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Who you know, where you live: social capital, neighbourhood and health

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Abstract

This article examines the degree to which relationships between social capital and health are embedded in local geographical contexts and influenced by demographic factors, socio-economic status, health behaviours and coping skills. Using data from a telephone survey of a random sample of adults ($N = 1504$ respondents, response rate = 60%), the article determines if relationships between involvement in voluntary associations and various measures of individual health are associated with neighbourhood of residence in the mid-sized city of Hamilton, Canada. Associational involvement and overweight status (assessed by body-mass score) were weakly but significantly related after controlling for the other variables; involvement had relationships with self-rated health and emotional distress before but not after controlling for socio-economic status, health behaviours and coping skills. Relationships between neighbourhood of residence and two health outcomes, self-rated health and overweight status, were statistically significant before and after controlling for the other characteristics of respondents; neighbourhood of residence was not a significant predictor of number of chronic conditions and emotional distress in multivariate models. The neighbourhood and associational involvement relationships with health were not dependent upon one another, suggesting that neighbourhood of residence did not help to explain the positive health effects of this particular measure of social capital.
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Introduction

The social capital and health discourse, intently focused on certain social networks, i.e., voluntary associations, has generally acknowledged the interconnectedness of the micro-level (individuals participating in such networks), the meso-level (the social networks themselves), and the macro contexts that shape both individuals and networks (e.g., political and economic structures). The discourse has not yet seriously grappled with the ways in which associational networks and their health effects are potentially embedded within specific *geographical* contexts such as the neighbourhood or community. In the context of four neighbourhoods in one mid-sized Canadian city, this article contributes to understanding how social capital influences health and well-being within geo-political contexts by: (i) assessing

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degree and type of involvement in networks of voluntary association for a random sample of adults, (ii) assessing relationships between associational involvement and various measures of physical and emotional health and (iii) determining the degree to which these relationships are dependent upon neighbourhood of residence.

Social capital and health

Social capital is generally described as a feature of social structure, e.g. a web of cooperative relationships between citizens, high levels of interpersonal trust, and strong norms of reciprocity and mutual aid, that serve to facilitate action for shared benefit (Coleman, 1988; Putnam, Leonardi, & Nanetti, 1993). Such features of social structure—potentially including networks based in voluntary associations—may serve to further the goals of individuals but may also act as direct resources for social groups and communities (Lin, 2001). 'Social capital' as a theoretical concept emerged from the sociological and political science literatures (Bourdieu, 1984, 1986; Coleman, 1988; Putnam et al, 1993) and since the mid-1990s has increasingly been incorporated into health research as a way to bring social theory into epidemiological studies, at times as a mechanism to link social or economic inequality and health (Hawe & Shiell, 2000). The social capital and health discourse is not a body of research that identifies a single capital that influences health in an easily identifiable way. Rather, social capital is an element in a theoretically and empirically contentious, broadly defined dialogue. To date, an amorphous group of indicators of social capital (e.g., social networks and support, involvement in associations, measures of trust) have been tied by various theoretical and empirical means (e.g., the character of political governance, economic growth, the quality of health care, stress, social support) to numerous health outcomes (e.g., self-rated health, mortality rates, life expectancy). The breadth of this dialogue makes it difficult to conceptualize as well as investigate empirically how social capital might manifest itself in neighbourhood contexts and subsequently influence health.

Social capital in various forms is hypothesized to affect health in three major ways. First, it may influence an individual's health as a result of its direct and beneficial effects on individual attributes and activities, what are often called the 'compositional' health effects of social capital. For example, Berkman, Glass, Brissette, and Seeman (2000) suggest that social networks in general (and, we argue, networks of voluntary association in particular) provide social support, exert social influence, encourage social engagement and facilitate interpersonal bonding for members. These aspects of social networks may then influence the health of members by influencing physiological stress responses, self esteem and security, health behaviours (e.g., smoking, exercise, high-risk sexual activity, health service utilization) and exposure to infectious disease agents (Berkman et al., 2000). The degree to which such networks, behaviours and exposures are spatially situated and/or their health effects potentially mitigated by spatial context are seldom addressed by public health researchers. In this article we seek to address this gap in the literature by determining if the breadth and depth of associational involvement interacts with neighbourhood of residence as a determinant of individual health in the city of Hamilton, Canada. We also determine if psychological coping skills and health behaviours operate as intervening variables in involvement–health relationships. Lastly, as some kinds of networks may be more likely than others to provide social support, social influence and interpersonal bonding, we explore the salience of participation in different types of associations, e.g., sports, religious, cultural and professional associations, for various measures of health and well-being.

Second, social capital may influence health indirectly through its effects on the larger social, economic, political and environmental factors that in turn function as determinants of the health of populations. These are usually referred to as the 'contextual' health effects of social capital. For example, social capital could affect health by influencing a community's access to economic resources and material goods (e.g., jobs and economic opportunities, housing, and institutional contacts—Berkman et al., 2000). It may also influence broader aspects of the economy and the polity (Putnam et al., 1993; Helliwell & Putnam, 1995; Rice & Sumberg, 1997; Woolcock, 1998; Fukuyama, 2000) in ways that may have consequences for the health of whole communities, populations and societies (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Veenstra, 2002). Conversely, social capital may be influenced by other social, economic and political phenomena, with subsequent health implications. For example, social capital is thought by some to mediate relationships between socio-economic factors such as income inequality and population health (Wilkinson, 1996; Kawachi et al., 1997). Given that income inequality may be predictive of health at the level of the neighbourhood (Wilson & Daly, 1997), variation in social capital among neighbourhoods may help to explain the differential effects of the inequality of resources within neighbourhoods on health. A neighbourhood or community with robust social capital may be better able to organize against local environmental hazards as well. In short, health researchers have suggested that social capital can influence the shape and character of the larger social (and geo-political) context in which individuals live their lives, indirectly affecting health (Mohan & Mohan, 2002).

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