



# The relationship between happiness and health: Evidence from Italy



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## ABSTRACT

We test the relationship between happiness and self-rated health in Italy. The analysis relies on a unique dataset collected through the administration of a questionnaire to a representative sample ( $n = 817$ ) of the population of the Italian Province of Trento in March 2011. Based on probit regressions and instrumental variables estimates, we find that happiness is strongly correlated with perceived good health, after controlling for a number of relevant socio-economic phenomena. Health inequalities based on income, work status and education are relatively contained with respect to the rest of Italy. As expected, this scales down the role of social relationships.

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## 1. Introduction

In recent years, subjective well-being and, more generally, happiness studies, have increasingly gained attention not only in the academic literature but also in the journalistic and political debates. The happiness literature started developing in the '70s and bloomed after 2000, when subjective quality of life became a recognized topic of various social sciences, including economics (Bruni and Porta, 2007; Sarracino, 2013). People's own evaluation of their own well-being is monitored through survey questions such as: "Taking all things together, how happy would you say you are?" or "All things considered, how satisfied are you with your life as a whole these days?" (Van Praag et al., 2003). A consolidated literature proved that subjective well-being is a reliable source of information about people's well-being. This is why an increasing number of researchers have employed it in many fields of social research. In economics and psychology, several authors have advanced the claim that happiness or, more generally, positive attitudes towards life can predict longevity and other indicators of physical well-being among healthy populations (Diener and Chan, 2011; Borghesi and Vercelli, 2012; Garrido et al., 2013; Siu et al., 2014; Straume and Vittersø, 2014).

Emotional states such as happiness and attitudes towards life are seen as a key determinant of the somatization of feelings of

stress and anxiety related to life events. Findings from medicine and psychology suggest that emotional reactions to life events can affect physiology in ways that are potentially damaging for health (Rozansky et al., 1999; Kuhn et al., 2009; Schröder, 2013).

Seminal studies pointed to the autonomic nervous system (ANS) as the main channel of transmission of the effects of happiness on health (Ekman et al., 1983; Levenson et al., 1991; Levenson, 1992). Unpleasant life events such as a job loss cause a negative emotional response which can significantly influence the functioning of the ANS. For example, Rozansky et al. (1999) found that the mortality of men who lose their wives doubles in the first month after the event. For women, the mortality rate after losing their husbands is three times higher than normal. The relationship between involuntary job loss, depression, and poor health conditions is well established in the literature (see for example Clark and Oswald, 1994; Field and Briggs, 2001; Kuhn et al., 2009). Sullivan and von Wachter (2009) estimated an approximately 20% excess risk of death in the 20 years following a job loss in two American states. Eliason and Storrie (2009) obtained similar results for job losers in Sweden. Using the Survey of Health, Ageing, and Retirement in Europe Schröder (2013) found that women who suffered from an involuntary job loss report poorer general health and more chronic conditions, which also causes limitations in their daily activities.

Numerous studies have shown that ANS responses to emotional states may activate physiological reactions that could have cumulative effects on health (Fredrickson and Levenson, 1998; Glassman and Shapiro, 1998; Carney et al., 2005). Adaptation to disruptive life events requires a variable amount of time depending, among other factors, on personality characteristics. Some people are unable to

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recover from the acute distress caused by the loss of a close friend or relative, while others suffer less intensely and for a shorter period of time (Bonanno, 2004). On the one hand, quick hedonic adaptation may make sustainable increases in well-being difficult, or even impossible to attain. Large increases in the standard of living (due for example to a lottery win) seem to have almost negligible effects on happiness (Kahneman and Krueger, 2006). On the other hand, quick adaptation contains the distress associated with negative events, thereby preventing damaging physiological reactions (Lucas, 2007). For example, in individuals with intensely negative emotional responses and slow hedonic treadmill, the ANS could prompt cardiovascular activity that accelerates certain pathologies such as atherosclerosis (Krantz and Manuck, 1984; Kubzansky and Kawachi, 2000; Stewart et al., 2007).

The claim that emotional responses to life events influence individual health is also supported by the evidence that happy people live longer (Diener and Chan, 2011). Happiness and positive attitudes towards life may in fact prevent the activation of physiological reactions to life events that could have cumulative detrimental effects on health (Frey, 2012). Field studies have shown the beneficial effects of positive mental states on physical health, as reported in recent reviews of the literature and meta-analyses of existing studies (Howell et al., 2007; Veenhoven, 2008). For example, Howell et al. (2007) integrated findings from 150 experimental, ambulatory and longitudinal studies that tested the impact of well-being on objective health outcomes. Results demonstrated that well-being positively impacts health outcomes, suggesting the existence of biological pathways, “such that well-being can directly bolster immune functioning and buffer the impact of stress” (2007, p. 83). In an experimental study, Cohen et al. (2003) exposed subjects to a cold virus and closely monitored their symptoms. Those who had reported a higher level of life satisfaction at baseline were less likely to contract the cold and quicker to recover if they became sick. According to Veenhoven (2008), the size of the effect of positive attitudes appears to be so strong to be comparable to that of smoking or not.

In addition to psychosomatization, the literature has mentioned other transmission mechanisms connecting happiness to health. Happy people are more inclined to live in a healthy way. They engage in sports more often (Rasciute and Downward, 2010), they are more likely to watch their weight (Veenhoven, 2008), to avoid unhealthy behaviours such as drinking, smoking and overeating, and less likely to commit suicide or be victim of accidents (Frey, 2012).

In this paper, we aim to test the relationship between happiness and self-reported health, after controlling for the influence of a number of economic and social phenomena, such as economic well-being, work status and education. Among control variables, particular attention is devoted to the role of social capital, which has been found to be strongly and positively associated with good health (Brown et al., 2006; De Silva et al., 2007; Engström et al., 2008; D’Hombres et al., 2010; Fiorillo and Sabatini, 2011a, 2011b). In this paper, we account for both the “structural” and the “cognitive” dimensions of the concept. The structural dimension of social capital deals with individuals’ behaviours and can take the form of relational goods consumption, participation in social networks, and volunteering activities. Cognitive social capital deals with agents’ perceptions and involves concepts such as trust, reciprocity, and shared beliefs (Uphoff, 1999). Structural social capital can influence health in a number of ways. More intense social relationships may facilitate individuals’ access to social support and healthcare, as well as the development of informal insurance arrangements (D’Hombres et al., 2010). They can promote a more rapid diffusion of health information, increase the likelihood that healthy norms of behaviour are adopted (e.g. physical activity and

usage of preventive services), and exert social control over deviant health-related behaviours (Kawachi et al., 1999; Melchior et al., 2003; Brown et al., 2006; Folland, 2007). Cohesive networks may exert the so-called “buffering effect”, balancing the adverse consequences of stress and anxiety through the provision of affective support and by acting as a source of self-esteem and mutual respect (Kawachi et al., 1997; Greiner et al., 2004; De Silva et al., 2007). Less evidence is available about the role of cognitive social capital. While several studies find social trust to be correlated with good health, several other studies find this correlation not to be robust to different specifications (Kim et al., 2006; Folland, 2007; Baron-Epel et al., 2008; Mansyur et al., 2008). The measurement of social capital has been the subject of an intense debate in the economics literature. Following Sabatini (2007; 2008), it is possible to identify three main measurement-related weaknesses that affect the empirical literature on the topic. The first one is the use of macro indicators that are not directly related to social capital’s key components. The use of these indicators – e.g. crime rates, teenage pregnancy, blood donation, participation rates in tertiary education – has led to considerable confusion about what social capital is, as distinct from its outcomes, and what the relationship between social capital and its outcomes may be. As stated in Stone (2001), research reliant upon an outcome of social capital as an indicator of it will necessarily find social capital to be related to that outcome. The second main problem is aggregation. Cross-country studies on the outcomes of social capital are based on measures of trust taken from international surveys. “Trust measured through surveys is a “micro” and “cognitive” concept, in that it represents the individuals’ perception of their social environment, related to the particular position that interviewed people occupy in the social structure. The aggregation of such data, however, creates a measure of what can be called “macro” or “social” trust which loses its linkage with the social and historical circumstances in which trust and social capital are located (Fine, 2001). The third problem is multidimensionality. Most empirical studies on the topic generally focus on just one or two indicators of social capital’s dimensions, neglecting the possibility that dimensions often influence each other and that each of them may exert a diverse effect on the outcome of interest (Antoci et al., 2013; Sabatini and Sarracino, 2014).

As explained in Section 2, we address these measurement issues by focussing on individual-level multiple indicators of the behavioural key elements of social capital, as given by measures of social relationships, social participation, and social support.

To reach our goal, we rely on a unique dataset collected through the administration of a questionnaire to a representative sample ( $n = 817$ ) of the population of the Italian Province of Trento in March 2011. The sample was stratified by age, gender and area of residence. The questionnaire was specifically designed for the evaluation of various aspects of well-being at the individual level.

Our choice to focus on the Province of Trento was due to results from recent empirical studies which found the territory to be characterized by contained inequalities (including health disparities), as well as by exceptional levels of well-being and social capital (Degli Antoni 2006a, 2006b; Sabatini, 2008, 2009a). In our view, two main reasons make this case study worthy of attention in the health economics literature. First, the low level of health inequalities and the extension of the public healthcare system allow us to carry out a better assessment of the behavioural determinants of health. Also, the exceptional wealth of social capital which previous studies attribute to the Province of Trento should help in isolating the possible role of happiness: if most citizens are endowed with high levels of social capital, we should be less likely to find social capital-based health disparities in the sample.

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