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Measuring social capital: further insights

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ABSTRACT

Social capital is defined as the resources available to individuals and groups through membership in social networks. However, multiple definitions, distinct dimensions and subtypes of social capital have been used to investigate and theorise about its relationship to health on different scales, creating a confusing picture. This heterogeneity makes it necessary to systematise social capital measures in order to build a stronger foundation in terms of how these associations between the different aspects of social capital and each specific health indicator develop. We aim to provide an overview of the measurement approaches used to measure social capital in its different dimensions and scales, as well as the mechanisms through which it is presumed to influence health. Understanding the mechanisms through which these relationships develop may help to refine the existing measures or to identify new, more appropriate ones.

La medición del capital social: nuevas perspectivas

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RESUMEN

El capital social se define como los recursos disponibles para individuos y grupos gracias a su membresía en redes sociales. Sin embargo, varias definiciones, dimensiones y subtipos de capital social se han utilizado para investigar y teorizar sobre su relación con la salud a diferentes escalas, lo que genera un panorama confuso. Esta heterogeneidad hace necesario sistematizar las mediciones de capital social con el fin de obtener una base más sólida acerca de cómo se producen estas asociaciones entre los diferentes aspectos del capital y cada indicador específico de salud. Nuestro objetivo es proporcionar una visión general de los métodos de medición utilizados para medir el capital social en sus diversas dimensiones y escalas, así como los mecanismos mediante los cuales se presume que este influye en la salud. La comprensión de los mecanismos por los que esta relación se produce puede orientar el perfeccionamiento de las medidas existentes o la identificación de otras nuevas y más adecuadas.

The measurement of social capital: further insights

The incorporation of social capital in the social determinants of health discourse has only increased, since it first appeared in the public health literature in the late 1990s. This is also evident in recent publications in Gaceta Sanitaria, which in 2015 motivated a methodological note on its measurement.[1] The purpose of this paper is to take over from Villalonga-Olives and Kawachi's work[1] to deepen in the measurement of social capital. Specifically, we aim to provide an overview to the measurement approaches used to measure social capital at different scales and to the mechanisms through which it is presumed to influence health with the final intention of offering new directions on how improved measures can help to obtain more trustworthy data.

A unified definition of social capital upon which all scholars agree is not available to date. Instead, multiple definitions, distinct dimensions and subtypes of social have been used to investigate and theorize about its relationship to health, creating a confusing landscape.[1,2] Pierre Bourdieu, James Coleman and Robert Putnam have been referred to as the parents of the concept, yet, significant differences stem from their approaches. Bourdieu explains social capital in terms of social networks and connections. In his model, individuals' network connections accrue shared norms and values, exchanges and obligations that can potentially provide access to different resources such as emotional, informational or instrumental support.[3]

Coleman defines social capital as a set of socio-structural resources "that have two characteristics in common: they all consist of some aspect of the social structure. And they facilitate actions of individuals who are within the structure", and he continues "Unlike other forms of capital, social capital inheres in the structure of relations between persons and among persons. It is lodged neither in individuals nor in physical implements of production".[4]

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Contrary to Bourdieu, Coleman highlights the fact that social capital is a resource between families and communities, introducing a socio-structural approach. Putnam extends the scope of the collectivistic approach by including in the definition elements such as sense of belonging, community cooperation, civic engagement and norms of trust and reciprocity.[5] The focus here is not in the individual, but in the community in which it is embedded.

Despite the differences, what all of them have in common and can be understood as the core of all social capital interpretations is "the presence of more or less structuralized networks between people or groups of people [...] that facilitate certain actions for different actors within the structures".[6] Social capital, then, comprehend the resources that individuals can access thanks to their membership in a network, and includes both the resources accessible through direct, individual connections as well as the ones that are available to all the members of a given network thanks to the relationships within the network itself.[7] Social capital represents a feature of the social structure, an ecologic characteristic whether we look at it from the individual (ego-centred) or collective (socio-centred) point of view. In studying the relationship of social capital and health, we should aim at understanding how these different resources and network characteristics influence individual and collective health.

A further relevant element of differentiation between Bourdieu's and Coleman's/Putnam's definition is the social framework within which relationships are understood. While Coleman and Putnam view on social capital departs from a rather static view of societies, Bourdieu's conceptualization of social capital is part of a more elaborated theory of conflict power distribution in society and, as such, entails that some of the potentially available resources may not be *actually* accessible. Authors like Carpiano, have pointed out that this is a relevant feature missing in the study of social capital in Public Health, which has mainly drawn upon Putnam's work (this is, overlooking aspects such as the availability of resources while intensively focusing on elements such as trust or reciprocity).[8] As we shall discuss in the next paragraphs, these are the origins of the two main schools in the study of social capital in Public Health, namely the social cohesion and social network approaches*.

Social cohesion refers to the extent of closeness and solidarity within groups, and as such, the most used measures tap into indicators such as sense of belonging, trust and norms of reciprocity. The terms social capital and social cohesion sometimes confusing. We agree with Kawachi and Berkman that social cohesion is a broader concept than social capital, and includes: a) the absence of latent conflict and b) the presence of strong social bonds and solidarity–of which social capital is one aspect. Thus, one can have social capital without social cohesion but not social cohesion without social capital. Network-based approaches to social capital, in turn, attempt to map and characterize individual relationships (in terms of degrees of separation, nature of the ties, connectedness among the different actors, etc.) and the resources embedded in those network ties. These resources are typically referred to as social support and are classified according to different subtypes, including emotional, instrumental, appraisal and informational support.[9] Although research normally restricts itself to one of these focuses, both dimensions are complementary and have been recognized and demonstrated to offer both benefits and downsides, although they unequivocally entail differences.[1,2,10] The reader will notice that our proposal departs from the social cohesion approach to social capital, but also includes the consideration of social support as a fundamental element of social connections.

In order to better operationalize the complexity of social capital, several subconstructs have been differentiated.[10] Discriminating between *bonding*, *bridging* and *linking* social capital allows to classify the links between the members of the group in terms of homogeneity. Bonding social capital refers to relations between members of a network that perceive themselves as being similar in terms of their shared social identity. Bridging social capital, by contrast, comprise relations of respect and mutuality between people who know that they are not alike in some socio-demographic (or social identity) sense (differing by age, ethnic group, class, etc.). *Linking* social capital introduces hierarchical or unequal relations, steaming from differences in power, resources or status.

A further differentiation is that of *structural* versus *cognitive* social capital. The structural component describes properties of the networks, relationships and institutions that bring people and groups together; while the cognitive dimension is derived from mental processes and reflects people's perceptions of the level of trust, confidence, and shared values, norms and reciprocity.[1,10]

Last, the scale which social capital is conceptualized at constitutes an additional point that needs to be addressed. Public health research has investigated the effect of social capital embedded in very diverse contexts, such as state or country level, neighbourhood, workplace or family. The mechanisms through which social capital may influence health at these different levels are not the same, and, in agreement, the measures used to capture social capital in each of the cases should not be the same either. Although the question of the variety of mechanisms underlying the relationship between social capital and health is beginning to be understood, more solid research is needed, as well as an extended debate and consensus about how we measure social capital at each scale.[1]

We suggest that using systematized social capital measures will allow to gain a stronger foundation on how the associations between the different aspects social capital and each specific health outcome occur and what the relationship of each of these with other social determinants of health is, since they are likely to be differently related.[2,10,11] From here, a further understanding of the mechanisms through which they happen can orientate the refinement of the existent measures or the identification of new, more appropriate ones. Even when social capital is certainly dependent on the social and cultural context, a minimum degree of agreement about what aspects of social capital to measure and through which ways is indispensable to advance in social capital research. Context adaptation should then be conducted when necessary.

In the next sections, we review the mechanisms through which the association between social capital at these scales and health outcomes is thought to happen as well as the measures used to assess it.

Social capital at the macro level: country and state measures

Two main pathways through which country/state level social capital is likely to influence health have been proposed:[2]

- Informal control and normalization of health-related behaviors, according to *shared* values of what is acceptable and desirable, thanks to which community members are able to maintain or achieve the desired goals.
- Enhanced collective efficacy and increased civic engagement in front of significant health-related issues, fruit of a cohesive community that is willing to intervene for common goods because of the mutual trust and solidarity among neighbors, including

* For a more detailed explanation on the genealogy and evolution of the concept of social capital in Public Health, see Moore S, Haines V, Hawe P, Shiell A. Lost in translation: a genealogy of the "social capital" concept in public health. J Epidemiol Community Health. 2006;60:729-34.