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# Inequalities in social capital and health between people with and without disabilities

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ABSTRACT

The poor mental and physical health of people with disabilities has been well documented and there is evidence to suggest that inequalities in health between people with and without disabilities may be at least partly explained by the socioeconomic disadvantage (e.g. low education, unemployment) experienced by people with disabilities. Although there are fewer studies documenting inequalities in social capital, the evidence suggests that people with disabilities are also disadvantaged in this regard. We drew on Bourdieu's conceptualisation of social capital as the resources that flow to individuals from their membership of social networks. Using data from the General Social Survey 2010 of 15,028 adults living in private dwellings across non-remote areas of Australia, we measured social capital across three domains: informal networks (contact with family and friends); formal networks (group membership and contacts in influential organisations) and social support (financial, practical and emotional). We compared levels of social capital and self-rated health for people with and without disabilities and for people with different types of impairments (sensory and speech, physical, psychological and intellectual). Further, we assessed whether differences in levels of social capital contributed to inequalities in health between people with and without disabilities. We found that people with disabilities were worse off than people without disabilities in regard to informal and formal networks, social support and self-rated health status, and that inequalities were greatest for people with intellectual and psychological impairments. Differences in social capital did not explain the association between disability and health. These findings underscore the importance of developing social policies which promote the inclusion of people with disabilities, according to the varying needs of people with different impairments types. Given the changing policy environment, ongoing monitoring of the living circumstances of people with disabilities, including disaggregation of data by impairment type, is critical.

## 1. Background

Disabilities are broadly described as health conditions or impairments that impose restrictions in functioning in multiple life areas, resulting from an interaction between people's health conditions and environmental or contextual factors (World Health Organization, 2002). Nearly one in five Australians are living with a disability (ABS, 2013), a prevalence similar to other high income countries (World Health Organization, 2011). Across the Organisation for Economic Co-operation and Development (OECD), people with disabilities are more disadvantaged than people without disabilities including having lower levels of income, education and labour force participation (Organisation for Economic Co-operation and Development, 2009). The extent of this disadvantage varies between countries, with Australia faring poorly on a number of indicators. For example, adult Australians with disabilities earn on average 68% of the income of those without disabilities, which is the lowest relative income of the 27 countries in the OECD (Organisation for Economic Co-operation and Development, 2009).

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*Abbreviations:* ABS, Australian Bureau of Statistics; CURF, Confidentialised Unit Record File; DSP, Disability Support Pension; GSS, General Social Survey; OECD, Organisation for Economic Co-operation and Development.

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Recent analyses of Australian data have demonstrated large inequalities in levels of education, participation in paid work, and income between people with and without disabilities (Kavanagh et al., 2014) which have persisted or worsened over the last decade (Kavanagh et al., 2013). Australians with intellectual and psychological impairments are particularly vulnerable to disadvantage across a range of outcomes including education (Karmel and Nguyen, 2005), housing (Beer and Faulkner, 2008; Beer et al., 2011) and employment (Hogan et al., 2012; Jones et al., 2011; Kavanagh et al., 2014).

International research has shown that people with disabilities experience poorer health than people without disabilities (Organisation for Economic Co-operation and Development, 2009; World Health Organization and World Bank Group, 2011), including lower self-rated health (Emerson et al., 2011), higher rates of obesity (Ells et al., 2006) and diabetes (Havercamp et al., 2004), lower psychological health (Emerson et al., 2012), higher levels of smoking (Australian Institute of Health and Welfare, 2010; Jablensky et al., 1999) and poorer diet (Department of Health, 2011), and there is evidence to suggest that the poorer health of people with disabilities is at least partly explained by the disadvantaged circumstances in which they live, with the evidence strongest for children and adults with intellectual impairments (Emerson and Hatton, 2007; Emerson et al., 2012; Honey et al., 2011). It is possible that other social and economic resources that are important for health, such as social capital, may also explain health differences between people with and without disability.

There is substantial literature, across a range of populations, indicating that an individual's social resources (such as those derived through social relationships, networks and interactions, sometimes conceptualised as social capital) are beneficial for health (Berry and Welsh, 2010; Kawachi et al., 2008; Ziersch, 2005). The evidence base regarding whether social capital varies between people with and without disabilities is limited, particularly in relation to different impairment types. This paper aims to describe variations in social capital between people with and without disabilities and according to type of impairment (sensory and speech, physical, intellectual, and psychological). The extent to which variations in social capital explain inequalities in health is also examined.

In the remainder of the introduction to this paper we (1) describe how we conceptualise and operationalise social capital, (2) provide a brief overview of the evidence about the relationship between social capital and health, and (3) outline previous research relating to disability and social capital, with reference to the relationship between social capital and health for people with disabilities.

### 1.1. *Social capital*

We draw on the work of the French sociologist Bourdieu, who conceptualises social capital as the resources that flow to individuals from their membership of social networks (Bourdieu, 1986). Bourdieu argues that social capital is inequitably distributed by social class and inextricably linked to economic and other resources in a reinforcing cycle, such that social capital can further contribute to inequalities. The role of inequitable power relations in determining the type of resources available to individuals through their social networks is central to his theorising. Bourdieu's approach is particularly relevant here as people with disabilities are often marginalised and economically disadvantaged in society (Beer and Faulkner, 2008; Beer et al., 2011; Hogan et al., 2012; Jones et al., 2011; Karmel and Nguyen, 2005).

We selected Bourdieu's approach to social capital over that popularised by Robert Putnam who defined social capital as "features of social organisation such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit" (Putnam, 1995, p. 67). Putnam's conceptualization of social capital sees it as a community-level resource and public good (Baum and Ziersch, 2003; Putnam, 1995, 2000). Unlike Bourdieu who conceived of social capital as inevitably inequitably distributed and linked to possession of other resources, Putnam's communitarian approach does not explicitly recognise the role of power in the way that individuals (or communities) may have differential social capital, the potential for social capital to exclude 'outsiders' (Arneil, 2006; Baum and Ziersch, 2003; Portes and Landolt, 2000; Schuller et al., 2000), and the consequences of this for health equity (Navarro, 2002; Portes and Landolt, 2000).

In operationalising Bourdieu's approach to social capital we focus on the structural aspects of social capital (Krishna and Shrader, 1999); that is, an individual's social networks. We consider access to both formal and informal networks and the extent to which they may be bonding, bridging and linking. We also examine potential social support resources which may flow from these different types of ties. This reflects our previous work in this area (Ziersch, 2005; Ziersch et al., 2005) and theorised distinctions between bonding, bridging (Harpham et al., 2002; Putnam, 2000) and linking social networks (Szreter, 2002). Bonding networks refer to close informal networks of families and friends and are often regarded as a means to '*get by*' (Poortinga, 2006). Bridging networks refer to weaker and heterogeneous ties between people from dissimilar backgrounds (e.g. age, ethnic group) and have the potential to generate resources not available through closer bonding ties, enabling people to '*get ahead*' (Kawachi et al., 2008). Linking social networks refer to relationships with those in positions of power and authority (Stone et al., 2003; Szreter, 2002) which likewise offer the potential resources to '*get ahead*'.

### 1.2. *Social capital and health*

The association between social capital and health outcomes has been demonstrated in studies both in Australia (Baum et al., 2009; Berry and Welsh, 2010; Kavanagh et al., 2006; Turrell et al., 2006; Ziersch, 2005; Ziersch et al., 2005) and internationally (Elgar et al., 2011; Kawachi et al., 2008; Murayama et al., 2012). However, the findings regarding the associations between social capital and health have been inconsistent. Some studies have found a beneficial effect of social capital for physical (Kawachi et al., 2008; Kim et al., 2008) and mental health (Almedom, 2005; De Silva et al., 2005; McKenzie et al., 2002), while others have demonstrated either null or negative associations (Murayama et al., 2012; Ziersch and Baum, 2004). These inconsistencies may reflect differences in conceptual approaches and measurement as well as the potential for social capital to be both an asset and a liability for health.

Social capital is believed to benefit health through access to resources such as emotional and material support and health information generated by social networks (Kawachi and Berkman, 2001; Poortinga, 2006; Ziersch and Baum, 2004). Detrimental health effects of social capital may occur because of unmanageable demands of networks or exposure to unhealthy behaviours such as smoking (Lundborg, 2006; Osborne et al., 2009; Ziersch and Baum, 2004). Social networks may provide different resources according to the extent to which they are bonding, bridging or linking, and there is some evidence that the potential benefits of different types of social networks for health may vary (Iwase et al., 2012; Poortinga, 2012; Verhaeghe et al., 2012).

Consistent with Bourdieu's argument that social capital is inextricably related to socioeconomic resources, there is evidence that social capital is inequitably distributed, in particular by social class (Arneil, 2006; Lin, 2000; Ziersch, 2005). A recent systematic