

## Health and Community Care

### **Social capital and health – findings from the Scottish Health Survey and Scottish Social Attitudes survey**

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This paper explores the Scottish evidence for a link between social capital and health outcomes in order to inform the ongoing development of an assets-based approach to addressing health problems and inequalities. It focuses on exploring whether or not various aspects of social capital are independently associated with (a) how people view their health in general and (b) levels of mental wellbeing. Most of the analysis focuses on the 2009 Scottish Health Survey (SHeS) 2009, which includes measures of both these outcomes. Data on factors associated with self-assessed general health from the Scottish Social Attitudes survey (SSA) 2009 are also included.

### **Main Findings**

- Overall, the findings suggest that understanding people's level of social capital assets does, to varying degrees, improve our ability to predict their level of general health or mental wellbeing.
- Contact with relatives, friends and neighbours in particular are associated with being more likely to view your health as good or very good. SHeS 2009 shows that 80% of those who had contact with friends and relatives on most days felt their health was good or very good, compared with 66% of those who had contact once or twice a month or less. This relationship was still apparent after controlling for age and other demographic variables.
- Those who felt involved in their local community were also more likely than those who did not feel involved at all to rate their health as good or very good, even after controlling for demographic factors.
- Similarly, those who agreed that they could influence decisions about their local area had higher levels of mental wellbeing than those who disagreed that this was the case. 91% of those who agreed or strongly agreed that they could influence their local area had an average or above average WEMWBS score, compared with 74% of those who strongly disagreed that this was the case.

## Introduction

Recent years have seen growing interest in understanding how an ‘assets-based’ approach might help address some of the long-standing problems and inequalities associated with health in Scotland. An assets-based approach focuses on supporting and utilising the innate capacities and coping mechanisms that individuals and communities possess. In doing so, it is hoped that health will improve, because people will be equipped to take control of their social circumstances and sustain their own wellbeing.

In focusing on psychosocial factors and on the associations and informal linkages that exist within the community and between the community and external institutions, the assets-based approach has clear links with research on the relationship between ‘social capital’ and health. In perhaps the best known account of social capital, *Bowling Alone*, Putnam (2000) argued that people in America had become disconnected from their family, friends, neighbours and social structures. This shrinking access to social capital was associated, Putnam argued, with a wide range of negative outcomes for health and wellbeing – from more teenage pregnancies to higher mortality rates.

## About this paper

This paper explores the Scottish evidence for a link between social capital and health outcomes in order to inform the ongoing development of an assets-based approach to addressing health problems and inequalities. It uses data from two sources – the 2009 Scottish Health Survey (SHeS) 2009 and the 2009 Scottish Social Attitudes survey (SSA) 2009.

Analysis focused on two general indicators of health:

- self-assessed general health, as measured by a question that asked people to say whether they felt their health in general was very good, good, fair, bad or very bad, and
- mental well-being, as measured by the Warwick-Edinburgh Wellbeing Scale (WEMWBS).<sup>1</sup>

These questions were chosen on the basis that they are broad, general measures of health and wellbeing, and that analysis of the relationship between social capital and health should start at this level.

The findings presented here focus on whether or not various aspects of social capital were independently associated with (a) how people view their health in general (included in SSA and SHeS), and (b)

<sup>1</sup> See Stewart-Brown, S and Janmohamed, K (2008) for full details of the questions used to create this scale.

their level of mental wellbeing, as measured by the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS – included in SHeS only). In particular, the analysis explored whether or not social capital assets were significantly associated with these health outcomes even after controlling for demographic differences which might impact on *both* health and social capital.

The questions on social capital included in the analysis related primarily to aspects of:

- social networks and social support (e.g. having people to turn to in a crisis, and contact with friends, family or neighbours)
- reciprocity and trust (in particular, feeling most people can be trusted vs. feeling you can’t be too careful dealing with people), and
- feelings of efficacy in relation to civic participation (e.g. the level of involvement people feel in their local community, and the extent to which they feel able to influence decisions affecting their local area).

## General health

People’s perceptions of their general health vary significantly with age, income, deprivation and economic status.<sup>2</sup> Perceptions of health tend to decline with age – in 2009, 91% of 16-24 year-olds considered their health to be good or very good, falling to 50% of those aged 75 and older. Meanwhile, the proportions who feel their health is good increase with income and affluence. 54% of those in the lowest income quartile rated their health as good or very good, compared with 91% of those in the highest income group. Similarly, 65% of those living in the most deprived areas of Scotland rated their health as good or very good, compared with 90% of those living in the least deprived areas. Economic status also matters, even after taking account of income. Those who were in paid employment (89%) or education (95%) had higher levels of self-assessed health than those who were unemployed (73%), retired (59%), permanently unable to work (14%) or looking after the home and family (73%).

However, further analysis of SHeS 2009 shows that even after controlling for these socio-demographic differences in perceptions of self-assessed health, people’s social capital assets are also significant. In particular, assets linked to people’s own social networks and their feelings of self-efficacy in relation to community involvement appear to be related to higher levels of self-assessed health. For example:

<sup>2</sup> Figures cited here are from SHeS, but similar patterns were apparent in SSA data.

- Those who had regular contact with friends, relatives and neighbours were more likely than those whose social contact was more restricted to report that their health was good or very good. 80% of those who had contact with friends, relatives or neighbours most days reported that their health was good or very good, compared with just 66% of those who had personal contact with friends, relatives or neighbours once or twice a month or less.
- Having more than two people to turn to in a crisis was also associated with higher levels of general health – 60% of those who had two or fewer people they could turn to said their health was good or very good, compared with 74% of those with three or four people they could rely on, and 81–83% of those with five or more people they could turn to.
- In contrast, feeling completely uninvolved in the community appears to be related to relatively lower levels of self-assessed health. However, here the difference appears to be between those who said they were not involved at all in their community and everyone else. 71% of those who said they were not involved at all in their community said their health was good or very good, compared with between 79–82% of those who felt they had some (even if not very much) community involvement.

Results of analysis of SSA 2009 were somewhat less conclusive. However, the findings again tend to suggest that having strong support networks may make a difference to people's general self-assessed health. For example, 76% of those who agreed strongly that there were people in their area they could turn to for advice and support had very good or good health, compared with 65% of those who disagreed with this statement.

## Mental wellbeing

As with general health, mental wellbeing (as measured in SHeS 2009 by WEMWBS) varies with age. However, in this case the relationship is not linear. Those aged 65–74 were most likely to have average or above average WEMWBS scores, but there was no clear pattern across other age groups. Mental wellbeing also varies with socio-economic status in a similar manner to general health. Those in employment or education have higher mental-wellbeing scores, particularly in comparison with those who are unemployed or permanently unable to work, while those living in the least deprived areas of Scotland had higher self-reported wellbeing than those in the most deprived areas.

Again, further analysis suggests that at least some social capital assets are positively associated with mental wellbeing even after controlling for these demographic and socio-economic variations. In particular, feeling able to influence decisions in the local area and having more than one or two people to turn to in a crisis were significant.

- Those who agreed or strongly agreed that they could influence decisions about their local area were more likely to have average or above levels of mental wellbeing (91%) compared with those who disagreed (81%) or strongly disagreed (74%) that they had such influence.
- Levels of mental wellbeing were also higher among those who had more than two people they could turn to for support in a crisis. Between 87% and 91% of those who had five or more people they could turn to reported average or above average levels of mental wellbeing, compared with 75% of those who only had three or four people and 70% of those with two or fewer people they could rely on in a crisis.

However, in contrast with general health, mental wellbeing did not appear to vary significantly by frequency of contact with family, friends or neighbours.

## Conclusions

These findings provide further evidence of the relationship between social capital assets and better health. In particular, they suggest that having people to turn to in a crisis, having frequent contact with family, friends and neighbours and feeling involved in and able to influence the local area are important. In interpreting these findings, it is worth noting that the greatest differences appear to be between the (often relatively small) group of people who have very little social capital – those who have social contact with others once or twice a month or less, those who have two or fewer people they can rely on in a crisis, and those who have no involvement in their community at all – and the rest of the population. Improving the social capital of these groups even a little might, therefore, have significant positive impacts on their health and wellbeing.

## Data and methods

The Scottish Health Survey (SHeS) is commissioned by the Scottish Government and aims to monitor health in Scotland, while the Scottish Social Attitudes survey (SSA) is an annual survey exploring social and political attitudes. In 2009, both surveys included a

number of measures of social capital, alongside a wide range of demographic measures and relevant health outcomes.

Both surveys are based on random probability sampling methods, designed to provide samples that are representative of the Scottish population. In 2009, questions on social capital were asked of a sub-sample of 2,584 SHeS respondents. SSA 2009 had a sample size of 1,482.

Full technical details of SHeS 2009 are available in Bromley, C and Given, L (eds.) (2009) *Scottish Health Survey 2009 - Volume 2: Technical Report*, The Scottish Government National Statistics. Technical details on SSA 2009 are provided in the technical annex to Ormston, R (2010) *Scottish Social Attitudes survey 2009: Core module – attitudes to the government, the economy and public services in Scotland*, Scottish Government Social Research. Both documents are available to download online.

The findings discussed in this paper were informed by logistic regression analysis. Details of this analysis and full tables for all figures cited in this research findings are available in a separate full report.

## References

- Putnam, R (2000) *Bowling alone*, New York: Simon & Schuster
- Stewart-Brown, S and Janmohamed, K (2008) *Warwick-Edinburgh Mental Well-being Scale (WEMWBS): User guide version 1*, University of Warwick and NHS Health Scotland

This document, along with the full research report of the project, and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Internet at: <http://www.scotland.gov.uk/socialresearch>. If you have any further queries about social research, or would like further copies of this research findings summary document or the full research report, please contact us at [socialresearch@scotland.gsi.gov.uk](mailto:socialresearch@scotland.gsi.gov.uk) or on 0131 244 7560.

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