

RESPONSES TO READER'S COMMENTS

We thank the anonymous reader for taking the time to comment on our paper. Below are our responses to his/her comments.

1) **COMMENT:** *"...the results in themselves do not add much to the literature."*

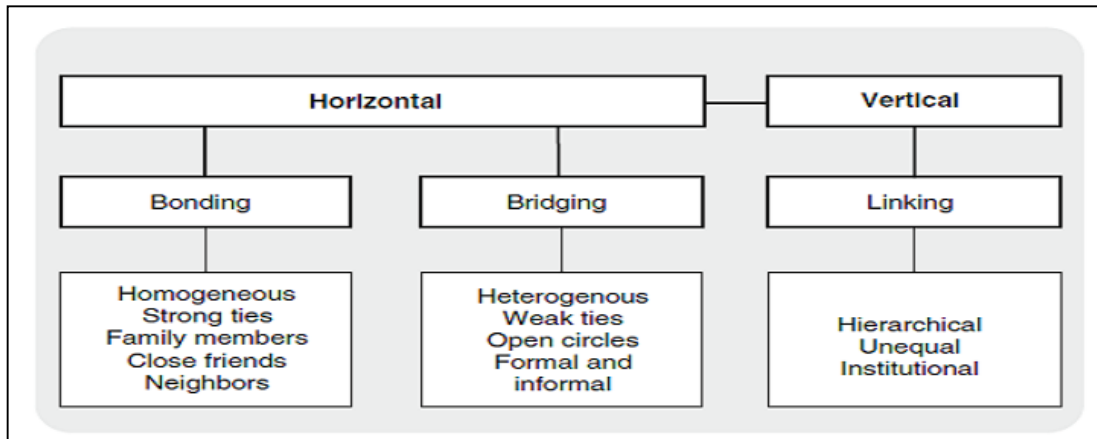
Response: As noted in the introduction, "our findings on trust and social participation are consistent with previous research on China, though previous studies do not allow a comparison of the magnitude of the estimated effects. Our findings on social relationships and social networks are new to the literature." Our paper is also the only paper in the literature to address endogeneity while studying the relationship between social capital and self-reported health in China.

2) **COMMENT:** *"The paper seems to have the data to make the bonding/bridging distinction. But it prefers the distinction in social trust, social relationships, social participation, and social networks, by mixing together close and weak ties. The paper should justify this choice, and why, instead, it did not adopt some statistical procedures, such as factor analysis, to select the proxies for social capital from the original available data."*

Response: There are many different ways of classifying social capital (SC). Cognitive versus structural is one way. As noted in our original discussion of the literature, another approach is to classify social capital into bridging, bonding, and linking social capital (Ng & Eriksson, 2015; Szreter & Woolcock, 2004). Our social capital variables fit comfortably into the cognitive/structural framework. They do not match well with the bridging, bonding, and linking categories.

To categorize social capital using these latter categories requires that relationships be grouped according to whether they are horizontal (e.g., family members, friends) or vertical (leaders) -- see the figure below. For example, in our paper, *Social Relationship* can be categorized as bonding social capital. However, *Social Participation* cannot because the CGSS does not report whether the respective social participation relationships are horizontal or vertical. Therefore, the categorization of bonding, bridging and linking is not amenable to the data we have available for our analysis. To avoid any confusion, the revised version of the manuscript drops the discussion of bonding, bridging, and linking social capital and focuses on the cognitive versus structural classification.

With respect to the use of factor analysis, our preference is to develop indices by straightforward summation of the individual survey questions. Factor analysis transforms the original data by creating artificial variables that represent the common core(s) of the original data. One problem with factor analysis is that one is never confident of the interpretation of the corresponding factor(s), as they are synthetic variables composed of bits from the original data. Some researchers find factor analysis an attractive approach while others do not. We prefer working with summation indices because this avoids the interpretation problem.



SOURCE: Hyyppä, M. 2010. *Healthy ties*. New York: Springer (page 15).

- 3) **COMMENT:** *“The paper does not introduce the key variable of self-reported health in relation with objective health and with self-reported well-being. While the subjective/objective health seems to be a weak relationship (Deaton 2008), the self-reported health/well-being seems to be a strong relationship (Helliwell 2003). A discussion of these aspects would enable the reader to better interpret the results of the paper.”*

Response: Unfortunately, the CGSS does not report measures of objective health, so there is no alternative to using self-reported health. This is common in the social capital literature, as studies examining the determinants of self-reported health greatly outnumber those examining objective health, no doubt due to data availability.

There is a large body of literature that examines the relationship between self-reported and objective health. Self-reported health has been identified as a robust and reliable predictor of objective health status (Prus, 2011; Snelgrove et al., 2009). It is well-established that self-reported health is strongly related to mortality (Idler & Benyamini, 1997; McCallum et al., 1994), morbidity (Idler, Russell, & Davis, 2000), disability (Mansson & Rastam, 2001), and functional limitations (Idler & Kasl, 1995). The revised version of the manuscript now includes this discussion. References can be found there. We note that all previous studies of social capital and health in China have used self-reported health, and not measures of objective health (Wang et al., 2009; Yip et al. 2007; and Meng & Chen, 2014)

Finally, our analysis does not consider self-reported well-being. While this is a subject of interest in its own right, we felt that addressing both self-reported health and self-reported well-being in the same paper would make the paper both physically, conceptually, too long.

References

- Ng, N., & Eriksson, M. 2015. Social capital and self-rated health in older populations in lower- and upper-middle income countries. In Nyqvist, F., & Forsman, A. (eds.), *Social Capital as a Health Resource in Later Life: The Relevance of Context*. New York: Springer.
- Szreter, S, & Woolcock, M. 2004. Health by association? Social capital, social theory, and the political economy of public health. *International Journal of Epidemiology*, 33(4): 650-667.