Commentary: Can subtle refinements of popular concepts be put into practice?

Anne Ellaway

This lengthy article provides a welcome contribution to current debates surrounding the field of social capital and public health. The authors provide, firstly, an analytical basis for discriminating between the different stances; secondly, they outline a theoretical framework for reconciling the polarized views; thirdly, they offer a historical perspective to support their theoretical framework; fourthly, they discuss the significance of their thesis for social capital theory and public health, and lastly they provide a brief summary of the policy implications for public health arising from their own framework and the broader social capital literature. In doing all this, they have assembled an impressive range of literature to support their thesis.

‘Bonding’, ‘bridging’, and ‘linking’ social capital

The authors note the conceptual revision within social capital theory of distinctions between ‘bridging’ and ‘bonding’ social capital. ‘Bonding’ social capital refers to trusting and cooperative relations between members of a network with similar socio-demographic characteristics. ‘Bridging’ social capital, by contrast, comprises relations of respect and mutuality between people who have different socio-demographic characteristics. The authors add to this distinction by bringing in a third kind, that of ‘linking’ social capital. They define ‘linking’ social capital as ‘norms of respect and networks of trusting relationships between people who are interacting across explicit, formal, or institutionalized power or authority gradients in society’. This refinement seeks to separate social relationships that would otherwise be grouped together in the ‘bridging’ social capital category, which they interpret as being between individuals who are otherwise more or less equal in terms of their status and power (despite being earlier differentiated on socio-demographic characteristics such as gender, class, and ethnicity which many would argue is not ‘more or less equal in terms of status and power’). The danger is that the distinctions between these three refinements of social capital are so subtle that the terms will be used interchangeably (indeed, looking up the term ‘link’ in a thesaurus came up with ‘bond’ and ‘bridge’ as suggested alternatives!).

As the authors note, their definition of social capital makes it difficult to measure empirically. However, this difficulty is further complicated by the issue that social capital is likely to be a product of class position and intersects with other social categories such as gender and ethnicity. Different levels and types of networks and variations in equality in interactions with powerful groups have long been noted as a feature of social class position, and measures of social stratification. This makes social capital difficult to test in statistical models with health as an outcome since controlling for social factors does not adequately remove their influence.

A related problem with subtle refinements is that, given the popularity of the concept, decision makers of all political hues will have their own ideas and agendas. As the Taoiseach (Prime Minister) for the Republic of Ireland, Bertie Ahern, stated in a speech:

We all know that the level and nature of interaction between people and groups is crucial to public well-being. But social capital could, at one extreme, be seen as so general and aspirational as to be irrelevant: at the other extreme it could easily fall into being merely another way of promoting old-style political ideologies. ... I know that Prime Minister Blair has also shown a lot of interest in Professor Putnam’s work. Indeed it is an indication of its quality, that both President Clinton and his successor President Bush have been influenced by it.

Social capital and social policy

The authors offer a brief summary of the policy implications for public health arising from their own framework and the broader social capital literature, using health care systems as one example of where insufficient ‘linking’ social capital is an important determinant of health outcomes (although some would argue this is a more ‘upstream’ component). Social class differences in access to health care have been documented for many years ranging from shorter consultation times for lower class groups as compared with higher class patients as well as increased likelihood of being referred to specialist services. This does not appear to be related to a failure by patients of lower socioeconomic position to interpret symptoms and seek health care but rather due to features of health care provision.

There are moves to increase access to information and patient involvement in health care. In the UK, a new emphasis on shared information, shared decision making, and shared responsibilities within policy documents relating to the UK National Health Service (NHS) has been noted. The Commission for Patient and Public Involvement in Health was established in January 2003 and its stated aim is to bring in a system which will produce a real culture change in health and health services for the future involving putting more power into the hands of local people. The Health and Social Care Act (2001) placed a new duty on the NHS to involve and consult patients and the public in service planning, operation, and in the development of proposals for changes.

However, it remains to be seen whether recent changes intended to increase patient involvement in their own health care and the
operation of the health service will in fact further deepen social class divisions as higher social classes may be more able to take advantage of these developments. Furthermore, the balance of power in the doctor–patient relationship held by the medical profession will not readily be relinquished.8

References

Commentary: Reconciling the three accounts of social capital
Ichiro Kawachi1, Daniel Kim1, Adam Coutts2 and SV Subramanian1

The three accounts of social capital
The subject matter of social capital tends to arouse passions. After years of debate that often generated more heat than light, Szreter and Woolcock1 have come up with a conceptual framework for examining social capital and health which promises to reconcile the opposing camps. They identify three existing accounts of social capital as it relates to population health, which they refer to respectively as the ‘social support’ perspective, the ‘inequality’ thesis, and the ‘political economy’ approach. As noted by Szreter and Woolcock, an often polarized debate has taken place within public health between proponents of the ‘inequality’ thesis and the ‘political economy’ approach. As noted by Szreter and Woolcock, an often polarized debate has taken place within public health between proponents of the ‘inequality’ thesis and the ‘political economy’ approach. As opposed to the ‘neo-material’ interpretation favoured by the latter group.3 We have argued elsewhere that the ‘debate’ between the psychosocial and neo-material positions poses an unnecessary distraction. We concur with Szreter and Woolcock’s view that in the absence of compelling empirical evidence to distinguish between them, ‘it would seem most sensible to assume that both viewpoints could be valid’.1

The novelty of the proposed framework by Szreter and Woolcock lies in distinguishing and unpacking the concept of social capital in its different forms, namely, ‘bonding’, ‘bridging’, and ‘linking’ social capital.1 The distinction between bonding and bridging social capital has existed for some time,5–7 and is by now widely accepted in the field. Bonding social capital refers to trusting and co-operative relations between members of a network who are similar in terms of social identity (e.g. race/ethnicity), while bridging social capital refers to connections between those who are unlike each other yet are ‘more or less equal in terms of their status and power’.1 The bonding and bridging varieties of social capital could be consistent with either or both the ‘social support’ and ‘inequality’ accounts of social capital and its relationship to population health. But according to the ‘political economy’ perspective on social capital, what is missing from the bonding/bridging distinction is an explicit recognition of vertical power differentials in social relations. It is to address this gap that Szreter and Woolcock introduce a third form of social capital—the ‘linking’ variety—which they define as ‘norms of respect and networks of trusting relationships between people who are interacting across explicit, formal, or institutionalized power or authority gradients in society’.1

1 Department of Society, Human Development and Health, Harvard School of Public Health, Boston, USA.
2 Magdalene College, Cambridge University, UK.
Correspondence: Prof. Ichiro Kawachi, Department of Society, Human Development and Health, Harvard School of Public Health, 677 Huntington Ave, Boston, MA 02115, USA. E-mail: Ichiro.Kawachi@channing.harvard.edu.