6
Health Inequalities Between European Welfare Regimes: The Contribution of Collective Social Capital

6.1 Introduction

Previous chapters of this book, as well as previous empirical studies, have suggested that there are differences between countries in terms of levels of social capital (van Oorschot and Arts, 2005). These diversities could very well be a result of the way welfare is produced, distributed, and directed by policy (see also Chapter 3) and it therefore seems plausible also to expect differences in social capital between large clusters of countries such as welfare state regimes.

In addition, there are explanations of the ways in which individual social capital could affect health and well-being (Kawachi and Berkman, 2000), as well as hypotheses about the mechanisms linking the social capital of contextual units, such as societies or neighbourhoods, and health. Empirical evidence about associations between social capital and health exists in some contexts or countries (Kawachi et al., 1999; Hyppä and Mäki, 2001), while no association has been found in others (Veenstra, 2000; Kennelly et al., 2003). The results largely depend on whether social capital is measured as a contextual or individual level variable, and on how social capital is theoretically defined and empirically operationalized. However, whether we find an association or not may also depend on the fact that social capital is a more important resource in some welfare contexts than in others.

Numerous previous studies have examined the associations between social capital and health (also see Chapter 4). Chapter 5 of this book examined whether the health consequences of social capital vary by welfare state context, and further whether the contribution of social
capital to health inequalities also differed depending on welfare regime type. However, no previous studies have examined whether collective social capital accounts for health inequalities between clusters of countries grouped into welfare state regimes. The overall aim of this chapter is therefore to analyse the association between welfare regime type and self-rated health, and the extent to which this could be related to social capital.

6.1.1 Social trust as a dimension of social capital
This chapter will focus exclusively on the cognitive aspect of social capital, namely social trust. Previous theoretical definitions suggest that social trust is an important feature of collective social capital (also see Chapter 2). Putnam, for instance, suggests that social capital is the “features of the social organizations such as trust, norms, and networks that can improve the efficiency of society by facilitating coordinated actions” (Putnam et al., 1993, p. 167). Accordingly, social trust is analysed here, as it is a central feature in core definitions of social capital (Putnam et al., 1993; Putnam, 2000). Numerous empirical studies use social trust as an indicator of social capital (see, for example, Kawachi et al., 1999; Putnam, 2000; Subramanian et al., 2002; Kennely et al., 2003). Nevertheless, trust should not be regarded as social capital per se, but as one aspect of the multifaceted concept of social capital that may promote the exchange of social resources (see Chapter 2). Finally, most researchers adhere to the perspective that social capital is more than the aggregated characteristics of individuals, and that social capital is a feature of social structures (Lochner et al., 1999; Kawachi and Berkman, 2000; Putnam, 2000). However, contextual social trust may be confounded by trust at the individual level in empirical analyses. This makes it important to theoretically and empirically try to separate collective aspects of social trust from individual aspects. However, the emphasis in this chapter will be on contextual social trust.

6.1.2 Welfare state regimes and social trust
Esping-Andersen’s (1990; 1999) theory could be useful in explaining eventual differences between welfare states when it comes to social trust. His theory of “the three worlds of welfare capitalism”, described in Chapter 1, suggests similarities between countries, when grouped into welfare regimes, in terms of the distribution and production of welfare, the direction of social policy, and the construction of social insurance systems. Even if there are similarities between countries belonging to