

Social Capital and Self-Rated Health: Support for a Contextual Mechanism

In the study by Kawachi et al.,¹ an indicator of social capital—the per capita membership of voluntary associations measured at the state level—was related to self-reported health after individual-level factors that predict health, such as income, education, and smoking behavior, were controlled for. The investigators were unable, however, to take the individual-level membership of voluntary associations into account.

In a postal survey of adults (n = 605) in socially contrasting localities in western Scotland,² we asked respondents whether they belonged to any local associations (such as neighborhood watches, residents' associations, or community councils). Respondents were asked to rate their own health in the last year as "excellent," "good," "fair," or "poor" (from this, we created a dichotomous variable "excellent/good" vs "fair/poor") and to report the number of symptoms they had experienced in the last month from a list of 20 common symptoms.

At the individual level, belonging to a local association was not related to any of these health measures after individual age, sex, and social class were controlled for. However, when we aggregated respondents' membership up to the postcode (zip code) sector level (each with an average population of 6000 in Scotland), we found that aggregate membership was associated with individual health for both health measures after individual age, sex, and social class were controlled for (higher rates of membership being associated with better self-reported health).

Thus, our data show that an individual's health is not associated with whether or not he or she belongs to a local association, but it

is associated with aggregate levels of participation. In our study, areas with higher levels of participation were also areas that had better amenities and services and a more pleasant, nonthreatening environment. It may be that local levels of participation in local associations influence the levels of resources that an area can command. Our findings support Kawachi et al.'s interpretation that the effect is operating through contextual (collective) rather than compositional (individual) mechanisms.

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References

1. Kawachi I, Kennedy BP, Glass R. Social capital and self-rated health: a contextual analysis. *Am J Public Health.* 1999;89:1187–1193.
2. Macintyre S, McIver S, Sooman A. Area, class and health: should we be focusing on places or people? *J Soc Policy.* 1993;22:213–234.