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SOCIAL CAPITAL AND HEALTH

An introduction

Lijun Song and Nan Lin

The concept of social capital has gained burgeoning research attention in the health literature since it was popularized in the late 1980s and early 1990s by four social scientists, including three sociologists – Bourdieu, Lin and Coleman – and one political scientist – Putnam.[1] Multidisciplinary efforts have examined the roles of social capital in the production process of multiple diseases and illnesses at multiple levels across cultures and societies. Available evidence leaves us little doubt that social capital is one potential social force in the social distribution of health. As is the case with new concepts in social sciences, social capital has controversial definitions and operationalizations. We distinguish two schools. Bourdieu and Lin exemplify a strict network-based approach. From a stratification perspective, they define social capital as assets embedded in social relationships, and specify it as resources of individuals' network members. Coleman and Putnam represent a normative approach. From a functionalist perspective, they emphasize social capital as a public good. They formulate social capital broadly as functional features of social structures or organizations, and propose diverse forms of social capital, such as social integration, norms of reciprocity and trust.

The normative approach to social capital has stimulated many more efforts, especially by public health researchers, than the network-based approach. It also provokes more debates. It has been criticized, for example, for confounding social capital with its sources and consequences, and for endangering the objective and neutral substance of social capital by subjective and moral elements such as trust and norms. This chapter briefly reviews empirical studies following the more rigorous network-based approach. Considering the fact that social integration creates and maintains social networks and furthermore produces and enhances network-based resources, we argue that social integration may serve as a proximate measure of network-based social capital. Thus we also introduce a few empirical studies on health using social integration as the indicator of social capital in the following review.

Social capital in the form of network resources can maintain and promote health. Multiple mechanisms are possible, including providing valuable health information; exerting influence on health policies, controls of health information and exposure and vulnerability to health risks; acting as social credentials; and reinforcing group identity and emotional support. Three studies in this section examine and find evidence for the positive association of social capital with health among normal population. Alan Acock and Jeanne Hurlbert analyzed the data from the 1985 General Social Survey. This survey used one network instrument, the name generator, and asked respondents to name up to five people with whom they had discussed important matters in the last six months. Acock and Hurlbert calculated the mean educational level of named contacts to indicate social capital. They found that social capital enhances life satisfaction and reduces anomia. Martin Webber and Peter Huxley studied data from a small general population survey in the UK. The survey employed another network instrument, the resource generator. It gave respondents a list of 27 items of social resources and asked them whether they currently had access to someone who could offer any type of those resources. These items form one scale, and also reflect four subscales including domestic resources, expert advice, personal skills and problem-solving resources. That scale as well as two subscales, domestic resources and personal skills, are negatively associated with mental disorder.

More recently, Lijun Song and Nan Lin examined the 1997 Taiwan Social Change Survey data, an island-wide stratified probability sample of adults in Taiwan. They derived social capital from two types of network instruments: two name generators and one position generator. One name generator asked respondents to name at most five contacts with whom they had communicated in the last year to discuss worries and personal problems, and the other asked respondents to name at most five contacts that they had reached out to for actual help or information in the last year when encountering difficulties in life. The position generator listed a sample of 15 ordered occupational positions salient in Taiwan, ranging from housemaids/cleaning workers up to physicians. Social capital (i.e. a factor score derived from extensity, upper reachability and range) measured through the position generator instead of through the name generators reduces depression and enhances self-reported health net of social support and personal capital. Also social capital interacts with education. It decreases depression to a greater degree for those with less education.

Furthermore, quite a few studies have used social integration as a proximate indicator of social capital. They examine its association with health at multiple levels, and report mixed evidence. At the individual level, T. Fujiwara and I. Kawachi analysed two-wave prospective panel data from a national representative sample in the U.S., and found no significant effect of volunteer work and community participation on major depression. At the community level, Kimberly Lochner and colleagues used community survey data to measure

neighbourhood social capital as the average per capita associational membership by neighbourhood. As their hierarchical analyses show, neighbourhood social capital negatively predicts all-cause and other-cause neighbourhood death rates for all race-sex groups and neighbourhood death rates from heart disease only for whites, but does not predict death rates from cancer. At the state level, as a study of 39 US states by Ichiro Kawachi and colleagues found, per capita membership of voluntary associations in each state is positively associated with individuals' self-reported health. At the country level, Brendan Kennelly and colleagues' study of 19 countries shows that the density of membership of organizations and the density of unpaid work for those organizations within a country exert no significant effects on population health including life expectancy, infant mortality and perinatal mortality. Some studies examine multiple levels of social integration simultaneously; Wouter Poortinga, for example, studied 22 European countries. The degree of voluntary participation at the individual level instead of its aggregate at the national level positively influences individual self-rated health. Also the effect of individual participation is stronger in countries with higher national participation.

In brief, the term of social capital has inspired substantial multidisciplinary health literature in the social sciences during the last two decades. Empirical evidence implies that social capital protects health not only directly but also indirectly through its interplay with other structural health risk factors such as personal capital and social support. Despite the quick and broad application of social capital to health research, more future theoretical, methodological and empirical studies are required. Diverse conceptualizations and operationalizations of social capital endanger its unique heuristic value. To achieve a coherent understanding of social capital, future studies should strictly distinguish social capital from other related but distinct social concepts, for example social integration, and examine their causal relations in the production of disease and illness. To obtain accurate measurement of social capital, future studies need to collect first-hand data sets and employ appropriate network instruments. To gain more knowledge of social dynamics and the mechanisms through which social capital impacts health, future studies should pay more attention to its mediating and moderating roles and to its downstream variables. For the purpose of generalizability and causal inference, future studies should collect more longitudinal data of nationally representative samples.

Note

1 For a recent review of this literature, see Lijun Song, Joonmo Son and Nan Lin (2009) 'Social Capital and Health', in William C. Cockerham (ed.) *The New Blackwell Companion to Medical Sociology*, Chichester: Wiley-Blackwell, pp. 184–210.