social protection, and the organization of different security schemes (Ferrera, 1996). By