



Which part of community social capital is related to life satisfaction and self-rated health? A multilevel analysis based on a nationwide mail survey in Japan



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ABSTRACT

This paper aims to clarify the association between various social capital components at the municipal level (community social capital) and two quality-of-life factors at the individual level [individual self-rated life satisfaction and self-rated health (SRH)] based on data from a nationwide social capital survey that the authors carried out in 2013 in Japan (N = 3406 in 99 municipalities). The survey covers residents in Japan between the ages of 20 and 79 years. We focus on both contextual social capital and household income inequality in terms of the Gini coefficient at the municipality level since, to the best of our knowledge, no paper has explicitly dealt with municipalities in Japan as the units of contextual social capital and the Gini. Our analyses show that the subjective life satisfaction of individuals, after controlling for socioeconomic status and health at the individual level, is associated with both an income gap and social capital at the municipal level. Every component of community social capital in this study except for generalized reciprocity, both cognitive (generalized trust, particularized trust, and particularized reciprocity), and structural (three types of group participation and daily contacts with neighbors, friends/acquaintances, and colleagues), and the Gini coefficient on earned income were associated with self-rated life satisfaction at the individual level with statistical significance. However, SRH is associated only with cognitive social capital at the community level. SRH has no significant association with structural components of community social capital or with a community income gap in terms of the Gini coefficient on personal income. Judging from the results of estimates in the study, most of the components of community social capital at the municipal level seem to play an important role in enhancing self-rated life satisfaction. Life satisfaction may be associated with the broad atmosphere of the municipal level where one resides, while SRH is associated with cognitive social capital rather than structural social capital. However, the difference in the impact of contextual social capital between the two QOL indices may indicate the importance of considering a proper contextual level that is suitable for the outcome.

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1. Introduction

The definition of social capital varies depending on the author (Lin, 2001; Coleman, 1990; Putnam, 2000; Portes, 1998; Kawachi et al., 2004). Putnam (1993, 2000) used a broad definition covering trustworthiness, norms of reciprocity, and networks,

while many researchers conducting empirical studies in the field of social epidemiology have tended to use narrowly defined social capital focusing on either structural components such as networks (Verhaeghe et al., 2012) or cognitive elements such as trust and reciprocity (Ichida et al., 2009; Suzuki et al., 2010). In this paper, we adopted a broad concept of social capital, defined as trust, norms of reciprocity, and networks with externalities through human minds (Inaba, 2005) because the broad definition is more suitable to express the *contextual* aspects of social capital that induce cohesion or collective behaviors among the members of the community. In

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other words, while narrowly defined social capital focusing on either cognitive social capital or structural social capital could be useful in explaining the behavior of *individual* actors, broadly defined, social capital could be of importance in explaining the formation of preferences or values among the members of the community, which leads to *collective behaviors*.

The contextual social capital can be measured at various levels, such as countries, states, metropolitan areas, counties, municipalities, school districts, census tracts, and neighborhoods. For instance, generalized trust, which is trust toward the general public, can be measured at the individual level as well as at the various contextual levels as, for instance, the average of individual generalized trust.

This paper focuses on contextual social capital at the municipality level in Japan since, to the best of our knowledge, no paper has explicitly dealt with municipalities in Japan as the unit of contextual social capital in spite of the fact that it is obviously one of the most important contextual levels. As shown in Table 1, preceding studies based on multilevel analyses have focused on either the broad side (prefectures – Hibino et al., 2012; Oshio and Kobayashi, 2009) or the narrow side (areas in one particular municipality, such as kyusons, old administrative districts that existed until 1953 – Ichida et al., 2009; Aida et al., 2009 – and the cyo–cyo, the smallest spatial unit – Fujisawa et al., 2009; Hamano et al., 2010; Murayama et al., 2012, 2014). As of May 2013, there were 1742 municipalities in 47 prefectures in Japan and as many as 217,351 cyo–cyos. With regard to kyusons, which literally means “old villages,” there were as many as 71,314 kyusons at the start of the regime in 1888, and the number had dropped to 9868 by 1953, when they were finally abolished as formal administrative areas (Mistry of Internal Affairs and Communication, 2015).

Another feature of our study is that the components of contextual social capital examined in our study are, as illustrated in Table 2, most comprehensive and include both cognitive social capital (generalized trust, particularized trust, generalized reciprocity, and particularized reciprocity) and structural social capital (participation rates for three types of group activities and contacts with neighbors, friends/acquaintances, and colleagues). This is of importance from the viewpoint of policymakers because, when it

comes to concrete policy proposals, more detailed analyses on the impact of each component of social capital are required.

This study focuses on self-rated health (SRH) and self-rated life satisfaction as outcomes. The importance of social capital for health has been frequently mentioned in the literature (Kawachi and Berkman, 2000, 2003; Islam et al., 2006; Kawachi et al., 2008; Verhaeghe and Tampubolon, 2012; Kawachi et al., 2013). In addition, many researchers have pointed out the interrelations among health, income gaps, and social capital (Kawachi et al., 1997; Subramanian and Kawachi, 2004; Ichida et al., 2009). The deterioration of social capital caused by a widening income gap has a negative impact on health (Kawachi and Berkman, 2000; Veenstra, 2002). Others have emphasized the direct relation between health and income gaps (Wilkinson and Pickett, 2006; Lynch et al., 2004; Subramanian and Kawachi, 2004). Therefore, we also included the income gap (Gini coefficient on the earned income of income tax payers) after controlling for the average income of the community.

In the 2010s, social capital has also been analyzed as a factor in life satisfaction and happiness. Elgar et al. (2011) examined the association among social capital, health, and life satisfaction in 50 countries. Aminzadeh et al. (2013) found that the association between subjective well-being and neighborhood social capital can differ depending on socioeconomic status (SES). The higher the income gap is, the lower self-rated happiness is (Alesina et al., 2004; Oshio and Kobayashi, 2010).

As mentioned above, many papers have analyzed health and happiness using social capital and an income gap as explanatory variables. However, most analyses use only a partial concept of social capital, such as generalized trust at the individual level (Ichida et al., 2009), norms (helpfulness, kindness, greetings, and cohesion index) (Fujisawa et al., 2009), or networks among actors (Ferlander and Makinen, 2009; Sabatini, 2009). Even in the case of studies that use a comprehensive concept of social capital, the scope of the social capital was limited to the individual level (Verhaeghe and Tampubolon, 2012). Narrowly defined social capital or social capital at the individual level alone may not be suitable to express the cohesiveness of the community. As mentioned above, we used broadly defined social capital at the municipal level to provide a more comprehensive bird's eye view of the collective

Table 1
Multilevel studies on contextual social capital in Japan.

Authors, year	Contextual unit	Sample population (age)	SC component GT: generalized trust GR: generalized reciprocity PT: particularize trust PR: particularized reciprocity	Outcome	Support for the association between SC and outcome
Ichida et al. (2009)	25 kyusons in Chita Peninsula	15,225 (≥65)	GT	SRH	Yes
Fujisawa et al. (2009)	206 enumeration districts with about 50 households	1157 (20–74)	Helpfulness, kindness, greetings, social cohesion	General health perception	Yes
Aida et al. (2009)	25 kyusons	5560 (≥65)	Vertical SC, horizontal SC	Remaining teeth	Yes on H. SC
Oshio and Kobayashi (2009)	47 prefectures	1305 (20–89)	GT, participation in hobby group, relation with friends, satisfied with where he/she lives	SRH	No
Suzuki et al. (2010)	46 companies in Okayama Pref.	1147 adults	PT, PR (helpfulness)	SRH	No on PR Weak on PT
Hamano et al. (2010)	212 neighborhoods (cho–chos)	5956 adults	PT in neighbors, neighborhood associations, participation in sports, recreation, hobby groups	Mental health	Yes
Hibino et al. (2012)	47 prefectures excluding 13 large cities + 13 large cities	11,702 (20–80)	GT, neighborhood safety, participation in groups	SRH	Yes on GT, no on group participation
Murayama et al. (2012)	72 districts (cho–chos) in Kashiwa, Chiba Pref.	1716 adults	Neighborhood mistrust, mistrust in the national security system, no participation in sports, hobby, or recreation groups, non-participation in neighborhood association	SRH Co-occurrence of lifestyle risk factors	Inverse association between NM and SRH, yes on MNS
Murayama et al. (2014)	152 administrative neighborhoods in Yabu, Hyogo Pref.	6416 (≥65)	GT, homogeneous network, heterogeneous network	Depressive mood	Yes (positive on Ho. N, negative on He. N)

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