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Neighbourly support of people with chronic illness; is it related to neighbourhood social capital?

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ABSTRACT

The neighbourhood may provide resources for health. It is to date unknown whether people who live in neighbourhoods with more social capital have more access to practical and emotional support by neighbours, or whether this is a resource only available to those who are personally connected to people in their neighbourhood. We investigated whether support by neighbours of people with chronic illness was related to neighbourhood social capital and to individual neighbourhood connections. Furthermore, we investigated whether support received from neighbours by people with chronic illness differed according to demographic and disease characteristics. We collected data on support by neighbours and individual connections to neighbours among 2272 people with chronic illness in 2015. Data on neighbourhood social capital were collected among 69,336 people in 3425 neighbourhoods between May 2011 and September 2012. Neighbourhood social capital was estimated with ecometric measurements. We conducted multilevel regression analyses. People with chronic illness were more likely to receive practical and emotional support from neighbours if they had more individual connections to people in their neighbourhood. People with chronic illness were not more likely to receive practical and emotional support from neighbours if they lived in a neighbourhood with more social capital. People with chronic illness with moderate physical disabilities or with comorbidity, and people with chronic illness who lived together with their partner or children, were more likely to receive support from neighbours. To gain more insight into the benefits of neighbourhood social capital, it is necessary to differentiate between the resources only accessible through individual connections to people in the neighbourhood and resources provided through social capital on the neighbourhood level.

Residential neighbourhoods are meaningful contexts of life and are important for health and wellbeing of their inhabitants (Cramm and Nieboer, 2015; Diez Roux, 2001; Diez Roux and Mair, 2010; Greenfield and Reyes, 2014; Lomas, 1998; Pickett and Pearl, 2001; Subramanian et al., 2003). The neighbourhood has gained increasing attention as a site for social support and help, for instance for elderly in the context of 'ageing in place' (Gardner, 2011; Gray, 2009; van Dijk et al., 2013; Wiles et al., 2011). Theories on the significance of neighbourhood relationships have traditionally emphasized their instrumental value (Cantor, 1979; Litwak and Szelenyi, 1969). Research shows that neighbours usually fulfil tasks that require proximity (for instance monitoring that someone is okay), tasks that are practical (for instance shopping, transportation or assistance with household maintenance) and non-intimate (not concerning personal care or nursing tasks for instance (Barker, 2002; Bridge, 2002; LaPierre and Keating, 2013; Litwak and Szelenyi, 1969; Nocon and Pearson, 2000). This study aims to gain more insight into support by neighbours, specifically for people with chronic illness. Previous studies have focused on support by neighbours for elderly in the general population (Gardner, 2011; Barker, 2002; Nocon and Pearson, 2000), but to date there is no information on support by neighbours specifically for people with chronic illness.

To manage the demand put on health care systems due to long-term health problems, there has been an increasing focus on the responsibility of patients and their social network for health (Lipszyc et al., 2012; Maarse and Jeurissen, 2016). However, people with long-term health problems, such as people with chronic illness, might not always be able to rely on support from social

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network members, such as friends and family. The growing number of people with chronic illness and the changing age structure of the population, place high demands on available informal caregivers and raise questions regarding the future availability of informal care (De Boer and De Klerk, 2013; Pickard et al., 2000; Pickard et al., 2007). Social network members, who possibly have to balance other responsibilities, including work and child care, can be busy and therefore limited in the amount of help they can provide (LaPlante et al., 2004). Furthermore, social network members might live far away and physical distance can be a barrier to support (De Klerk et al., 2009; Linders, 2010; Wellman and Wortley, 1990). When there are barriers to support from social network members, or when people with chronic illness otherwise lack the resources they need for health, the neighbourhood can possibly provide compensatory resources. A previous study found that people with less frequent contact with friends and family were more likely to report good health when they lived in neighbourhoods with more social capital (Mohnen et al., 2015). This study however did not provide information on the specific compensatory resources provided in neighbourhoods with more social capital. It is valuable to shed more light on the specific resources that are provided in neighbourhoods, such as practical and emotional support.

A rich literature on neighbourhood resources has shown that social capital in the neighbourhood on both the individual and the neighbourhood level can benefit people's health. Here we link the literature on support for people with chronic illness and the literature on neighbourhood resources by asking the question whether more support by neighbours is available for chronically ill people in neighbourhoods with more social capital. Or is more support by neighbours only available if they are personally more connected to their neighbours, i.e. when they have more individual social capital?

Social capital is defined by the resources that develop through social relations. These resources can facilitate the achievement of goals and contribute to health and wellbeing (Coleman, 1988). Social capital can be conceptualized on a number of analytic levels, among which the macro level (countries, states and regions) (see for instance Kawachi et al., 1997), the meso level (neighbourhood and blocks) (see for instance Lochner et al., 2003), and the individual micro-level (individual social relationships, trust and norms) (Portes, 1998; Veenstra, 2000). Social capital on the individual level differs from social capital at the community level, for instance the neighbourhood. Individual social capital is a personal asset and consists of resources that are only accessible to individuals that are part of the relationships that generate specific resources (Portes, 1998). On the other hand, social capital on a community level is the source of collective resources that do not belong to a specific individual, or inhere in a specific set of relationships, but are part of the social structure of a community (Coleman, 1988). Social capital on the community level provides public resources that can benefit even people with poor personal social connections. Neighbourhoods with more social capital might for instance be more successful at realizing informal social control, which might result in reduced violence (Sampson et al., 1997). More neighbourhood safety benefits all neighbourhood residents and not only those personally connected to specific others in their neighbourhood. In addition to a distinction made between social capital on different levels, it is also possible to distinguish between bonding and bridging social capital. The distinction between 'bonding' and 'bridging' social capital helps to differentiate between people in homogeneous networks with similar social identities (intragroup relations) and relations between people in heterogeneous networks (intergroup relations) (Putnam, 2002). There is evidence that community or collective social capital in the neighbourhood can benefit health of people in the general population as well as people with chronic illness (Anonymous, 2014; Gilbert et al., 2013; Hunter et al., 2011; Islam et al., 2006; Subramanian et al., 2003; Sundquist and Yang, 2007; Vyncke et al., 2013). Examples of public resources provided through neighbourhood social capital that can benefit health, are increased informal social control and increased access to health information (Kawachi et al., 1999; Kawachi and Berkman, 2000; Sampson et al., 1997). Another possible mechanism might be the provision of support by neighbours (Kawachi et al., 1999, Kawachi et al., 1997). It might be case that in a neighbourhood with more collective social capital there is more of a general tendency to help each other (for instance with work in the garden, carrying groceries, or by having a conversation on the street), even when people don't know each other very well. Others, however, stress the importance of being connected to people or networks that generate specific resources, and state that access to social support is restricted to people who are embedded in specific relationships with those that can provide social support (Carpiano, 2006, 2008). Simply living in a neighbourhood with more social capital, without having relationships with specific neighbours or being integrated into neighbourhood networks, might thus not be enough for an individual to gain access to social support by neighbours.

Not only might support by neighbours depend on personal integration in the neighbourhood and individual connections to others. The use of social support by neighbours might also differ according to demographic and disease characteristics of people with chronic illness. Based on demographic and disease characteristics, people with chronic illness might either have more access to support by neighbours or might have a higher need for support by neighbours. Regarding differential access to neighbourhood resources, a study showed differences in the effect of neighbourhood social capital based on duration and intensity of exposure to the neighbourhood environment (Mohnen et al., 2013).

To gain more insight into the relationships between support by neighbours, neighbourhood social capital and individual neighbourhood connections, we will explore differences in the use of support by neighbours according to demographic and disease characteristics of people with chronic illness and we will test the following hypothesis:

People with chronic illness more often receive support from neighbours if they live in neighbourhoods with more social capital, beyond individual connections to neighbours.

1. Methods

1.1. Data collection

1.1.1. National panel of the chronically ill and disabled (NPCD)

We used data from the 'National Panel of the Chronically ill and Disabled'. This is a nationwide prospective panel study in The Netherlands, established to gather information on the consequences of chronic disease and disability from a patient perspective. For the NPCD, participants are recruited from random samples of general practices that are drawn from the Dutch Database of General Practices. They are selected according to the following criteria: diagnosis of a somatic chronic disease by a certified medical practitioner, aged >15 years, not permanently institutionalized, aware of the diagnosis, not terminally ill (life expectancy > 6 months according to their general practitioner), mentally capable of participating, and sufficient mastery of Dutch. Members of NPCD are also recruited on the basis of a self-reported moderate or severe physical disability from several national population surveys conducted by the Netherlands Institute for Social Research, the Dutch Ministry of Infrastructure and the Environment and Statistics