



Does the level of wealth inequality within an area influence the prevalence of depression amongst older people?



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ABSTRACT

This paper considers whether the extent of inequality in house prices within neighbourhoods of England is associated with depressive symptoms in the older population using the English Longitudinal Study of Ageing. We consider two competing hypotheses: first, the wealth inequality hypothesis which proposes that neighbourhood inequality is harmful to health and, second, the mixed neighbourhood hypothesis which suggests that socially mixed neighbourhoods are beneficial for health outcomes. Our results are supportive of the mixed neighbourhood hypothesis, we find a significant association between neighbourhood inequality and depression with lower levels of depression amongst older people in neighbourhoods with greater house price inequality after controlling for individual socio-economic and area correlates of depression. The association between area inequality and depression is strongest for the poorest individuals, but also holds among the most affluent. Our results are in line with research that suggests there are social and health benefits associated with economically mixed communities.

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1. Introduction

This paper examines whether neighbourhood wealth inequality is associated with risks of depressive symptoms (from hereon referred to as depression) amongst the elderly in England using house price sales as a proxy for area wealth. We test two competing hypotheses, the 'wealth inequality hypothesis' and the 'mixed neighbourhood hypothesis', that predict associations between depression and area inequality that act in opposing directions. The wealth inequality hypothesis is based on the premise that greater inequality drives poorer health outcomes as a result of stresses associated with harmful social comparison, less cohesive neighbourhoods and as a consequence of lower support for public investment of time and money in communal facilities, services and infrastructure (Lorgelly and Lindley, 2008). So, under this hypothesis we would expect higher risks of depression in the most unequal areas. Alternatively, the mixed neighbourhood hypothesis proposes that a degree of inequality within a neighbourhood can have positive influence on various social outcomes including health. The focus here tends to be on homogenous poorer areas where it is argued that residents have reduced social opportunities as a result of cultures of worklessness, crime or substance abuse (Musterd and

Andersson, 2005) or, alternatively, because of overstretched public services with little incentives for the private sector to invest within the area (Ostendorf et al., 2010). The thinking goes that these problems are mitigated by socio-economic mixing. Thus, under the mixed neighbourhood hypothesis we would expect lower risks of depression in the most unequal areas, particularly for the poorest individuals.

Depression is a growing health issue in both developing and developed countries; major depressive disorders are ranked 11th in the global causes of years lost due to disability and are the 4th most important cause of years lost due to disability in Western Europe (Murray et al., 2012). There is a particular interest in depression in later life because the consequences are particularly severe. Depression is a strong predictor of suicide in older people and has important implications for the onset and progression of other health problems (e.g. disability, morbidity and mortality) (Beekman et al., 1997; Blazer, 2003). Avoidance of depression in later life is an important aspect of 'healthy ageing' (Simons et al., 2000) that is recognised as essential to mitigate the challenges associated with global projected trends towards more elderly populations.

Depression is associated with a number of individual socio-economic and demographic characteristics. For example, the condition is more prevalent amongst women, those who are single, living in care institutions, suffering from other health problems and who have fewer social contacts (Rodda et al., 2011; Chapman

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and Perry, 2008; Beekman et al., 1995). Depression exhibits a strong social gradient with higher risks for the lower social classes explained by psychosocial, behavioural (e.g. smoking, excessive alcohol consumption and lack of physical exercise), and physical health factors (Koster et al., 2006). Additionally, research suggests that characteristics of place of residence, such as deprivation and poor neighbourhood perception are associated with depression independently of individual risk factors (Yen and Kaplan, 1999; Stafford et al., 2011; Hooge and Vanhoutte, 2011). Older people are thought to be particularly susceptible to area influences as a result of greater attachments to their neighbourhood that stem from living in an area longer, spending more time day to day within their neighbourhood (especially if retired or less mobile) and making more use of local services compared to younger people (Bowling and Stafford, 2007; Stafford et al., 2011; Beard et al., 2009).

The hypothesis that the greater income or wealth inequality within a society the less well that society performs according to a range of social indicators, including health outcomes, has attracted a great deal of debate within academic, policy and media circles. Although the wealth inequality hypothesis was originally developed to explain differences in health between countries, researchers have attempted to assess the extent to which the inequality hypothesis holds for areas within countries (for a review, see Wilkinson and Pickett (2006)). Findings on associations between area inequality and health are thought to be influenced by the health measure under investigation, the geographical scale of analysis, methodological factors such as the control variables that are included or whether a single or multilevel model is used (Riva et al., 2007). More generally, area effects are usually small, meaning that determining such an effect, after accounting for the relevant individual characteristics, is often difficult. However, a small area effect can have a significant impact on population health as it applies to each member living within an area (Craig, 2005). A review of international studies suggests that the wealth inequality hypothesis is most salient for large geographical areas and in countries with high levels of sub-national inequality such as the USA (Subramanian and Kawachi, 2004; Wilkinson and Pickett, 2006).

Within the UK there is little consensus on the impact of area inequality on health. For example, in terms of self-reported health, some studies show no association with area inequality (Lorgelly and Lindley, 2008; Gravelle and Sutton, 2009), whilst others find increasing area inequality to be associated with both better (Craig, 2005) and worse (Weich et al., 2002) health outcomes. Although most research in the UK focuses on self-reported health, two studies on mental health (measured using the General Health Questionnaire and the Mental Health Inventory (MHI-5)) reveal an association in the opposite direction to that postulated in the inequality hypothesis; for persons with the lowest incomes or in the poorest areas, increasing levels of inequality within UK regions appear to have a protective effect in terms of mental health (Fone et al., 2013; Weich et al., 2001). This finding is in line with the mixed neighbourhood hypothesis, although neither paper explicitly refers to this body of literature. Weich et al. (2001) also report an association of better mental health in more equal areas for the most affluent and so it appears that the effects of area inequality are sensitive to social position, a finding noted elsewhere (Dahl et al. 2006). National contextual factors are also important; a Brazilian study (Filho Chiavegatto et al., 2013) reports an association between depression and area inequality in the opposite direction (higher risks of depression in the more unequal areas) to that observed by Fone et al. (2013) and by Weich et al. (2001) for people with the lowest incomes. It is argued that the greater extent of inequality in Brazil (compared to countries such as the UK) drives the health harmful social comparison that underlies the

association observed between area inequality and depression (Filho Chiavegatto et al., 2013).

The mixed neighbourhood hypothesis has a long history with important impacts on planning policy that can be traced back to the 19th Century in England and the Garden City movement. In the UK, the emphasis on positive aspects of mixed communities formed a key element of Government policy under New Labour (ODPM 2005) and in legislation around planning permission that requires new developments to have a proportion of affordable housing. Mixed neighbourhoods have been championed by influential organisations such as the Joseph Rowntree Foundation, a charity concerned with social justice, tackling poverty and building sustainable communities. Similar legislative aims have been enacted in the Netherlands, France, Germany, Sweden and Finland (Musterd and Andersson 2005) and in the USA (Cheshire 2009).

However, the evidence in favour of the mixed neighbourhood hypothesis is inconclusive. Studies that examine the effects of programmes to reduce concentrations of poverty (e.g. the Moving to Opportunity scheme and Hope IV scheme in the USA) reveal mixed results and limited evidence to suggest individuals moved to more mixed area were better off than those who did not (Cheshire, 2009; Manley et al., 2012). Other research, usually using survey data sources, reveals no, or limited, evidence in favour of the benefits of mixed neighbourhoods for health and other social outcomes (Graham et al., 2009; Ostendorf et al., 2010; Atkinson and Kintrea, 2001; Galster et al., 2008; Musterd and Andersson, 2005).

This paper makes three contributions to these literatures. First, we extend existing research on the association between area inequality and depression to the older population, a group thought to be particularly susceptible to area health effects. We might expect clearer area effects on depression as a result, especially as research has suggested the area effects associated with social mix do indeed vary across population groups (Galster et al., 2008). Second, we use house price sales as our main measure of area inequality rather than the more commonly used indicator of income. This is a valuable contribution because for many people, and particularly older people, property is a major financial asset. Additionally, house prices are a particularly stark and visible form of wealth inequality in the UK across regions and neighbourhoods where factors such as demand for housing close to desirable schools have exacerbated divisions. Third, we test the effect of area inequality on a health outcome (depression) at a finer geographical scale within England than in much of the previous research, assessing whether the level of neighbourhood inequality influences risk of depression across Middle Super Output Areas (average population 7200) (MSOAs).

In summary, the central aim of the paper is to test two hypothesis relating to the theorised impact of neighbourhood inequality (measured here using house prices) on depression. Under the mixed neighbourhood hypothesis we would expect to see a negative association between area inequality and depression with increases in area inequality associated with lower probabilities of depression. Alternatively, under the wealth inequality hypothesis we would expect to observe a positive association between depression and area inequality so that increases in area inequality are associated with increases in probabilities of depression.

2. Data and methods

The main data source for this research is the English Longitudinal Study of Ageing (ELSA) (Banks et al., 2012), a representative sample of the population aged 50 and over, living in private households in England. In this paper we use the first wave (2002/3) of data, which contains a sample selected from the Health Survey

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