

# The relationships of social participation and community ratings to health and health behaviors in areas with high and low population density<sup>☆</sup>

K. Allen Greiner<sup>a,b,c,\*</sup>, Chaoyang Li<sup>b,c</sup>, Ichiro Kawachi<sup>d</sup>, D. Charles Hunt<sup>b,f</sup>,  
Jasjit S. Ahluwalia<sup>a,b,c,e</sup>

<sup>a</sup>Department of Family Medicine, University of Kansas Medical Center, Kansas City, KS, USA

<sup>b</sup>Department of Preventive Medicine and Public Health, University of Kansas Medical Center, Kansas City, KS, USA

<sup>c</sup>Kansas Cancer Institute, University of Kansas Medical Center, Kansas City, KS, USA

<sup>d</sup>Department of Health and Social Behavior, Harvard School of Public Health, Kansas City, KS, USA

<sup>e</sup>Department of Internal Medicine, University of Kansas Medical Center, Kansas City, KS, USA

<sup>f</sup>Kansas Department of Health and Environment, Topeka, KS, USA

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## Abstract

Previous studies have linked social participation and community levels of trust with improved health status. We examined the associations between levels of community participation, self-reported community ratings (trust), and health within a public health surveillance survey conducted in Kansas ( $N=4601$ ). Independent variables were individual ratings of their communities (excellent, very good, good/ fair, poor), and their involvement in community groups or organizations in the last 5 years (yes/no). Dependent variables were self-rated health status, depressive symptoms, physical activity, smoking, obesity, and binge drinking.

After controlling for age, gender, race/ethnicity, education, and having a medical doctor, self-rated health status ( $p<0.001$ ) and physical activity (PA) ( $p<0.001$ ) were positively, and smoking ( $p<0.001$ ) and depressive symptoms ( $p<0.001$ ) were negatively associated with community ratings. Only PA ( $p<0.001$ ) remained associated with community involvement in a multivariate analyses. Multilevel analysis using county-level data showed no significant interactions between population density and dependent variables. Individuals from rural areas had the highest community involvement but relatively low levels of community ratings.

Our findings suggest that individuals in rural areas, especially in densely settled rural areas, may face increased risks of poor health.

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\*Corresponding author. Family Medicine and Preventive Medicine, University of Kansas Medical Center, 3901 Rainbow Boulevard, Kansas City, KS 66160, USA. Tel.: +1-913-588-1931; fax: +1-913-588-2095.

E-mail address: agreiner@kumc.edu (K.A. Greiner).

## Introduction

Social capital has been defined as the resources available to individuals and communities through their social connections (Putnam, 2000). Beyond this broad definition, however, there is no firm consensus about how social capital ought to be measured (Macinko & Starfield, 2001; Portes, 1998). Most definitions of social capital appear to encompass structural aspects of social relationships, such as the extent and intensity of

associational links and activity in society; as well as the so-called cognitive dimension of social relationships, including such things as people's perceptions of trust, reciprocity, and sharing (Harpham, Grant, & Thomas, 2002).

Indicators of social capital are often unavailable on administrative data sets (such as the government census), hence researchers have frequently resorted to the use of secondary sources to tap indicators of social capital, such as the density of membership in civic associations, national opinion poll data on interpersonal trust, and perceptions of reciprocity (Lochner, Kawachi, & Kennedy, 1999). In ecological and multi-level studies, each of these indicators have been linked to diverse health outcomes, including mortality rates (Kawachi, Kennedy, Lochner, & Prothrow-Stith, 1997; Lochner, Kawachi, Brennan, & Buka, 2003; Skrabski, Kopp, & Kawachi, 2003); self-rated health (Kawachi, Kennedy, & Glass, 1999; Subramanian, Kim, & Kawachi, 2002; Veenstra, 2000, 2002); violence and homicide rates (Galea, Karpati, & Kennedy, 2002; Kawachi, Kennedy, & Wilkinson, 1999; Sampson, Raudenbush, & Earls, 1997); mental health (Drukker, Gunther, Feron, & van Os, 2003); as well as high-risk behaviors such as smoking (Lindstrom, 2003; Lindstrom, Hanson, Ostergren, & Berglund, 2000; Lindstrom & Isacson, 2002; Lindstrom & Ostergren, 2001), sedentary lifestyle (Lindstrom, Hanson, & Ostergren, 2001); and binge drinking (Weitzman & Kawachi, 2000).

At least four separate mechanisms have been hypothesized to link community stocks of social capital to health outcomes. These include (Kawachi & Berkman, 2000): (a) the ability of social capital-rich communities to enforce healthy norms through *collective socialization* (e.g., exercising informal social control over "deviant" behaviors such as smoking and drug use by minors); (b) the ability of social capital-rich communities to realize shared goals through organization and *collective action* (e.g., to introduce smoking restrictions in public places via local ordinances; or to garner services and amenities that promote the health of residents, such as building recreational facilities or to prevent the closure of local health clinics); (c) the ability of social capital-rich communities to transmit health promotion messages more efficiently via information channels and the *diffusion of innovations*; and (d) a direct psychosocial or *cognitive* effect of social cohesion on the mental health and well-being of residents.

In general, scholars have assumed that the *action* and *cognition* mechanisms of social capital work in a co-linear fashion to positively influence health outcomes. But, the relationship between the four mechanisms of social capital listed above and health outcomes need not always be beneficial or health promoting. The so-called "downsides" of social capital

have received increasing attention (Portes, 1998). For example, close involvement in a community with a high background prevalence of unhealthy behaviors (e.g., smoking) may be associated with a more deleterious pattern of health behaviors, through a process of contagion. The exact relationship between social capital and health outcomes may therefore depend on the balance between its negative effects (e.g. contagion) and its positive effects (e.g., community organization and action). For mechanisms such as *collective socialization*, *collective action*, and what has been described as "social participation" in prior studies (Fratiglioni, Wang, Ericsson, Maytan, & Winblad, 2000; Emmons, Wechsler, Dowdall, & Abraham, 1998; Weitzman & Kawachi, 2000; Lindstrom & Isacson, 2002; Lindstrom et al., 2001) health behaviors are an important mediator of community-level health outcomes (Cohen, Doyle, Skoner, Rabin, & Gwaltney, 1997).

Relatively few studies have examined potential interactions between community social capital and other community characteristics (e.g., urban/rurality) as well as individual characteristics (e.g., race/ethnicity, socioeconomic position). Studies of the geographic and environmental determinants of health have advanced sophisticated methods for looking at health behaviors, health outcomes and social correlates of each (Diez-Roux, 2001, Diez-Roux et al., 2001, 1997; Jackson, 2003; Leyden, 2003; Srinivasan, O'Fallon, & Dearth, 2003). Scholars have not taken a systematic approach in exploring how the individual mechanisms through which social capital acts (i.e. *socialization*, *action*, etc.) mediate or confound the relationship between social capital and health behaviors and how these factors relate to contagion or maintenance of healthy norms (Lindstrom, 2003). Recent scholarship suggests that decreased trust (a *cognitive* component) among communal groups with high participation rates and narrow political or social allegiances may be a growing phenomenon (Fukuyama, 1999; Putnam, 2000). Such "miniaturization of communities" calls into question the assumption that high rates of social participation in communities necessarily correlates with subjective perceptions of a community's strength.

In the present study, we sought to examine the relationships between community social capital and health outcomes within a US state with a high proportion of rural residents. We utilized the "community involvement" module of the 2001 State of Kansas Behavioral Risk Factor Surveillance System (BRFSS) to examine the relationships between social participation (a structural indicator of social capital), subjective ratings by residents of their communities ("community ratings"), and their self-reported health status, depressive symptoms, exercise, smoking, obesity, and binge drinking.

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