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Reflecting on ‘An economic model of social capital and health’

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Social capital

Social capital - recognition that the *ecological nature* of one’s social environment (as distinct from simple social networks) influences wellbeing - feels like a modern invention. In fact, it has been around as an idea for at least 200 years, and even ‘modern’ discussions of the concept go back 50 years. Social capital has many meanings, some of them contested, but at its core is a set of group characteristics such as reciprocity, trust, community participation, community mindedness, shared rules and behaviours, and social integration for mutual benefit. In what has become a classic metaphor, it is the glue that binds communities together.

The idea of ‘social capital’ has been linked to 19th Century writers such as Alexis de Tocqueville ([1835] 1990), the French political thinker whose observations on American life made long-lasting contributions to the understanding of ‘associational life’ and social cohesion, and who is still heavily cited in the field of Third Sector (non-profit, charitable, voluntary sector) studies. Social capital’s more recent historical roots are particularly in sociology (Bourdieu, 1983; Coleman 1988, [1990] 1994) and political science (Putnam, 1993, 1995). However, both Coleman and Putnam recognise the earlier work of the economist Glenn Loury, who examined social capital in his 1976 PhD dissertation on the economics of racism. In turn, Loury credited the urban economist Jane Jacobs (1961) with the 20th Century coining of the term. Others have suggested that classical political economists such as Mill, Bentham, Ricardo, Jevons, Marshall and Adam Smith contributed to the notion (Woolcock, 1988). Part of the difficulty in establishing provenance, of course, is that the concept ‘social capital’ has been defined in many different ways and assigned many labels across a number of disciplines.

Theoretical and empirical advances

This is all by way of background to a reflection on Sherman Folland’s 2008 paper in *Health Economics, Policy & Law*. Folland sought to bring together two fields of academic

argument and evidence that had largely remained separate: the already vast empirical literature on social capital and health (which has become noticeably vaster in the intervening seven years) and economic theory. In particular, he lamented the underdeveloped theoretical grounding for the frequently demonstrated associations between various measures of social capital and various measures of health.

After a brief canter through key literature in the former area - and emphasising that there is little sense in excluding family and close friends from definitions of social capital - Folland identifies three 'theoretical ideas'. The first two are that social capital reduces stress and provides information, and are prominent in the health care and epidemiology literatures. The third is that social capital invites responsibilities to oneself and others, and has roots in economics. He then develops this third strand further - while also connecting to hypotheses developed in other literatures - by adapting and extending ideas expounded by Becker and Murphy (2000). In particular, the popularity of good y ('social capital' in Becker and Murphy's book) is a complement of good y :

To the extent that increased positive bonds enhance one's sense of responsibility to self and to these relationships, an increase in social capital would reasonably enhance the benefit from becoming and staying healthy. Taken in this sense, social capital is naturally a complement to health (Folland, 2008, p.337).

Complementarity between social capital and health goods is not an *assumption* of the model, nor is substitutability between social capital and health bads; rather, these interrelationships potentially emerge from suitably designed empirical study. The theoretical framework is developed further by examining choice in the face of risk. It is then tested using cohort data from the US National Longitudinal Survey of Youth, merged with marketing data on dimensions of social capital, to examine influences on cigarette smoking and quitting. Findings for smoking behaviour provide stronger support for his theoretical arguments than do findings for quitting smoking. Indeed, in the latter his variable for 'got married' is *negatively* associated with quitting smoking, which Folland sees as counter-intuitive (although it might not be if the new spouse is a smoker).

Folland's paper has attracted interest because of his careful use of longitudinal data to test some carefully developed theoretical precepts. A lot of empirical work in the social capital field continues to apply poor statistical methods to sometimes quite limited data. Because social capital has many different disciplinary roots, many different empirical 'traditions' have been applied to explore it and its associations, and perhaps economists have agonised longer over the robustness of their analyses. For example, as Folland remarks, the challenge of (statistical) identification is one that exercises economists

greatly. One constraint applying across all disciplines is heavy reliance on extant data collected for other purposes, with the result that the actual measures employed to capture social capital are sometimes rather remote from the underlying concept. That has not always stopped researchers making grand statements, of course.

My own work has not focused much on social capital *per se*, although I am interested in community capacity (one manifestation of social capital) and (for much longer) in the forms and roles of Third Sector entities. My research today concentrates on long-term conditions such as mental illness and dementia, and on social care. Re-reading Folland's interesting paper therefore led me to wonder whether analysis of social capital with a solid theoretical foundation and that accordingly demanded rigorous empirical examination might provide answers to some questions currently exercising policy-makers and care professionals in the areas of mental health and social care. I therefore offer some thoughts on social capital-based approaches and what they might contribute in those areas.

Mental health

Mental health is a field where social capital might be expected to have especial relevance, given the chronic course of most mental illnesses and their associated needs; complex aetiologies combining biological, environmental and social causes; and endemic social stigma and discrimination. Many practice and policy issues come to mind where a better understanding of social capital might be helpful.

Social networks and interactions can cause or protect against emotional disorders, and can support their alleviation through psychosocial therapies. Tew *et al.* (2012) review evidence on the influence of social factors on recovery (interpreted in its modern broader sense of achievement of personal goals, rather than the clinical sense of symptom alleviation). They highlight three areas as central to recovery: 'empowerment and control over one's life; connectedness (including both inter-personal relationships and social inclusion); and rebuilding positive identities (often within the context of stigma and discrimination)' (p.443). These influences go beyond mere interactions, and pick up elements immediately recognisable as social capital. Appropriate community action might therefore be a suitable response, or perhaps systemic therapy might address what could be seen as intra-familial issues of social capital.

A review published ten years ago focusing specifically on social capital found mixed evidence (De Silva *et al.*, 2005). It stressed the common distinction between

behavioural/activity components of social capital (such as that embodied in participation) and cognitive/perceptual components (such as trust). They found cognitive social capital to be the more influential: it was associated with common mental disorders (depression and anxiety) and childhood mental illness. But in their conclusions, De Silva and colleagues were not sanguine about lessons for treatment: the evidence in 2005 was too weak, they thought, 'to inform the development of specific social capital interventions to combat mental illness' (p.619).

An even earlier editorial by McKenzie and colleagues (2002) proposed an interesting hypothesis. Could the 'ethnic density' effect observed in some epidemiological studies - to the effect that members of ethnic minority groups living in areas where their ethnic minority population is proportionately small are at greater risk of psychotic disorders and suicide - be linked to degrees of cohesion in the majority group population, i.e. to aspects of social capital? This makes a neat connection to Loury's doctoral work on racial discrimination, but more pertinently opens up possibilities for shaping or facilitating preventive or ameliorative action.

Another area to view through a social capital lens might be the effects of negative social behaviour such as bullying, even 40 years after it occurred (Takizawa *et al.*, 2014). Again, if it is some *ecological* manifestation of social dynamics at play here, rather than just some malfeasant interpersonal behaviour, then again that might help to design anti-bullying strategies in schools, workplaces or communities.

Social care

A major topic that crosses between mental health and social care is dementia. The rapidly growing global prevalence of dementia is concentrating attention on this most distressing set of illnesses (of which Alzheimer's disease is the most common) and on the wider challenges of a 'cognitive footprint' (Rossor and Knapp, 2015). In the absence of any known cure, policy-makers worried about the future affordability of health and social care for the projected large numbers of people with dementia are today prioritising risk-reduction and the alleviation of burdens carried by many family and other unpaid carers.

Known risk factors for dementia include diabetes, midlife hypertension, midlife obesity, smoking and low educational attainment (Norton *et al.*, 2014). It has not yet been demonstrated whether social support, including social capital, could protect against cognitive decline. But it has certainly been demonstrated that supporting family carers can benefit them greatly, and by extension can also benefit the people they support. Many

family carers - particularly co-resident and spouse carers - live very stressful and often isolated lives, with round-the-clock duties that often go unrecognised.

As many as 40% of family carers of people with dementia have clinically significant depression or anxiety (Cooper *et al.*, 2007), yet poor carer mental health is a major factor in the breakdown of community-based care, resulting in (expensive, unwanted) care home or hospital admissions. Well-structured support for family carers - such as the START programme recently evaluated in London - can reduce carer psychological morbidity and improve quality of life (Livingston *et al.*, 2014). START includes elements that look suspiciously like ways to improve the social capital experienced by carers. Every society across the world will have to continue to rely heavily on unpaid carers if they want to avoid bankrupting public health and care systems because of the rapidly growing aggregate needs of people with dementia. Social capital enhancement has an obvious role to play.

One further social care example can be offered. Social isolation among older people is growing in many societies (Victor *et al.*, 2002). It is a risk factor for loneliness and poor health (including depression, cardiovascular problems and cognitive decline) (Stephoe *et al.*, 2013; Courtin and Knapp, 2015). Interventions such as structured befriending programmes and time banks (i.e. markets in exchangeable skills that use time rather than money as currency) both quintessentially embody aspects of social capital, both being heavily reliant on trust. Such approaches may help to tackle the problem, although evidence in support of their benefits is not yet overwhelmingly clear (Mead *et al.*, 2010; Knapp *et al.*, 2013). Efforts are needed to understand the mechanisms through which social capital might become a resource for better health and wellbeing for older people (Sirven & Debrand, 2012; Nyqvist & Forsman, 2015).

Such efforts are running in parallel with policy moves to promote telecare, telehealth and other approaches based on information and communication technology (ICT) to improve health and care systems, and also in parallel with wider changes to the ways that societies function. Both could actually be *worsening* the risk of isolation of older people. ICT, for example, is slowly replacing centuries-old social and economic conventions and habits: online shopping and banking make it possible to carry out core transactions without leaving home; email and social media allow connections with friends and family without being in the same physical location; and online games make it possible to entertain yourself by competing against a computer rather than a human. Are these changes destroying or creating new social capital? Many older people are 'e-excluded' because they do not have the experience or skills to 'connect', or because they worry excessively

about the costs or online fraud, which means that the risk of their social isolation is quite high (Damant and Knapp, 2015). And while telecare and telehealth might eventually generate cost savings and improve wellbeing, they risk destroying some of the already diminished social capital resources available to vulnerable older people by taking away their care-based networks and some of the human interactions they treasure (Sanders *et al.*, 2012).

Conclusion

Sherman Folland made a valuable contribution to the social capital and health literature with his 2008 *HEPL* paper. Although my own musings on unanswered questions in areas familiar to me have not all built *directly* on his paper, Folland's emphases on the need for solid theoretical foundations and to build robust empirical methods upon them are recommendations that should clearly be repeated at every opportunity. There is much to be gained from examining the roles that social capital plays in affecting health and wellbeing, and also the roles that it can potentially play in shaping health care, but only if the research is well enough designed to be reliable.

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