

Social Capital, Health and Neighbourhood Renewal in the City of Hull



A Baseline Assessment

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Foreword

Once we have access to the basic necessities of life, then few things make more difference to the quality of our lives than the quality of the social environment. We all need to feel included, valued, appreciated, and treated as equals. But all too often, people are instead made to feel excluded, ignored and looked down on as inferior.

It is encouraging to see a city taking steps to look at social capital and the quality of social relations locally. Though the findings of this study are often perplexing, we can at least take action on things we know inhibit social contact. We need to think about what divides people, making them feel too timid to take social initiatives, too hesitant – or defensive – to make friends. Social contact often provokes anxiety about how we are seen. We all have fears that we may be too unattractive, too boring, too stupid, too fat: in short that we won't be liked. Such anxieties may mean social contact has to be eased by drink or drugs.

The psychosocial risk factors for poor health affect us by making us feel stressed for long periods. The main ones are intensely social: low social status, lack of friends, and an emotionally difficult early life. They are key sources of stress because they affect how we feel others see us. Insecurities from early childhood are related to the insecurities which may come from low social status. Friendship fits into this pattern because friends make you feel liked and valued, just as feeling left out and not having friends may leave you feeling rejected and full of self-doubts.

One of the characteristics of societies with low social capital is great inequality: people are divided by gradations of income and status. Wider income differences increase the social distances between people and the scale of class differentiation.

We have long known that inequality is socially corrosive, just as we have always known that we tend to choose friends from social equals with whom we feel at ease. Wider income differences lead to slower social mobility, increased residential segregation, and a growth of downward prejudice and discrimination. There is ample evidence that more unequal societies, with bigger income difference are unhappy societies: they not only have worse health but also more violence, higher homicide rates, less involvement in community life, lower levels of trust, higher teenage pregnancy rates and more obesity (Wilkinson 2005).

But social capital is not just a matter of income distribution and class differentiation, it is also about what we might call an extension of good manners into the wider society. In his usual provocative style, Bernard Shaw said "There is no word that has more sinister and terrible connotations in our snobbish society than the word promiscuity; but if you exclude... (its sexual meaning) you will see that social promiscuity [by which he meant talking to people regardless of social distinctions] is the secret of good manners" (p.418). If we were to treat people in the public sphere, on the street, in shops, at work and in schools, with the respect and consideration we accord to friends and guests in the private sphere, problems of low social capital would disappear and community life would flourish. But if we really treated each other as equals and with consideration, we would surely not tolerate the gross inequalities which we do tolerate.

Shaw GB. *The intelligent woman's guide to Socialism and Capitalism*. Brentanos, N.Y., 1928.
Wilkinson RG. *The impact of inequality: how to make sick societies healthier*. Routledge 2005.

Introduction

On behalf of the Hull Social Capital Steering Group, I am pleased to present the findings of this important research project considering social capital in Hull and its links with health. This is part of a programme of work to support the development of Hull's Neighbourhood Renewal Strategy (NRS), whose goal is to improve quality of life in disadvantaged neighbourhoods.

In March 2002, the Hull Local Strategic Partnership approved the NRS as a means of achieving real improvements in quality of life judged against a range of 'floor targets' including reductions in crime, improved education attainment, better housing, improved economic prospects, life expectancy and teenage pregnancy. During the development of that original strategy the notion of social capital as a productive resource was seen as one means of providing an assessment of 'community spirit'. It would then be theoretically possible to identify changes in the level of social capital over time, and thus provide some more qualitative assessment of performance improvement (with health as the outcome measure) that would complement the output driven floor targets.

In response to this, detailed interviews with over 4000 people in Hull were completed between March and May 2004 as the first stage in producing a baseline assessment of the level and nature of social capital across the city. A comprehensive report with appendices has now been produced (running to 200 pages) the findings which are summarised here. Copies on CD can be made available.

Throughout the process of developing, undertaking and reporting the research we have worked closely with a range of partners including the city's Area Directors who are keen to use the findings to develop their own plans. The importance of local ownership and involvement in such research is crucial to its dissemination and to understanding what the report is really saying about Hull. It is hoped that this summary will assist with this process.

I would like to pay tribute to the work of the Steering Group and to Andrew Gibson Consulting Ltd who undertook much of the data collection and initial analysis. I would also like to thank the interviewers, and all those who took part in the survey, for all of the efforts to produce this report. I hope that all of you reading it will find it valuable, and will use it to contribute to a more informed policy debate about the potential benefits of social capital to health improvement and sustainable regeneration.

Simon C Hunter
Director – Hull and East Riding Health Action Zone
Steering Group Chair

July, 2005

Executive Summary

This major research project started in May 2004 when a sample of over 4000 adults representative of the population of Hull took part in detailed face to face interviews collecting data about their health, lifestyle, employment status, qualifications, and their views on local services. We also wanted to explore in more detail what it was like to live in Hull – how much people liked the city, how long they had lived in a particular area, and the sorts of problems they had. But we were also very interested in finding out about the quality of life in the city in terms of levels of social capital. To do this we asked questions about people's involvement in local groups and whether they had taken action to solve a problem in their area. We also collected data about neighbourliness and trust, how safe people felt, the kinds of networks of family and friends that existed and the extent to which they could rely on those networks in a crisis.

A summary of the findings from this research is presented in the following pages and there is also a full report available on CD. There is a wealth of data that will be valuable to those working in health improvement but also for others working in neighbourhood renewal such as the police, council departments, wardens, community planners and community organisations. Most of the analysis looks at the data in terms of age, gender, employment status and geography (based on which of the seven areas of the city respondents were from) and provides a comprehensive picture of Hull. Background to the research is provided in the first three chapters.

Chapter 4 looks general perceptions of life in Hull. Most people said they enjoyed living in the city but they also identified issues of concern such as safety.

Chapter 5 uses some national data to support finding from the survey about the poor health status of Hull as a whole but also shows how health differs across the city.

Chapter 6 covers the different dimensions of social capital (civic engagement, neighbourliness/trust, social networks and social support) which are analysed showing that levels of social capital do vary across the city but the pattern is not consistent. Areas showing less trust, for example, also had comparatively high levels of social support.

Chapter 7 looks in detail at how the findings on social capital relate to health status across the city and again the findings are complex. They demonstrate:-

- Those who felt well informed about local issues and felt they could influence them reported better health
- Regular contact with neighbours and non-household family members is linked to better physical and mental health
- Social support is important to health

Some of the conclusions drawn from the research indicate mixed results. There is conflicting evidence about the impact of being a member of an organisation on health, and the importance of trust is unclear. Three key factors do emerge as being strongly associated with health and these are:-

1. Having someone to help when ill in bed
2. Close access to family and friends
3. Feeling safe walking home after dark.

These are important findings but there are many more in the subsequent pages and in the full report. This research is a major resource for community planning, empowerment and development and it is at a very local informal level that investment in the stock of social capital should be explored. An inclusive approach to neighbourhood renewal that prioritises social support for those more isolated people (including means of increasing access to family and friends), and improves perceptions of safety after dark, will have a real impact on health and contribute to narrowing the gap in health inequalities experienced by the people of Hull.

Background and Context

Hull is an historic city with a population of approximately 253,000 people. Situated on the north bank of the Humber estuary, 38 miles from York and 55 miles from Leeds, it is one of Yorkshire's major centres and is the focal point for much of the eastern part of the Yorkshire and Humber region.

The city serves the needs and provides most of the employment, entertainment, learning, social and cultural facilities not just for those living in the city but also for the greater population within the 'city region'.

Hull has a number of attractions, including the Old Town, and more recently through successful regeneration projects, has seen the development of The Deep (a marine life centre) and the Kingston Communications Sports Stadium, with much more planned.

Hull has always prided itself on its fishing heritage, and up until the late 1960s the communities of Hull typically resided around its major industries. However, with the industrial decline experienced across the UK, including the fishing industry, and the housing clearances in the early 1970's, these established communities were often fragmented, resettled in other areas and provided with local authority housing on purpose-built estates situated on the outskirts of the City.

High levels of unemployment in the 1980s and lack of investment have left their mark. The evidence of exclusion is particularly apparent in a number of the city's communities where economic disadvantage is exacerbated by crime, unacceptable levels of social disorder, and poor and unpopular housing. There are also marked differences in health and life expectancy within the city and compared to the national average.

Genuine neighbourhood renewal is crucial to the future prospects of Hull. An understanding of social capital is one component of that renewal because it explores core community relations and resources. This research sets out to develop such understanding across the spectrum of regeneration, but with a specific interest in health status.

Chapter 1

What is Social Capital?

There are numerous definitions of social capital but an early and influential one is 'Social capital...refers to the features of social organisation, such as trust, norms and reciprocity, that can improve the efficiency of society by facilitating co-ordinated action' (Putnam, 1993). Berkman and Kawachi et al (2000) draw together several definitions, concluding that common features focus on the 'social', or external, rather than individual 'ownership' of the resource. It is also defined as a 'public good' with benefits shared beyond those who create it.

This concept is important for public health because, if it can be shown that different levels of social capital impact on health status, then its measurement should be a more important part of epidemiology (the science of the distribution and determinants of disease); and public health action should develop at community or neighbourhood level rather than its more traditional focus on individual behavioural factors and choice.

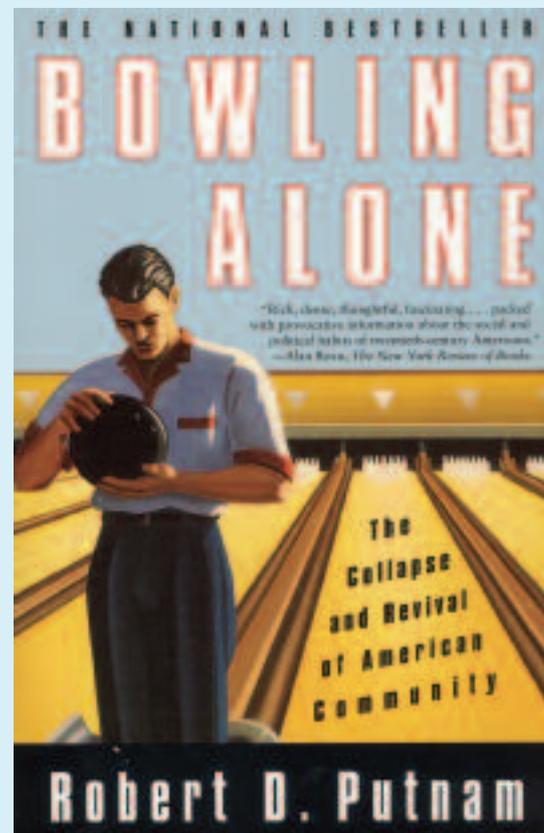


Whilst social capital as a concept has long antecedents back to Durkheim, it was only ten years ago that it became popularised by Robert Putnam, a Harvard Professor of Political Science in two major works: 'Making Democracy Work: Civic Traditions in Modern Italy' (1993) and 'Bowling Alone: The Collapse and Revival of American Community' (2000). Putnam's work and that of others has been adopted by the World Bank as a likely explanation of the failure of economic investment in the developing world.

Putnam's more pluralist approach places greater weight on trust and social networks. Other theorists such as Bourdieu (1986) stress the role social capital plays in the power imbalance that reinforces social and economic inequity thus reinforcing material deprivation. In Britain Ichiro Kawachi has worked with Richard Wilkinson whose 'Unhealthy Societies: The Affliction of Inequality' (1997) makes a powerful case for the important role differing levels of social capital play in health inequalities. Further work in the UK has been co-ordinated by the Health Development Agency (HDA) through quantitative and qualitative projects, including its Social Action Research Programme.

Health Action Zone area-based initiatives also considered the concept when developing innovative approaches to tackling health inequalities. In particular, the work commissioned in South Yorkshire Coalfields from the Centre for Regional Economic and Social Research based in Sheffield is an important forerunner whose experience was used to inform this current study. It is important to pay tribute to the work of Professor Geoff Green from Sheffield Hallam University who also provided advice during the development of the research proposal.

In 'Bowling Alone', Putnam's chapter on health describes how high levels of social capital might actually stimulate the immune system to fight disease and lead to lower mortality.



'Of all the domains in which I have traced the consequences of social capital, in none is the importance of social connectedness so well established in the case of health and well being'

To help inform the development of this study (and enhance the understanding of the community interviewees), the importance of social capital was emphasised at 3 levels: -

Level 1 Social Organisation

Networks of secondary associations, high levels of interpersonal trust and norms of mutual aid and reciprocity – which act as resources for individuals and facilitate collective action.

Social capital has both direct and indirect consequences for a wide range of positive social and economic outcomes in areas such as employment, education, crime and well being, and therefore health inequalities.

For example, a community rich in stocks of social capital is supposedly more likely to possess effective civic institutions and, hence, to prosper and be more likely to be effective in maintaining law and order.

Level 2 Community Spirit and Connectedness

Citizenship, neighbourliness, trust and shared values, community involvement, volunteering, social networks and involvement in local democratic processes. These are seen to be important features of social life that encourage co-ordination and co-operation within and among groups for mutual benefit. This research seeks to identify the quality of different types of social capital evident across all areas of Hull, and to relate these findings to how well the city is doing in terms of education, employment and well being.

Level 3 Well-being

It is important to find out what influences people to feel confident or happy (or not) about where they live, and whether these influences bear any relationship to their feeling of well being, health and life opportunities.

Developing the Research Project

Funding to support the production of a baseline assessment of social capital in Hull was secured from the Neighbourhood Renewal Fund for 2003/4 and a Steering Group established to manage the project. In agreeing funding it was noted that this work would provide an initial attempt to assess and understand the nature of this complex concept. Such an assessment would be valuable in generating a more structured debate about the role and value of social capital in Hull and its relationship to levels of health.

Andrew Gibson Consulting Ltd (AGC) was appointed to develop and deliver a face to face questionnaire to 4000 people across the seven Area Partnerships in the city. Those interviewed met a statistical profile of each area, based on age, gender, and employment status. It was important to have a high response rate and to reduce possibilities for bias or the return of incomplete questionnaires. Data collection would be through face to face interviews (rather than a postal survey) even though this was inevitably more costly and time consuming.

The work of AGC included recruitment, selection and training of interviewers, design and monitoring of the quota sample, management of all fieldwork, and initial statistical analysis and reporting of findings.

Research Objectives

The Steering Group developed a number of key questions: -

1. What is the nature and pattern of social capital in Hull?
2. How do social capital levels vary according to age, gender, social group?
3. How do levels of social capital and health vary geographically across the seven Area Partnerships?
4. How do the levels in Hull compare with the national picture and the South Yorkshire Coalfields survey?
5. What are the levels and pattern of social capital as defined by specific dimensions of social capital?
6. What are the attitudes and views of residents to their local area and facilities?
7. What is the relationship between levels of social capital and health, including particular indicators of health and health-related behaviours?
8. Do areas with different levels of social capital tend to have better health?
9. What further research should be considered e.g. into particular dimensions of social capital, or in particular areas? What elements of qualitative research should be pursued?

The answers to most of these questions emerge from the preliminary findings reported here. Further detailed analysis has also begun, some of which is also outlined in the subsequent pages. It is intended to develop a programme of research into aspects of social capital and health over the next 12 months, to be managed by the Steering Group who are keen to share the data with other researchers.

Doing the Research

There are a number of important issues concerning the research methodology that should be kept in mind when considering this report.

Quantitative Design

There are many ways to research social capital, often using qualitative survey methods because measuring such a complex community concept in a numerical way is seen as either difficult or inappropriate. This was considered during the development of the research proposal, which was informed by findings from a variety of qualitative studies. However, it was felt that a baseline assessment would best be achieved through a quantitative research method, in order to capture citywide differences in social capital and to seek to relate these to health status. This would allow us to produce a snapshot that was reliable in measuring the concept consistently, repeatable on the basis that a subsequent snapshot could be undertaken if needed, and valid by enabling wider descriptions of the city to be made from the findings in the sample.

Indicators for the dimensions of social capital to be administered in questionnaires do exist. Lochnar et al (1999) have produced a 'guide' to the measurement of social capital which brings together several existing measures under the headings collective efficacy, psychological sense of community, neighbourhood cohesion and community competence. The Office for National Statistics (Harper, 2001) has produced a matrix of social capital survey questions following their assessment of eighteen large national surveys. As part of the Health Development Agency research programme, Pevalin and Rose (2002) investigated links between social capital and health using the British Household Panel Survey.

Their detailed analysis of both the appropriateness of the questions used and outcome in terms of the relationship between social capital and health was helpful in informing this study which used the EuroQol, visual analogue scale or Health Thermometer, and the Mental Health Inventory (as measured by five questions from SF-36). A number of robust research questions had, therefore, previously been tested and piloted.

Chapter 2

The final questionnaire was 10 pages long, with 35 questions (some with multiple components) - requiring 76 responses/sections of information in total covering: -

Personal details including housing type

Area issues including facilities, safety, crime etc

Neighbourhood/trust

Relations with family and friend

Health status

Lifestyle

Qualifications and employment status

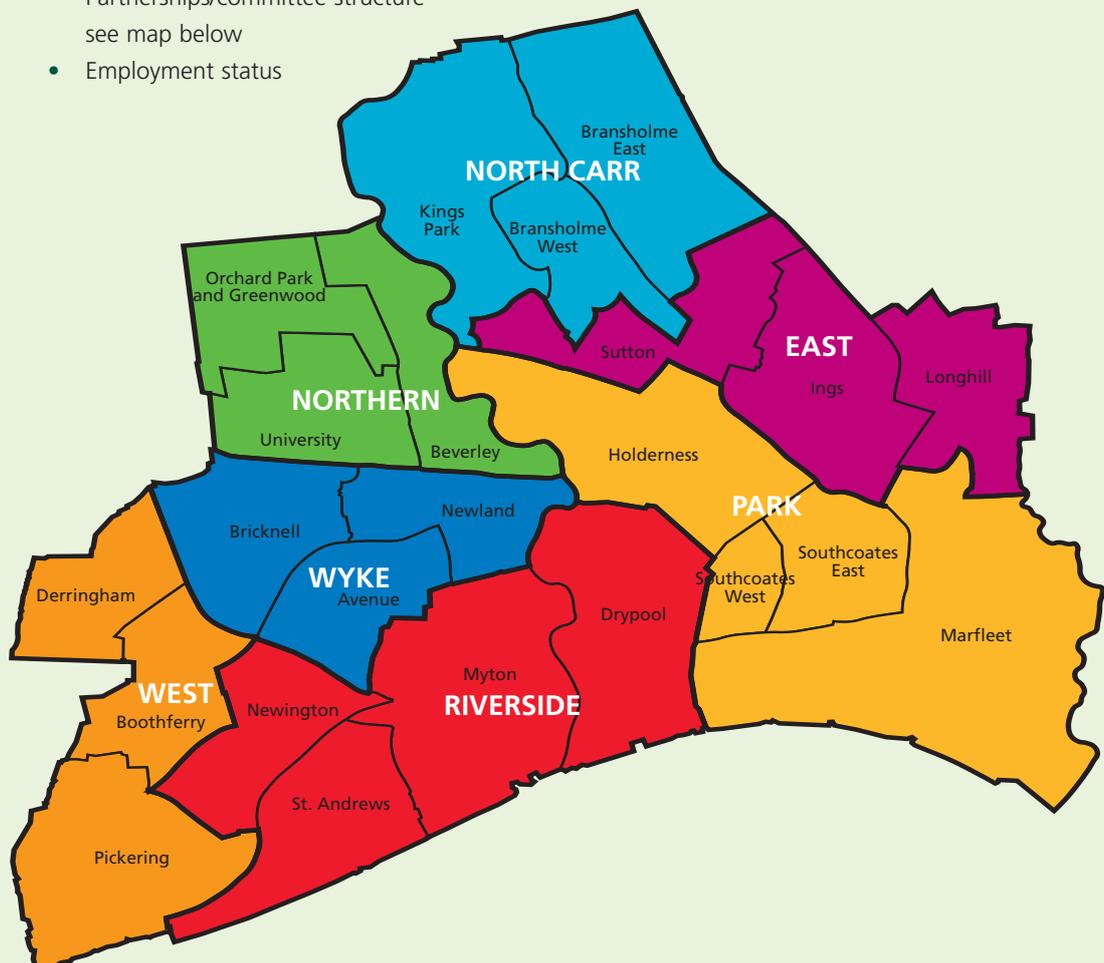
Achieving a Representative Sample

Achieving a sample representative of the whole local population was of prime importance in this study. Budgets available enabled 4000 interviews to take place (the full sample was over 4700), and using available statistics for the population of Hull a “target” sample profile was drawn up. Four criteria were agreed for use in determining this target profile because they were believed to be important variables for social capital research: -

- Gender
- Age
- Geographical area, comprising seven areas based on Hull City Council's Area Partnerships/committee structure – see map below
- Employment status

The agreed minimum age for respondents was 16 years. Statistics by age, gender and employment status for the city, sub divided by committee area were taken from the 2001 Census. No account was taken of ethnic differences in relation to social capital because this is a relatively small population in Hull. In addition surveying in neighbourhoods with a concentration of asylum seekers was avoided.

Given the sample represents the population structure, potential biases are less of a problem than may have been the case if the sample was derived by more frequently used methods of survey selection.



Rationale for Using Community Interviewers

There were significant merits in using local residents to undertake interviews, rather than professional market research interviewers.

Three main reasons prompted this decision:

- Local residents might be more able to gain the confidence of respondents in their area, thereby generating higher quality information.
- Training (and paying) local residents invests in local awareness and expertise; i.e. it builds social capital in its own right.
- This was in line with the ethos of the Neighbourhood Renewal Strategy.

It was envisaged that the community interviewers might need to be supplemented by professional interviewers. In practice the fast moving timescales for this project (10 weeks from selection of community interviewers to completion of fieldwork), and the longer than expected settling in period for many of the community interviewers, meant that the professional team were required to undertake more interviews than was originally anticipated. Nonetheless, the ambition of creating a resource of local residents interested in helping with further research was achieved.

Recruiting the Community Interviewers

Rigorous efforts were made to recruit interviewers who would be representative of communities across the City. Hull Community Network helpfully provided a mail-shot of the literature describing social capital, together with the training event application forms, to hundreds of groups and individuals who were actively interested in neighbourhood issues. 20 interviewers were recruited locally which was less than anticipated.

A full day training programme was delivered including introducing the concept of social capital, interviewing skills (including avoidance of bias and 'socially desirable' responses, non-verbal behaviour), health and safety, and conducting interviews based on the questionnaire.

Information was also included about local helplines as it was recognised that certain questions might trigger an emotional response if, for example, someone had been a recent victim of crime. Whilst this was probably unlikely to occur, it was nevertheless emphasised within the training that it was not the interviewer's role to adopt a counselling approach, and it would be more helpful to pass on a telephone number for accessing assistance, if the resident so wished.

Ensuring Consistency in Fieldwork

A number of mechanisms were used to guard against biasing the sample of respondents interviewed in terms of consistency with which questions were asked and responses recorded. Each interviewer worked to a personal quota, and questionnaires were returned on a continuous basis (typically 10 at a time), such that the sample profile, and consistency in undertaking the fieldwork, could be monitored.

Interviewers were required to undertake interviews through knocking on doors, but with the final phase of fieldwork being undertaken in public places as well as using a door to door approach in order to provide additional flexibility in achieving the pre-defined quotas.

Bias in any survey must be kept to a minimum. It was felt that this work was best undertaken on a face to face basis rather than using telephone interviews or postal questionnaires. Face to face interviews usually produce the best response rates and can handle long or complex questions plus issues of item non-response. The closed nature of the majority of questions (drawn from validated questions from existing surveys) also reduced question complexity and avoided the expense of extensive piloting.

Further advantages of face to face interviews include being able to explain the purpose of the survey in detail, answer questions and provide a supporting letter from the Primary Care Trust – all of which tend to increase response rates. The views of hard to reach groups such as those who have difficulties reading or writing are also more effectively gathered through face to face interviews.

A 10% check on respondents was undertaken from both the community and professional teams, primarily by telephone. Interviewers were required to supply (separately for the sake of confidentiality) lists of those they had interviewed, together with address or phone number.

Community Interviewers' Experience

Following an initial enthusiasm for the task, a number of interviewers dropped out of the survey. Each one received a telephone call from Andrew Gibson Consulting and a letter to ask their reasons for withdrawing.

One particularly enthusiastic participant from the initial training day had experienced an increase in her workload at work. As a teacher, working 50+ miles outside of the City, her interest in continuing became untenable. This resulted in a further participant, planning to work alongside this lady, also deciding not to continue.

A young woman, working in two areas, was affected by an interviewee's unease when asked about mental health issues. Despite offering her support and advice to encourage her to continue, she felt unable to do so.

The comments of community interviewers who responded to a feedback sheet relating to their fieldwork activity are as follows:

What did you find helpful in maintaining your involvement with the project?

'Personal Interest - that if I ceased involvement, I would not be paid for work already completed'

'The participation of the people interviewed. Once it was explained what the survey was about, they were very willing to give their opinion, which is uplifting.'

'The leadership provided by Wendy and all the staff of Andrew Gibson Consulting was very helpful. They all were very polite and encouraging. It was a pleasure to work with you.'

'My interest in the nature of this type of work and also meeting people.'

'I enjoyed interacting with people and finding out for myself what people thought and had been through in the local area. I enjoy research and look forward to seeing the results of the project.'

'Contact, (phone calls from project.)'

If you had to discontinue your work as an interviewer, what were the reasons for this?

'Lack of time, deadline quite tight to do as part-time.'

'Just wish I had time to do more than one hundred.'

An incentive was introduced to encourage interviewers, requesting them to approach like-minded friends / contacts who would be interested in the second training event. Those who nominated candidates who completed the training and questionnaire activity received a cash bonus. The payment of interviewers for their training was initially dependent upon their delivering their questionnaire quota of at least 100. As many interviewers discontinued fieldwork before this, AGC decided to pay these individuals a proportionate payment toward their training day. Interviewers who continued beyond 100 received enhanced payments for their persistence.

The community interviewers completed 980 interviews, all undertaken on a doorstep basis. The remaining interviews were undertaken by professional interviewers, all of whom were registered with the Market Research Society. All lived in the Hull and East Riding of Yorkshire area. It is hoped in future to learn from this experience by providing more time for community interviewers and establishing a 'bank' of such interviewers whose skills could be used in undertaking similar research projects.

Key Characteristics of Sample

Chapter 3

Figure 1: Distribution of age by gender separately

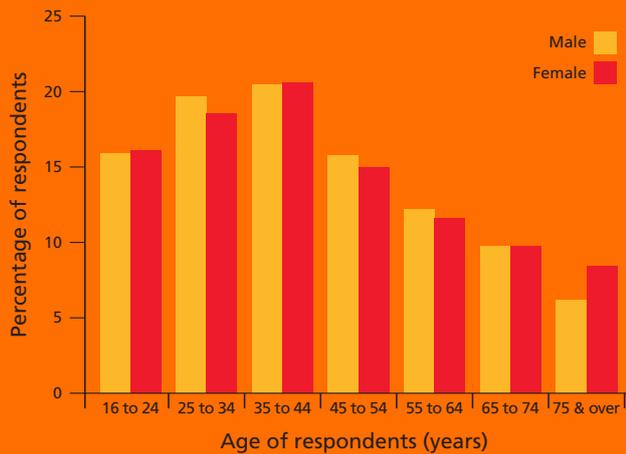


Figure 2: Gender distribution by area

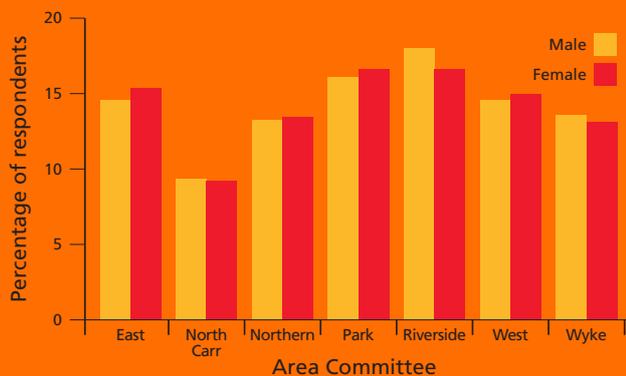
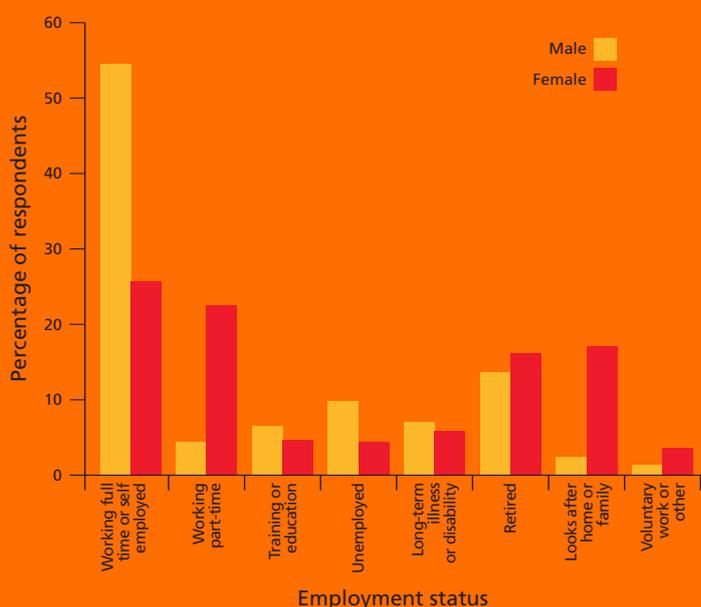


Figure 3: Distribution of employment status by gender separately



The sample used to collect the data was based on a quota that reflected the make-up of the population of Hull in terms of age, gender, employment status and residential area.

Age and Gender of Sample

Just under 250,000 people live in the city (around 193,000 aged 16 or over) and given the survey sample was 4002 people then this represents 2% of the total adult population. Within Hull, North Carr has the greatest proportion of under 16s and the lowest for over 65s. The West and East areas have the highest proportion of older people.

Over the last decade (from 1991), Hull has seen a fall in the number of the very young, teenagers and young people and a growth in the numbers of the most elderly. The overall population reduced by 8% during that time.

There are approximately equal percentages of men and women in each age group but slightly more women aged 75 years old or more (Figure 1).

Figure 2 shows there are also approximately equal percentages of males and females within each area committee. Riverside has the highest percentage of study responders and North Carr the lowest.

Employment Status and Qualifications

Figure 3 gives the distribution of employment status for males and females separately. Working full-time is classified as working 30 or more hours per week, and carers are included in those who look after the home or family.

Perceptions of Life in Hull

Summary

- The people of Hull have a high regard for their city, appreciate its facilities and like living there. Most residents enjoyed living in their area (range 84% in Northern to 94% in North Carr and West).
- Wyke and West areas tended to have the lowest percentage of residents rating local services as good or very good, and the highest percentages tended to occur for North Carr residents.
- The main concerns within the areas were for car crime, and alcohol or drugs use (8% and 7% reporting they were a very big problem in their area). Road traffic, parking, litter, dog mess, graffiti and vandalism, and noise having less than 7% reporting they were a very big problem in their area.
- The East area was seen as the least safe after dark together with Riverside. In addition, a sizeable percentage of East residents in these areas never went out alone after dark (10% for males and 20% for females).
- West was the safest in terms of crime within the last year followed by Park (10% and 13% had been a victim of crime respectively). East, Riverside and Wyke had the highest percentage of crime identified in the survey with between 17% and 19% of residents reporting they had been a victim of a crime within the last year.

Chapter 4

As part of the context setting, but more importantly because it provides important background material to understand the workings of social capital, a series of questions were asked about the length of time people had lived in the area, enjoyment of the area, and quality of local facilities and services. Local area safety issues and problems were also recorded. This provides information that should be useful generally across the city. From a social capital perspective, how people view their local area can have an impact on civic engagement and how much trust they have. If people have lived in the area for a long time then they are likely to have built up more immediate support and information networks.

< and > Explained

This report makes use of the signs < and > when describing numbers and percentages. These signs are a way of saying less than a figure (< 10%) or more than a figure (> 10%). For example, <10% means less than ten percent.

Longevity and Enjoyment of Local Area

Most people reported living in their area for 20 years or less with just under one in five saying they had lived in the same area for more than 20 years (Table 1). The longest attachment to particular areas is seen in East, Park and West, whereas Riverside, North Carr and Wyke had the 'newest' residents with over one third having lived there for less than 5 years.

The percentage of each person's lifetime spent in the particular area indicates that almost one third of North Carr and Riverside residents had lived in that area for less than 10% of their lifetime. So it is possible that the social capital for these areas may be lower because networks have had less time to develop compared to other areas.

Most respondents (90%) enjoyed living in their local area ranging from 84% in Northern to 94% in North Carr and West (Table 2).

Table 1: Number of years living in same area for each area

Living in area (years)	Percentages within each area							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
0 – 5	22	41	26	21	38	24	34	29
6 – 10	24	25	26	26	23	28	28	26
11 – 20	31	24	30	32	22	31	23	28
21 – 30	12	7	10	9	6	7	8	8
>30	11	3	8	12	10	11	7	9

Table 2: Enjoy living in area separately for each area

Enjoy living in area	Percentages within each area							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Yes	90	94	84	91	89	94	86	90
No	9	5	13	7	8	5	10	8
Don't know	1	2	4	2	2	2	4	2
Total	100	100	100	100	100	100	100	100

Table 3: How safe residents feel when walking alone in the area during daytime for each area

Safety within area during daytime	Percentages of responders for each area							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Hull
Very safe	33	37	50	43	32	55	62	44
Fairly safe	48	54	38	45	56	40	31	45
A bit unsafe	14	8	9	9	9	4	6	8
Very unsafe	3	1	2	1	2	<1	<1	1
Never goes out	2	1	<1	2	2	2	<1	2
Total	100	100	100	100	100	100	100	100

Safety Issues

We asked people how safe they felt when walking alone either during the day or after dark. Table 3 shows that between 88% and 95% of people felt very or fairly safe when walking alone during the daytime in all areas except the East (81%).

After dark, the East area was also reported as the most unsafe; 33% of men and 44% of women felt a bit or very unsafe in this area. In addition, a further 10% of men and 20% of women living in this area reported that they never went out alone after dark.

The West and Wyke areas were reported as the safest areas for both men and women after dark, with 71-80% of men and 70-75% of women feeling very or fairly safe. For men, there was also a similar level of safety reported for North Carr as there was for Wyke.

Conclusion

The majority of people within each area enjoyed living there, The number of years they had lived there differed across the seven areas and this could influence the build up of social capital. The majority of people within all areas rated local health services as good or very good, but this was not true for every area committee for other services, for example, education, social facilities or the police services. Feelings of personal safety when walking alone within the areas and reported crime differed among the areas, but it was not always the areas that felt the least safe that had the highest levels of reported crime.

Health in Hull

Chapter 5

Summary

- Life-expectancy for people living in Hull is lower than the national average. For men, the gap between life-expectancy and the national average increased between 1991 and 2001.
- The age-sex standardised mortality ratio (SMR) is higher than the national average for all seven areas (and 17 out of the 23 wards).
- Age has a big impact on health. The percentage reporting they suffered from a long standing illness or disability which limited daily activities increased from 3% of those aged 16 to 24 years to 58% for those aged 75 years or more. Age differences were not, however, seen in relation to the Mental Health Inventory.
- Riverside residents tend to report much higher levels of physical ill-health, with approximately 60% of residents aged 55 years and over reporting they suffer from a long standing illness, health problem or disability. This figure is higher even for those aged over 75 years in all other areas with the exception of the oldest residents in Wyke.
- The percentage reporting a moderate or large amount of stress or pressure differed substantially among the areas. North Carr and East reported the lowest percentage with stress (<30%), and Riverside, West and Wyke tended have the highest percentages (30% to 45% depending on age group).
- Those unemployed or not working due to long-term illness or disability have, on average, more mental health problems.
- Between 20% and 30% of those working report they suffer from a moderate or large amount of stress or pressure (depending on age). Those who look after the home, or who are not working due to long-term illness or disability and who are undertaking voluntary work report the lowest levels of stress.

We know that health in Hull could be better.

Each year the Director of Public Health for the city produces a report describing the health status of the population (usually measured by the extent of disease or death as compared to regional or national averages).

In the 2003 report, it was shown that for both men (Figure 4) and women (Figure 5) average life expectancy was less than the average for England and Wales (although women fair better than men).

There are also real differences in health status across Hull. Figure 6 shows differences in the standardised mortality (death) ratio for those aged less than 75 years among Area Partnerships (with the blue dots representing the individual areas and the red dots represent individual wards). This type of graph shows average mortality for England and Wales at the 100 line (adjusted to take into account age and gender). Anything above that line indicates death rates that are higher than average. As can be seen there is considerable difference among the wards within each area with the exception of Wyke. In particular, Riverside, North Carr and Northern each have one ward that has a considerably lower mortality rate compared to the other wards within their area.

Overall, Riverside has the highest standardised mortality ratio and the West the lowest. However, it can also be seen that all except 5 of the 23 ward averages are above 100 and therefore show more premature deaths occurring than expected in Hull compared to the national average.

Full details from past Director of Public Health Annual Reports can be found at www.westhullpct.nhs.uk or www.hullcityvision.com

Figure 4: Male life expectancy in Hull compared to England and Wales (1991-2001)

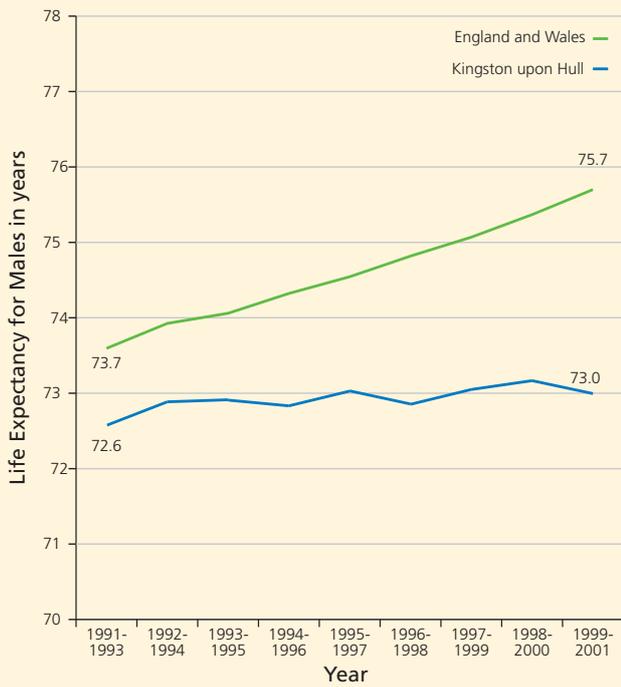


Figure 5: Female life expectancy in Hull compared to England and Wales (1991-2001)

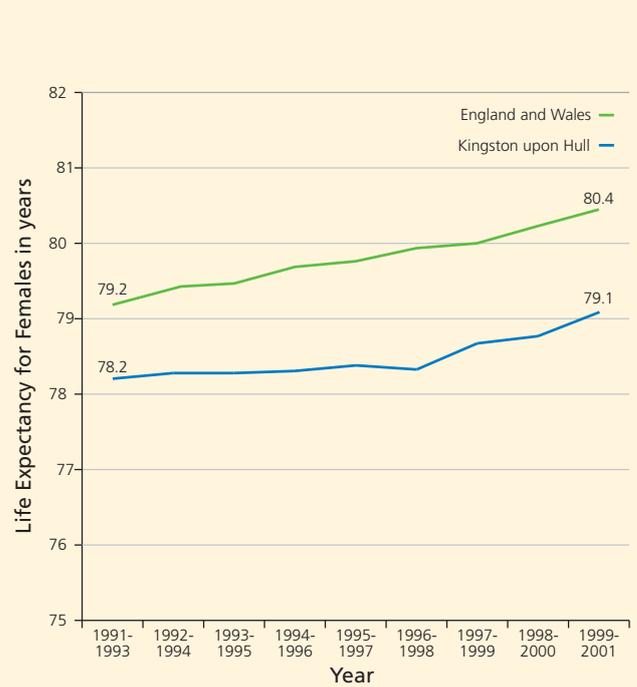


Figure 6: Standardised mortality ratio for persons less than 75 years of age in Hull over the period 1998 to 2000

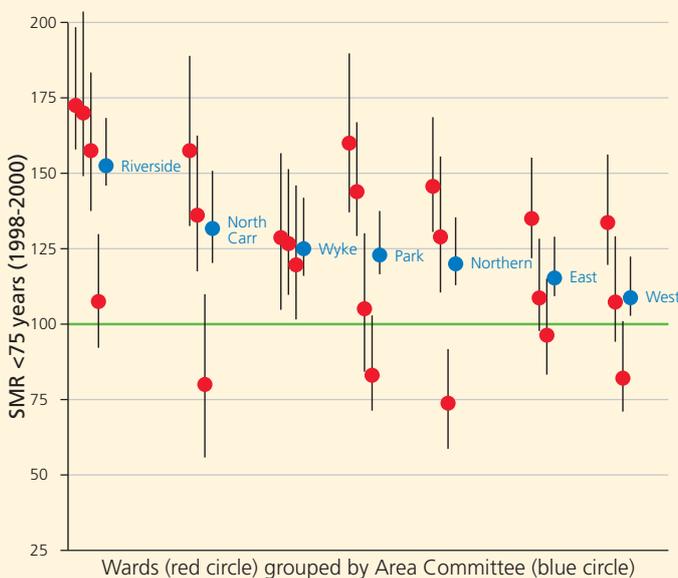
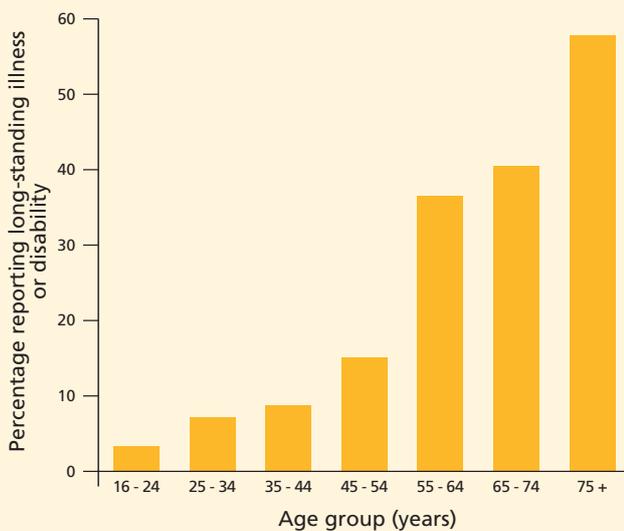


Figure 7: Percentage of responders suffering from a long standing illness or disability which limits daily activities for each age group



Health Status in the Survey

The survey asked a number of questions about people's perceptions of their health, whether they had long term illness or disability, and how they would describe their health and mental well-being. The answers to some of these questions were combined to produce an overall score for general health or mental well-being.

A separate report presenting health and lifestyle findings has been produced in conjunction with this report and is available from the authors on request.

a) Age and Gender

There were no real differences between men and women in terms of health status from the survey, although men reported slightly better mental health than women. Most of the differences in health status are associated with age and ageing which is not unexpected (Figure 7). In response to the question 'Do you suffer from any long standing illness, health problem or disability which limits your daily activities?' there was a significant difference among the age groups.

There was a gradual increase from 3% for those aged 16 to 24 years to 15% for those aged 45-54 years. Thereafter, a more dramatic increase occurred. Similar percentages in the 55-64 and 65-74 year age groups were reported (36% and 40% respectively), but this increased to 58% in those aged 75 years or more. Over all age groups combined, this figure was 19% which is comparable to the 2001 census when the same question was asked (21%).

The Visual Analogue Scale (VAS) or Health Thermometer was used as a measure of self-reported health. Study responders were asked to rate their health that day on a scale from zero to 100, with 0 representing the worst state and 100 representing the best state they could imagine.

One quarter of responders aged 16 to 24 years rated their health as 85 or less. Whereas one quarter of people aged 75 years or more rated their health as 50 or less (half way between the worst and best state).

Figure 8: Percentage suffering from any long standing illness, health problem or disability which limits their daily activities for each area separately

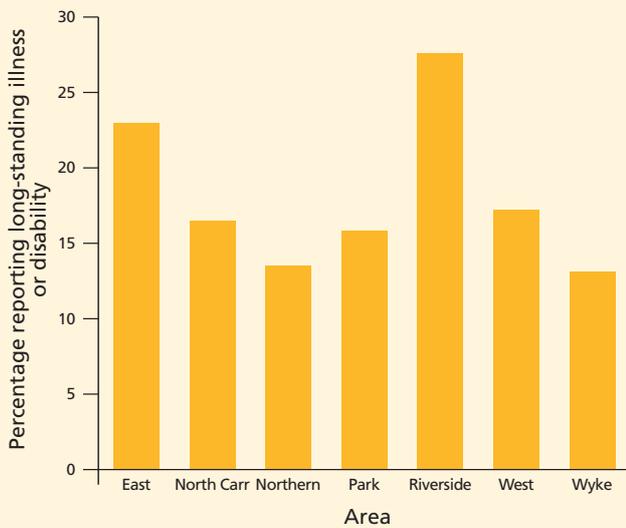
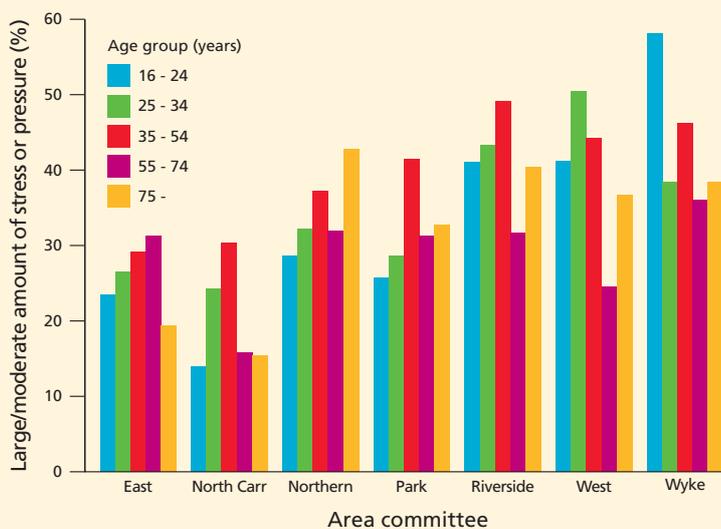


Figure 9: Percentage of residents in different age groups reporting large or moderate amounts of stress or pressure for each area



b) Area

An analysis of health status by area is complicated by their age profile in that older people have been identified as having poorer health and if there are more older people living in one area than another this could bias the results.

The majority of the analyses presented below do not take this factor into account because it is important to describe the areas as reported in the survey, and it becomes much more complicated examining age simultaneously. North Carr and Wyke, for instance have the youngest profile in the city with the West and East areas having the highest profile of older people.

Figure 8 illustrates the percentage of respondents who suffer from any long standing illness, health problem or disability which limits their daily activities. There is considerable difference between the area committees; Riverside residents are more inclined to suffer from such illnesses or disabilities, whereas Wyke residents are the least likely to report this.

Figure 9 reveals a large difference in the percentage of responders who report having experienced a large amount or moderate amount of stress or pressure within the last 12 months. In general, East and North Carr report lower levels of stress while residents in Riverside, the West and Wyke report the most.

In particular, those aged 16-24 years living in Wyke (where 58% report a large or moderate amount of stress or pressure). Wyke is an area where a relatively large number of students live, and since the survey interviews were completed around the time of their examinations (June), this finding may not be unexpected.

c) Employment Status

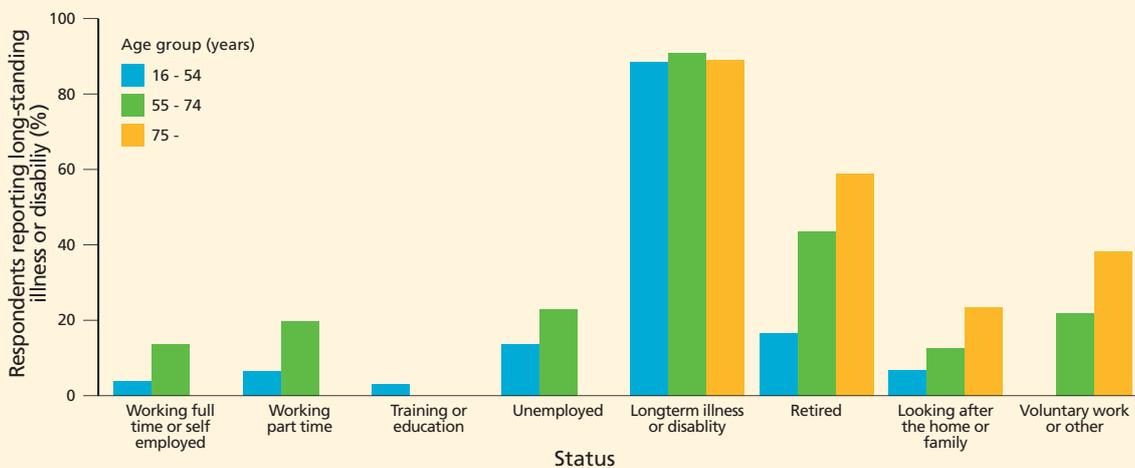
Figure 10 illustrates the percentage of responders who report they suffer from a long-standing illness, health problem or disability that limits their daily activities for three age groups by employment status. As expected, those who report they cannot work due to long-standing illness or disability tend to report that they suffer from such a condition that limits their daily activities, but interestingly not all of them.

In the 16-54 year age group, 4% of those working full-time or are self-employed report that they suffer from such a condition, compared to 14% of those who are unemployed within this age group. For those aged 55-74 years, the percentages are higher for those who are retired compared to those working, and it is likely that some of these people could have retired due to ill health.

Conclusion

As expected, there was a strong association between reported health status and age with deteriorating health as age increases. Health status also varied over the different areas and by employment status. Residents in Riverside reported the worst physical health. Residents of North Carr reported the lowest levels of stress or pressure, with those in Riverside, West and Wyke reporting the most (in particular young people in Wyke). There was also an association between health and employment status, with those who were unemployed or had retired reporting the worst health (except those stating that they were not working due to health problems). Those who were not working due to health problems reported the worst mental health, particularly those in the youngest age groups. Those who were working full-time or were self-employed tended to report the highest levels of stress or pressure.

Figure 10: Percentage of responders reporting long-standing illness, health problem or disability which limits their daily activities for three age groups by employment status



Social Capital in Hull

In this section we consider the findings central to the research objectives. Each of the dimensions is described in turn commencing with an explanation of why they are relevant to social capital

Civic Engagement

Why is civic engagement related to social capital?

This section looks at the degree to which people participate in community life, and the extent to which they feel empowered to change their community. The questions all relate to the local area in which the respondent lives.

Involvement in organisations is seen as important in creating social capital, as it allows people to interact with others. Through this people can learn more about their community, develop their sense of efficacy and promote trust, both between similar types of people (bonding social capital) and diverse types of people (bridging social capital). By working collectively, people can make improvements to their communities and solve local problems.

Civic engagement is both a community and an individual quality. Individuals differ in the degree to which they are civically minded, but the capacity of the community to work together to solve problems is a resource that people within the community can access. The measures reported here, however, refer only to the degree to which the respondents act and feel civically engaged, and are not measures of the neighbourhood they live in.

Chapter 6

Summary

- Almost half of the people surveyed felt well informed about things that affect their area, and one in four felt they could influence decisions affecting their area.
- One in ten had been involved with a local organisation within the last three years. Involvement increased as people got older.
- East and North Carr residents felt the least informed about local issues and Northern and Wyke residents the most. This was also true for feeling able to influence decisions that affected the local area.
- 30% of residents in East and North Carr had taken action to resolve a local problem compared to 10% of residents in West and Wyke, but it is not known if this is associated with increased problems or increased motivation to take action.
- People unemployed or on training schemes or in education felt the least informed about local issues (38%) and those who looked after the home or undertook voluntary work the most informed (58%). A similar pattern occurred for feeling able to influence local decisions.

Almost half of the people surveyed felt well informed about things that affect their area, and one in four felt they could influence decisions affecting their area. When asked about action taken in the past three years to try and solve a local problem over one fifth had done so. It is possible, however that many of those who took no action, did not need to as they did not perceive there was a problem within their local area at the time.

Overall, of the 883 individuals in the survey who undertook some action, half contacted an organisation; 17% contacted a local councillor or an MP. The majority either contacted the appropriate organisation or wrote to the newspaper.

The percentage of responders involved in local organisations was similar by gender but differed among the age groups with the youngest age group (16-24 year olds) least likely to be involved (7%). Involvement increased with age until retirement (9% for those aged 25-44 years, 11% for those aged 45-54 years and 13% for those aged 55-64 years) with a slightly smaller percentage involved after retirement (11% for those aged 65-74 years and 10% for those aged 75 or more).

In terms of perceived levels of information and influence the following was reported: -

- Northern and Wyke were the areas where residents felt most well informed (53%), with the least well-informed (42%) being East and North Carr.
- In Northern, West and Wyke residents felt more able to influence decisions (>30%), whereas those in East, Park (<20%) and North Carr (<10%) felt least able.
- Areas where residents were more likely to have taken action to solve local problem (>30%) were North Carr and East. Those less likely (<15%) were West and Wyke. However, it is not known whether these findings indicate that there are more local problems in the East and North Carr areas or whether the residents of these areas are more likely to take action, or a combination of these factors.

People unemployed or on training schemes or in education felt the least informed about local issues (38%) and those who looked after the home or undertook voluntary work the most informed (58%). A similar pattern occurred for feeling able to influence local decisions.

Neighbourliness and Trust

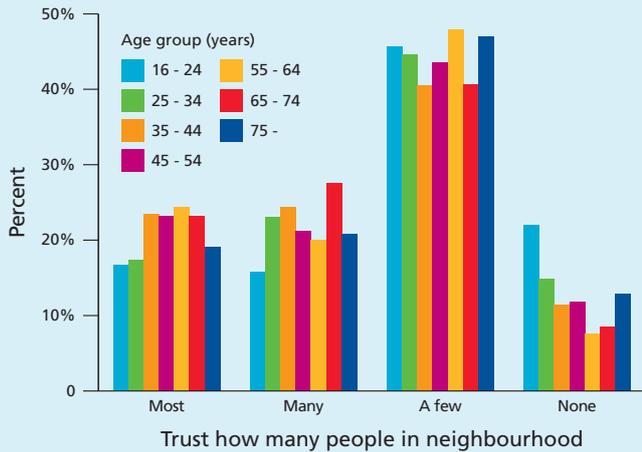
Why is neighbourliness related to social capital?

This section examines the extent of interaction, trust and reciprocity between neighbours. Trust is seen as being linked to social capital, either as a source, an outcome, or both. Reciprocity as an important aspect of social capital, as it measures people's willingness to 'co-operate for mutual benefit'. If people believe that others would be prepared to help them, then they will be willing to help others.

Summary

- Overall, 13% did not trust people in their neighbourhood. On the whole, females trusted more than males. Those aged 16-34 expressed the least trust followed by those aged 75 years and above. A similar pattern occurred when asked whether their neighbours looked out for each other, with the lowest percentage reported by young men (40%) and the highest for women aged 65-74 years (75%).
- The majority of people spoke to their neighbours regularly.
- Residents of North Carr, Northern and Wyke were more likely to report they did not trust their neighbours (20%, 19% and 17% respectively). The lowest percentages occurred for West, Riverside and East (8%, 10% and 11% respectively) indicating higher levels of trust.
- Two thirds of residents believed their neighbourhood was a place where neighbours looked out for one another except for Wyke (62%) and Northern (58%). These residents were more likely to speak to neighbours infrequently.
- Those who were on training schemes or in education, or who were unemployed were a) the least likely to trust most or many of their neighbours, b) to agree that neighbours looked out for one another and c) to speak to neighbours at least weekly, compared to other employment status groups.

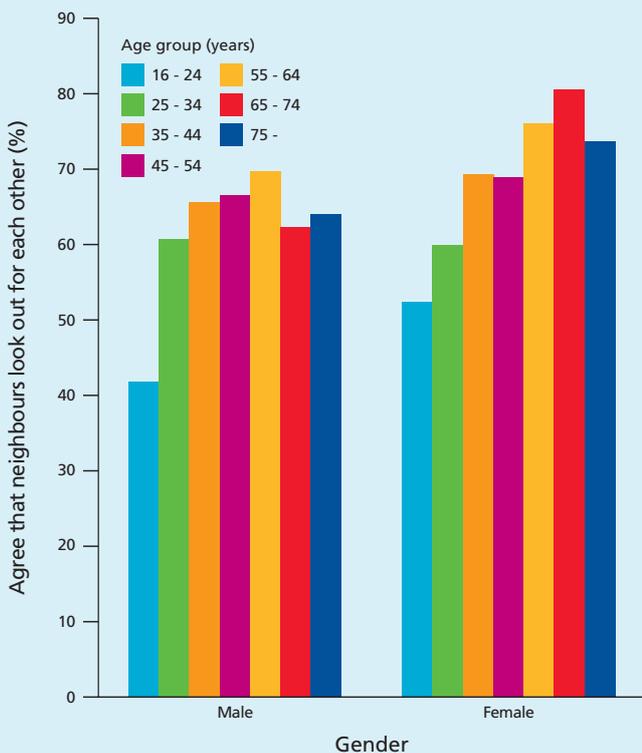
Figure 11: Percentage of people who feel they can trust other people within their area for each age group



There were only slight gender differences relating to levels of trust although there were age group differences (Figure 11). The youngest age group (16-24 years) had 68% who trusted “a few of the people in their neighbourhood” or “do not trust people in their neighbourhood”. This gradually decreased as age increased to 49% in the 65-74 year age group. It did, however, increase in the oldest age group to 60%.

Residents were asked ‘Would you say this neighbourhood is a place where neighbours look out for each other?’. Their responses differed depending on their gender and age group (Figure 12). A higher percentage of women tended to agree with the statement compared to men for all age groups except those aged 25-34 years. The lowest percentage who agreed with this statement occurred for the men aged 16-24 years (40%). More than half of older residents agreed with the statement.

Figure 12: Percentage agreeing that neighbours look out for each other for age group for each gender separately



Frequency of speaking to neighbours daily or weekly by gender and age group separately identified the following: -

- Approximately nine out of every ten women over 25 years talked to their neighbours once or twice a week or more frequently. This was slightly lower for men.
- Those in the youngest age groups spoke to their neighbours less frequently (75% for women and 66% for men).

Table 4: Level of trust in neighbourhood by area

Level of trust [of people in neighbourhood]	Responses (in %)							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Total
Most of the people	29	28	17	19	23	17	15	21
Many of the people	17	13	22	21	24	25	28	22
A few of the people	43	39	42	48	44	50	40	44
You do not trust people	11	20	19	12	10	8	17	13
Total	100	100	100	100	100	100	100	100

Table 5: Neighbourhood is a place where neighbours look out for each other for each area separately

Believe that neighbours look out for one-another	Responses (in %)							
	East	North Carr	Northern	Park	Riverside	West	Wyke	Total
Yes	66	65	58	65	66	67	62	62
No	22	32	30	23	21	15	24	24
Don't know	12	3	13	12	13	17	14	14
Total	100	100	100	100	100	100	100	100

The area analysis throws up some useful findings (Table 4) with the highest percentages not trusting neighbours (17-20%) being found in Northern, Wyke and North Carr although interestingly the latter (along with East) exhibited the highest levels of trust.

The differences in how much neighbours 'look out' for each other are less, although this time the level of non-responses is quite interesting with almost one in five of respondents in West area not able to answer this question compared to less than one in twenty in North Carr (Table 5).

Over 80% of residents, except those in Wyke (75%), speak to their neighbours daily or weekly. Only 1% of residents in North Carr speak with their neighbours once or twice a year or not at all in the last year compared to 6% in the Wyke area.

In terms of employment status the survey found that in terms of trust: -

- Between 45% and 50% of people who were working full-time or part-time or were self-employed or were retired trusted most or many of their neighbours.
- The figures were considerably lower for those undertaking voluntary or other work (34%), on training schemes or in education (32%), and those who were unemployed (26%).

Overall, over 60% feel that their neighbourhood is a place where neighbours look out for one another with the exception of those who are unemployed or who are not working due to long-term illness or disability where the figure is only 44%. Nine out of ten people speak with their neighbours daily or weekly. This was less for those who are not working due to long-term illness or disability (83%), those unemployed (72%) or those on training schemes or in education (68%).

Social Networks

Why are social networks related to social capital?

This section investigates social networks as an aspect of social capital. Social networks have been examined extensively as an area of research in their own right, particularly in relation to health. They are defined as the personal relationships accumulated when people interact with each other in families, neighbourhoods and elsewhere.

Responses to these questions may reflect the respondent's sense of belonging in that locality and their degree of access to immediate support networks. Social support is examined in more detail in the next section.

The questions provided information on the patterns of networks but not on the quality of contacts. For example, a telephone conversation could be a short call or an hour-long discussion and may serve as a duty or a pleasure.

Summary

- The majority of people speak to non-household family members frequently, but for a small group (5%) this is less than once every couple of months. A similar pattern occurs for frequency of speaking to friends.
- The frequency of speaking to family, friends and neighbours at least weekly differed depending on the person's age and gender. Over 90% of young men spoke to friends daily or weekly compared to 75% for family and neighbours. Whereas, the reverse pattern was true for those aged 55 years or more.
- Less than 4% spoke to family, friends and neighbours (each group considered separately) twice a year or less frequently, (slightly higher for men aged 16-34 years).
- North Carr had the highest percentage of residents who spoke with family at least weekly (89%) and the East had the lowest percentage (83%). The East also had the lowest percentage who spoke with friends at least weekly (78%) with Riverside at 86%. More of North Carr residents spoke to neighbours at least weekly (92%); Wyke residents spoke to neighbours the least (75%).
- A small percentage rarely spoke to family, friends and neighbours suggesting that approximately 1,500 people across the city could be experiencing extreme isolation.
- Those who were unemployed, and those who were on training schemes or in education spoke to family the least frequently (65%-70% speaking at least weekly compared to approximately 80% for other groups). Those who were not working due to long-term illness or disability, or who were retired or were undertaking voluntary or other work spoke to friends the most infrequently (<70% speaking daily or weekly compared to around 75%-95% for other groups). The unemployed and those on training schemes or in education spoke with neighbours the most infrequently (approximately 70% speaking at least weekly compared to approximately 80% for other groups).

The majority of responders spoke to non-household family members daily or weekly with almost one-quarter speaking daily, another 15% speaking with family 5 or 6 days per week and a further 27% speaking 3 or 4 days per week. The majority of people also spoke with friends frequently.

Figure 13 shows the frequency of speaking to family, friends and neighbours at least weekly by gender and three different age groups. It indicates that women spoke with non-household family members, friends and neighbours more frequently than men.

Figure 13: Percentage speaking with family, friends and neighbours daily or weekly by gender and for three different age groups

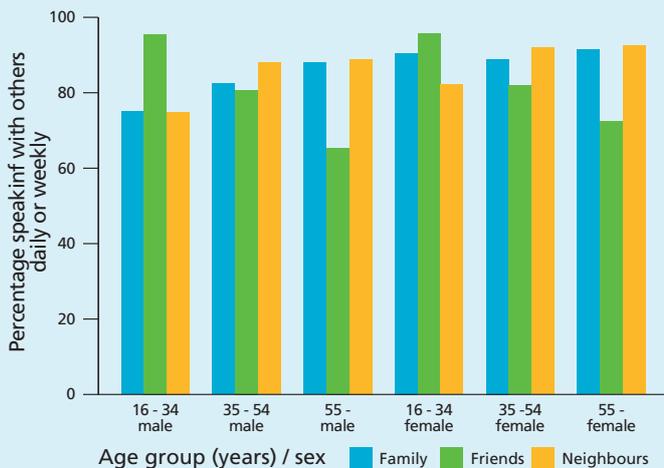
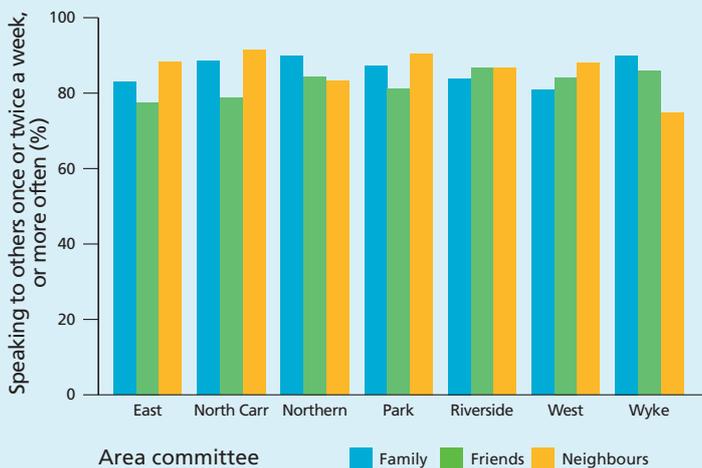


Figure 14: Frequency of speaking to non-household family, friends and neighbours on a daily or weekly basis by area



Men and women 55 years or older were less likely to speak to friends daily or weekly, but more likely to speak with family and neighbours daily or weekly compared to all other age groups.

Whilst the majority spoke to non-household family members, friends and neighbours daily or weekly, there was a small minority who spoke with these groups twice a year or less frequently. This was particularly the case for men aged 16-34 with regard to speaking with neighbours (6%) and men aged 55 years and over with regard to speaking with friends (10%).

Figure 14 shows Wyke and Northern have the highest percentage of residents who spoke with family at least weekly and the West area reported the lowest. More Riverside residents spoke with friends at least weekly compared with other areas and fewer East residents spoke to friends weekly.

North Carr residents were the ones most likely to speak to neighbours at least weekly compared to Wyke residents.

Those who were unemployed, or who were on training schemes or in education spoke to family the least frequently (65%-70% speaking at least weekly compared to approximately 80% for other groups). Those who were not working due to long-term illness or disability, or who were retired, were undertaking voluntary or other work spoke to friends the least frequently (<70% speaking daily or weekly compared to around 75%-95% for other groups). The unemployed and those on training schemes or in education spoke with neighbours the most infrequently (approximately 70% speaking at least weekly compared to approximately 80% for other groups).

Social Support

Why is social support related to social capital?

Whereas the previous section investigated the frequency of social contacts this section focuses on functional support and the quality of social contacts.

The first set of questions looked at practical support. People were asked if they could request help if they were ill in bed and needed help at home, for example.

The second set of questions focused on emotional support. Respondents were asked how many people they could turn to for comfort and support if they had a serious personal crisis.

Summary

- Overall, 94% had someone they could ask for help if ill in bed. Less than 1% of those aged 16-24 years had no one to turn to in a serious crisis. Approximately 10% of those in the oldest age groups (65 years and over) did not have anyone to help or they weren't sure.
- Two thirds of those who had someone to ask would feel able to ask a non-household relative and 58% felt able to ask a wife, husband or partner. Of those living with a partner, over 95% of them aged 25-64 years would ask their partner for help, but the figure was lower in the youngest (86%) and oldest (89%) age groups.
- The number of close relatives or friends that lived nearby differed depending on age, with 11% of those aged 16-24 years having no one nearby compared to 19% for those aged 75 years and over.
- North Carr residents were more likely to have someone to ask if they were ill in bed (98%) whereas Northern (91%) and Wyke (88%) were the least likely to have someone to help. A similar pattern occurred for number of close friends and relatives living nearby and number of people who could be relied upon in a serious crisis.
- Over 95% of those who were working or looking after the home or family had someone they could ask for help, but only 88% of those who were unemployed and 90% of those who were not working due to long-term illness or disability.
- Those who were unemployed, long-term sick or retired were more likely to have no close relatives or friends nearby (>20%). Those undertaking voluntary or other work had the lowest number of people to turn to in a serious crisis.

All age groups had similarly high rates of being able to ask someone for help if they were ill at home although this was slightly more of an issue for elderly people. Table 6 gives the person that they would ask for help if ill in bed (for those stating they had someone to ask). Note that it is possible to specify more than one person to help so that the percentages may add to more than 100%.

More than two-thirds of people aged 25 to 64 years would ask their wife, husband or partner. The youngest people were more likely to ask household members, relatives or friends, whereas the eldest people were more likely to ask relatives.

As age increased, people were more likely to ask neighbours or organisations for help. Of those who stated they had someone they could ask for help, very few of them went on to state that they would prefer not to ask for help.

The number of close relatives or friends who live nearby decreased as age increased. When asked about being able to rely on support in a crisis those aged 75+ years had the lowest level of support with the youngest people (16-24 years) having the highest (Table 7).

Table 6: Type of person to ask for help if ill in bed by age group

Help available from whom when ill in bed	Responses (in %) by age in years							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Wife/husband/partner	29	65	72	70	65	49	32	58
Other household member	57	22	37	50	33	16	24	36
Non-household relative	71	59	62	72	70	66	70	66
Friend	62	51	52	54	47	33	29	50
Neighbour	16	24	30	36	40	36	37	30
Organisation	1	<1	2	2	9	14	19	4
Would prefer not to ask	0	<1	<1	1	<1	1	1	<1

Table 7: Number of people to turn to when in a serious crisis by age group

Number of people to turn to when in serious crisis	Responses (in %) by age in years							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
None	<1	2	1	3	2	3	3	
One or two	15	20	19	17	16	27	36	
Three or four	17	25	20	17	22	22	17	
Five or more	67	53	60	63	60	60	43	
Total	100	100	100	100	100	100	100	

Table 8: Whether or not responder could ask someone for help if ill in bed by area

Help available when ill in bed?	Response (in %) by area						
	East	North Carr	Northern	Park	Riverside	West	Wyke
Yes	96	98	91	96	95	95	88
No	2	1	3	1	2	2	5
Don't know/depends	2	1	5	3	3	4	7
Total	100	100	100	100	100	100	100

On an area basis asking for help when ill was high across Hull (Table 8). For those who do not have anyone to ask for help (or not sure) the lowest percentage was recorded in North Carr (1%) and the highest in Wyke (7%).

For most areas, more than 95% of residents felt that they had someone to ask for help except for Northern (91%) and Wyke (88%).

The number of close relatives or friends who lived nearby differed among the areas. North Carr and Northern areas tended to have the fewest close relatives or friends who lived nearby with 56% and 58% having two or fewer close relatives or friends living nearby respectively. In terms of the number of people a person could turn to in a serious crisis over 95% of people could turn to at least one person for comfort and support. Over half of people could rely on five or more relatives or friends, except in the Wyke area where 39% could rely on five or more people.

Over 95% of those who were working or looking after the home or family had someone they could ask for help, but only 88% of those who were unemployed and 90% of those who were not working due to long-term illness or disability. Those who were unemployed, long-term sick or retired were more likely to have no close relatives or friends nearby (>20%). Those undertaking voluntary work had the lowest number of people to turn to in a serious crisis.

Social Capital and Health

In the previous chapter we have seen how levels of social capital differ across Hull. We have also seen how the health of people tends to get worse as they get older and that there are real differences in health status across the city. Several probable links between social capital and health have already emerged: -

- Feelings of safety when walking alone during the day and after dark may be related to actual levels or experience of violence or may link to worry or stress about the potential for such violence.
- Stress may also be more likely if people don't know or trust their neighbours.
- Levels of civic engagement may relate to a sense of powerlessness to influence decisions that affect health e.g. quality of housing, availability of services.
- Lack of available help when ill is likely to impact on recovery time if people can't get to see a doctor, pharmacist or even to buy food.

Examining social capital in relation to health is complex because there are many inter-relationships that may mean that an association is observed but only through another factor. For example, involvement with a local organisation might be associated with worse health, but this may only be because older people are more likely to be involved with a local organisation and also more likely to have worse health, therefore analysing factors singly may not tell the whole story. Additionally, if an association is found to exist it cannot be assumed to be causal.

Ideally, it would be useful to examine social capital and health within each of the seven area partnerships. However, since there is a very strong association between age and health, and various aspects of social capital are associated with age, it is very important to take age into consideration when examining the relationship between health and social capital as failure to do so could be potentially misleading. Therefore, this chapter will largely examine the relationship between social capital and health across the city taking into account age group, and not examine the relationship for different areas.

Chapter 7

Statistical Significant Explained

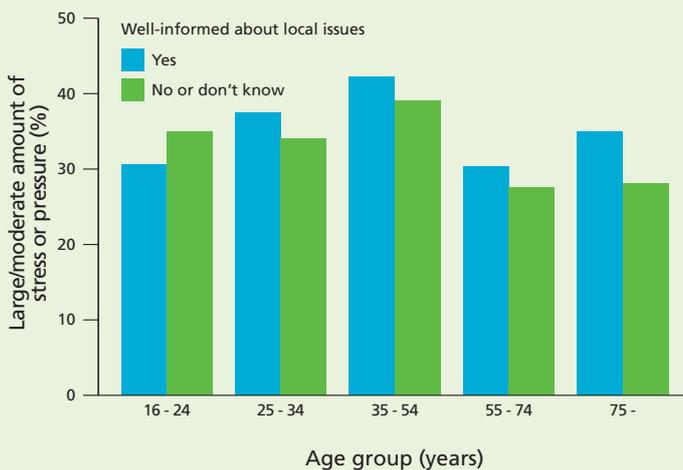
This section of the report refers to different statistical tests principally the χ^2 test (which uses a model that takes factors such as age into account) to examine whether there are difference in percentages and values between different groups. These statistical tests result in p-values. In order to conduct such a test, an initial assumption is made that there is no difference between the groups. The probability is then calculated of obtaining the result observed in the sample. If this probability (called a p-value) is small, this means that it is unlikely the result observed has occurred by chance and therefore it can be assumed that the initial assumption (of no difference between the groups) is incorrect. Traditionally, if a p-value is less than 0.05 (or a 1 in 20 chance) then it is assumed that the initial assumption is not correct (and we can state that there is a 'statistically significant difference between these groups').

Civic Engagement and Health

Summary

- Those who felt better informed about local issues and felt they could influence local decisions tended to report better health.
- Whereas those who had taken action to resolve a local problem tended to report worse health.

Figure 15: Percentage feeling under a large or moderate amount of stress or pressure by whether or not person feels well-informed about local issues for each age group



For those aged 55 years and over, the percentage of people reporting a long-standing illness or disability differed significantly ($p < 0.0001$) between those who were well informed about local issues (37%) and those who were not (50%). There was no difference for those aged less than 55 years.

After taking into consideration the effect of age, gender, smoking status, healthy diet, area and employment status, there was no statistically significant difference in the Mental Health Inventory score between those who felt well-informed about local issues and those that did not (or did not know).

There was a statistically significant association between levels of stress and how informed about local issues people felt (Figure 15). Those who felt well-informed tended to report more stress than those who were not well-informed. Except for the youngest age group (where the reverse was true) and the oldest age group where, due to small numbers the result was not statistically significant.

No association was found between the percentage of responders reporting a long-standing illness or disability and the responders feeling that they could influence local decisions, except in the 55-64 age group. 26% reporting ill health felt they could influence decisions compared to 40% feeling they could not (or did not know if they could influence decisions).

There was some relationship between those reporting long-standing limiting illness and whether action had been taken to resolve a local problem with 22% of those taking action reporting such illness compared to 19% who had not taken action. There was a small but statistically significant difference for mental health.

Neighbourliness, Trust and Health

Summary

- The relationship between trust and physical health is not clear – for some groups trust is related to good health – for others the opposite is seen. People who did not trust their neighbours or did not believe that their neighbours looked out for one another tended to report worse mental health.
- People who spoke to their neighbours more regularly tended to report better physical and mental health and less stress than those who spoke infrequently.

In the 16-64 years group, interestingly a higher percentage of responders reported that they suffered from a long-standing illness or disability for those who trusted their neighbours (but only statistically significant in the 25 – 34 year age group). The reverse was true for those aged 65 years or older. It is important not to overstate this finding that may be due to confounding factors such as gender or even lifestyle. Having said that, trust does emerge as having a negative impact on health in the regression analysis below.

There is no evidence of a relationship between the percentage of responders reporting a long-standing illness or disability and whether the same responders feel that neighbours look out for one another or not.

The highest percentages reporting stress were found in those neighbourhoods where people were perceived to not be looking out for each other. The strongest association occurred for the youngest age groups ($p < 0.01$ for those aged 16-44 years).

There was a strong association between the Health Thermometer and frequency of speaking with neighbours even after adjusting for age, gender, smoking status, healthy diet, area and employment status. Those who spoke to neighbours less frequently reported a lower (worse) health score.

There was an association between reporting a large or moderate amount of stress or pressure and speaking to neighbours (Table 9) with a much higher percentage reporting stress for those who spoke to neighbours infrequently.

Table 9: Percentage reporting large or moderate stress or pressure for those speaking to neighbours daily or weekly compared to those speaking to neighbours less frequently by age group

Frequency of speaking to neighbours	Reporting stress or pressure by age in years (%)							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Daily or weekly	26	32	38	39	29	24	30	32
Less frequently	53	58	61	62	52	54	60	56
χ^2 test, p-value	<0.001	<0.001	<0.001	0.002	0.003	<0.001	0.004	<0.001

Social Networks and Health

Summary

- People who spoke to non-household family members more regularly tended to report better physical and mental health and less stress than those who spoke infrequently.
- The pattern differed for frequency of speaking to friends with no relationship observed for stress or mental health. There was a higher percentage reporting long-term illness and disability who spoke infrequently with friends compared to those who spoke frequently (likely to be associated with age).

There is no evidence to suggest that the percentage reporting long-standing illness or disability differs between those who speak with family at least weekly and those that do not. There was, however, strong evidence of an association between the percentage reporting long-standing illness or disability and frequency of speaking with friends (Table 10). Those who spoke to friends less frequently than weekly were more likely to report a long-standing illness or disability.

There was no evidence that speaking with friends daily or weekly or not was associated with reporting a moderate or large amount of stress or pressure.

Table 10: Percentage reporting long-term illness or disability for those speaking to friends daily or weekly compared to those speaking to friends less frequently by age group

Frequency of speaking to friends	Reporting long-term illness or disability by age in years (%)							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Daily or weekly	3	6	8	13	28	31	49	14
Less frequently	22	24	14	22	54	67	73	43
χ^2 test, p-value	<0.001	<0.001	0.055	0.009	<0.001	<0.001	<0.001	<0.001

Social Support and Health

Summary

- The relationship between health and having someone to rely on when ill in bed was strong. Those who did not have anyone to rely on had more stress, were more likely to report long-term illness or disability, and worse physical and mental health.
- People who had more than two close relatives or friends nearby and those who had more than two people they could rely on in a crisis were less likely to suffer from stress, and had better physical and mental health.

There was strong evidence of an association between help if a person was ill in bed and a reported large or moderate amount of stress or pressure (Table 11). Overall one third of those who had such help reported a moderate or large amount of stress or pressure compared to two-thirds of people who had no help.

There was no evidence to suggest that there was a difference in the percentage reporting long-standing illness or disability between those who had less than three close relatives or friends living nearby and those who had more nearby.

Those who had two or less people they could rely upon in a serious crisis had a lower Health Thermometer score than those who had more people. A similar finding occurred for the Mental Health Inventory scores.

Table 11: Percentage reporting large or moderate stress or pressure for those who have someone to help if ill in bed compared to those who don't by age

Someone to help if ill in bed	Reporting stress or pressure by age in years (%)							Total
	16-24	25-34	35-44	45-54	55-64	65-74	75+	
Yes	31	33	40	39	30	25	29	34
No or don't know/depends	81	68	49	82	62	46	61	64

Summary

Overall, those who felt better informed about local issues and felt they could influence local decisions tended to report better health.

Those who had taken action to resolve a local problem tended to report worse health. It is not known whether lack of action taken is due to lack of a problem or because they were not the type of person to take action. However, those that did take action clearly felt that there was a local problem to resolve and this problem may have had health implications, for example, housing conditions.

There were conflicting results for trust of neighbours and health. Younger respondents who trusted their neighbours reported more long-standing illness or disability, but higher Health Thermometer scores. People who believed neighbours looked out for one another tended to report better health using the same scale. Responders who did not trust their neighbours or felt their neighbours did not look out for one another tended to report worse mental health and more stress.

People who spoke to their neighbours more regularly tended to report better physical and mental health than those who spoke infrequently to neighbours. There were relatively large differences in the Health Thermometer and Mental Health Inventory scores between those who spoke to their neighbours weekly and those who spoke only annually or less, with the latter group having a score on average, adjusting for other health-related factors, of 7% and 10% lower respectively. Those who spoke to neighbours infrequently were more likely to report they suffered from stress.

A similar pattern was observed for speaking to family (non-household family members) with associations between reported stress, the Health Thermometer (mean 6% lower) and Mental Health Inventory (mean 7% lower).

The relationship between health and speaking to friends differed slightly to that observed for neighbours and friends. No relationship was observed for stress, but a relationship was observed for reporting long-term illness or disability. The Health Thermometer was reduced (mean 9% less) for those who spoke to friends less frequently, but there was no difference for the Mental Health Inventory.

The relationship between health and having someone to rely on when ill in bed was strong. Those who did not have anyone to rely on had more stress, more long-term illness and disability, and worse Health Thermometer (7% lower) and Mental Health Inventory scores (15% lower).

People who had more than two close relatives or friends nearby and who had more than two people they could rely on in a serious crisis were less likely to suffer from stress and had better physical and mental health scores but the differences in the scores were relatively small considering the scales of the indices.

Table 12: Health thermometer regression results

NO RELATIONSHIP	POSITIVE	NEGATIVE
Gender	Has help if ill	Age
Employed	Speak to family regularly	Deprivation
Highest qualification	Speak to friends regularly	Smoking
Look out for each other	Speak to neighbours regularly	Skilled
Friends/relatives nearby	Feels safe walking alone after dark	Trusting of neighbours
Organisation membership		

Regression Analysis:

This section summarises more detailed work that has been undertaken and may appear more complex due to the nature of the analysis being performed. Central to this approach is the need to alleviate problems identified in the previous section, where in a descriptive graphical analysis it is not possible to control for all confounding factors that may indirectly influence the results. To address this cross-sectional regression analysis was undertaken.

Methodology

The aim of this analysis is to examine the relationships between a number of variables relating to social capital, personal consumption and health outcomes etc. The advantage of this approach is that we may examine the relationships as they are with all other factors/variables held constant at their mean, thereby controlling for confounding effects and biases due to differences in age, gender, social class and other variations between areas. In subsequent research, it will be possible to move beyond this level of analysis when, for instance, it would be better to look at specific subgroups based on ideal types.

This approach acknowledges individual heterogeneity relating to the fact that people have different views of what constitutes good health, and that these views may be influenced by social, cultural or gender groupings.

As we only have one time period we are not able to say that one event causes the other; we would need to identify that one event preceded another in order for it to influence the second event. Additionally, even if one event precedes another and there was a relationship between the two it still does not mean it is causal.

In the cases where a statistical relationship does not appear, it could be because a) there is no relationship or b) there is a relationship but the statistical methods are not able to detect it, possibly because of other confounding factors or lack of statistical power (i.e. too small a study).

In each case an analysis was undertaken within the Stata 8 Statistical Software Package and a summary of the effects on health of several variables is given based on either a positive, negative or nil health effect.

Health Thermometer

The Visual Analogue Scale (VAS) or 'Health Thermometer' is where a person is asked to point out where, on a scale between 0 (representing the worst state imagined) and 100 (representing the best state imagined) they consider their current health to be that day. Table 12 describes what (if any) the relationship is between self-assessed health status and the variables analysed.

Gender, employment and highest qualification did not have any association with VAS/Health Thermometer whereas age, deprivation and current smoking had unsurprisingly a negative effect. Those who reported they had skills but no formal qualifications also reported poorer health.

In terms of social capital, speaking to family, friends and neighbours regularly had a positive effect with those speaking more regularly reporting a higher better VAS/Health Thermometer health score. Those who felt safe when walking alone in their area after dark also reported better health.

Table 13: EuroQol regression results

NO RELATIONSHIP	POSITIVE	NEGATIVE
Gender	Employed	Age
Highest qualification	Has help if ill	Deprivation
Skilled	Speak to friends regularly	Smoking
Trusting of neighbours	Speak to neighbours regularly	Look out for each other
	Friends/relatives nearby	Speak to family regularly
	Feels safe after dark	Organisation membership

Those who reported that they trusted their neighbours reported that they had poorer health than those who did not trust their neighbours. Trust is thought by some to be a very important indicator of social capital, and the effect is seemingly counter-intuitive. However, there are a number of possible reasons why this has occurred. One reason could be that increased trust of neighbours encourages harmful behaviour in terms of health, for example, peer-pressure to smoke or facilitate trading of smuggled alcohol or tobacco.

The results of this are interesting for the city of Hull as a whole. Four of the social capital variables show a statistically significant and positive relationship with the VAS self reported health scale. People who have help when ill, speak to friends and/or neighbours regularly, and those who feel safe walking out at night all report better self-reported health.

As people become older, they report worse health and, as would be expected, living in a deprived area achieves statistical significance within the sample, indicating that deprivation is a determinant of poor health.

The analysis shows variations in the results by area. Certain variables show consistent results across the different Area Partnerships. Smoking is a consistent negative influence on health outcomes, except in Riverside area, where the variable did not achieve statistical significance. Age is the most consistent influence on health outcomes, where in all cases self reported health is lower as people get older. Within the social capital variables, factors which are associated positively with good health consistently across the areas (statistically significant in six out of seven areas) are feeling safe walking alone after dark (except West Area) and speaking to friends (except Riverside).

The EuroQol

This is a health related quality of life scale based on five attributes: mobility, self-care, ability to perform usual activity, pain/discomfort, and anxiety/depression. Each attribute has three levels – no problem, some problem, major problem.

Table 13 shows that gender, being employed, and having skills did not have any association with the health related quality of life measure. Age, deprivation and current smoking had unsurprisingly a negative effect.

In terms of social capital, speaking to friends and neighbours regularly had a positive effect with those speaking more regularly reporting a better health EuroQol score. Those who had more friends and relatives living nearby also reported better quality of life, as did those who felt safe when walking alone in their area after dark. There was no relationship with trust.

Those who reported that neighbours looked out for each other, those who spoke to family more regularly and those who were members of organisations had a lower health related quality of life. These findings are unexpected and may be explained by more malign factors e.g. reinforcement of harmful health behaviour.

Organisational membership is thought by many to be a strong indicator of social capital. This appears counter-intuitive here, in that those who are members of an organisation report poorer health. It is possible that membership of an organisation increases poor health behaviour in terms of reinforcement by peers of attitudes to alcohol, smoking, or lack of employment, etc.

Table 14: Mental health inventory regression results

NO RELATIONSHIP	POSITIVE	NEGATIVE
High qualification (NVQ 1-3)	Employed	Gender
Skilled	Has help if ill	Age
Look out - each other	Speak to neighbours regularly	Deprivation
Trust	Friends/relatives near	Smoking
	Feels safe walking alone after dark	High qualification (degree level)
	Organisation membership	Speak to family regularly
		Speak to friends regularly

The Mental Health Inventory

Questions relating to mental health have been analysed as an inventory and the association with personal and social capital variables is given in Table 14.

Males, older residents, more deprived residents and those who smoked had poorer mental health. Smoking may have a negative effect on mental health, but it is also probable that those with mental health problems are more likely to smoke cigarettes.

Those who had a degree (NVQ 4) also had poorer mental health (all other variables held constant at the mean).

Those who were employed tended to have a better mental health. This might be explained by work being protective of mental health, or that those who have worse mental health are less likely to be employed.

In terms of social capital, having help when ill and speaking to neighbours regularly, having friends or relatives nearby, feeling safe when walking in the local area alone after dark and membership of organisations have a positive effect on mental health. However, it may be that those with worse mental health are less likely to speak to neighbours, be less likely to have friends or relatives nearby and be less likely to be involved with an organisation as a consequence of their mental health.

Those who speak with family and friends more regularly tended to have worse mental health. It is possible that those with worse mental health have more contact with family and friends due to their difficulties. Again, no relationship with trust was identified.

Regression Summary

A summary of the social capital related dimensions from the separate analysis outlined above confirms those elements such as age; deprivation and smoking that consistently have a negative impact on health. It is interesting that membership of an organisation appeared in different columns for each of the measurement scales; trust, gender and qualifications turn out to have either no impact on health or a negative impact.

The three consistent positive health outcomes however, are having help when ill, having friends or relatives nearby, and feeling safe when walking after dark. These also emerged as having a positive impact on health in the earlier analysis so it can be stated with some confidence that of all the dimensions of social capital included in this study the association here is strong and worthy of further investigation.

Conclusions Chapter 8

In drawing together this initial summary of the data from the Hull social capital study it is important to be clear about what we have learned so far. We have known for a long time how health status and premature mortality varies across the city. We now also know that levels of social capital impact on health status although the pattern is different and there is no simple causal link between one or the other.

We have however provided a wealth of information about the health status, lifestyle behaviour and health perceptions of people within the city and can now consider health status in the context of other dimensions of the life of the residents of Hull, and of their communities and neighbourhoods.

The picture of social capital and health that emerges from this study is one based on a complex set of interactions. The study confirms the association between age and levels of social capital and also suggests that the social support dimension in terms of having help when ill and access to family and friends are very important factors. A third key factor is feeling safe walking alone after dark which also has a strong association with good health.

Other dimensions such as civic engagement and trust indicate a weaker relationship, with trust in particular showing a negative impact on good health on the health thermometer. Whilst there has been some speculation about the reasons for this in the report e.g. age may be a confounding factor, it will be important as part of the more detailed subsequent analysis to consider this further.

The general summary of findings has demonstrated the following: -

- Those who felt better informed about local issues and felt they could influence local decisions tended to report better health; whereas those who had taken action to resolve a local problem tended to report worse health.

- People who did not trust their neighbours or did not believe that their neighbours looked out for one another tended to report worse mental health.
- People who spoke to their neighbours and/or non-household family members more regularly tended to report better physical and mental health and less stress than those who spoke infrequently.
- The pattern differed for frequency of speaking to friends with no relationship observed for stress or mental health. There was a higher percentage reporting long-term illness and disability who spoke infrequently with friends compared to those who spoke frequently.
- The relationship between health and having someone to rely on when ill in bed was strong. Those who did not have anyone to rely on had more stress, were more likely to report long-term illness or disability, worse physical and mental health.
- People who had more than two close relatives or friends nearby and those who had more than two people they could rely on in a crisis were less likely to suffer from stress, and had better physical and mental health.
- In broad terms, many of those who are not in work or on training schemes have poorer health but also lower levels of social capital.

In terms of where next, this benchmark study should be used to point the way for individual projects and qualitative research work that could include how to preserve and enhance levels of social capital. Care should be taken to ensure that local decisions do not destroy current levels of social capital. Such work should consider using the techniques, tools and outcome measures of this project as a baseline when evaluating local projects.

We are keen to make the dataset available for further work by interested groups.

The study results should be used to inform local planning and as a means to involve community interests in public health initiatives. It is a key resource for the development of the forthcoming community and neighbourhood renewal strategies which will drive forward the vision for the city. It will also be invaluable to the development of local area agreements which present a significant opportunity towards empowering communities to take ownership of improved outcomes for their local area and as a means of encouraging greater active citizenship and more formal volunteering in civic life.

Whilst the emphasis has been on health, the data collected clearly relates to many aspects of community life as well as services provided by other key players in the regeneration of Hull. Because it is community-based research, it reflects the views and feeling of residents as they live their lives. In this very important sense it will defy attempts to put such experience into planning silos and should foster genuine community planning across sectors based on community needs and preferences. This is certainly the expectation of how the findings will be used by each area partnership; they are a crucial conduit between communities and community planners.

As a baseline study this research will also allow progress to be tracked in improving the quality of life (including social capital) across the city. In addition to the important floor targets as part of the neighbourhood renewal strategy, this more qualitative assessment of life in Hull in 2004 sets a benchmark for further evaluation. It is recommended that the same study is repeated by 2008 which will allow changes over four years to be assessed.

Finally, this study should have immediate relevance to service planners and operational managers.

From lifestyle behaviour and health perceptions, for example, the Specialist Health Promotion Service can more effectively target groups in particular areas.

The more detailed information about smoking status for each of the seven areas combined with age profiles and attitudes to risk offer a more comprehensive profile against which services could be delivered. In those areas where safety after dark is an issue, police, wardens and other services could consider action to address this. The need to provide specific help to isolated people is already part of the community wardens' role, and the results of this research begins to describe more general characteristics of this group that may support earlier interventions. The quality of data concerning mental health offers an enhanced profile of factors that affect local people and will be useful to GP's and community based mental health teams.

There will also be a clear role for the voluntary and community sector in strengthening local organisations providing social networking opportunities and support. Hull Community Network have played an important role in steering this research and they, along with numerous other formal and informal groupings, have a key responsibility in driving forward understanding of social capital and action to enhance it. But the greatest relevance of this research goes beyond this sector, to communities themselves whose views on these findings will be important to the ongoing debate about social capital in Hull.

Ultimately if this is a resource for community empowerment and development then it is at a very local informal level that investment in the stock of social capital should be led. An inclusive approach to neighbourhood renewal that prioritises social support for those more isolated people (including means of increasing access to family and friends), and improves perceptions of safety after dark, will have a real impact on health and contribute to narrowing the gap in health inequalities experienced by the people of Hull.

Further Reading

For those interested in the authors who have inspired this research and who may want to read more about this subject, the following brief list is commended: -

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Hull Community Network

