Social capital, population health, and the gendered statistics of cardiovascular and all-cause mortality

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1. Introduction

The journal SSM - Population Health is an excellent opportunity for practicing interdisciplinarity and transdisciplinarity to the extent that its contributors represent a variety of disciplines within the social sciences and the biomedical sciences, and the peer-review system prioritizes topical expertise rather than a particular disciplinary affiliation. This opportunity translates into clashes between authors and peer-reviewers ad as well as between peer-revewers of the same paper regarding conceptual, theoretical, and methodological commitments on how to approach a given empirical problem. I had a chance to experience this ideological clash as a reviewer of Lindström et al.’s fascinating paper “Social capital, the miniaturization of community, traditionalism and mortality: A population-based prospective cohort study in southern Sweden”. In this commentary I aim to describe this ideological clash because it strikes me as a good way to collectively learn how to negotiate pluralism and difference in the social study of health (cf. (Simandan, Rinner, & Capurri), in press), but also as a good way to make sense of what Lindström et al.’s empirical findings say and don’t say.

2. Ideologies of social capital and population health research

Lindström et al.’s paper is a prospective cohort study exploring the associations between social capital and mortality using the 2008 public health survey in Scania and linking it to the regional prospective public death register data. It is part of a broader research effort to evaluate the extent to which a popular social science construct – social capital – can predict important outcomes for population health and wellbeing. The fact that the paper is a significant contribution to this field becomes especially apparent when juxtaposed with the systematic review of prospective studies on this topic by Choi et al., 2014, which found that the pooled estimates of the fourteen studies under consideration showed no association between most social capital dimensions and all-cause mortality, CVD or cancer (p. 1895) and warned that “lack of consensus on measurements for social capital hinders the comparability of studies and weakens the evidence base” (p. 1895). Interestingly, of the seven dimensions of social capital identified by Choi et al. - social participation, social network, civic participation, social support, trust, norm of reciprocity and sense of community – only two dimensions – social participation and civic participation – appeared to have some predictive value for mortality, but even this finding was limited to cases of “comparing the most extreme risk comparisons” (p. 1895).
systematic reviews with such meagre results, one would expect some
generalized despondency among researchers in this area and a strong
temptation to move on to other, more promising research topics. To
their credit, the coauthors have shown dogged persistence on this
problem, continuing to research the association between social capital
and mortality even after the publication of Choi et al., 2014 (e.g.
Lindström & Rosvall, 2019). However, scholars like myself who tend to
approach the social study of health partly through the lens of critical
theory (Simandan, 2010, 2011, 2017a–c, 2018) are compelled to look at
that dogged persistence as a clue to an unacknowledged ideological
commitment. Seen in this light, “social capital” is a concept that carries a
tacit ideological load as an articulation of fuzzier values and beliefs that
promote what Miranda Joseph beautifully called “the romance of the
community” (Joseph, 2002). It embodies in a convenient and “catchy”
phrase pre-analytical intuitions that prosocial behavior, social partici-
cation, civic participation, generalized trust, caring, solidarity, and an
“other” orientation are unadulterated goods that should be promoted in
public discourse and academic discourse. Of course, what this warm and
cozy feeling toward the concept of “social capital” leaves out is the dark
side of community dynamics, represented by ostracism, social exclusion,
marginalization, persecution, “us” versus “them” polarized thinking,
and so on. To be sure, the revised version of Lindström et al.’s article
makes a gesture toward acknowledging the literature on this darker side
(e.g. Pawar, 2006; Villalonga-Olives & Kawachi, 2017), but is that
enough? I don’t think so. In everyday life as well as in academic
discourse we usually convince ourselves and others that a particular
issue is good or desirable, by showing how the presence of the good
thing triggers other good things in its wake, whereas its absence brings
negative outcomes. This maneuver can be argued to underpin most of
the research on social capital and health outcomes: in our heart of
hearts, we want to prove that more social capital leads to better health
and reduced mortality and if reality refuses to cooperate with us, we
need to figure out more ingenious study designs that yield the results we
want to get. In other words, we need to be on the constant lookout for
the danger that our tacit ideological commitments translate into sys-
tematic biases in the manner in which we interpret our empirical results.
In the discussion section of his paper, Lindström et al. write that their
new findings “partly contrast” with the deflating conclusions of the
systematic analysis by Choi et al., 2014. That particular choice of
framing is telling because it pushes in the background the equally valid
framing of saying that their findings “largely agree” with Choi et al.’s
overall conclusion. Let’s recapitulate the actual results. Social capital
fails to predict cancer and other causes mortality for both men and
women. The finding of an association between social capital and card-
iovacular and all cause mortality, on the other hand, holds only for
men, but not for women. That is alarming because we do not have a
readily available, widely accepted, and empirically confirmed biomed-
ical or psychosocial explanation for this gendered outcome. Lindström
et al. refuse to see the elephant in the room and move past the intriguing
finding of a gendered disparity without any attempt at either explaining
it or looking into the available literature to try to find plausible expla-
nations. An earlier population-based prospective study from Finland
that operationalized individual-level social capital into three factors
(leisure participation, interpersonal trust, and residential stability)
found that the first two factors did predict both all-cause and cardio-
vacular and all cause mortality, on the other hand, holds only for
social capital and mortality.
There is yet another framing of gender, namely gender as an epis-
temological sensibility, and it can act as a much-needed complement to
the idea of gender as an ontological conundrum. Feminist epistemol-
ogists maintain that “differences in the social locations of inquirers make
for epistemic differences” (Ashton & McKenna, 2020, p. 28) and thereby
encourage researchers to explicitly account for their positionality and
the situatedness of their knowledge claims (Simandan, 2016, 2002,
2019a–b, 2020). Instead of hiding one’s identity behind statistics,
impersonal language, and the rhetoric of neutrality, objectivity, and
impartiality, feminist approaches to the production of scientific
knowledge urge us to do the opposite and reflect on how the forms of
social difference that we embody (race, ethnicity, age, gender, sexual
orientation, social class, etc.) influence the choice of topics we research,
the methods we use, and the manner in which we interpret the empirical
evidence. Lindström et al.’s paper relies on a set of concepts such as
tradition, trust, social capital, community, or gender, that carry an
insufficiently acknowledged political and ideological load. My take-
home message is that even the quantitatively oriented research that
dominates SSM – Population Health must engage with this problematic,
instead of just brushing it under the rug.
Ethics statement

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