At the EUPHA annual meeting in Malta last November, a colleague of mine who had not attended these meetings since a few years asked me: ‘What has happened to social capital?’ His impression was that there were hardly any contributions on the topic at this meeting, whereas there used to be several at each EUPHA conference in the beginning of this millennium. A look at the database of abstracts does in fact confirm that ‘social capital’ was a more common component in titles of abstracts earlier than in the past years. A rapid glance in PubMed and reference lists of standard articles do not indicate a reduced interest, and the article by Mohnen et al., in this issue confirms that there is still much to do in the field and that findings are relevant to policy.¹

There was indeed a burst of interest in social capital after the landmark book ‘Bowling Alone’ by Putnam,² and articles such as those by Kawachi³ and Lynch,⁴ which now have become classics. And I have the personal observation that questions on social capital (contacts with neighbours, extent of trust, participation in associations, etc) were introduced in many health surveys regularly carried out on regional and national level. Thus, many reports were produced on social capital and health, without much distinction of whether individual or neighbourhood social capital was measured, and which causal direction one might interpret an association found. On the individual level, reporting poor indicators of social capital can be a cause as well as an effect of poor health. One might say that ‘social capital’ is a misused term, as it has been used to denote many different types of exposures and to explain many different phenomena. ‘Social capital’ sounds good, just as does ‘sense of coherence’, another misused term. It is therefore good that Mohnen et al.⁵ summarize key concepts in the introduction and clarify how the authors interpret and conceptualize the terms used.

There has also been a concern that focus on social capital might detract attention from socio-economic inequities, and that policy makers may be tempted to hand over responsibility to local communities and neighbourhood associations, thus reducing the need for state intervention. Several studies have taken into account neighbourhood socio-economic conditions in the analyses,⁶ including a previous article by Mohnen et al.⁶ So there is evidence to disentangle socio-economic conditions from social capital, although any information can always be misused for ideological purposes.

What Mohnen et al.¹ want to add to existing knowledge is basically length of exposure. They hypothesize that both duration of residence and intensity of exposure (how much time residents spend in the community) determine the effect of social capital. They do find an effect of both duration and intensity of exposure, and that a minimum duration of 6 years of exposure is needed to give an effect. The authors acknowledge the limitation of the cross-sectional design, and a proxy measure for intensity of exposure. It would be worthwhile to address the research question using longitudinal data sets.

So although the concept of ‘social capital’ has sometimes been misused, and sometimes criticized, the Mohnen et al.¹ article illustrates that this is still an important area for research, and that there are still challenges to improve our understanding on how socio-economic conditions and social capital may affect health.

References