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## Is religion a health resource for the poor?

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### Abstract

This paper uses data from the 2004 General Social Survey to examine the relationship between religious belief and practice (religiosity), spirituality, social support, and health status. Health status is conceptualized first in terms of a subjective assessment and, second, as two objective indicators of physical problems. These relationships were examined first within the total GSS sample, and then separately for respondents who reported below or above the median annual income. Results indicate that spirituality is a positive predictor of respondents' subjective assessment of their health in the overall sample, but not in either separate income group. Social support does not predict positive subjective or objective health outcomes in the entire sample or for any income group. However, religiosity is a positive predictor of physical health, but only for the most severe of the physical health problems measured, and only for respondents whose annual income is below the national median. Thus, it appears that religiosity is a health resource for those below average income.

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### 1. Introduction

Does religious practice affect health? Ferraro and Albrecht-Jensen (1991) reported a statistically significant but qualified “Yes.” However, they also noted a puzzling finding in that there was a negative effect of conservative religious affiliation on health. They suggested the presumed positive health effects of reduced smoking and drinking among religious conservatives might be out-weighted by a tendency to resist medical intervention for religious reasons, or take a more fatalistic approach to illness. More likely, this finding may be an artifact of social class; conservative Christians in America tend to be of lower socioeconomic status (Pyle & Koch, 2001).

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Conversely, Ferraro and Koch (1994) noted that the positive relationship between religious belief, practice, and health outcomes was significant for African Americans, but not for Anglo Americans. This was partially attributed to the persistent inequities between Blacks and Whites with regard to health care, education, income, and wealth, and to a greater reliance among African Americans on the church for social and material resources.

What, then, are the combined effects of religion, health, and social class? This paper examines religion and health more broadly across income groups. This work improves upon previous research in that the analysis of these relationships is done on separate income groups in order to pinpoint whether or not religious belief or practice are health resources for everyone, or whether they are compensators more for the poor than for the wealthy.

## 2. Method

Data for this research are taken from the 2004 General Social Survey, a national probability sample of noninstitutionalized adults, compiled by the National Opinion Research Center (Davis, Smith, & Marsden, 2004). Questions regarding specific measures of subjective health, physical manifestations of health, social support, and spirituality, as well as components of religious practice were included.

Three dependent variables measuring health status are used in this research. The first of these is subjective health. The GSS question measuring this concept and used here is: “Would you say your own health, in general, is excellent, good, fair, or poor?” (This question was reverse-coded in the analysis.) A second, more objective, indicator of health status queries respondents’ need for minor medical intervention. The GSS question measuring this is: “First, thinking about health related matters, did any of the following happen to you since February/March, 1990? ‘Ill enough to go to the doctor?’” (Yes or No). Finally, an equally objective measure of more severe health problems involved this question: “During the past twelve months, were you unable to work at your job or carry on your regular activities for one month or more because of injury?” (Yes or No). These questions measure indicators of health status that are conceptually distinct from one another, and pinpoint the differing types of health problems potentially influenced by respondents’ religiosity.

Three substantive independent variables are used in this project as well as five standard controls. The first of the independent variables is scale of religious practice. Because previous research has noted the problems measuring the impact of religious practice on health when the measures of religious practice involve only physical activity (Ferraro & Koch, 1994), this scale is comprised of two measures, only one of which presumes the respondent is physically able to leave his or her dwelling. The items are: (1) “How often do you attend religious services?” Response categories were: Less than once a year; About once or twice a year; Several times a year; About once a month; 2–3 times a month; Nearly every week; Every week; Several times a week. (2) “About how often do you pray?” Responses were: Several times a day; Once a day; Several times a week; Once a week; Less than once a week; Never. (This item was reverse-coded for the scale.) The alpha measure of reliability for this religious practice scale is .695.

As previous research examines social support and spirituality as important vectors of religions impact on health, especially among African Americans, a carrier of each is included in

this study (Ellison, Hummer, Cormier, & Rogers, 2000; Ferraro & Koch, 1994; Levin, Chatters, & Taylor, 2005). Social support is measured by this question: “How often do you . . . spend a social evening with relatives?” Responses were: Almost every day; Once or twice a week; Several times a month; About once a month, Several times a year; About once a year; Never. (This item was reverse-coded for analysis.)

Spirituality is a two-item scale consisting of the following questions: (1) “I feel God’s presence: Every day; Most days; Some days; Once in awhile; Never or almost never.” (2) “I feel deep inner peace or harmony: Every day; Most days; Some days; Once in awhile; Never or almost never.” These items were reverse-coded for the analysis and the alpha measure of reliability for the spirituality scale is .730.

Finally, control variables included interval measures for age and income, as well as dummy coded variables for Sex (Female = 1); Race (Black = 1); and Marital Status (Married = 1).

The analysis proceeded in three steps. First, three Ordinary Least Squares Regression models were run using each of the health status measures as dependent variables. The independent variables in each model were religious practice, social support, spirituality, age, income, sex, race, and marital status. Second, the same three models (leaving out income) were run using only respondents who reported income below the national median (\$45,000). Finally, the second model was run again using only respondents reporting income above the national median.

### 3. Results

Table 1 summarizes results from nine regression models, three each for the total sample, subsample below median income, and subsample above median income.

As expected, income is a statistically significant predictor of health status in the total sample. However, this relationship holds only for subjective health, which essentially measures the respondent’s opinion that he or she is, by and large, healthy. Income is not a statistically significant predictor of health status as measured by going to the doctor or being out of work.

Spirituality is also a significant predictor of subjective health. It seems to follow that one’s self-assessment of closeness to God and inner peace and harmony would be similar sentiments to positively assessing one’s health status.

Religious practice is a statistically significant predictor of good health, but only with the most severe measure—out of work. Conversely, age and race are negative predictors of good health by this measure. Older respondents and Blacks are more likely to report missing work for a month or more due to injury.

Surprisingly, social support is not a significant predictor of any health variable in the entire sample, although it must be noted that the variable used to measure this is rather crude and highly specific. This finding neither supports nor refutes any previous work examining the salutary effects of social support measured in other more precise ways.

There are also no statistically or substantively significant relationships among any of the variables for the subsample above median income. Religious practice, spirituality, and social support failed to predict any of the three health status outcomes. Similarly, age, sex, race, and marital status were not statistically significant predictors of health status within this income group.

Table 1  
Regressions of health status variables on independent variables

Independent variables	Total sample	Subsample I	Subsample II
	Subjective health ( <i>N</i> = 248)	Income below median Subjective health ( <i>n</i> = 160)	Income above median Subjective health ( <i>n</i> = 88)
Religious practice	.008 <sup>a</sup>	.030	-.025
	.036 <sup>b</sup>	.120	-.137
Spirituality	.052 <sup>*</sup>	.054	.065
	.190	.182	.291
Social support	.004	-.035	.057
	.009	-.071	.138
Sex (Female = 1)	.027	-.095	.181
	.018	-.060	.133
Age	-.004	-.006	.001
	-.078	-.112	.017
Race (1 = Black)	-.197	-.196	-.253
	-.098	-.095	-.137
Marital (1 = Married)	.056	.044	.069
	.038	.028	.057
Income	.030 <sup>**</sup>		
	.221		
<i>R</i> <sup>2</sup>	.081	.065	.096
Independent variables	Total sample	Subsample I	Subsample II
	Been to doctor ( <i>N</i> = 473)	Income below median Been to doctor ( <i>n</i> = 299)	Income above median Been to doctor ( <i>n</i> = 174)
Religious practice	.007	.012	.000
	.048	.074	-.003
Spirituality	-.001	-.011	.015
	-.007	-.058	.086
Social support	.004	-.003	.022
	.013	-.010	.067
Sex (Female = 1)	-.107 <sup>*</sup>	-.076	-.098
	-.108	-.077	-.092
Age	.002	.000	.004
	.050	.014	.086
Race (1 = Black)	.007	.041	-.064
	.005	.030	-.041
Marital (1 = Married)	.060	.104	-.004
	.061	.107	-.004
Income	-.003		
	-.033		
<i>R</i> <sup>2</sup>	.015	.019	.031

Table 1 (Continued)

Independent variables	Total sample	Subsample I	Subsample II
	Out of work ( <i>N</i> = 473)	Income below median Out of work ( <i>n</i> = 299)	Income above median Out of work ( <i>n</i> = 174)
Religious practice	.013 <sup>a</sup> .138	.016 <sup>a</sup> .161	.006 .077
Spirituality	−.009 −.078	−.015 −.123	.002 .024
Social support	.011 .057	.014 .066	.007 .040
Sex (Female = 1)	−.017 −.028	−.004 −.007	−.047 −.080
Age	−.004 <sup>b</sup> −.160	−.003 <sup>b</sup> −.155	−.004 −.160
Race (1 = Black)	−.110 <sup>b</sup> −.126	−.113 <sup>b</sup> −.128	−.104 −.122
Marital (1 = Married)	.006 .010	.005 .008	.007 .013
Income	.004 .083		
<i>R</i> <sup>2</sup>	.048	.049	.047

<sup>a</sup> Unstandardized coefficient.

<sup>b</sup> Standardized coefficient.

\* *p* < .05.

\*\* *p* < .01.

By contrast, the same three variables that were significant predictors of health status in the total sample were also the statistically significant predictors of health status for the subsample below median income. Religious practice is a positive predictor of good health; age and race are negative predictors of good health, but only for the most severe measure of health status—out of work. Thus, the significant predictors of out of work in the total sample are also found to remain significant in the subsample below median income, but not in the subsample above median income. And yet again, social support as measured here is also not a significant predictor of any health outcome in the low-income group.

#### 4. Discussion

Is religion a health resource for the poor? This research offers a more specific “Yes” to the question. Moreover, it adds to previous literature by specifying the types of health problems that are positively impacted by respondents’ religiosity. There are three substantive findings that merit further research. First, income is a positive predictor of subjective health for the entire sample. This is not surprising in itself. However, income does not seem to predict better health for respondents as measured in their likelihood of having been examined by a physician or in their having been out of work due to injury. Higher income apparently makes us feel better

about our health, but for reasons that may not be related to specific health problems. It seems that wealth may give individuals a sense of well-being in that they may feel better equipped to handle future health problems and translate that peace-of-mind into an expression of general wellness. Further research is needed to parse this seemingly anomalous finding.

Second, spirituality persists as a positive predictor of subjective health in the overall sample, lending support to previous research (Ferraro & Kelley-Moore, 2000; Ferraro & Koch, 1994; Gilk, 1990; Idler, 1987; Pollner, 1989).

Third, and most important, the positive impact of religiosity on health status shows up most clearly when the models are run separately for the two income groups. Religiosity is a positive predictor of better health – measured as out of work – for the below median income group but not the above median income group. Thus, the positive association measured in the overall sample seems to be located among those with below average income. Moreover, religiosity and spirituality are not significant predictors of subjective health, going to the doctor, or out of work for those whose income is above the median. Religiosity and spirituality are also not significant predictors of subjective health or going to the doctor for either income group.

Religion appears to be a health resource for those whose income is below the median, but only with reference to being put out of work for health reasons—the most severe indicator of health measured in this study. These findings support those of Musick (1996) indicating the effects of religion on subjective health are most prominent for those whose health problems are most severe, but also add to that finding by noting the positive effects of religion on a specific indicator of poor physical health.

Further research is needed to broaden the scope of the investigation using more variables and subdividing income groups as well as using more indicators of health status. The data set used in this research limits the scope of the analysis to the questions that were asked in the GSS and the indicators of religion and health that can be gleaned from them. The analyses reported here are also limited by a sample size that is reduced due to the balloting of questions such that not all questions were asked of all respondents, and not all respondents answered all the questions.

In sum, however, religious belief and practice seem to be resources for those whose health problems prevent them from working, especially if their need to work is most critical – that is – when their income level is below the median. With the cost of health care and the number of uninsured Americans on the increase, the ongoing need to monitor, examine, and further specify the role of religion as a health resource becomes ever more important in understanding the institutional relationships that characterize American culture.

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