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Social capital, political trust and self rated-health: A population-based study in southern Sweden

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Abstract

Objective: To investigate the association between political trust (an aspect of institutional trust) and self-rated health, taking generalized (horizontal) trust in other people into account.
Design/setting/participants: The 2004 public health survey in Skåne is a cross-sectional postal questionnaire study answered by 27,963 respondents aged 18-80 yielding a 59% response rate. A logistic regression model was used to investigate the associations between political trust in the *Riksdag* and self-rated health. Multivariate analyses of political trust and self-rated health were performed in order to investigate the importance of possible confounders.
Results: 28.7% of the men and 33.2% of the women reported poor health. A total of 17.3% and 11.6% of the male and female respondents, respectively, reported that they had no trust at all in the *Riksdag* (national parliament). The addition of generalized (horizontal) trust in the multivariate models reduced the odds ratios of poor self-rated health in the "no political trust at all" category compared to the "very high political trust" category from 2.4 (1.8-3.1) to 2.1 (1.6-2.7) among men and from 1.9 (1.4-2.4) to 1.6 (1.3-2.1) among women.
Conclusion: Low political trust in the *Riksdag* seems to be significantly associated with poor self-rated health, even after adjustments for plausible confounders including generalized (horizontal) trust.

Keywords: Social capital, political trust, generalized (horizontal) trust, self-rated health, Sweden.

Introduction

Social capital has been suggested to promote health by a number of causal pathways which include a decrease in psychosocial stress, healthy behaviours mediated by health oriented norms and values, increased access to health care and other amenities, and a decrease in violent crime (1).

Social capital is primarily a contextual phenomenon. A society with high levels of social capital is characterised by high civic engagement and social participation among the citizens, high generalized trust in other people, high levels of political trust in the institutions of society and generalized reciprocity (2,3). Social capital works both horizontally, i.e. between individuals (generalized trust in other people/horizontal trust), and vertically, i.e. between individuals and institutions (institutional/vertical trust) (4,5). Social capital has been studied both as a social characteristic of larger geographic areas and social contexts (3,6), and as social relations in the local environment and trust between individuals (7,8).

Many studies have investigated the associations between social capital and health (9,10), but comparatively few studies have investigated the associations between the political and institutional (vertical) aspects of social capital, i.e. vertical/institutional trust in the institutions of society. This is surprising given the fact that *macro* level politics and the general health care system are regarded to have direct influence on public health (11). In Sweden the association between institutional (vertical) trust in the health care system and self-rated health has been investigated with results indicating a significant and positive association (12). Other authors have used voting participation as a measure of institutional (vertical) trust (13). We argue that it is more optimal to use specific items specifying the specific institution in which respondents have trust or lack trust. Furthermore, high voting participation may in different political situations be either an indicator of high trust or an indicator of low trust in the political system with the elections in Germany during the end of the inter-war Weimar Republic with strong voter support for anti-system parties in combination with high voting participation being the most spectacular example (14). This study will deal with the association between political trust in the Swedish *Riksdag* (the national parliament in Sweden), which may be regarded as an aspect of institutional (vertical) trust, and self-rated health.

In the 1960s political scientist David Easton defined three levels of political support and political trust: the political community, the political regime and the political authorities (15,16). Easton's model has later been re-defined into five levels of political trust: the political community, regime principles, regime performance, regime institutions, and political leaders (17,18). In the Scandinavian countries people have retained generally high trust in the political community and the fundamental democratic principles, but the levels of political trust in regime performance, regime institutions, and political leaders have declined. In fact, political trust in the *Riksdag* (the national parliament in Sweden) and politicians has declined more dramatically in Sweden during the past decades than in other countries in northern Europe including Denmark, Norway, Iceland, the Netherlands and Finland. This aspect of political trust is particularly low among the young (17).

Low trust is associated with poor self-rated health (1). Social participation and generalized trust in other people have been shown to be associated with self-rated health in Sweden (19). Self-rated health, which has been recommended by the WHO for monitoring in health surveys, is a multifaceted method to assess overall health. Self-rated health assessment is increasingly used to measure population health. It has been shown to be a significant predictor of morbidity and mortality (20,21). The hypothesis of this study is that high political trust in the *Riksdag* is associated with good self-rated health.

The aim of this study is to investigate the association between political trust in the *Riksdag* (the Swedish national parliament) and self-rated health, taking generalised (horizontal) trust in other people into account.

Study design and setting

Study population

Data from the 2004 public health survey in Skåne in southern Sweden were used. A postal questionnaire was sent out to a random sample of 47,621 persons aged 18-80 years during the autumn (September-December) of 2004. Two letters of reminder were sent to the respondents, and a subsequent phone call was made to the remaining non-respondents. A total of 27,963 respondents returned complete answers (right persons in the household

according to age and sex answered the questionnaire). The response rate of this cross-sectional study was 59%. The random sample was weighted by age, sex and geographic area in order to increase the statistical power in some smaller administrative areas. In the statistical calculations of this study this has been corrected by a weighted variable, so that the representative prevalences (%) for the entire Skåne region are given. The differences in prevalences between the uncorrected and corrected data are very small.

Assessment of variables

Outcome variable

Self-rated health was assessed by the question "How would you rate your general health status?" on a five-point scale (very good=1, good=2, neither good nor poor=3, poor=4, very poor=5). This variable was further dichotomised into good (alternatives 1 and 2) and poor (alternatives 3, 4 and 5) health.

Explanatory variables

Age was divided into five age intervals 18-34, 35-44, 45-54, 55-64, and 65-80 years.

All analyses were stratified by *sex*.

Country of origin. All persons born in countries other than Sweden were merged into a single category, which yielded the two categories "Sweden" and "other".

Education was divided by length of education into 9 years or less, 10-12 years, and 13 or more years of education.

Economic stress was categorized by the answer to the question "How many times during the past year did you not have money enough to afford the food or the clothes you and your family need?" There were four alternative answers: (I) "Every month", (II) "Approximately six months a year", (III) "Very occasionally", and (IV) "Never".

Generalised/horizontal trust in other people is a self-rated variable that encompasses an individual's perception of generalised trust in other people. It was appraised by the item "Generally, You can trust other people" with the four alternative answers: "Do not agree at

all", "Do not agree", "Agree", and "Completely agree". It was dichotomised with the two first alternatives as low trust and the two latter alternatives depicting high trust.

Political trust (an aspect of institutional/vertical trust) is a self-reported item which reflects trust in the Swedish *Riksdag* (Swedish national parliament in Sweden). The question "What trust do you have in the following institutions in society?" concerned the *Riksdag* (the national parliament), the regional parliament as well the respondent's local municipal assembly. It had four alternative answers: "Very big trust", "Rather big trust", "Not particularly big trust", "No trust at all", and "No opinion". Only the political trust in the *Riksdag* item was analysed in this study.

Statistics

Prevalences (%) stratified by sex of self-rated health, demographic, socio-economic, generalized (horizontal) trust and political (institutional/vertical) trust in the *Riksdag* variables were calculated (table 1). Crude odds ratios and 95% confidence intervals (OR, 95%) were calculated in order to analyse associations between the demographic, socio-economic, generalised (horizontal) trust and political trust variables, and poor self-rated health (table 2). Multivariate analyses were conducted using a logistic regression model to assess the potential importance of various confounders (age, country of origin, education, economic stress, and generalized trust in other people) on the relationship between political trust and poor self-rated health (table 3). All data were analysed with the SPSS statistical software package (22).

Results

The characteristics of the sample population are summarized in table 1. The distribution of self-rated health, demographic, socio-economic, and horizontal trust variables was similar between men and women. A 28.7% proportion of the men and 33.2% of the women rated their health as poor. Almost 12% of the respondents were born in other countries than Sweden. The prevalence of high education was 32.5% among men and 38.9% among women. The proportion with 9 years of education or less was somewhat higher among men than among women (43.5% compared to 37.3%). Most of the respondents had never (74.1%) or only occasionally (17.7%) experienced economic stress during the past year. The prevalence of low generalised (horizontal) trust in other people was 40.7% among men and

44.3% among women. The level of political trust in the *Riksdag* ranged from 4.4% with very high trust in the *Riksdag*, 30.2% with high trust, 38.2% with not particularly high trust, to 17.3% with no trust at all among men (9.9% having no opinion). Among women the corresponding proportions were 3.6%, 29.2%, 36.2%, 11.6% and 19.4%, respectively.

Table 2 shows that the odds ratios of poor self-rated health were significantly higher among both men and women born in other countries than Sweden. The odds ratios of poor self-rated health were also significantly higher among men and women with higher age, low/medium education, economic stress, low generalized trust, and low political trust (the political trust alternatives "not particularly high trust" and "no trust at all") as well as the "no opinion" category.

Table 3 shows that the odds ratios of poor self-rated health were significantly higher for the "not particularly high trust", "no trust at all" and "no opinion" categories of the political trust in the *Riksdag* variable compared to the "very high trust" reference category among both men and women. The age-adjusted odds ratios for the "not particularly high trust" category were 1.6 (1.3-2.0) and 1.3 (1.1-1.6), for the "no trust at all" category 2.7 (2.1-3.4) and 2.2 (1.7-2.7), and for the "no opinion" category 2.1 (1.6-2.7) and 1.6 (1.3-2.0), for men and women, respectively. These significant odds ratios remained largely unaffected after the inclusion of age and country of origin in the models. The addition of education and economic stress in the multivariate models reduced the odds ratios to some extent, although they remained significant. Finally, the inclusion of generalized (horizontal) trust in the models further reduced the odds ratios of poor self-rated health in the "no trust at all" category among both men and women, although all odds ratios that were initially significant remained significant. In these final models the odds ratios of self-rated health in the "no trust at all" category were reduced from 2.4 (1.8-3.1) to 2.1 (1.6-2.7) among men and from 1.9 (1.4-2.4) to 1.6 (1.3-2.1) among women.

Discussion

This study is one of the first to study the relationship between political trust (which is a form of institutional or vertical trust) and self-rated health. This study demonstrates that the category with low political trust and people with "no opinion" concerning the *Riksdag* (national parliament in Sweden) to a significantly higher extent have poor self-rated health

than the very high political trust reference category. The interpretation could be that political trust affects (self-rated) health. This association may be partly associated with generalised (horizontal) trust in other people.

It is plausible that political trust has an independent effect on self-rated health. Macro politics level political factors may thus influence both population health and individual health. These results have implications for health policy and public health. First, trust in the *Riksdag* and its politicians may have health consequences. Public health is not only a matter for particular politicians, public officials and some private enterprises making decisions exclusively within the health care sector. Public health considerations should be taken into account in all decisions within other policy areas as well. They should also always be taken into account when decisions are made at the *macro* politics level. Health policy should also entail a healthy public policy in general (11). Second, new right wing populist parties have emerged in several West European countries in recent decades. They express discontent and lack of trust in what they regard as the political "establishment", i.e. the government and the other political parties and their representatives (23,24). They are opposed to the European Union, the process of internationalisation, the immigration policy, and the political "establishment" in general (25). Underlying factors explaining this development include processes of change on the labour market, changing skills requirement to obtain a job, and the decline of traditional social environments, which are developments experienced as threats by some segments of the population (25). In Skåne in southern Sweden an average of 7% of the voters voted for a right wing populist party in the municipal elections in 2006. The corresponding number was more than 5.5% in the *Riksdag* election the same year (26). It may be that the disappearance of social environments and identities tied to occupational skills and other social contexts affect both political trust and general health in the population to an important extent, although this has not been investigated in this study. However, after adjustments for both education and economic stress in the multivariate models the significant association between political trust and self-rated health remained, which indicates that the association between political trust and self-rated health may be partly independent of these socio-economic factors.

Strengths and limitations

The participation rate is 59% which is comparable to other recent investigations (19). The study population shows similar composition according to socio-demographic variables compared to the general composition of the population of Skåne when compared with statistical registers. However, the group born in other countries than Sweden is under-represented by approximately 4 per cent units in this study compared to official register statistics for Skåne. Still, the risk of selection bias was considered low in a previous study on a random sample conducted with approximately the same sampling design and the same participation rate (59%) in Skåne 2000 (27).

The reliability (28) and validity (21) of self-rated health has been demonstrated in previous studies comparing other alternative health measures. Poor self-rated health has been shown to predict incidence of acute myocardial infarction in southern Sweden (10). The trust items (generalized/horizontal and political/institutional/vertical) are self-reported items, which are impossible to validate. However, the items used in this study have been used in previous nationwide investigations in countries such as the USA (2) and Sweden (29). Furthermore, low social capital (low trust and low social participation) have been demonstrated in a previous prospective study linking the previous 2000 public health questionnaire in Skåne to prospective register data on acute myocardial infarction incidence to be associated with an increased risk of acute myocardial infarction (10). The political trust item has been used previously in Sweden (17).

Only the political trust in the *Riksdag* item was analysed in this study. The question concerning political trust also entailed items on trust in the regional parliament and the respondent's local municipal assembly. The Cronbach's alpha for the three political trust items was 0.85, indicating a high concordance between the three items. Still, the political trust in the *Riksdag* item directly relates to the political authority level responsible for the functioning of both the economic system and the general welfare system in Sweden. Furthermore, it also directly relates to the measurements of political trust conducted within the political science literature (16,17).

Age, sex, country of origin, education, economic stress and generalized (horizontal) trust might be confounders of the association between the political trust in the *Riksdag* and self-rated health variables. Adjusting for these potential confounders and stratifying for sex produced some change in the effect size associated with political trust in the *Riksdag* and self-rated health.

The cross-sectional study design makes it impossible to draw inferences about direction of causality and causal pathways. However, it is probably not a serious weakness in this study, because the relationship between political trust in the *Riksdag* and self-rated health is a matter that should be seriously considered regardless of direction of causality. One likely direction of causality would plausibly be from political trust in the *Riksdag* to self-rated health. However, poor self-rated health may also lead to a higher demand for health care and other public amenities. If this demand is not met by the welfare system, the result may be a loss of political trust in the *Riksdag*. This cross-sectional study should most importantly be regarded as an exploratory study of the association between political trust and self-rated health, not as an analytical study inferring conclusions concerning a specific direction of causality.

Conclusion

Political trust in the *Riksdag* (the Swedish national parliament) is associated with poor self-rated health. This association may be partly associated with social capital in the form of generalised (horizontal) trust in other people. However, this is a cross-sectional exploratory study and the causality may go in both directions.

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Table 1- Prevalences (%) of the self-rated health, demographic, socioeconomic, economic stress, horizontal trust, and political trust in the *Riksdag* variables. N=27,963.

	Men (N=12,720)	**Women (N=15,243)**	**Total (N=27,963)**
Self-rated health (dichotomous)			
Good	71.3	66.8	68.8
Poor	28.7	33.2	31.2
(Missing)	(277)	(424)	(701)
Age			
18-34	23.1	25.7	24.5
35-44	17.7	18.3	18.0
45-54	18.2	17.7	17.9
55-64	20.6	19.1	19.8
65-80	20.4	19.2	19.8
(Missing)	(0)	(0)	(0)
Country of origin			
Sweden	88.5	88.0	88.2
Other countries	11.5	12.0	11.8
(Missing)	(667)	(586)	(1253)
Education			
13- years	32.5	38.9	36.0
10-12 years	24.0	23.7	24.0
-9 years	43.5	37.3	40.0
(Missing)	(1192)	(1701)	(2893)
Economic stress			
Never	75.9	72.5	74.1
Occasionally	16.9	18.4	17.7
6months a year	3.4	4.4	3.9
Every month	3.8	4.7	4.3
(Missing)	(265)	(331)	(596)
Trust (horizontal)			
High	59.3	55.7	57.4
Low	40.7	44.3	42.6
(Missing)	(182)	(263)	(445)
Political trust in the *Riksdag* (national parliament)			
Very high	4.4	3.6	4.0
High	30.2	29.2	29.6
Not particularly high	38.2	36.2	37.1
No trust at all	17.3	11.6	14.2
No opinion	9.9	19.4	15.1
(Missing)	(504)	(601)	(1105)

The Public Health Survey in Skåne 2004.

Table 2- Prevalences (%) and odds ratios (OR) with 95% confidence intervals (95% CI) of poor self-rated health according to demographic, socioeconomic, economic stress, horizontal trust, and political trust in the *Riksdag* variables. N (men) =12,720 and N (women) =15,243.

	Men		**Women**	
	%	**OR (95% CI)**	**%**	**OR (95% CI)**
Age				
18-34	16.7	1.0	22.0	1.0
35-44	22.5	1.4 (1.3-1.7)	26.6	1.3 (1.1-1.4)
45-54	29.0	2.0 (1.8-2.3)	32.8	1.7 (1.6-1.9)
55-64	35.0	2.7 (2.4-3.1)	42.1	2.6 (2.3-2.9)
65-80	40.8	3.4 (3.0-3.9)	46.3	3.1 (2.8-3.4)
(Missing)	(277)		(424)	
Country of origin				
Sweden	27.7	1.0	31.9	1.0
Other countries	35.7	1.3 (1.2-1.5)	40.8	1.5 (1.3-1.6)
(Missing)	(927)		(989)	
Education				
13- years	18.7	1.0	22.4	1.0
10-12 years	24.8	1.4 (1.3-1.6)	31.1	1.6 (1.4-1.7)
-9 years	37.0	2.5 (2.3-2.8)	43.1	2.6 (2.4-2.9)
(Missing)	(1419)		(2064)	
Economic stress				
Never	25.7	1.0	30.2	1.0
Occasionally	33.8	1.5 (1.3-1.7)	35.1	1.3 (1.1-1.4)
6 months a year	45.1	2.4 (2.0-2.9)	43.6	1.8 (1.5-2.1)
Every month	49.3	2.8 (2.4-3.4)	55.9	2.9 (2.5-3.4)
(Missing)	(523)		(734)	
Trust (horizontal)				
High	23.6	1.0	27.3	1.0
Low	35.9	1.8 (1.7-2.0)	40.2	1.8 (1.7-1.9)
(Missing)	(450)		(665)	
Political trust in the *Riksdag* (national parliament)				
Very high	19.7	1.0	26.0	1.0
High	21.3	1.1 (0.9-1.4)	23.8	0.9 (0.7-1.1)
Not particularly high	29.2	1.7 (1.3-2.1)	33.9	1.5 (1.2-1.8)
No trust at all	38.9	2.6 (2.1-3.3)	45.4	2.4 (1.9-3.0)
No opinion	33.7	2.1 (1.6-2.6)	38.0	1.8 (1.4-2.2)
(Missing)	(866)		(1101)	

The Public Health Survey in Skåne 2004.

Table 3. Age-adjusted and multivariate odds ratios with 95% confidence intervals (OR:s, 95% CI:s) of political trust in the *Riksdag* in relation to poor self-rated health.

Men

Political trust in the *Riksdag* (national parliament)	**OR (95% CI)** *	**OR (95% CI)** §	**OR (95% CI)** #	**OR (95% CI)¤**
Very high	1.0	1.0	1.0	1.0
High	1.1 (0.9-1.4)	1.1 (0.9-1.4)	1.2 (0.9-1.6)	1.2 (0.9-1.6)
Not particularly high	1.6 (1.3-2.0)	1.7 (1.4-2.2)	1.7(1.3-2.2)	1.6 (1.2-2.0)
No trust at all	2.7 (2.1-3.4)	2.8 (2.2-3.6)	2.4 (1.8-3.1)	2.1 (1.6-2.7)
No opinion	2.1 (1.6-2.7)	2.1 (1.6-2.7)	1.7 (1.3-2.3)	1.6 (1.2-2.8)

Women

Political trust in the *Riksdag* (national parliament)	**OR (95% CI)** *	**OR (95% CI)** §	**OR (95% CI)** #	**OR (95% CI)¤**
Very high	1.0	1.0	1.0	1.0
High	0.9 (0.7-1.1)	0.9 (0.7-1.1)	0.9 (0.7-1.2)	0.9 (0.7-1.2)
Not particularly high	1.3 (1.1-1.6)	1.4 (1.1-1.7)	1.3 (1.1-1.7)	1.3 (1.0-1.6)
No trust at all	2.2 (1.7-2.7)	2.3 (1.8-2.8)	1.9 (1.4-2.4)	1.6 (1.3-2.1)
No opinion	1.6 (1.3-2.0)	1.6 (1.3-2.0)	1.4 (1.1-1.8)	1.4 (1.1-1.7)

* Adjusted for age.
§ Adjusted for age and country of origin.
# Adjusted for age, country of origin, education, and economic stress.
¤ Adjusted for age, country of origin, education, economic stress, and trust.
The Public Health Survey in Skåne 2004.