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Social capital and health at the country level

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ABSTRACT

This study examines the relationship between social capital and health. We use various estimation methods such as pooled OLS, a split-sample approach, a quadratic regression, and fixed effects model to investigate country-level unbalanced panel data of 194 countries for the time period 1990–2015. The results support the negative effect of bonding social capital and the positive effect of bridging social capital on health. The effects are more pronounced in low income countries. The first contribution of the paper is to better explain the mixed results of previous studies by focusing on the distinction between the two types of social capital. The second contribution of the paper is to address endogeneity and nonlinearity problems and to capture dynamic change by using various econometric methods. The findings imply that the socio-economic effects of social capital are different depending on the type of social capital.

1. Introduction

This paper examines the relationship between social capital and health. Social capital is often defined as "resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition—or in other words, to membership in a group—which provides each of its members with the backing of the collectivity-owned capital, a 'credential' which entitles them to credit (Bourdieu, 1986, p. 248)," and "social networks and the norms of reciprocity and trustworthiness that arise from them (Putnam, 2000, p. 19)." Scholars commonly identify two important concepts in social capital: social networks and trust (or norms of reciprocity) (Woolcock, 1998, p. 153). Accordingly, in this study, social capital refers to trust within and across social networks.

Interest in the association between social capital and health has emerged in late 1990s and early 2000s, when there was debate on the relationship between socio-economic status and health inequalities. Social capital has been identified as a possible mediating variable in the relationship between income inequality and health (for review, see Harpham, Grant, & Thomas, 2002; Hawe & Shiell, 2000; Macinko & Starfield, 2001; McKenzie, Whitley, & Weich, 2002). Szreter and Woolcock (2004) explain three perspectives on the health effect of social capital: (i) a social support perspective holds that informal networks are central to welfare; (ii) an inequality perspective argues that economic inequalities erode citizens' sense of social justice and inclusion, which in turn gives rise to anxiety and limits life expectancy; and (iii) a political economy perspective claims that the socially and politically mediated exclusion from material resources leads to poor health. Recent studies extend the social capital research from residential areas into workplaces (Oksanen, Suzuki, Takao, Vahtera, & Kivimäki, 2013).

Many studies have been conducted to evaluate the hypothesis of the effect of social capital on health (for review, see Carlson & Chamberlain, 2003; Muntaner, Lynch, & Smith, 2001). Self-reported trust and self-rated health

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Table 1
Previous studies of trust and health.

	Country	Period	Result
Kawachi, Kennedy, and Glass (1999)	US	93–94	+
Rose (2000)	Russia	98	+
Veenstra (2000)	Canada	97	0
Hyyppä and Mäki (2001)	Finland	91–96	+
Knesebeck, Dragano, and Siegrist (2005)	Europe	03	+
Mellor and Milyo (2005)	US	95–99	+
Kim, Subramanian, and Kawachi (2006)	US	00	+
Poortinga (2006a)	Europe	02–03	+
Poortinga (2006b)	UK	00–02	+
Rostila (2007)	Europe	02–03	+
Yip et al. (2007)	China	04	+
Fujiwara and Kawachi (2008b)	US	95–96	+
Mansyur, Amick, Harrist, and Franzini (2008)	45 countries	90–04	+
Petrou and Kupek (2008)	UK	03	+
Schultz, O'Brien, and Tadesse (2008)	US	06	+
Yamaoka (2008)	East Asia	02–04	+
Ichida et al. (2009)	Japan	03	+
Snelgrove, Pikhart, and Stafford (2009)	UK	98–03	+
Wang, Schlesinger, Wang, and Hsiao (2009)	China	02	+
Borges, Campos, Vargas, Ferreira, and Kawachi (2010)	Brazil	09	+
Borgonovi (2010)	UK	58–04	+
d'Hombres, Rocco, Suhrcke, and McKee (2010)	former Soviets	01	+
Giordano and Lindström (2010)	UK	99–05	+
Lindén-Bostöm, Persson, and Eriksson (2010)	Sweden	04	0
Suzuki et al. (2010)	Japan	07	+
Cramm and Nieboer (2011)	South Africa	07	+
Elgar et al. (2011)	50 countries	05–08	+
Giordano, Ohlsson, and Lindström (2011)	UK	08–09	+
Hurtado, Kawachi, and Sudarsky (2011)	Colombia	04–05	+
Moore et al. (2011)	Canada	08	+
Yiengprugsawan, Khamman, ang Seubsman, Lim, and Sleigh (2011)	Thailand	05	+
Giordano, Björk, and Lindström (2012)	UK	00–07	+
Rocco and Suhrcke (2012)	Europe	02–04	+
Verhaeghe and Tampubolon (2012)	UK	06–08	+
Chola and Alaba (2013)	South Africa	08	0
Nyqvist and Nygård (2013)	Sweden/Finland	05	+
Tampubolon, Subramanian, and Kawachi (2013)	Wales	07	+
Carpiano and Fitterer (2014)	Canada	08	+
Goryakin, Suhrcke, Rocco, Roberts, and McKee (2014)	former Soviets	10	+
Herian, Tay, Hamm, and Diener (2014)	US	10	+
Miyamoto, Iwakuma, and Nakayama (2014)	Japan	11	+
Riumallo-Herl, Kawachi, and Avendano (2014)	Chile	09–10	0
Rocco, Fumagalli, and Suhrcke (2014)	Europe	02–09	+
Koutsogeorgou et al. (2015)	Finland/Poland/Spain	08–09	+
Campos-Matos, Subramanian, and Kawachi (2016)	Europe	02–12	+

The table summarizes previous studies of the effect of self-reported trust on self-rated health. +, −, and 0, refer to positive, negative, and insignificant (or very weak) effects, respectively.

are most common measures in the studies of social capital and health, which are summarized by Table 1. A meta-analysis performed by Gilbert, Quinn, Goodman, Butler, and Wallace (2013) finds the positive effect of social capital on self-reported health and mortality. However, literature on the relationship between social capital and health is not entirely consistent. While many studies support the positive effect of social capital on health (for review, see Agampodi, ad Glozier, & Siribaddana, 2015; Islam, Merlo, Kawachi, Lindström, & Gerdtham, 2006; Murayama, Fujiwara, & Kawachi, 2012), some do not provide such results as shown by Table 1. The mixed evidence could be due to differences in measures of social capital and health, contexts, periods and areas studied. Most previous work on the relationship between social capital and health has been carried out using individual-level cross-sectional data. The current study contributes to the literature by providing a panel data study at country-level. Panel data are useful for the analysis of causal relationships since changes in a set of variables are directly measured (Finkel, 1995). Moreover, by focusing on the distinction between bonding and bridging social capital, this study expands the understanding of the effect of social capital on health.

2. Main concepts, theories and earlier research

The current study proposes that the effect of social capital on health depends on the type of social capital. Early studies such as Putnam (1995) distinguished between two types of social capital: bonding social capital and bridging social capital. Bonding social capital is a social tie between homogeneous members of a community, such as family members and the members of religious groups. Bridging social capital is a loose connection between mem-

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