What is social capital and how does it relate to health?

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Abstract

During the last 25 years, a new term has cropped up in social sciences, social capital. In the last 10 years, this term acquired a new dimension which relates it to health. Following an analysis of theoretical issues surrounding social capital and social support, recent research is used to illustrate how these are affecting health. It is argued that more theoretical development is needed before social capital can be used to form a new community nursing practice. Until then, the ideas of social capital (social contact, companionship, etc.) may guide our mode of operation during nursing interventions.

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1. Introduction

Nettleton (1995) begins her book ‘The sociology of health and illness’ by giving an account of attitude changes to health issues during the last 25 years. This account underlines the shift from the biomedical to psychosocial model. However, attitude changes to health issues go further back in time. There is an undercurrent of changes all through the history of health care.

Papadatou and Anagnostopoulos (1995) list interesting facts concerning developments in health disease: Approximately 2500 years ago, Hippocrates associated health with the environment and the human soul. This view was abandoned in the 17th century as non-scientific. According to French philosopher Descartes, the soul is a separate entity that exists in parallel with the body but cannot affect organic functions. Cartesian dualism gave new impetus and orientation to scientific positivism. The time was ripe for Pasteur to develop his theory of microbes, which states that diseases are the result of microbial action. The linear mode of thought, incorporated in the biomedical way of viewing health, supports the idea that each and every result can be traced to a specific cause. Therefore, to explain a particular pathological phenomenon, it suffices to look for the cause responsible for it. Before the end of 19th century, Snow (as cited in Lomas, 1998) again focused the interest of public health on the ‘physical structure’ of the community as well as on individuals. The implication is that the etiology of the disease was focused outside the individual and the microbes, while a connection with social and environmental factors was established. Since then, research has related social phenomena to health.

During the last 25 years, a new term has cropped up in social sciences, ‘social capital’. Although this term is relatively novel, it can be traced back to the origins of the century (see e.g. Hanifan, 1916; Silverman, 1935). In the last 10 years, social capital has acquired a new dimension and has been related to health.

2. Defining social capital

As it is the case with many terms specific to social sciences, defining social capital is rather problematic.
This is because the concept is pregnant with constituent elements of meaning which sometimes contradict one another (Price, 2002; Durlauf, 2002; Whitehead and Diderichsen, 2001; Lochner et al., 1999; Portes, 1998; Muntaner and Lynch, 1998). When Loury (1977) used this term, he defined it as: the set of resources that inhere in family relations and in community social organisations and that are useful for the cognitive or the social development of a child or a young person.

Loury’s definition suggests that social capital is the total of social elements, which are required for the development of human capital. One of the main theorists of social capital in the last decade is Putnam. Putnam utilised the term social capital to explain the level of efficiency of local governments in Italy. He defined social capital as the sum of the following characteristics (as cited in Campbell et al., 1999)

- **The existence of community networks**: it involved human interaction within a community through clubs, societies, the church, and other organisations/networks.
- **Civic engagement**: the participation of people in communal processes and the use of the above networks.
- **Civic identity**: the feeling of equal participation within a community.
- **Reciprocity**: mutual help among members in a community.
- **Trust as opposed to fear**.

From the definitions above, we may understand that the concept of social capital was created to describe social relations of both familiar and non-familiar people. ‘Social capital is a feature of the social structure, not of the individual actors within the social structure’ (Lochner et al., 1999, p. 260), and for the World Bank social capital is the ‘glue that holds society together’ (World Bank web site).

### 3. Questions concerning social capital

The concept of social capital gives cause for a number of questions. The first has to do with the idea of ‘community’, which we do not intend to define, since this is beyond the scope of this paper. Coleman (1988) says that social capital is possible in communities characterised by social and environmental isolation from other communities. This may be explained by the fact that people know each other better, participate in the same organisations/clubs, and consolidate their relationships on the basis of cultural, social and moral elements. In other words, they have the sense of belonging and the sense of ‘internal identity’. However, these communities manifest the highest rates of intolerance to anything that is foreign to them or clashes with established ideas, which are characteristics of communities with low social capital (Putnam, 1995; Cox, 1995). Consequently, we must follow Woolcock’s (1998) distinction between intra-community and inter-community ties. With intra-community ties, we mean integration within the communities and when we speak of inter-community ties, we mean the linkages between communities. Social capital provides information about the existence of relationship(s) among people in a community, not about their mode of association. An identical quantitative or qualitative outcome may correspond to a variety of social organisation models. Cattel (2001) has identified at least six different social network typologies:

- The socially excluded or truncated network
- The homogeneous network
- The traditional network
- The heterogeneous network
- The network of solidarity
- The relocating network

The networks differ in structure, functions and interactional characteristics as distinguished by Israel (1985).

We must make clear, however, of the type of social capital we are referring to. Labonte (1999) expresses his concern about the mode of operation of social capital: ‘Do we trust only those around us which may mean only our elite neighbours in our gated community?’ (Labonte, 1999, p. 431). The question that arises is the following: does social capital lead to closed societies and the severing of channels of communication in the name of better health care? If this is the case, then it is a fearsome prospect. So in the level of nursing policy, we should be concerned ‘not how to care for those whom we know (our neighbourly civil society obligations), but those whom we do not (the thousands of anonymous others with whom we share our cities, states and planet)’ (Labonte, 1999, p. 431). Naturally, even if we trusted all people we cannot expect them to be members of the same club/societies as we are. The characteristics attributed to social capital by Putnam (1993) and Kawachi et al. (1997) seem to create a certain coercion at this point. That is because they are quite inflexible concerning the organisation of society (participation in communal organisations) while they ignore possible alternative forms of organisation. For example, the anarchists; how are they to be treated when we know that by definition, they are people who deny any form of authority; consequently, they lack inter-community linkage? Leeder and Dominello (1999, p. 426) raise the question: what are we to say to them? That they are wimpy non-contributors to social capital? Leeder and Dominello, commented a health and family policy proposition, yet their question applies to all those that do not choose a conventional life, with its consequences. As Lynch et al. (2000) comment, ‘Scratch beneath the
surface of social capital and things get complicated rather quickly’ (p. 404).

Putnam (2000) in his recent work ‘Bowling alone’ distinguished between bonding (intra-group) and bridging (inter-group) social capital without changing the major characteristics attributed to his concept, i.e. only a positive aspect of social capital. On the contrary, Bourdieu (1986) sees in social capital the potentiality to be used by those in power to maintain their power. Portes and Landolt (1996) also attribute a dark side to social capital that includes among others restrictions on individual freedom and business initiative, ethnocentrism, etc. In our view, these are characteristics of the bonding social capital. During health care delivery we have to clearly distinguish between bonding and bridging social capital and promote the last one. Of course this is quite difficult at the time because as Kawachi and Berkman (2000) point out, we know very little about what helps to build it.

The fact that participation in communal organisations is not a one-way street is supported by many researchers: Cattel (2001) researching on a deprived area of East London concluded that participation is not the main source of social capital for the majority of residents. In addition, Price (2002) suggested that ‘civic engagement fluctuates mostly because opportunities and incentive structures fluctuate, not because notions about the intrinsic worth of participation do’ (p. 126). Onyx and Bullen (2000) claim that ‘people may find their social networks in a variety of contexts and not necessarily in others, i.e. that different people are connected in different ways’ (p. 37). The same researchers developed 36 questions to measure social capital in relation to three parameters by Kawachi et al. (1997). The questions include more factors, e.g. tolerance to what is different, invitation to a stranger if a car breaks down, picking up others’ rubbish in public places, etc. Other researchers ascribe more characteristics to social capital. For example High et al. (1999) claim that reading to children could be a form of social capital. These new characteristics can provide an integrated account of social capital in comparison to Putnam’s (1993) and Coleman’s (1990) account of the concept. Health researchers should use these expanded indicators of social capital and not just the per capita participation and trust.

4. Social capital and health

After the publication of Putnam’s book ‘Make democracy work’, in 1993, interest was stirred about the effects of social capital on health. Kawachi et al. (1997) published a paper that linked social capital with income inequality and mortality. They devised a means of measuring social capital based on the following two parameters: the first is the level of civic engagement that is measured by the per capita number of groups and associations to which residents of a community belong to. The second, which is the level of mutual trust among community members, was measured using the following two questions:

(1) Do you think that most people would try to take advantage of you if they got a chance, or would they try to be fair?
(2) Generally speaking, would you say that most people can be trusted or that you cannot be too careful in dealing with people?

The first question refers to the perceived lack of fairness and the second refers to social mistrust. In the research, 39 American states were included and adjustment was done for potential sampling bias. What came out was that ‘the effect of income inequality (as measured by the Robin Hood Index) on mortality is mediated by social capital (as measured by the level of perceived fairness’ (Kawachi et al., 1997, p. 1495).

Another example comes from the research conducted by Sen (1999): in the USA, African Americans have a lower life expectancy rate than people in other countries with much lower economic development (e.g. Indian state of Kerala, Sri Lanka, Jamaica). Although the per capita income of African Americans is much lower than that of the white USA population, it is much higher compared with that of the countries mentioned above (even after correcting for cost living differences). The casual influences on these contrasts (i.e. between living standards judged by income per capita and those judged by the ability to survive to higher ages) include social arrangements and community relations…’ (Sen, 1999, p. 620). In another research study Kawachi et al. (1999) established that people living in areas with low social capital are more likely to score poorly on self-rated health measures, even after control for individual risk factors (e.g. low income, low education, lack of access to health care, smoking, obesity). Wilkinson (1996, p. 4) stated that healthy egalitarian societies ‘have more of what has been called social capital…’. Lindström et al. (2001) argued that social capital may be useful, both in lowering the prevalence of health-related risk behaviours and in countering socioeconomic differences in such behaviours. Wilkinson et al. (1998) found that social capital is inversely proportional to rates of violent crime, i.e. the lower the level of social capital, the more the rate of violent crime. Jack and Jordan (1999) stated that the existence of social capital in a community is much more appropriate and essential for the children’s welfare compared with the traditional view of formal child protection and family support services. Runyan et al. (1998) concluded that positive health and developmental outcomes for high-risk pre-school children are associated with high levels of social capital. In a recent
research, Bolin et al. (2003) also found a positive effect of social capital on health capital.

There are also contrary research findings: The most important is the second analysis carried in a cross-national level by Kennelly et al. (2003): they did not find any strong positive relation between the indicators of social capital and population health. Again, they only used measures of participation and trust and not an enhanced model of social capital. Hyypää and Mäki (2001) showed that most participating activities do not associate with self-rated health. Veestra (2000) found that civic participation (which defines social capital) is unrelated to health. Research held in Luton revealed that a high level of local identity, a measure of social capital according to Putnam’s theory, was associated with poorer health (Campbell et al., 1999).

In spite of the above positive connotations, there are a number of researchers who claim that social capital requires further elaboration to establish whether it could add something new to the theory of social sciences. Could we use social capital as a basis for the design of a new nursing practice? A brief bibliographical reference regarding the meanings of social capital (social support, civic engagement, social trust) will be made to examine whether this concept has something new to contribute to existing theories or we are caught up in the process of reinventing the wheel.

5. How new is social capital in relation to health?

Cohen and Syme (1985) conducted a research study in Alameda County, California. They concluded that larger network size and greater frequency of contact was related to decreased mortality for both men and women at all ages even after control for socioeconomic status, initial health status and health practices. The researchers looked at: marital status, a person’s contacts with friends and relatives, church membership, organisational affiliations, political and group activities, such as membership in a garden club or in a bridge club, etc. One of the defining characteristics of social capital is voluntary participation in communal organisation. This idea of participation was also used by Putnam (1993) and Kawachi et al. (1997). The research of Hanson et al. (1987, quoted from Hafen et al., 1996) came to the same conclusion: their study was conducted with Swedish men who were born in 1914. It showed that good social support and social networks decreased mortality from all causes. In the study, the men who did the worst were those who felt a lack of social and emotional support, those who were dissatisfied with their social activities and those who lived alone. One more research study was conducted by Cohen and Syme (1985) with people over 55 years old. Initially, it was established the level of satisfaction from life. Then the researchers looked at the source of patients’ satisfaction and it was ascertained that it was human contact—it was contact with friends that made the difference. Another research conducted by Locke and Colligan (1986) showed that those who were the most socially isolated had four times the mortality rate of those who were socially involved.

One could argue that all the details mentioned above refer to idea of social support, which needs distinguishing from the idea of social capital. Moss (2002), proposing a framework of factors influencing women’s health puts social capital/social networks/support in one category of health-related mediators. Wilkinson (1996) in addition to ‘social capital’ uses the term ‘social cohesion’ when referring to the characteristics of healthy egalitarian societies. Kennelly et al. (2003) use the phrase ‘social cohesion or social capital’ when defining the term (p. 2). Campbell et al. (1999) utilise the term social support when referring to social capital, while others (Labonte, 1999) believe that social capital does not exist but we are all working towards its materialisation. Therefore, we must ask ourselves whether social capital articulates something different to social support with practical applications in health.

Further elaboration on social support is called for at this point, to be able to distinguish it from the other concept. Hafen et al. (1996) define social support as ‘the degree to which a person’s basic needs are met through interaction with other people’ (p. 263). According to Amick and Ockene (1994), social support involves five components as resulted from research in heart disease:

- being cared for and having the opportunity for intimacy,
- being esteemed, valued and having a sense of personal worth,
- having the sense of belonging as well as mutual obligations with others,
- having access to information, appraisal, and guidance from other people,
- having access to material assistance.

By comparing the terms social capital with social support we find the following common ‘elements’: social networks and social engagement, the sense of belonging and reciprocity. In other words, we have two concepts with the same theoretical characteristics which describe two different phenomena: social support refers to relations a person develops in his/her social environment, while social capital breaks away from this individualistic approach to address more effectively the influence of the society to the individual. So we agree with the statement of Hean et al. (2003, p. 1071) that social capital ‘...is not simply a new term for an old product—but a new multidimensional and measurable concept that offers a new combination of old ideas in a new and useful package’. Of course, we still do not know
what influences health more, social capital or social support, or what is the relationship between these two.

Kawachi et al. (1997, p. 1492) concluded that ‘a vast literature has linked social networks to health outcomes at the individual level’. This means that up to date emphasis has been placed on social support while the researchers’ interest on social capital is because it is something new and different. The only apparent difference, in the way we have measured it until now, is that social capital deals more explicitly with the idea of ‘trust’ in relation to health. Trust is based on ‘a sense of confidence that others will respond as expected and will act in mutually supportive ways, or at least that others do not intend to do harm’ (Onyx and Bullen, 2000, p. 24). Consequently, although the concept of trust is not explicitly mentioned in the definition of social support, mutual obligation, which is inherent in social support, presupposes trust. Therefore, while there is no explicit reference to ‘trust’ in social support; it is, however, understood. Hean et al. (2003) proposed an analytical framework to measure social capital based on the ‘capital’ element described in Marxist terms, but describing how ‘social recourses’, rather than money can be accrued. If this model is generated, we will be able to study social capital in specific contexts, acquiring better insights of the concept.

According to Kawachi et al. (1997), social capital came to fill in the gap that had been created in epidemiology by reorienting the focus of the latter from isolated individuals to isolated social groupings. However, in spite of the fact that both concepts are similar, there is no cause and effect or any direct relationship between the two. A particular community without social capital may feature individual social support and vice versa. This means that in communities with high social capital people may not enjoy the required social support. The fact that one participates in communal processes does not necessarily imply that one has also been accepted by the community. In this aspect, the concept of social capital is deficient: it does not take into consideration the quality of relationships, neither the quality of participation. It simply gives a quantitative description of a phenomenon without taking into account its fundamental parameters. This can lead us to oversimplification of social phenomena and force conclusions about their causes.

In their research Kawachi et al. (1997) did not make any distinction and treated their sample as if it was a homogenous community. This may be problematic for health sciences, because it cannot contribute to shaping health interventions for the benefit of all people. Despite the fact that it provides clear-cut information about the relationship between social capital and health, it ignores the cultural subgroups of a community with a variety of health and social problems. Social capital provides the degree of people dissociation and social isolation. However, up to now, social support allowed us to take into consideration the particular characteristics of a population. This helped us in shaping effective nursing interventions that significantly improved health indices.

Another problem is that there is not enough research data to support a clear interaction of various social factors in health. Existing research fails to explain various contradictory phenomena. The research conducted by Kawachi et al. (1997) made clear the relation between age-adjusted mortality rates and lack of social trust. Other phenomena are pressing for elucidation: e.g. how do we explain the difference in the age-adjusted mortality rate among the US states Utah—Wisconsin, Colorado—Ohio (Kawachi et al., 1997) with similar level of social trust?

We do not underestimate, in any case, the solid epidemiological correlation, but we want to argue that these are issues for future research.

6. Issues in nursing practice

Many researchers proposed that social capital (Pesut, 2002; Ervin et al., 1999) as well as sustaining all four forms of capital—human, natural, social, financial—(Gorski, 2000) may lead to potentially useful health interventions. Veenstra (2002), researching 30 health districts in Canada, found that places with high levels of mobility tend to have lower social capital scores. These are usually places with proportionately more single parents, women and elderly people. Community nursing should target these places/groups making effective interventions to improve their health care. Drevdahl et al. (2001, p. 26) argue that ‘as an intervention, building social capital does not necessarily result in moving us any closer to a form of social justice that requires recourses to be distributed based on egalitarian principles rather than on deservedness’. So, we should keep in mind that the promotion of social capital may not cure the problem of health and social inequalities.

If current theoretical deficiencies are to be overcome and (bridging) social capital policies to be promoted, there are two things that must be taken into consideration during nursing practice.

The first is about the process of participation in social clubs and institutions, a central concept of social capital according to its definition. One very interesting finding that Stone (1986) reported is that minority groups are not keen on participating in community affairs. This is particularly true with the poor and the disadvantaged. This comes as no surprise since, ‘trust’ing social institutions, maximising inter-personal supports and engaging in self-disclosure are strategies most appropriate for middle-class and affluent individuals whose interests are served by those institutions, whose social supports can multiply available resources and contacts,
and for whom self-disclosure may in fact lead not only to personal, but also to structural change (Fine, 1992, p. 69). It is, therefore, necessary to place particular emphasis on the issue of participation during the design and organisation of nursing interventions. What we need not do is to simply reinforce the position of those in power by marginalising the majority of people who are devoid of any form of power/leverage. Elkan et al. (2001) commenting on British Health Visiting Policy proposed that within a universally provided service, there is certainly scope to devote more time and resources to those with the greatest needs (p. 118).

Kritsotakis (2002) proposed a way to deal with these challenges: in case a nursing-led participatory intervention is organised, instead of making the most obvious choices—i.e. those that were favoured by a majority—we can select from both ends of the spectrum of available choices. In other words, instead of a top-down approach, adopt the bottom-up alternative. For example, we are dealing with a community which has identified six issues that need attention. For some reason only two of the six issues can be dealt with. Now, instead of selecting two of the most preferred issues, we can select one from each end of the list of six, as Kritsotakis (2002, p. 251) says ‘This procedure by itself changes the way we perceive participation:

1. It affects a radical change to the way we operate today—the utilitarian approach—which takes into account the good of the many as opposed to the good of the few.
2. It applies qualitative instead of quantitative criteria to problem solving.
3. It champions the rights and choices of the minorities.
4. It implements redistribution of power by adopting the bottom-up and not the top-down approach to making a choice. A choice by the few does not necessarily say anything about the quality of the choice itself.
5. It tapers off social injustice because it instills assertiveness to all those who are in need of it.

Our position with regard to this issue should be clear: are we in need of social capital projects that reproduce the current system, or projects that bridge over social gaps?

The second thing to be taken into account is the political parameter of social capital. Leeder and Dominello (1999) express their concern about the way in which social capital could be implemented by conservative governments. They feel that the treatment of chronic diseases could be transposed from health authorities to families. We are inclined to agree with this prospect. Health services should reorient themselves from health institutions to family and community environments. However, more research is required to confirm this view. If this is the case, then the question is under what terms and conditions could this shift take place? This poses a great challenge both for nursing and social policy: to secure services (sufficient and efficient network of primary health care) so that health services move closer to them and not away from them.

We will refer to a community care program based on the village Arhanes, Crete, Greece. The program describes the symbiosis of community health services with the features of social capital. It shows that where social capital exists, health services move closer to the community. This program addresses residents over 60 years old that do not have, for any reason, access to health services, and they need health care. The program requires volunteers for two reasons: firstly to help their neighbours daily in simple but important things, i.e. shopping, paying bills, etc. Secondly, it needs volunteers to mediate the community and the health and social services. The program officially has very few volunteers because the residents refused to volunteer. They said that they do not need a formal obligation—to sign up as a volunteer—to help their co-citizens. Actually, most of them were doing what the program intended and asked them to do long before the program began. This comes in accordance with Lavis and Stoddart (1999) finding that cohesive communities provide better care for the elderly. Of course, in a strictly bureaucratic evaluation the program did not accomplish its aims because it did not identify many volunteers. But social capital makes the program work irrespective of the existence of any formal obligations between community members. In this case, the health team acting as a facilitator helps the community to work better, ensuring better health care for all. The description of the social environment is purely empirical since there are no research findings measuring social capital for the specific area.

Still we do not know if the existence of the community health team can promote social capital or it will just be social support?

7. Conclusions

There are a number of questions that have to do with the mode of application of the idea of social capital (Hawe and Shiell, 2000). Constituent elements of this concept are either contradictory or merit further research. However, people need social contact, companionship and a sense of belonging. These ideas may guide our mode of operation. We cannot be sure yet whether this has to do with social capital or social support. But as Drevdahl et al. (2001, p. 28) say, ‘there are undoubtedly benefits that may accrue to communities where social cohesion is fostered, neighbours are trusted, and a sense of civic participation exists’.
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