Twenty Years of Research on Social Capital and Health: What is the Utility for Health Promotion?

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Despite the huge amount of research about social capital and health during the last 20 years, the utility of this knowledge for health promotion remains unclear. This article aims to conceptualise social capital in relation to health promotion and to identify what is required for social capital to be used as a resource in health promotion. It suggests that social capital has become an important concept in health promotion but that many challenges remain on how it could be utilised in policy and practice. Social capital does not add any ground-breaking new knowledge in health promotion but complements already existing knowledge within social networks/social support and community development approaches in health promotion. Utilising social capital in health promotion requires an awareness of power relations and social inequality, as well as the political structures that exist were the intervention take place. There is a need for more systematic explorations of case studies attempting to utilise social capital in health promotion.

Introduction

Over the past two decades, we have seen an overwhelming volume of research about social capital and health. A search in the PubMed database for articles with "social capital" in the title gives only two results until December 1995. The same search gives as many as 1,589 results as of December 2019.

This huge, and still growing, research field can be framed within the renewed interest in the social determinants for health (SDH), seen during the last decades. In health promotion, this represents a shift in focus, from individual lifestyle and behaviour, to the broader social and living environments. Already in 1986, the Ottawa Charter for Health Promotion underlined the importance of developing health-promotion approaches that tackle the broader social and environmental determinants for health. This was further emphasised with the launching of the WHO Commission on Social Determinants of Health in 2005. However, despite this awareness and an enormous amount of studies about

social capital and health, the utility of this knowledge for health promotion remains unclear. Accordingly, literature focusing on social capital and health promotion is scarce: a search in PubMed for articles with social capital AND health promotion in the title/abstracts gives only 18 results until April 2020.

This article aims to conceptualise social capital in relation to health promotion and to identify what is required for social capital to be utilised as a resource in health promotion. The intention is not to systematically review literature on social capital and health promotion, but to discuss key literature on social capital and health (i.e. recent systematic reviews and well-cited literature from some of the main contributors within this research field) in relation to basic approaches in health promotion. In so doing, the paper contributes to existing literature by providing an understanding of how the concept of social capital relate to what is already known in health promotion, and what it adds to this knowledge.

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

Social capital has several definitions, but they all have in common that social capital involves "*social networks, the reciprocities that arise from them and the value of these for achieving mutual goals*" (Schuller, Baron & Field, 2000, p.2). Further, social capital is conceptualised as both an individual and a collective feature and these different approaches are often referred to as social networks versus social cohesion approaches (Moore & Kawachi, 2017). The individual (social network) approach views social capital as "*the ability of actors to secure benefits by virtue of membership in social networks or other social structures*" (Portes, 1998, p.6). The underlying idea is that individuals can secure certain benefits or "states" (such as health) by belonging to social networks (or being socially connected to someone). The collective (social cohesion) approach views social capital as something characterising local areas or settings (e.g. schools, workplaces) by levels of social participation, trust and reciprocity norms (Kawachi & Berkman, 2000; Putnam, 1993; 2000; Szreter & Woolcock, 2004). These characteristics are believed to promote various collective and individual benefits such as democracy, safety as well as health (Putnam 1993; 2000).

Coleman (1988) as well as Woolcock (2001) emphasise social capital as a facilitator for action, and their perspectives are thus relevant for understanding how social capital can become a resource in health promotion. Michael Woolcock defines social capital as "*norms and networks that facilities collective action*" (Woolcock, 2001, p.13). Coleman (1988) discusses how different forms of social capital facilitate actions. According to him (Coleman, 1988), *obligations and expectation* within a social structure is a vital form of social capital. Doing something for others establishes an obligation for those to reciprocate, and these obligations are thus debts to collect when needed. Further, *information* constitutes an essential basis

for actions, but gaining information is costly. Another vital form of social capital is therefore the potential information embedded in social relations. Existing *norms* also have powerful effects on actions, and is a third form of social capital according to Coleman (1988). There are rewards (in terms of status or honour, etc.) that can be expected if one adheres to the norms or effective sanctions (such as social exclusion) if one do not follow the norms.

In addition, social capital is divided into different forms. *Structural* social capital refers to actual participation in various networks, while *cognitive* social capital refers to perceptions about social network involvement (Krishna & Shrader, 2000; Harpham, Grant & Thomas, 2002). Another distinction is made between bonding, bridging and linking social capital. *Bonding* social capital consists of strong ties within a network of people that are similar to each other. *Bridging* social capital consists of weaker ties that link diverse people from heterogeneous networks (Moore & Kawachi, 2017). Finally, linking social capital consists of vertical ties between people in different formal or institutionalised power hierarchies (Szreter & Woolcock, 2004; Moore & Kawachi, 2017).

With more than 20 years of research on social capital and health, there are now many systematic reviews about the links between different forms of social capital and various health outcomes. Gilbert et al (2013) conducted a systematic review of 39 studies investigating the links between different constructs of social capital and self-reported health and all-cause mortality, and the results suggest a strong positive relationship between social capital and health. A stronger effect was found on individual- as compared to collective level, and the strongest positive health effects were found from bonding social capital, followed by bridging and linking (Gilbert et al, 2013). Kim et al (2008) reviewed literature (published 1995-2006) about the association between social capital and physical health and found a consistent association between trust (as one indicator of social capital) and better physical health, and this association was stronger on individual compared to area level. An updated review of 145 studies about social capital and physical health (published 2007-2018) found that the majority of studies (59%) reported mixed results, i.e. social capital showed both positive and negative or null effects on health. Almost a third of the studies, 28% reported strictly positive findings and 12% of the studies reported strictly null or negative effects of social capital on physical health, and these findings were similar across social cohesion- and network-based studies (Rodgers et al, 2019).

Ehsan et al (2019) reviewed 20 systematic reviews of social capital and health, and conclude that there is a good amount of evidence to indicate that social capital is associated with better health. Most systematic reviews found particularly strong evidence for a positive association between cognitive social capital and health, while the results were more mixed on the association between struc-

tural social capital and health, and seemed to vary depending on the particular context. The authors (Ehsan et al, 2019) conclude that few studies were able to disentangle how different forms of social capital affected various health outcomes for different groups of people in various contexts. Thus, they suggest that further research need to conceptualise the link between social capital and health within a "what, who, where, when, why and how framework" (Ehsan et al, 2019).

Villavonga-Olives and Kawachi (2017) systematically reviewed 44 studies that found *negative effects* of social capital on various health outcomes. Among other things, they conclude that many downsides of social capital seem to occur in the context of strong bonding, at the expense of bridging social capital. Strong bonding social capital seem to increase the risk for social exclusion of outsiders and create heavy obligations on community members to follow a dominant social hierarchy.

How to explain the links between individual and collective social capital and health?

There are several hypotheses about the links between individual social capital, i.e. resources embedded in social networks, and health. The most obvious association is that involvement in social networks provides various forms of *social support* (such as emotional, instrumental and appraisal support) that affect health through functioning as a buffering resource for the negative effects of long-term stress (Bartley, 2004). Social influence is another possible pathway between social networks and health, since role modelling by trusted peers is found to be an effective way of influencing (health) behaviour (Merzel & DÁfflitti, 2003). Further, social participation can promote health by giving opportunities to learn new skills, and by increasing a sense of belonging and life meaning (Berkman & Glass, 2000). In addition, being involved in social networks can provide access to material resources and health services needed to maintain or improve health (Berkman & Glass, 2000).

However, research also suggest that social networks may have negative effects on health by increasing stress for those who are expected to be the main provider of support to others (Kawachi & Berkman, 2001). In addition, social influence may influence health behaviour in both health-enhancing and health-damaging ways depending on the norms that exist in a particular network (Villavonga-Olives & Kawachi, 2017). Further, another dark side of social network involvement might be strong demands to obey existing norms within the network and thus oppressive consequences and social exclusion for those who fail to conform to existing norms (Kawachi & Berkman, 2001). These ideas were articulated in the work of James Coleman (1988) and also in Pierre Bourdieu's (1986) writings about social capital. Bourdieu (1986) states that social network

involvement is a product of individual "investment strategies", and those with higher assets to invest, i.e., those with more resources (material or cultural), are more easily invited into powerful networks. Thus, Bourdieu adds a clear power and inequality perspective on social capital in saying that the dominant groups in a society have more power to decide what networks are valuable and to include or exclude people from these networks (Bourdieu, 1986).

On a collective level, place-specific social capital is believed to influence health by enabling a safe and supportive environment, trust and collective action (Eriksson, 2010). It may facilitate "collective efficacy" in that community members increase control over their lives and their living environment (Campbell,l 2000), and may also influence health through facilitating community members' ability to express solidarity by enforcing social norms (Kawachi & Berkman, 2000). Further, it might facilitate faster and wider diffusion of health information and norms since this is spread more effectively in areas where people trust and interact with each other (Kim, Subramanian & Kawachi, 2008). Hence, collective social capital is viewed as an attractive "conceptual tool" for what constitutes a "health-enabling" living environment (Campbell & Gillies, 2001). What is particularly appealing is the hypothesis that place-specific social capital is a non-exclusive good in that living in a high social capital area can be beneficial even for individuals with poor social connections, with "spill over" benefits (Putnam, 2000). The idea is that a socially cohesive and trusting place is good for all, not only for those that are socially active themselves. Non-participating individuals may still benefit from the fact that others in their neighbourhood interact to care for their local area, as well as from the information spread in the area. However, research has also indicated the risk for social exclusion and decline in trust if negative bonding social capital is developed at the expense of bridging and linking social capital (Svendsen, 2006; Eriksson, Dahlgren & Emmelin, 2009; Deuchar, 2011). The same mechanisms that spread healthy norms in a community may also lead to social exclusion of groups that do not manage to conform to the norms.

How does social capital relate to what is already known in health promotion?

The ideas about the importance of individual social capital for health clearly relate to the well-developed social networks/social support models in health promotion. These models rely on empirical evidence that social relations can have a positive effect on health (Berkman, 1995). Therefore, one key goal for health promotion projects could be to strengthen people's opportunities for social participation and involvement in social networks, i.e. strengthening individual social capital. Several models for social support/network interventions

exits, such as enhancing existing social networks or developing new social networks linkages. One could thus question whether social capital adds anything new to the field of social networks and health promotion, or if it is like 'pouring old wine into new bottles' (Kawachi et al, 2004). However, the need for more theory driven social network interventions has been underlined, in order to rule out the most effective strategies for different groups of people (Heaney & Israel, 2002). Further, any social support/network intervention need to begin with an assessment of the networks that are available in the target population in order to diagnose the strengths and weaknesses of existing networks (Heaney & Israel, 2002). Hence, the conceptualisation of bonding, bridging and linking social capital could help by this means by facilitating the mapping of what kind of social networks are available and for whom. Adding Bourdieu's (1986) power perspective on social capital and social network involvement could also be helpful for assessing the "costs and returns" of social networks involvement. Thus, the distinction of bonding, bridging and linking can further be utilised to map out which forms of social networks are health enhancing or damaging, and for whom.

The ideas about the importance of collective social capital for health connects to the "community development approach" within health promotion (Wakefield & Poland, 2005). The main purpose of community development health-promotion programmes is to support community capacity to improve the foundation for a flourishing community (Mittelmark, 1999). These principles were also underlined in the Ottawa Charter (WHO, 1986), especially in two of their five action areas for health promotion, namely: Creating Supporting Environments, and Strengthening Community Actions. These two goals for promotion of health go hand in hand with the ideas behind collective social capital. Thus, mobilising social capital in local communities could therefore be seen as a key goal for community health promotion. Community-based health promotion implies broad and complex interventions in a continuously changing society. Evaluations have shown that that many community-based programmes have had only modest impacts, and Merzel and DÁfflitti (2003) bring up limited use of theory as one reason for this. Most interventions tend to draw on theories that are based on behavioural psychology, not adequately targeting the many contextual factors influencing health. The ideas behind collective social capital offer an understanding of community-level determinants of health, with its focus on collective identities and collective action (Campbell, 2000). By utilising the theoretical lens of collective social capital, case studies have suggested how community development programmes can influence social capital for health promoting purposes through interventions in the physical and social living environment (for a summary see Eriksson & Emmelin, 2016).

Investments in the physical environment that facilitate social interactions and safety among residents are essential. Planning and designing attractive meeting places and green areas may increase social capital, as well as efforts to improve an area's reputation, and organising community activities that are perceived as meaningful and attractive by community members. Local associations and activities with a conscious and clear inclusive strategy may specifically facilitate the development of bridging social capital. Such efforts will have the potential to increase participation, social interaction and social connections as well as trust and solidarity between people. In the end they can promote health at area level (Eriksson & Emmelin, 2016).

How has social capital been discussed in the health-promotion literature?

Already in 2000, Hawe and Shiell reviewed the concept of social capital in relation to health promotion and suggested that social capital need to be framed within what is already known in health promotion. Still, they acknowledged the potential value of social capital as a rhetoric, as it may help to engage new community "players" into health promotion. Further, they (Hawe & Shiell, 2000) underlined the importance of utilising Bourdieu's power perspectives on social capital, since, this perspective clearly articulate community complexity and power relations, which need to be acknowledged if social capital is to be used for health-promotion purposes.

Wakefield and Poland (2005) discussed social capital in relation to community development in health promotion and proposed that social capital needs to be placed in its economic and political context, since social connections are dependent on and structured by material and cultural resources. Hence, in line with Hawe and Shiell (2000) they underline the importance of considering Bourdieu's power perspective on social capital. Attempts to build social capital for health-promotion purposes need to ensure that this does not paradoxically compromise equity and social justice (Wakefield & Poland, 2005).

Based on a review of 28 systematic reviews linking social capital and health, Shiell, Hawe and Kavanagh (2018) suggest a need to rethink social capital interventions. Despite strong evidence of a positive association between at least some aspects of social capital and one or more aspects of health, they conclude that the evidence from social capital interventions remains inconclusive. They suggest a way forward that puts more focus on the various and specific components of social capital rather than trying to encompass the whole concept as such in an intervention. Further, they (ibid) underline the need for carefully describing and analysing the local context, in order to tailor social capital interventions to the specific local circumstances.

Villavonga-Olives, Wind and Kawachi (2018) systematically reviewed articles that reported from social capital interventions with the specific objective to influence health outcomes. Seventeen articles were included, but the authors also found many examples of interventions that clearly build social capital without referring to the concept as such. The majority of the reported interventions focused on individual-level change and focused on tackling loneliness and creating structures for social networks between people, in order to change health related behaviours. There were fewer examples of interventions that aimed to achieve environmental changes at the community level. The authors conclude that more studies at the community level are needed, since these kinds of interventions allow a wider audience to be reached. Likewise, the authors (Villavonga et al, 2018) found a general lack of considerations of segmentation in social capital interventions, i.e. that some groups might selectivity benefit from social capital interventions, at the expense of other groups. Putland et al (2013) described key lessons from social capital interventions designed to improve health and well-being, based on findings from three case studies in Adelaide, Australia. They found that in order to succeed, these kinds of interventions need strong structural and political support at the highest governmental level, long-term visions, endorsement for cross-sectional work, well-developed relationships as well as theoretical and practical knowledge.

Conclusions – what is the utility of social capital in health promotion?

More than 20 years of research on social capital and health has resulted in strong theoretical and empirical support for a positive link between (some forms of) social capital and (some) health outcomes, at both the individual and community levels. Hence, there is no doubt that social capital is a relevant and useful concept in health promotion. However, many challenges remain on how it could best be utilised in health promotion policy and practice.

The concept of social capital does not per se add any groundbreaking new ideas into health promotion. Rather, it contributes with significant perspectives to existing knowledge about the importance of social relations, social networks and supportive environments in health promotion. Combining the ideas of social capital with various health-promotion approaches, might make an important contribution to health promotion.

Based on our current theoretical and empirical knowledge, the following conclusions could be drawn on what is required for social capital to be utilised as a resource in health promotion:

- Social capital needs to be used as a complementary concept, not as an

absolutely new and/or opposing idea in health promotion. The use of social capital in health promotion should be included in already existing knowledge within social networks/social support approaches and community development approaches.

- Rather than trying to implement and assess the whole concept as such, health promotion-interventions should focus on specific aspects of the concept (e.g. sense of community, problem-solving capacity, social networks). Studies that clarify what aspects of the concept are being studied, at what level, in what context and for whom, could make an important contribution to developing the "what, who, where, when, why and how" framework, proposed by Ehsan et al, (2019).
- There is a need for more systematic case studies of ongoing attempts to utilise social capital in health promotion. Clearly, many projects take place in various settings that evidently builds social capital, without using the concept as such, and/or without being systematically studied. Careful and detailed descriptions and analyses of the local context, the actual social capital intervention as well as the outcome of the intervention could be most useful for others to learn from.
- Social capital in health promotion needs to be framed within an awareness of power relations and social inequality. A major challenge is the balancing between developments of bonding versus bridging social capital. Social capital interventions need to aim for building not only bonding but also bridging social capital to ensure equal opportunities for all community members to benefit from these interventions.
- Utilising social capital in health promotion requires considering the political structures that exist were the intervention takes place. Current knowledge stresses the need for strong political support for these interventions to succeed. Without political support, there might be a need for long-term collaboration with a broad spectrum of "community players" to "prepare the ground," before any social capital intervention could be implemented.

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