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An Exploratory Study on the Association Between Social Capital and Self-Rated Health of South Korean Women with Disabilities

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Abstract

The purpose of this chapter was to explore the relationship between social capital and self-rated health status as assessed in the activities of the everyday life of South Korean women with disabilities. For this purpose, the authors analyzed the 8th data of the panel survey of employment for the disabled (PSED) that included a sample of 275 women with disabilities who are paid worker. The authors found that working environment, working hours, personal development possibilities, communication- and interpersonal-relationships, the fairness of performance assessment, welfare benefits, training opportunities, and job satisfaction differed significantly in relation to the self-rated health status of women with disabilities. The authors also found that for working hours, communication, and interpersonal relationships, significantly higher self-rated health status was found for satisfied compared to the satisfaction group. For personal development possibilities, welfare benefits, and training opportunities, self-rated health status was significantly higher for the satisfaction group than the dissatisfied group. For fairness of the performance assessment, self-rated health status of the satisfaction group was significantly higher than in the dissatisfied and the normal group. Therefore, in order to improve the self-rated health of South Korean women with disabilities, it is necessary to provide working environment considering their disability characteristics and various training opportunities in their workplace.

Keywords: women, disabilities, social capital, everyday life, health

1. Introduction

1.1. Women with disabilities in South Korea

The number of registered people with disabilities in South Korea has steadily increased from 2,148,686 in 2005 to 2,683,477 in 2011 and then to 2,726,910 in 2014 [1]. Women with disabilities constitute 42% of this total [2].

Women with disabilities are in a very vulnerable position in terms of health care due to complex interactions between a number of factors [3]. As we know, the burden of domestic labor, as well as childbirth and childcare is traditionally placed on women. Moreover, the entry of women into the labor market due to industrialization and family nuclearization, which are the characteristics of modern capitalist societies, adds to the burdens of social and economic activity, in addition to domestic work [3–5]. In particular, and unlike other English speaking countries, inequality of gender roles based on patriarchal values is very deeply rooted in South Korea. This presents various conflicts and problems between the roles traditionally required for women and the new roles that modern capitalist society demands [6–9]. This situation for South Korean women can be a very negative factor in terms of their health. However, despite the impact of these stressors on women, health policy in South Korea mainly focuses on maternity issues, specifically, pregnancy and childbirth [4]. Of course, such a phenomenon can be seen as critical when considering that the total fertility rate in South Korea is the lowest in the world, being 1.21 births per woman in 2014 [4]. However, since South Korea's extremely low birth rate problem is not the only cause health conditions for women of child-bearing age, the excessive emphasis on the health of women during the fertility period is not only detrimental to the effectiveness of the policy but also the equity of the health policy for women of all ages.

Disability can have a negative impact on the most basic conditions required for the management of health [10, 11]. In general, people with disabilities have very low access to medical facilities, due to physical and/or environmental constraints. Previous research has indicated that factors affecting the accessibility of people with disabilities include architectural elements within health care facilities [12], medical equipment [13–16], and the degree of understanding of disability in health care facilities staff [14]. Further factors associated with disability can negatively affect an individual's health care. This is evident in the health promotion policy of South Korea. Article 1 of the National Health Promotion Act, which was enacted in 1995, states "The purpose of this Act is to improve the health of the citizens by providing them with the correct knowledge about health with which they can enhance the awareness of the value of and develop a sense of responsibility for health, and by creating a given condition where they can spontaneously lead a healthy life." In other words, it means that individuals can acquire various health-related information provided by the national healthcare system to prevent them from being managed [17, 18]. However, due to the abovementioned problems of accessibility [12–16], combined with low levels of health literacy due to the low educational level [1], and issues relating to compliance, people with disabilities may experience problems in acquiring health-related information, and this can make management difficult. In addition, the health promotion policy which mainly focuses on people with disabilities in South Korea remains at the same basic level as the production of relevant statistical data [4]. Therefore, it is

very important for the national policy to promote the health of women with disabilities across all age groups located in this blind spot of South Korean health care.

1.2. Self-rated health

Self-rated health is an individual's subjective, internal judgment of their health and psychological status. Self-rated health may predict mortality as found in major health surveys such as the National Health and Nutrition Examination Survey and National Health Examination Follow-up Study in the United States in the 1990s [19, 20]. Since then, the importance of self-rated health has increased in various fields of study, including not only mortality rates but also in assessing the outcomes of clinical treatment, and satisfaction with the use of medical services after treatment [21–23]. The further advantages of assessing subjective health status include the potential to identify internal information, which may be affecting the current health status of an individual [24], and that the questions required to identify current health status are simple to complete. Thus, this method is very useful for understanding the health status of socially vulnerable groups such as the elderly and the disabled with low accessibility to medical facilities and/or health-related information [20, 25, 26]. In South Korea, 53.4% of the total disabled population, and 63.3% of women with disabilities have negative perceptions about their self-rated health status [1]. Nevertheless, research on the self-rated health of women with disabilities is very limited.

1.3. Self-rated health and social capital

Over the past two decades, various researchers have looked at social capital as a major factor influencing self-rated health [27–31]. This concept of social capital is based on the definitions provided by Putnam (1993) and Coleman (1994). According to Putnam (1993), social capital is a micro level concept aimed at improving the efficiency of society by facilitating coordinated actions [32]. Coleman (1994) on the other hand, defines social capital as a macrolevel concept aimed at improving the efficiency of society by facilitating coordinated actions [33]. Measures of social capital based on these definitions have focused specifically on “trust” within the context of interpersonal and intergroup relationships. For instance, interpersonal trust has been assessed by asking questions, such as, “Generally speaking, would you say most people can be trusted? [30],” “[Can] most people can be trusted [31],” and “Generally speaking, would you say that most people can be trusted, or that you can’t be too careful? [29].” On the contrary, intergroup trust has been assessed by asking questions, such as, “Would you say that most of the time people try to be helpful, or are they mostly looking out for themselves? [30]” and “How much can you trust people [31].”

However, although the notion of social capital focusing on trust considers the role of interpersonal or intergroup factors, it does not take into account the actual conditions under, which such trust can be formed [26]. What does actual condition mean that trust can form here? According to Bourdieu (1986), social capital should be defined as “the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition [...] these relationships may exist only in the practical state, in material and/or symbolic exchanges which help to maintain them [34].” Therefore, to examine the actual conditions in which trust can be formed either

within interpersonal or between intergroups, it is necessary to consider the “field [34–36]” in which these activities are specifically carried out, that is, everyday life [26].

1.4. Everyday life for women with disabilities

This study focused on the outdoor activities of women with disabilities in order to examine an area of everyday life for which the social capital of South Korean women with disabilities could be assessed. In the case of people with disabilities, external activities are restricted unless necessary due to the physical and environmental constraints [26, 37]. According to the Korea Institute for Health and Social Affairs (2014), the major outdoor activities of South Korean women with disabilities are (1) commuting to school and commuting to work (30.8%), (2) walking and exercise (26.0%), and (3) seeking medical consultation (13.0%) [1]. Therefore, this study focused on women with disabilities who commute to work within the economically active population (age range 18–60 years old). This was based on the fact that this is one key area of everyday life for women with disabilities. The purpose of this study was to investigate the relationship between social capital (i.e., social action, interpersonal relationships, and trust) and self-rated health, in the everyday life of South Korean women with disabilities. Specifically, we hypothesized that greater social capital would be associated with better self-rated health.

2. Method

2.1. Data and sample

In this study, we used data from the panel survey of employment for the disabled (PSED) in South Korea, with a specific interest in the major everyday life areas of women with disabilities concentrated on economic activities. The PSED is a survey of the panels representing the people with disabilities in South Korea and a longitudinal survey that conducts follow-up surveys every year from 2008 to present. Basic data on the participation of people with disabilities in the labor market were obtained. The survey included demographic characteristics, disability characteristics, economic activity status, waged/non-waged work/unemployment, effort and support for employment, vocational ability, employment attitude and environment, daily life, and quality of life. We used the survey data of the 8th PSED to examine whether social capital was related to the economic activity of women with disabilities. These data were collected from May to July 2015, and were collected from 3983 to 5092 registered people with disabilities aged 15–75 years old at the time of the survey [38]. The sample used in this study was first screened for the basis of economically active population age (18–60 years) among 1530 women surveyed, followed by self-employed (69), unpaid family workers (73), and economically inactive population (1113) were excluded from the survey. In addition, the total sample for the analyses was 275 women with disabilities who are paid worker.

2.2. Measures

The dependent variable was self-rated health. This was measured by the following question: “What is your overall health status at the moment?” Response options ranged from

1 (very poor) to 4 (excellent). The independent variables were the relating to the social capital of women with disabilities in the workplace, namely, ten factors that can give credibility to workers with disabilities. These were: job stability, working environment, working hours, personal development possibilities, communication and interpersonal relationships, the fairness of performance assessment, welfare benefits, training opportunities, acceptance and understanding of people with disabilities, and overall job satisfaction. Each variable was measured through the following questions: "How satisfied are you with the job stability of your current job?", "How satisfied are you with the working environment of your current job?", "How satisfied are you with the working hours of the job you are currently working on?", "How satisfied are you with the possibility of personal development in the job you are currently working for?", "How satisfied are you with communication and interpersonal relationships in the job you are currently working for?", "How satisfied are you with the performance assessment of the job you are currently working on?", "How satisfied are you with the welfare benefits of the job you are currently working on?", "How satisfied are you with the job training opportunities you are currently working for?", "How satisfied are you with the current acceptance and understanding of the people with disabilities of the job you are working on?", and "Given the overall details, how much do you satisfied with your current job?" In the original data, the response to each item was measured as 1 (very unsatisfactory) to 5 (very satisfied), but in this study, we re-coded these to 1 (unsatisfactory) to 3 (satisfactory) to reduce the number of cases difference between response groups. In the case of the performance assessment item, if there was no specific performance assessment system, it was judged whether the compensation system corresponding to the personnel affairs department was operated fairly [38].

The purpose of this study was to explore the relationship between social capital and self-rated health status of women with disabilities. Therefore, we focused on the differences in self-rated health status according to the level of thought and satisfaction of their job. To do this, we conducted one-way ANOVA to see whether the mean difference between the groups was statistically significant. Before performing ANOVA, it was verified whether the data for each variable met the assumptions of independence (the error between the population and the population is independent of one another), normality (the distribution of the population corresponding to each group is the normal distribution), and equal distribution (the variance of the population corresponding to each group is the same). The variables for understanding and acceptance of people with disabilities, and job stability were excluded from the final analysis because they did not satisfy the assumption of equal distribution.

3. Results

Analyses were conducted using SPSS 22.0, which includes descriptive statistics and one-way ANOVA analysis.

Table 1 shows the descriptive statistics results for the demographic characteristics of the study sample. In terms of type of disability, 152 were with external physical disability, 104 were with sensory disorder, 8 were with mental disorder, and 11 were with internal physical disability. With regards to educational attainment, 29 were received no education, 79 completed

Variable	M	SD	N (%)
Self-rated health	2.45	.62	
Average age	54	10.22	
Average income (\$)	10,372	7551	
Type of disability			External physical disability 152 (55.3) Sensory disorder 104 (37.8) Mental disorder 8 (2.9) Internal physical disability 11 (4.0)
Education attainment			Uneducated 29 (10.5) Elementary 79 (28.7) Middle 47 (17.1) High 92 (33.5) College 28 (10.2)
Marital status			Unmarried 26 (9.5) Married 142 (51.6) Divorced 36 (13.1) Separation by death 65 (23.6) Separation 6 (2.2)
Working hours for one week ¹			Less than 18 hours 31 (11.3) 18~36 hours 51 (18.5) More than 36 hours 193 (70.2)
Continuous service years			1-5 years 162 (59.0) 6-10 years 66 (24.0) 11-20 years 39 (14.0) 21-30 years 5 (2.0) More than 31 years 3 (1.0)
Periodic job			Yes 29 (89.5) No 246 (10.5)
Contract of employment			Yes 79 (28.7) No 196 (71.3)
Regular work			Yes 69 (25.1) No 206 (74.9)
Possibility of continuous work			Yes 69 (25.1) No 206 (74.9)
Total			275 (100.0)

¹Based on the week before the survey.

Table 1. Demographic data and descriptive statistics for the sample.

Variable	Group	M	SD	F	P	Scheffe
Working environment	Dissatisfied group(a)	2.21	.550	5.594	.004*	—
	Normal group(b)	2.39	.613			
	Satisfaction group(c)	2.59	.564			
Working hours	Dissatisfied group(a)	2.35	.629	6.663	.001*	b < c
	Normal group(b)	2.33	.638			
	Satisfaction group(c)	2.61	.572			
Personal development possibilities	Dissatisfied group(a)	2.26	.727	7.291	.001*	a < c
	Normal group(b)	2.42	.597			
	Satisfaction group(c)	2.72	.536			
Communication and interpersonal relationship	Dissatisfied group(a)	2.31	.208	6.242	.002*	b < c
	Normal group(b)	2.34	.051			
	Satisfaction group(c)	2.61	.054			
Fairness of performance assessment	Dissatisfied group(a)	2.10	.553	9.371	.000*	a,b < c
	Normal group(b)	2.41	.613			
	Satisfaction group(c)	2.71	.589			
Welfare benefits	Dissatisfied group(a)	2.20	.586	14.553	.000*	a < c
	Normal group(b)	2.46	.623			
	Satisfaction group(c)	2.74	.538			
Training opportunities	Dissatisfied group(a)	2.11	.614	11.768	.000*	a < c
	Normal group(b)	2.45	.599			
	Satisfaction group(c)	2.78	.584			
Overall job satisfaction	Dissatisfied group(a)	2.07	.616	7.398	.001*	—
	Normal group(b)	2.38	.631			
	Satisfaction group(c)	2.62	.567			

*p < .005.

Table 2. One-way ANOVA results by group (dissatisfied, normal, and satisfied).

elementary school, 47 completed middle school, 92 completed high school, and 28 completed college. For marital status, 131 were unmarried, 142 were married, 36 were divorced, 65 were separation by death, and 6 were separation. Regarding working hours for 1 week, 31 were less than 18 hours, 51 were between 18 and 36 hours, and 193 were more than 36 hours. In terms of continuous service year, 162 were between 1 and 5 years, 66 were between 6 and 10 years, 39 were 11 and 20 years, 5 were between 21 and 30 years, and 3 were more than 31 years. With regards to periodic job, 29 responded “yes” whereas 246 responded “no.” For contract of employment, 79 responded “yes” whereas 196 responded “no.” Regarding regular work, 69 responded “yes” whereas 206 responded “no.” In terms of the possibility of continuous work, 69 responded “yes” whereas 206 responded “no.” Regarding the average age and average

annual income were 54 years old and 11,072,600 Korean won (KRW; equivalent to \$ 10.372 USD), respectively. In terms of descriptive analysis for the key variable, the average for self-rated health was 2.45 (SD = .62).

Table 2 shows the results of the one-way ANOVAs. We analyzed whether, there is a statistically significant difference in the mean value of self-rated health status according to the level of thought and satisfaction of their job. As a result, there were statistically significant differences in the mean value for self-rated health according to all analyzed variables, that is, working environment of the employment of the women with disability ($F = 5.594$, $p < .004$), working hours ($F = 6.663$, $p < .001$), personal development possibilities ($F = 7.291$, $p < .001$), communication and interpersonal relationships ($F = 6.242$, $p < .002$), fairness of performance assessment ($F = 9.371$, $p < .000$), welfare benefits ($F = 14.553$, $p < .000$), training opportunities ($F = 5.594$, $p < .004$), and overall job satisfaction ($F = 5.594$, $p < .004$).

Scheffe tests were conducted to determine whether there were any differences between the groups for each variable (see **Table 2**). As a result, the difference in self-rated health status between the dissatisfied group (a), the normal group (b), and the satisfied group (c) of the overall satisfaction level of the working environment and the job was statistically significant. However, the comparisons did not show any differences between groups. For working hours, the self-rated health status of the satisfaction group was significantly higher than for the normal group ($b < c$). For personal development possibilities, self-rated health status was significantly higher for the satisfaction group than the dissatisfied group ($a < c$). For communication and interpersonal relationships, significantly higher self-rated health status was found for satisfied compared to the satisfaction group ($b < c$). For fairness of the performance assessment, the self-rated health status of the satisfaction group was significantly higher than in the dissatisfied and the normal group ($a, b < c$). For welfare benefits, self-rated health status was significantly higher for the satisfaction group than the dissatisfied group ($a < c$). For training opportunities, the self-rated health status of the satisfaction group was significantly higher than the dissatisfied group ($a < c$).

4. Discussion

The purpose of this study was to explore the relationship between social capital and self-rated health status as assessed in the activities of the everyday life of South Korean women with disabilities. These data were obtained from the national survey on persons with disabilities (2014), which mainly concentrated on economic activities [1]. Based on this, we examined whether there was a difference in self-rated health status according to the levels of job satisfaction and related variables as a measure of social capital in women with disability.

We found that working environment, working hours, personal development possibilities, communication-and interpersonal-relationships, the fairness of performance assessment, welfare benefits, training opportunities, and overall working satisfaction differed significantly in relation to the self-rated health status of women with disabilities.

In order to, investigate the difference of self-rated health status according to satisfaction level of each variable, Scheffe test was performed after dividing the response item of each variable into

three groups of dissatisfaction, normal, and satisfaction. As a result, the difference in self-rated health status in terms of both overall working satisfaction and the working environment were significant, but there were no differences between the groups for these variables. This suggests that these variables are closely related to self-rated health status, but not in terms of the level of satisfaction. Personal development possibilities, welfare benefits, and training opportunities were found to be higher in relation to self-rated health status for the satisfied group than in the dissatisfied group. These variables may be associated with direct and indirect comparisons with peers, so the items in a variety of conflicts can be caused by it, to a higher self-rated health status of the satisfied group more than dissatisfied groups for each variable. For working hours, communication and interpersonal relationships, higher self-rated health was found for the satisfied group compared to the normal group. It should be noted here that the difference in self-rated health status between the normal group and the satisfaction group, rather than the dissatisfied group, was statistically significant. This may mean that dissatisfaction with working hours, communication-and interpersonal-relationships may lead to resignation or disruption in human relationships, which may be less relevant to current self-rated health status. It is important to note that these results may indicate that invisible conflicts (i.e., the application of flexible working systems considering the characteristics of disability, microaggression, etc.) that occur are closely related to self-rated health status [37]. For Fairness of performance assessment, self-rated health was higher in the satisfaction group than in the dissatisfied and the normal group. Responses to this item included whether the compensation system corresponding to the personnel affairs department was fairly operated if there was no performance assessment system to the job. This question thus considers whether respondents felt that evaluation and compensation were properly performed. It is worth noting here that even if the personnel department thinks that it is not fair (dissatisfied group) and fairly unfair or justifiable (normal group), it is closely related to the self-rated health status of women with disabilities.

Importantly, we found that social capital is positively associated with self-rated health, which is partially consistent with past study findings. Social capital may affect health behaviors through social control over divergent health-related behavior, such as trust between individuals, and reciprocity [30, 39–41], and has an influence on the self-rated health at the community levels [31]. In addition, social capital may influence health outcomes, psychological health, self-rated health [26–29], and mental health [42].

One limitation of this study is that the number of women with disabilities is relatively small for analysis. As a result, it has been difficult to determine the extent and causality of the relationship between social capitals on the self-rated health status of women with disabilities. A further limitation is that we did not take into account the types of disability or various types of jobs undertaken by women with disabilities. Subsequent studies should consider such variables in order to more specifically examine the relationship between social capital and self-rated health status of women with disabilities.

5. Conclusion

South Korea's unequal gender role recognition based on patriarchal Confucian values still exists today. As a result, women in South Korea are experiencing various conflicts and problems that arise between the role of domestic work traditionally demanded of them, and the new role of wage

labor required by modern capitalist society. This double distress has a very negative effect on the health status of South Korean women [4, 5]. Nevertheless, despite the impact of these stressors on women, health policy in South Korea mainly focuses on maternity issues, specifically, pregnancy and childbirth [4]. In addition, their disability characteristics can have a negative impact on the most basic conditions for their health care, such as access to health care facilities or the acquisition of relevant information. Moreover, the health promotion policy, which mainly focuses on people with disabilities in South Korea remains at the same basic level as the production of relevant statistical data [4]. Thus, women with disabilities in South Korea are experiencing the triple distress of domestic work, wage labor, and disability, which means that women with disabilities in Korea are located in vulnerable areas of health care. Considering this situation, it is the most realistic and timely alternative for improving the health of women with disabilities in South Korea by examining the self-rated health status and social capital factors influencing it.

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Conflict of interest

No potential conflicts of interest are reported by the authors.

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