

**Literature Review***Copyright © All rights are reserved by Zafeirios Thomakis*

Social Capital, Health, and Their Relationship with the Local Community

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The relationship between social capital and health has begun to be studied scientifically in recent years. Researchers from various fields, such as public health researchers, social workers, and economists focusing on health economics, are starting to examine the relationship between social capital and health [1]. It is enough to note that just three decades ago, Eriksson reported that there were 5 articles related to social capital and health; within about 10 years, this number grew to 100 (2006), and to 475 by 2010 [2]. In this paper, a literature review of articles and studies regarding the relationship between social capital and health will be conducted, along with the benefits for local communities.

Keywords: Social capital; health; local community**Introduction**

The development of literature in the scientific field of social capital and health, although not very extensive in duration, shows rapid growth. About three decades ago, Eriksson noted that there were five articles related to social capital and health; however, it demonstrates a swift increase, reaching around 100 articles within approximately 10 years (2006), and 475 by 2010 [2]. As Muntaner et al. state, before 1995, there was only one reference to the term "social capital" in the Medline database... [3]. The majority of studies indicate a positive relationship between social capital and health. According to Kawachi and Berkman [4], studies show a positive relationship between social ties and mental health. Additionally, Ζήση και Χίου [5], based on international studies regarding the importance of material conditions and social ties for the mental health of children and adolescents, they conclude that these factors are considered to influence the social and psychosocial-emotional development of children and adolescents. However, as Lee [6] notes, there are also several studies whose results indicate either an unclear or negative relationship between social capital and health.

To understand the issue under investigation, a narrative literature review will be conducted.

Definition of the Concept of Social Capital

Regarding social capital, there is a plethora of definitions. According to Koniordos [7], generally, social capital refers to the relationships that individuals create with each other and the benefits they will later derive from these relationships. At the same time, Koniordos states that "there is no commonly accepted perception, let alone a commonly accepted definition of what social capital is. In essence, not only are opinions divided, but the concept is characterized by a differentiation of perception and a pluralism of approaches and views" [7]. According to Coleman, "Social capital is defined by its functions. It does not consist of a single entity but is characterized by a multitude of different entities, with two common features: they consist of some aspect of social structure and facilitate certain actions of individuals, whether they are individual persons or collectives that are subject to them" [8]. According to Bourdieu, "Social capital is the sum of the

actual or potential resources linked to the possession of a viable network, with more or less institutionalized relationships, mutual acquaintance, and recognition—or in other words—the inclusion in a group that provides its members with the support of capital possession, granting them the right to draw advantages in every sense of the term” [9].

According to Bourdieu (1986), capital is divided into three forms: economic, cultural, and social. Economic capital is defined by the resources, both financial and material, that an individual possesses. Cultural capital pertains to those elements, cognitive and ideological, the titles, the education, the skills, and the heritage that an individual receives from previous generations. The third category according to Bourdieu is social capital, which concerns the social relationships and connections that an individual has. Under certain conditions, it is possible for cultural and social capital to be transformed into economic capital [9]. Bourdieu [10] refers to social inequalities that appear in education. Inequalities exist in other aspects of individuals’ lives, such as health. Therefore, it is important to study the relationship between social capital and health. Additionally, Putnam defines social capital as “the characteristics of social organizations, such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions” [11]. Furthermore, according to Fukuyama (2001:7), “social capital is a standardized informal rule that promotes cooperation between two or more individuals.” There are several other definitions that refer to social capital; however, we will focus on the first three, which are the definitions of Bourdieu, Coleman, and Putnam, who are considered the greatest thinkers on the concept of social capital in the last four decades.

Social Capital, Health, and Local Communities-Literature Review

The World Health Organization (WHO) states that social capital represents the degree of social cohesion that exists within communities. It refers to the processes among individuals that create networks, norms, and social trust, facilitating coordination and cooperation for mutual benefit [12]. Veenstra [13] studied the impact of social capital on health. He used data from eight (out of thirty) health regions in Saskatchewan, Canada. The sample consisted of 534 adults randomly selected. Three age categories were created: young individuals aged 18-39, middle-aged individuals aged 39-65, and seniors aged 65 and older. The results showed that income and education are significantly related to individuals’ self-assessment of their health status [13]. The above results have partial applicability for the middle age group, where education is significantly related to health, while for the older age group of 65 and above, income and education are related to health; for the young individuals aged 18-35, the results do not have significant applicability. The empirical results do not differ significantly from previous studies, but further research is needed on the relationship between health and social capital [13].

Villalonga-Olives and Kawachi [14] conducted a literature review in three scientific journals (Pubmed, Embase, and PsychInfo) in the field of health regarding the potential negative outcomes

between social capital and health. From the total number of articles in the three journals, 44 articles were ultimately recorded from 2008 to 2017, documenting the negative consequences of social capital. Porter’s reports on the negative consequences of social capital remain relevant. Villalonga-Olives and Kawachi [14] conclude that both positive and negative behaviors can spread through social networks very quickly, in broader social contexts. They reference the study by Andersson and Christakis [15], where the desire to lose weight becomes a more pressing need for individuals when the perception of weight loss that individuals should have is disseminated through social networks. The result is that people who are considered overweight (while they actually are not) attempt to lose weight, leading to health issues in the general population from the attempt to lose weight even when it is not necessary. Additionally, while several studies report that in societies with high social capital, there is a good level of health, this is not the case for all members of society. As Schöllermerich and Kawachi (2016a, 2016b, in Villalonga-Olives and Kawachi, 2017: 125) state, members with a high level of trust can enjoy the positive outcomes of high social capital, in contrast to individuals who do not have a high level of trust, resulting in their marginalization. Furthermore, the researchers continue, it is often observed that there is high kinship social capital, but weak bridging social capital, and additionally, high kinship social capital may exclude members of the inner group from the broader social environment [14].

Rocco and Suhrcke [1], on behalf of the World Health Organization, studied the relationship between social capital and health. The following three mechanisms could play a positive role between social capital and health [1]. Improved access to health-related information. Interpersonal relationships, social interactions with individuals, and participation in organizations contribute to better access to health-related information, such as developments regarding new therapeutic methods for diseases and their effectiveness, new drugs for treating diseases, and contribute to better market functioning between health producers and consumers. The provision of informal healthcare and support in case of illness. In addition to the official healthcare system, informal healthcare also operates concurrently. In the care of children, the elderly, or patients who need short-term hospitalization and cannot be admitted to any official healthcare system, networks of mutual assistance are created among relatives, neighbors, and individuals who have mutual trust in each other for the purpose of providing care and support when necessary. This occurs more frequently in less developed countries, where the healthcare system does not cover large parts of the state’s areas. However, it is also found in developed countries. In the mechanism of political economy, well-organized groups are more effective in exerting pressure. In this particular case, social capital can contribute, through solidarity and cohesion among individuals, to citizens’ demands for better healthcare infrastructure, the creation of sports facilities, recreational spaces, and generally structures that contribute to better health for citizens. Using data from the European Social Survey from the first and second rounds for the years 2002 and 2004, which include data for 21 countries. Their sample consists of 80,000 respondents distributed equally across

the two rounds. The results of the empirical analysis show that there is a positive relationship between individual social capital and health. The positive relationship exists in societies where the overall social capital of the community is high. In societies with average social capital, the marginal effect of social capital on health is small. In conclusion, Rocco and Suhrcke [1] find that individual social capital increases the likelihood of good health when there is also high overall social capital, which can only indirectly influence individuals' health in an area.

Eriksson [2] states that knowledge about social capital can contribute to shaping appropriate policies so that through social network actions, the conditions for promoting health throughout the social community can be created. Murayama, Fujiwara, and Kawachi [16] conducted a literature review regarding the relationship between social capital and health, using the PubMed database in August 2011. They utilized keywords such as "social capital" or "social cohesion" or "collective efficacy," "multilevel" or "association outcome," "expected" or "longitudinality" or "time-series study". Thirteen relevant articles were found, of which nine pertained to community studies and four related to the workplace (Murayama, Fujiwara, Kawachi, 2012). From the analysis of the literature, the researchers conclude that although an effect between social capital and health is observed based on epidemiological data, it appears to be limited. Further study is needed, as well as investigation into the relationship between social capital and health, in order to yield results that will provide answers regarding the relationship between health and social capital [16]. Vidali and Bitsiori [17] explore, through a literature review over the last decade, the contribution of social capital to achieving healthy aging of the population. The researchers conclude that social capital can contribute to promoting healthy aging of the population. Enhancing social interaction, sociability, strengthening relationships among individuals, particularly in older age, as well as improving living conditions are factors that contribute to the healthy aging of the population. They consider social capital to be a factor in promoting healthy aging. Clearly, further research is needed as there is ambiguity regarding the relationships between social capital and health [17].

Lee [6], using data from 194 countries for the period 1990-2015, studied the relationship between social capital and health. A key feature of this research is the examination of the relationship between social capital and health, depending on the type of social capital, whether it is bonding or bridging social capital. It utilized three indicators: trust, religiosity, as reported by the World Values Survey, and the rule of law index from the World Bank. Additionally, two widely used measures were employed: life expectancy at birth and the infant mortality rate, sourced from the World Health Organization [6,12]. Furthermore, it included three control variables: per capita health expenditure, the number of doctors per 1,000 inhabitants, and GDP (Gross Domestic Product). By employing various estimation techniques in the regression analysis to examine the relationship of the defined variables, the following results were derived. The pooled linear regression indicated an unclear relationship between social capital and health, but there was a

positive relationship between health and bridging social capital and a negative one with bonding social capital. The ordinary least squares model showed that the relationship between general social capital and health is not significant, while the relationship between bonding social capital and health is statistically insignificant, in contrast to the positive relationship between bridging social capital and health. Additionally, the regression with two samples indicates that in low-income countries, the effect of social capital is more pronounced [6]. Overall, Lee's research findings somewhat confirm previous studies regarding the relationship between social capital and health, though this study also has certain limitations. The most significant is the lack of reliable measures used in the regression analysis. The numerous and varied definitions of social capital, as well as the many different aspects through which the concept of social capital can be approached, create challenges in utilizing appropriate measures when applying empirical analysis [6].

Eriksson, Dahlgren, Janlert, Weinehall, and Emmelin [18] studied the relationship between individual social capital and self-rated health, which is the subjective summary of how individuals perceive their health, depending on gender and educational level. They used data obtained from residents of Umeå, a city in northern Sweden. They sent a questionnaire to 15,000 individuals and received responses from 4,836 women and 3,980 men, totaling 8,816 individuals. The structure of the questionnaire included socio-demographic factors, perceptions about the living environment, civic and political engagement, reciprocity and trust, social networks, social support, self-rated health, and health-related quality of life. The study was divided into two parts. One part concerns the cognitive form of social capital, that is, attitudes, perceptions, social values, and trust, while the second part pertains to structural social capital, such as institutions, rules, measuring it, kinship, bridging, and bonding social capital. The study focused on measuring individual social capital, taking into account both the cognitive and structural aspects of social capital, in accordance with the empirical studies that had been conducted up to that point. The research findings indicated that both the structural and cognitive forms of social capital increase the likelihood of good self-rated health for men and women, regardless of their educational level. In contrast, the likelihood of accessing social capital differs from men to women, with men having a higher probability of access. Although there is a positive correlation between social capital, educational level, and gender, there is still differentiation in access to social capital based on gender. Men are more likely to access bonding and bridging social capital compared to women, while they have less access to bridging social capital than women. The higher the educational level, the easier the access to each form of capital [18].

Verhaeghe and Tampubolon [19], using data from the second and third waves of the Taking Part Surveys of England conducted during the periods 2006-2007 and 2008-2009 respectively, studied the impact of individual social capital between neighborhood deprivation and self-rated health in England. The results showed that generalized trust and socializing with friends contribute to better self-rated health. Additionally, socializing with friends shows better outcomes compared to socializing with relatives.

Furthermore, the researchers report that regarding the study of neighborhood deprivation and self-rated health, the results indicate a negative correlation between the two when controlling for socioeconomic and sociodemographic parameters. Verhaeghe and Tampubolon [19] conclude that further research is needed to examine more factors affecting the level of self-rated health and neighborhood deprivation, as well as individual social capital and self-rated health. Cronin et al. [20], in their research, find that in areas with high social capital, communication among health providers, social services, and hospitals is easier, making the care provided to community members facing health issues more effective.

Carpiano [21] studied the relationship between neighborhood social capital and adult health. Based on the social capital theory according to Bourdieu [9], he utilized data from the Los Angeles Family and Neighborhood Survey (LA. FANS), which includes all neighborhoods in Los Angeles County. At the neighborhood level, the sample consisted of 2,462 observations. At the individual level, the sample was 2,522 observations [21]. He used two hypotheses: For every form of social capital, higher levels would be associated with a lower likelihood of smoking, excessive alcohol consumption, and higher health perception; and hypothesis 2, Higher levels of any form of social capital combined with higher levels of individual attachment to the neighborhood would be associated with a lower likelihood of daily smoking and excessive alcohol consumption and higher health perception. The results of Carpio's empirical analysis showed that at the neighborhood level, high levels of social leverage and informal social control are related to low chances of daily smoking and excessive alcohol consumption. Also, high levels of social support at the neighborhood level are related to a high probability of daily smoking and excessive alcohol consumption. Additionally, there was no evidence found indicating that higher neighborhood attachment is associated with better health levels related to forms of social capital [21].

Gramm, Dijk, and Neiboer [22] studied whether social capital and social cohesion in neighborhoods positively affect the well-being of older adults. The selected areas were four neighborhoods in the city of Rotterdam, Netherlands. The sample consisted of 1,440 older adults, of whom 945 responded. The method used was the completion of a questionnaire. The research results showed that the well-being of older adults is positively related to the individual social capital of neighborhood residents, the social capital present in the neighborhood, and the social cohesion in the neighborhood. Additionally, it was observed that older adults with low incomes and those living alone had lower levels of well-being compared to married older adults. Gramm, Dijk, and Neiboer argue that when designing policies, not only should the socioeconomic characteristics of the social groups they wish to strengthen be considered, but also the daily lives of those individuals [22]. Hoi, Wu, & Zhang [23] believe that it is likely that in societies that maintain strong ties, organizations and institutions operating within those societies contribute to collaborations related to improving the health of the local population.

Aldrich and Meyer [24] mention the contribution of social

capital during times of emergencies (disasters from floods, earthquakes, etc.). In communities where there was a reservoir of social capital, individuals could more easily obtain information, updates, and assistance either just before, during, or after the catastrophic events [24,25]. A recent study by Panday et al. [26] refers to the contribution of social capital during periods when various types of natural disasters (earthquakes, extreme weather events, etc.) have occurred in a community. Their research showed that all three types of social capital positively contribute to the faster recovery of damages caused by natural phenomena. Studying natural disasters, earthquakes that occurred worldwide, they observed that communities with reserves of bonding, bridging, and linking social capital were able to address the "wounds" left behind by the disasters from extreme events more quickly and effectively [26]. According to the researchers, bonding and bridging social capital is important for the entire community, especially for vulnerable social groups, as it provides the possibility of immediate assistance after disasters to the affected individuals, the existence of bonding (help to relatives, friends, etc.) and bridging (help to third parties, neighbors, etc.) social capital [26], as well as linking contributions to recovery and restoration to the pre-disaster state.

Methodology

With the present research the objective is to study social capital and health and their relationship with the local community. A bibliographic review was carried out regarding the relationship between social capital and health, and corresponding research was presented that has been carried out. At a later stage, the aim is to carry out a quantitative analysis using questionnaires regarding the study and measurement of social capital in specific areas of Crete, which is the largest island in Greece and has health infrastructure at all levels of health care in all three main stages: Primary, Secondary and Tertiary Health Care. From simple prevention to the most difficult operations. The choice of this particular method lies in the fact that it is desired to study the amount of social capital in relation to health. With the structured questionnaire method, it is believed that the required data will be collected in order for the research to arrive at thorough results. The study area will be Western Crete, the Regional Units of Chania and Rethymno. Studying factors such as trust, the level of social relationships, and solidarity among individuals can provide insights into the level of social capital and its contribution to individuals' health. The sample for the quantitative analysis will consist of about 100-120 people in total. It is believed that from the data to be collected and from the statistical analysis, which will be carried out at a later stage after the questionnaires have been received, useful results will be extracted that will contribute to the field of the study of social capital and health.

Conclusions

This paper attempts an initial approach to the relationship between social capital and health, based on studies and data available in the international and Greek literature. It is more concerned with the outcomes of the relationship between social capital and health in local communities. The theoretical approaches

of the three theorists of social capital, Bourdieu, Coleman, and Putnam, were developed [27]. It is observed that there is a relationship between social capital and health; however, to reach accurate conclusions, a qualitative or quantitative research study is needed. The qualitative or quantitative approach to the issue can constitute the second part of the paper, which will be conducted at a later stage. The research will employ a quantitative methodology. The choice of this specific method lies in the fact that there is a desire to approach a representative sample of the population and, based on the analysis of the resulting data, the research aims to yield substantiated results.

References

1. Rocco L, Suhrcke M (2012) Is social capital good for health? A European perspective. Copenhagen, WHO Regional Office for Europe.
2. Eriksson M (2011) Social capital and health: Implications for health promotion. *Global Health Action* 4: 5611.
3. Muntaner C, Lunch J, Smith JD (2000) Social capital and the third way in public health. *Critical Public Health* 10(2): 108-124.
4. Kawachi I, Berkman LF (2001) Social Ties and Mental Health. *Journal of Urban Health: Bulletin of the New York Academy of Medicine* 78 (3): 458-467.
5. Ζήση Α, Χίου Β (2017) Material conditions, social capital and mental health of children and adolescents: A brief review. *Psychology: The Journal of the Hellenic Psychological Society* 22(1): 30-43.
6. Lee S (2018) Social capital and health at the country level. *The Social Science Journal* 55(1): 37-51.
7. Koniordos SM (2006) Social Capital: Between Theoretical Clarity and Confusion. *Science and Society: Journal of Political and Moral Theory* 16: 1-38.
8. Coleman JS (1988) Social Capital in the Creation of Human Capital. *The American Journal of Sociology*, Vol. 94, Supplement: Organizations and Institutions: Sociological and Economic Approaches to the Analysis of Social Structure PP. 95-120.
9. Bourdieu P (1986) The Forms of Capital. Στο J.G. Richardson (ed.), *Handbook of theory and research for the sociology of education*, N. York, Greenwood.
10. Bourdieu P (1985) The conservative school: Inequalities in education and schooling. In A. Fragoudaki (Ed.), *Sociology of Education* PP. 359-391.
11. Putnam RD (1993) *Making Democracy Work: Civic Traditions in Modern Italy*. Princeton NJ, Princeton University Press.
12. World Health Organization (1998) *Health Promotion Glossary*. Geneva: World Health Organization.
13. Veenstra G (2000) Social Capital, SES and health: an individual-level analysis. *Social Science and Medicine* 50(5): 619-629.
14. Villalonga-Olives E, Kawachi I (2017) The dark side of social capital: A systematic review of the negative health effects of social capital. *Social Science and Medicine* 194: 105-127.
15. Andersson MA, Christakis NA (2016) Desire for weight loss, weight-related social contact, and body mass outcomes. *Obesity* 24(7): 1434-1437.
16. Murayama H, Fujiwara Y, Kawachi I (2012) Social capital and health: a review of prospective multilevel studies. *J Epidemiol* 22(3): 179-187.
17. Vidali P, Bitsiori Z (2018) The significance of social capital in process for achieving the survey of healthy aging. *Perioperative nursing (GORNA)*, E-ISSN:2241-3634 7(2): 81-88.
18. Eriksson M, Dahlgren L, Janlert U, Weinehall L, Emmelin M (2010) Social Capital, Gender and Educational Level-Impact on Self-Rated Health. *The Open Public Health Journal* 3(1): 1-12.
19. Verhaeghe PP, Tampubolon G (2012) Individual social capital, neighborhood deprivation, and self-rated health in England. *Social Science & Medicine* 75(2): 349-357.
20. Cronin CE, Franz B, Garlington S (2021) Population health partnerships and social capital: Facilitating hospital-community partnerships. *SSM Population Health* 13: 100739.
21. Carpiano RM (2007) Neighborhood social capital and adult health: An empirical test of a Bourdieu-based model. *Health Place* 13(3): 639-655.
22. Gramm JM, Dijk van H, Neiboer AP (2013) The Importance of Neighborhood Social Cohesion and Social Capital for the Well Being of Older Adults in the Community. *The Gerontologist* 53(1): 142-152.
23. Hoi CK, Wu Q, Zhang H (2018) Community social capital and corporate social responsibility. *Journal of Business Ethics* 152(3): 647-665.
24. Aldrich DP, Meyer M (2014) Social Capital and Community Resilience. *American Behavioral Scientist* 59(2): 254-269.
25. Heller K, Alexander DB, Gatz M, Knight BG, Rose T (2005) Social and personal factors as predictors of earthquake preparation: The role of support provision, network discussion, negative affect, age, and education. *Journal of Applied Social Psychology* 35(2): 399-422.
26. Panday S, Rushton S, Karki J, Balen J, Barnes A (2021) The role of social capital in disaster resilience in remote communities after the 2015 Nepal earthquake. *International Journal of Disaster Risk Reduction* 55: 102112.
27. Putnam Robert (2001) *Social Capital: Measurement and Consequences*. Isuma: Canadian Journal of Policy Research 2 (Spring 2001): 41-51.