

# Self-Assessed Health and Perceptions of Fairness in Metropolitan China: A Social Capital Perspective

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*This article uses the novel survey data of three megacities in China, including Beijing, Shanghai and Guangzhou, to examine the relationships among social class, social capital, individual self-reported health, and perceptions of fairness. Using two sets of ordinal logit regression models, the study reveals the predominantly significant role of class position in determining self-assessed health, and in turn, the strong associations among social capital, health and perceptions of fairness. In conclusion, the article provides policy implications for treating health inequity in the broader social context of an increasingly complicated class structure in urban China.*

**Keywords:** health, social networks, class, perceptions of fairness

## Introduction

It has been more than three decades since the first social surveys on the theme of social networks were conducted in China (Zhang 2011a). Although most of these surveys were restricted to single-city or multi-city samples, they formed an important starting point for research of social capital in China. Ever since Lin's survey of social networks in Tianjin, scholars of social capital both within and outside China have contributed to a rich literature covering various dimensions of social capital, including social networks and civic participation. Linked to both the academic discourse of social capital raised in the western societies and the commonly known concept of *guanxi* rooted in the Chinese context, the concept of social networks has been adopted to probe into various social issues, such as occupational attainment in urban areas (e.g. Bian 1994; Bian and Zhang 2001; Zhang 2006), job mobility of migrant workers (e.g. Li 1996), class disparities in stock of social capital at the individual level (e.g. Bian 2004; Zhang 2005), and issues of social support (Ruan 1990; Zhang et al. 1999a, 1999b).

In response to continuous economic growth and the public's rising concern with both social quality and quality of life, academic attention in recent years has been drawn to issues other than objective life chances, such as subjective wellbeing and civic behavior. A new generation of social capital research in China has turned to investigate the impact of social networks on urban political participation (Sun 2010), health behavior (Zhao and Hu 2013) and life satisfaction (Ma 2015). Like other rapidly developing economies with drastic social changes, China is being challenged by the widening gap in individual wellbeing, including health status, and social attitudes, such as perceptions of fairness. Despite the expanded scope of research, the existing literature on social capital in China provides little empirical evidence regarding the possible link between subjective wellbeing (as well as health status) and social attitude. Health inequality and disparity in subjective wellbeing may bear greater political importance than it seems. Meanwhile, individual perceptions of social justice and fairness also have an impact on social cohesion. With this in mind, I find it important to understand what the likely social consequences of health inequality are, and, whether they may further affect people's perceptions of the society they live in, which, in turn, may lead to other socio-political attitudes. Specifically, I need answers to these questions: 1) does social capital at the individual level have an impact on an individual's health status? and, 2) if such an association exists, does it

further affect people's perceptions of fairness?

"Foundation stones of social capital" though they may be (Li 2016, p. 2), social networks are by no means the only dimension to be considered when examining the relationship among social capital, people's subjective evaluation of their health and the level of unfairness in a society. In order to incorporate both informal and formal social capital and differentiate networks by quality, this analysis uses a network size consisting of two types of informal networks, network diversity and civic engagement as indicators of social capital. Further, linking social capital to selected demographic characteristics and information on people's actual experience in their social circumstances, I further break down the two general questions listed above into the following research questions: 1) is an individual's self-assessed health status associated with different dimensions of social capital? 2) what other social determinants play a role in affecting self-assessed health status? 3) to what extent is social capital related to people's perceptions of fairness? and, 4) is there an association between self-reported health and perception of fairness? In seeking answers to these questions, this article is aimed at bringing in a new perspective to analyze the impact of social capital on individual life and social cohesion.

The rest of this article is organized as follows. In the next section, I give a brief review of theoretical accounts of social capital and review the key findings on social networks, health and perceptions of fairness. After an introduction of data and methods used in this study, I then move on to present and discuss three sets of statistical models that address the research questions. Drawing on data collected recently in Beijing, Shanghai and Guangzhou, I conclude that social capital, *via* network quality and civic participation, has an impact on people's perceptions of fairness, whereas health is affected more by class positions rather than social capital. In addition, individual perceptions of fairness are significantly related to their health status.

## Literature review and research hypotheses

Compared with other types of "capital," namely economic capital, human capital and even cultural capital, the concept of social capital was once described as a "seductive, but infuriating" one (Li, Pickles, and Savage 2005, p. 109). On the one hand, its power to engage research topics and questions in different disciplines has drawn academic discussions by sociologists,

political scientists, economists, psychologists, scholars from management and business studies as well as other disciplines of social science (Li 2007; Zhang 2011b). When this article was being written in October 2016, a search on Google Scholar using “social capital” and “China” as key words, with results restricted to the time span between 2000 and 2016, would indicate over 1.5 million items, whereas replacing the key words with “social networks” and “China” would still lead to nearly 60,000 items published during the same period. On the other hand, the elusiveness of the concept of social capital has led to critiques of the application of social capital in academic research. A typical concern is that the employment of the concept of social capital tends to be uncritical, indiscriminate, and thus imprecise (Woolcock 1998; Portes 1998).

That said, the concept of social capital has proven its theoretical strength and operational feasibility in quantitative analyses in various research areas. Despite the differences in their theoretical accounts of social capital, it is commonly agreed by the most important scholars in this research area that social capital refers to resources embedded in social networks (Bourdieu 1984, 1986; Coleman 1988; Putnam 2000; Lin 2001). On this common ground, nonetheless, social capital is sometimes understood more from the instrumental side as a type of private resource and, at other times, viewed from the “social” side as a public good that helps boost the civic spirit of a society. Following Lin’s definition of social capital, it is rooted in social networks and social relationships. Primarily utilized to explain an individual’s occupational attainment, social capital as defined by Lin is a kind of resource that is embedded in social structure that can be accessed and utilized in intentional action (Lin 1999, 2001). Lin further differentiated instrumental action from expressive actions. Compared with instrumental actions, which bring about the gain of additional resources that are “not presently possessed by ego,” expressive actions may help maintain the already- possessed resources (Lin 1999, p. 36). It is in this sense that bridge links generated via social networks may be important to maintain physical and mental wellbeing, and in turn, overall life satisfaction.

In terms of its components, Lin (2001) argued that social capital involves social networks, civic participation and general trust, among which social networks serve as the most important channels for individuals to access resources. The emphasis on social networks as the core element of social capital was confirmed by Bian, a pioneer of social network analysis among Chinese scholars, who stressed that resources are the raw status of capital that help individuals access benefits and returns. He pointed out that social

capital, by its very nature, consists of the transferrable resources that are embedded in relationship networks, which can be accessed only through the development and accumulation of those networks (Bian 2004).

In Putnam's theory, however, informal social networks are not the only primary source of social capital. In his earlier work, Putnam emphasized the significance of civic participation as the main source of social capital, suggesting that the experience of being engaged in civic associations means opportunities for reconciling differences and cooperation, which in turn help develop the firm foundations of "good government" (Putnam 1993). In his later work, Putnam (2000) revised his argument to stress informal networks as the major source of social capital and differentiated "machers," those who are engaged in formal social connections, and "schmoozers," those involved in informal social networks. Despite the turn in Putnam's theory of social capital, the importance he attached to civic engagement provides good reason to consider both formal and informal social connections in analysis of the impact of social capital.

As aforementioned, the concept of social capital has been applied to analyze the impact of various relevant factors on a wide range of outcomes. In the case of China, the major research questions asked regarding social capital at the individual level include the effect of social capital on individual life chances, occupational attainment in particular, stratification in social capital and social networks, social support networks, and the political participation as well as trust (see for an extensive review of application in the case of China in Zhang 2011). In recent years, sociologists have started to pay more attention to the impact of social networks on subjective wellbeing and health (Ma 2015; Yu 2008; Zhao 2008), yet we still need more relevant empirical evidence to better understand how social capital at the individual level is associated with health and how it further affects people's social attitudes.

The importance of social factors for health can be traced back early as the mid-nineteenth century when the English physician John Snow stressed the impact of structural elements in his practice of what would now be called health public policy (Lomas 1998). In modern research on how social factors affect individuals' health, attention has been paid not only to the influence of social changes at the macro level, but also to the effect of the micro-level social context people live in, among which the stock and quality of social capital are an important consideration. People's health and wellbeing are not only affected by their own socio-economic and demographic attributes, but also are sensitive to institutional and communitarian factors.

Among the heated discussions on social capital, researchers in this area

have contributed a considerable amount of empirical evidence regarding how people's health status and wellbeing are associated with social ties and networks, general trust and civic engagement. It is widely acknowledged that social capital works as a crucial determinant of health and wellbeing, and this also applies to East Asian societies (Yamaoka 2008). With the dynamics among social exclusion, health and wellbeing, attention is called to the role of social networks and other dimensions of social capital in the background. Using the British longitudinal data, Li (2007) found that higher levels of social capital embedded in informal social networks are positively associated with people's health, happiness and overall life satisfaction even when sociologically important individual and contextual characteristics are controlled for. In North American societies, civic engagement, trust and social ties were also found to enhance subjective wellbeing via their positive association with health (Helliwell and Putnam 2004). When qualitative researchers explored the dynamics between social exclusions in health and wellbeing, the role of social networks and social capital was reconfirmed (Cattell 2001). Cattell's analysis of the in-depth interview data from London revealed that it involved various network structures to create social capital, and bridging ties was particularly important to generate inclusive social capital and enhance health.

That is not to say, however, that there are unanimous conclusions with reference to the effect of social capital on health outcomes. Given the burgeoning literature that investigates social capital's role in health and wellbeing outcomes, however, the strength of evidence is not constant. Both the findings and strength of evidence vary depending on a range of factors, including the conceptualization and measurement of social capital, the study population and the level of economic development of the country (or countries) studied (Yip et al. 2007). In high-income industrial societies, cross-country studies have indicated mixed results, which implies that it is virtually impossible to draw widely applicable conclusions regarding the relationships between social capital and health outcomes (e.g. Pollack & von dem Knesebeck 2004 for Germany and the United States; Kennelly, O'Shea, and Garvey 2003 for OECD countries; Poortinga 2006 for European countries). In comparison, several studies of developing and middle-income countries confirm positive associations between social capital and health (e.g. Skrabski, Kopp, & Kawachi, 2004 for Hungary; Rojas & Carlson 2006, Rose 2000 for Russia). Again, it is noteworthy that these studies used different measures of social capital and were in some cases concerned with different types of health outcomes. For instance, while Pollack & von dem Knesebeck

(2004) looked into self-reported health, depression and functional status, and included self-reported reciprocity as a measure of social capital, some comparative studies of OECD countries and European countries conducted by Kennelly, O'Shea and Garvey (2003) and Poortinga (2006) paid more attention to the effects of social trust and civic participation.

As one of the most rapidly growing economies in the world, China has been and is increasingly being challenged by the issue of health inequality. Empirical evidence provided in the existing literature points to a widening urban-rural gap and distinct regional disparities in health status (Fang et al. 2010; Liu et al. 1999; Tang et al. 2008). Behind the rising health inequality is a wide range of social determinants. As far as the macro-level social determinants are concerned, uneven distribution of wealth and health resources are explained as major determinants (Fang et al. 2010). Turning to the individual level, Chen, Yang, and Liu (2010), whose study focused on health disparities over the life course indicated a strong cohort and found more profound effects of education and income on health in rural areas. Further, income inequality was also found to be significantly associated with health inequality, as sociologically important indicators widely employed in industrial societies are also applicable to the Chinese society, such as education, income and occupational status (Anson and Sun 2003; Pei and Rodriguez 2006).

Compared with endeavors dedicated to this issue in developed societies, studies that directly address the relationship between social capital and health outcome in China are relatively limited in number. That said, relevant empirical evidence has been accumulating. Using data from three rural counties in Shandong Province of north China, Yip et al. (2007) examined the relationship between social capital, self-reported health and overall subjective wellbeing. With structural and cognitive social capital differentiated, the analysis showed positive associations between cognitive social capital, measured with trust, with both self-assessed health status and subjective wellbeing, which are interpreted as having occurred via social networks. In contrast, structural social capital, measured with organizational memberships, is hardly associated with either health or subjective wellbeing. Focusing on the effect of social capital on general health and mental health in the rural areas, Wang et al. (2009) distinguished trust from mistrust in the way that it affects individual health status. Whereas trust is positively associated with both general health and mental health, mental health is negatively affected by mistrust. In an analysis employing national survey data that covers both urban and rural samples, Zhao (2008) also probes into both

physical and mental health. The study disclosed the role of social networks in determining people's health. While networks featuring strong ties and low degrees of heterogeneity positively affect people's mental health, their physical health benefits from networks with opposite characteristics. Although Zhao's analysis revealed a greater impact of social networks for the rural sample than the urban sample, this is one of the few studies that provides evidence for the relationship between social capital and health status in urban China where the demographic structure is more complex and social networks can be more diverse and sophisticated in both types and the way in which they affect the quality of people's daily life. In another study that is restricted to the single-city data of Shanghai, Yu, Huang, and Gui (2008) confirmed the impact of both individual and collective social capital on mental health.

Reviewing the existing research on social capital and health status, I can see that more investigations have been conducted on the issue in rural China, while urban areas have not received sufficient attention regarding how health inequity may be affected by social capital at the individual level. Despite the importance of studying the rural population of China, urban areas, especially metropolitan areas, serve as a good testing ground for the association between social capital and health status for a few reasons: 1) the metropolitan areas have a diverse population and more heterogeneous social structures; 2) the sophisticated social networks and vibrant social context of other dimensions of social capital, such as civic engagement, provide better comparability with what has been found in developed industrial societies; and 3) the complex social context allows researchers to further examine how health status, alongside social capital, may in turn affect people's social attitudes, including their perceptions of fairness.

Turning to the studies that address similar issues in urban areas, scholars tend to focus on the likely impact of various dimensions of social capital on subjective wellbeing or mental health (Ma 2015; Yu, Huang, and Gui 2008; Zhao 2008). Next, as the majority of previous studies focus on the association between social capital variables and health, empirical evidence regarding the effect of network diversity is scanty. Furthermore, in this study, I understand health inequality as an issue of significant political importance and one that may affect social safety (Liu et al. 1999). In this sense, it is pertinent to extend analysis of the relationship between social capital and health status to further consider how such relationships may affect people's social attitudes, such as their perceptions of fairness. While a recent study conducted in Beijing claimed that individuals' subjective wellbeing is affected by their perceptions



of policy fairness (Sun and Xiao 2012), it is not clear whether people's perceptions fairness, as an important kind of social attitude, may be associated with their self-assessed health.

As far as perception of fairness is concerned, previous studies have found a relatively low rate of perceived inequality and unfairness (Whyte 2009). Coming to the class differences and urban-rural differences, the rural farming population has shown higher tolerance for socio-economic inequality than urban residents, whereas individual perceptions of distributive justice is found to be affected more by contextual effects than by people's positions in the class structure (Ma and Liu 2010; Whyte 2009). Given the large internal migrant population in urban areas, especially the metropolitan cities, the association between class positions and perceptions of fairness in the metropolitan areas remains unclear.

Based on the above review of the existing literature, this study attempts to test the following hypotheses.

As aforementioned, correlations between health inequality and increasing income have been well recognized, which applies well to the Chinese society. Nationwide, income inequality is found to be an important determinant of population health (Pei and Rodriguez 2006), while education, income, and occupational status may have a profound impact on individual health (Anson and Sun 2003; Chen et al. 2010). The burgeoning middle class in urban China and the large population of migrant workers moving from rural areas to cities have widened the income gap and class disparity in many aspects of socio-economic life. Bearing this in mind, our first hypothesis is about the effects of class positions on health status.

*Hypothesis 1:* Social positions are positively related to self-assessed health. Specifically, I expect those in more advantaged class positions to report better health.

*Hypothesis 2:* Social capital, informal and formal, measured by the size of different networks, network diversity and civic engagement, affect self-assessed health. To be specific, a diversity of high-status social networks enhances health, whereas diverse networks in low-status occupations are negatively associated with health status. Civic memberships tend to promote health.

An expanded wealthy, educated and consuming middle class is an important step for China to build an orderly and efficient, well-off society. It is widely

acknowledged that the middle class is not only instrumentally important to China's economic development (Easterly 2001), but also it is crucial for maintaining the social and political stability of the Chinese society. While society needs to ensure a large middle class that "acts as a force of stability" (World Bank 2012), the middle class should by no means be viewed as a homogeneous population. Adopting the classification of middle class into "core middle class," "semi-middle class" and "marginal middle class" in Li and Zhang (2008), this study also tests whether individuals from different "layers" of the middle class report differing perceptions of fairness.

*Hypothesis 3:* More advantaged class positions are related to one's perception of fairness. Treating the middle class as a heterogeneous social group, I expect the core middle class to be those who are most likely to report perceived fairness.

*Hypothesis 4:* Both informal and formal social capital affects one's perception of fairness. Specifically, high-status networks and civic engagement boost one's perception of fairness, whereas low-status networks lower perceived fairness.

An important contribution of this study is to link health status, social capital and perception of fairness. Such a linking strategy also distinguishes this study from those that address only the relationship between social capital and health. In addition to the role of social networks and civic participation, I also test the hypothesis related to the role of health status for perception of fairness. Considering the widely reported anxiety of the urban middle class in China (Chunling 2016), I thus hypothesize the following:

*Hypothesis 5:* One's perception of fairness is also affected by health and negative family or social experiences. The healthier the person, the more he or she is likely to report perceived fairness. The more negative the experience, the less likely one is to view society as fair.

## Data and methods

The data for this article are drawn from the Survey of Living Conditions in Megacities (2015) (hereafter SLCM) jointly conducted by Shanghai University, China Academy of Social Sciences, and Sun Yat-Sen University in

Beijing, Shanghai and Guangzhou. The first social survey featuring middle class research, the SLCM provides rich information that is needed for this study, including socio-economic positions, self-reported health, social networks, civic engagement and social attitudes. While it is theoretically desirable to look into the effect of social capital on both health and life satisfaction, the two issues have engaged two different sub-samples in the survey. Although a total of 6,010 residents from the three cities participated in the survey, the analytical sample size is 3,007, given that the information required is restricted to half the total sample.

### *Dependent variables*

There are two major dependent variables in this article. Although it may be preferable to obtain objective information on health outcomes, self-reported health has been acknowledged as a valid indicator by which I can understand health disparity across various groups of the population (Zheng 2016; Qi 2014). In the SLCM survey, the respondents were asked to assess their overall health status. The variable was coded on a three-category ordinal variable, “1” indicating “fair/poor health,” and “3” indicating “excellent.”

Similarly, respondents were asked whether they regard the society as a fair one. The variable was also coded into a three-category ordinal variable, with “1” indicating “unfair” and 3 “fair.”

### *Major independent variables: middle class and measures of social networks*

Given the emphasis on middle class in this research design and the hypothesis relating to class difference, I generated *class* variables to distinguish the middle class from the non-middle class. Viewing the middle class as a heterogeneous population, I follow Li and Zhang (2008) to define the middle class with household income, occupation and education. According to Li and Zhang’s classification, the middle class is further categorized into the “core middle class,” “the “semi-middle class,” and the “marginal middle class.” With some adjustments, I regard household income as a better indicator of an individual’s economic situation, and define as the “income middle class” as those whose household is above the city average household income. In terms of education, the “education middle class” is defined as those whose highest educational qualification is college and above, and the “occupational middle class” as those who are engaged in non-manual white-collar occupations. Combining these three criteria, while the core

middle meets the overall criteria of occupation, education and household income, accounting for merely 8.78 percent of the total sample, the semi-middle class meets at least two of the three standards, making up 25.14 percent. The marginal middle class refers to those who meet only one of the three criteria, making up 27.6 percent of our sample. When class is used as a two-way variable to distinguish the middle class from the non-middle class, the core and semi-core middle class are grouped as the middle class, while the marginal middle class and non-middle class form the non-middle class.

Based on a list of questions asked in the SLCM survey about the respondent's relatives and friends, I have constructed a variant of the position generator (Lin and Dumin 1986). Specifically, the list of occupations given in this section of the survey questionnaire is reclassified into two new lists of occupations that respectively stand for high-status occupations (scientist, lawyer, economy/business-related staff, administrative staff, engineer, government officials, enterprise officials, university academics, teachers in primary/secondary education, doctors and policeman), and low-status occupations (chef, restaurant server, domestic worker, nurse, driver and salesperson). For both high-status and low-status occupations, network size is measured with the number of occupations that respondents reported knowing a relative or friend in. The higher the sum of occupations in each list, the larger the size of their occupational social network.

To describe the network diversity, I make use of the respondents' answers regarding those whom they are usually in touch with, make friends with, receive help from, talk with and spend leisure time together with. The network diversity is derived by summarizing the scores relating to proportions of such contacts similar to the respondents in terms of sex, *hukou* (household registration), and hometown. The constructed variable of network diversity has a scale ranging from 0 to 50. The higher the value, the more bridging of social capital the respondents have.

As far as the purpose of this study is concerned, it is desirable to measure only active association memberships for civic engagement. Given the relatively low rate of association memberships reported by the respondents, however, the measure for civic engagement employed here refers to the sum of nominal memberships of nine type of voluntary associations: trade unions, home owner's committees, industry associations, religious, environmental, educational and cultural, recreation and sports, fellow-townsmen, and alumni associations. While different types of associations may have different effects in terms of health and perception of fairness, the measure of civic engagement is included to examine the effect of engagement in voluntary

**TABLE 1**  
**DESCRIPTIVE CHARACTERISTICS OF SAMPLE**

|                                                                  | Mean  | SD    | Min | Max | N    |
|------------------------------------------------------------------|-------|-------|-----|-----|------|
| <b>Dependent variable</b>                                        |       |       |     |     |      |
| Perceived fairness                                               | 1.88  | 0.77  | 1   | 3   | 2999 |
| Self-reported health                                             | 2.40  | 0.70  | 1   | 3   | 2993 |
| <b>Personal attributes</b>                                       |       |       |     |     |      |
| Male                                                             | 0.48  | 0.50  | 0   | 1   | 3007 |
| Age                                                              | 41.92 | 13.83 | 18  | 66  | 3007 |
| Urban <i>hukou</i>                                               | 0.81  | 0.40  | 0   | 1   | 2999 |
| Local <i>hukou</i>                                               | 0.77  | 0.42  | 0   | 1   | 3007 |
| Education                                                        | 2.58  | 1.16  | 1   | 4   | 3003 |
| Marital status                                                   | 1.84  | 0.50  | 1   | 3   | 2998 |
| Employment status                                                | 1.59  | 0.77  | 1   | 3   | 2999 |
| Middle class                                                     | 0.34  | 0.47  | 0   | 1   | 3007 |
| Individual annual income (quartile)                              | 2.39  | 1.10  | 0   | 4   | 2813 |
| <b>Social networks, civic engagement and negative experience</b> |       |       |     |     |      |
| High-status network size                                         | 4.45  | 3.30  | 0   | 11  | 3007 |
| Low-status network size                                          | 2.66  | 1.99  | 0   | 7   | 3007 |
| Network diversity                                                | 18.97 | 9.24  | 0   | 50  | 3007 |
| Civic engagement                                                 | 0.87  | 1.22  | 0   | 8   | 3007 |
| Negative economic experience                                     | 0.93  | 1.22  | 0   | 5   | 3007 |
| Negative social experience                                       | 0.78  | 1.18  | 0   | 5   | 3007 |

associations in general.

The statistical models also include socio-economic and demographic characteristics as control variables, including gender, age, *hukou*, marital status, employment status and individual income. Table 1 presents the descriptive statistics for the sample.

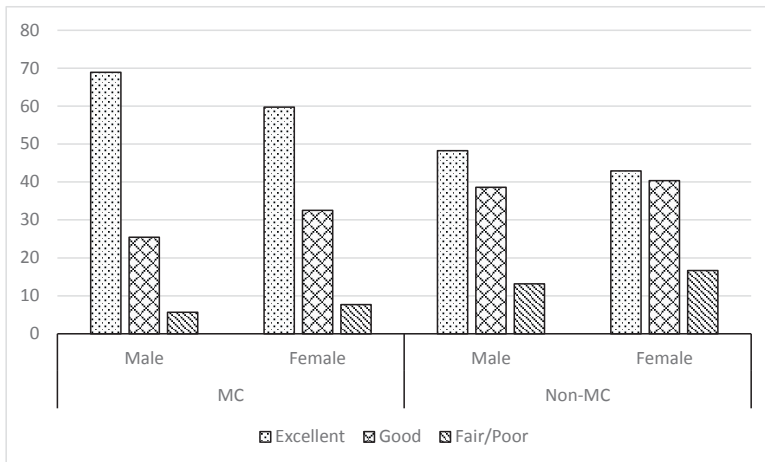
### *Statistical methods*

With both self-assessed health and perception of fairness coded as ordinal

categorical variables, our analysis involves two sets of ordered logit regression models, respectively fitted on these two dependent variables. Both sets of models control for sociologically important background variables that have been listed above. By adding the key independent variables to the models, I test the hypotheses raised above.

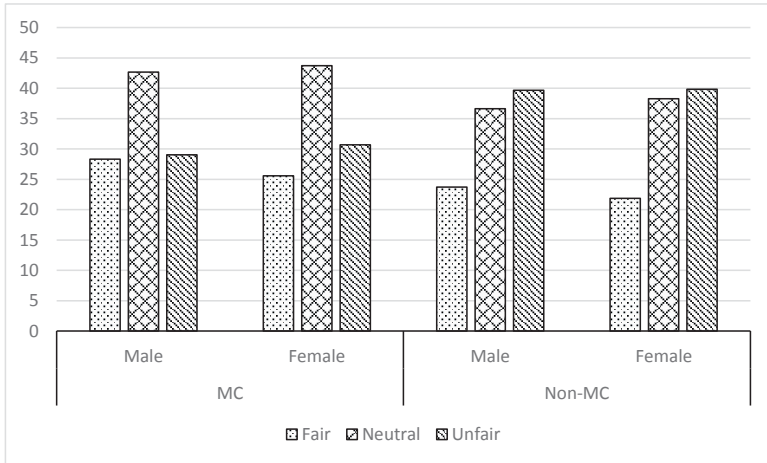
## Results

I start with an overview of distribution of self-assessed health and perceptions of fairness. In Figure 1, I can see a clear difference between the middle class and non-middle class in health. While the middle class is more likely than the non-middle class to report excellent health, both men and women from the non-middle class are more likely to report fair and poor health. Meanwhile, both middle class and non-middle class men are more likely than women to regard themselves as being in excellent health, whereas women, those in the non-middle class in particular, tend to report fair/poor health more than men. Figure 2 shows the distribution of perceptions of fairness by gender and class. Whereas there is no significant gender difference in perceived fairness, the non-middle class is significantly more



NOTES.—1. Gender difference significant at 0.05 level for the non-middle class; significant at 0.01 level for the middle class. 2. Class difference significant at 0.001 level for both men and women.

FIG. 1.—Distribution of self-reported health by sex and class



NOTES.—1. Gender difference non-significant. 2. Class difference significant at 0.01 level for women and at 0.001 level.

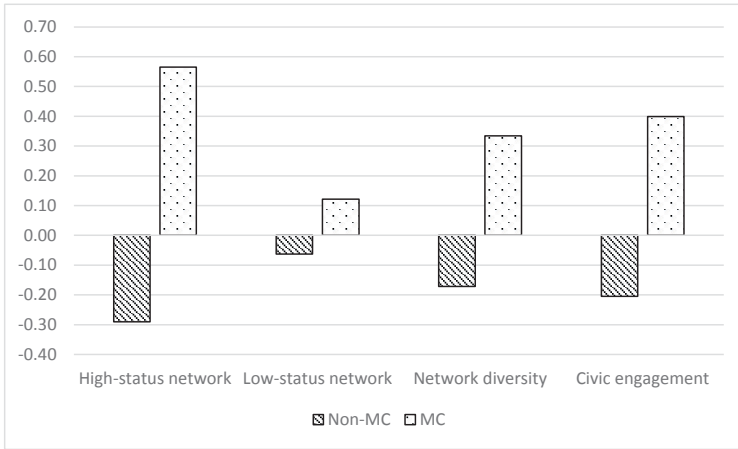
FIG. 2.—Distribution of perceived fairness by sex and class

likely than the middle class to feel a sense of unfairness and is less likely to perceive society as a fair one.

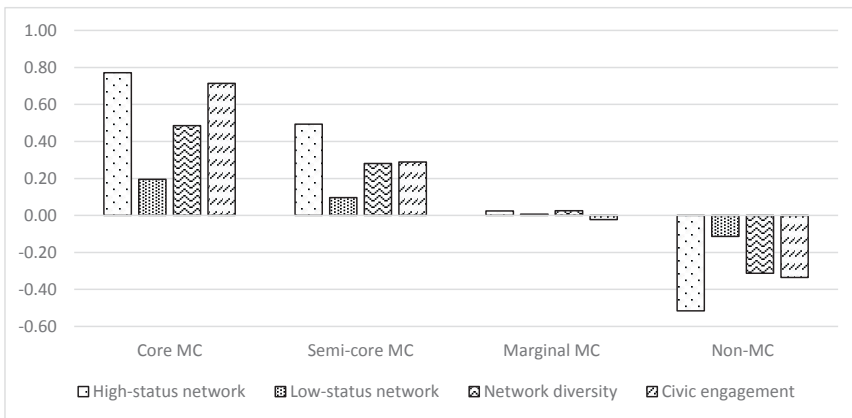
Figure 3 evidences significant class disparity in both social networks and civic engagement. Compared with the middle class, the non-middle class in Figure 3-a has smaller social networks of both high-status and low-status types, enjoys markedly lower network diversity, and participates less in civic associations. If I extend the analysis on the basis of a four-class classification, the four classes show clearly declining social resources as I move from the left-hand core middle class to the right-hand non-middle class. To briefly summarize the information I obtain from Figures 1-3, class makes a difference in self-assessed health and perception of fairness. Moreover, class also matters for social networks, in terms of both size and quality, and civic engagement.

### *Class, social networks, and health*

With a basic understanding obtained from the descriptive statistics, I now turn to explore in detail how one's health status is affected by the social determinants I am interested in. Table 2 reports the results from a set of ordered logit regression models on self-assessed health. Model 1 considers the effect of socio-demographic attributes and their relationship to health. Model 2 tests our Hypothesis 1, i.e. whether individuals in more advantaged



a) Two-way class



b) Four-way class

NOTES.—1. Data on network size, network diversity, and civic engagement based on standardized measures. 2. Class differences for all four variables significant at 0.001 level.

FIG. 3.—Class difference in social networks and civic engagement

class positions enjoy better health. In Model 3, I add the measures of network size, network diversity and civic participation to test our Hypothesis 2, namely the impact of social capital on health. Model 4 adds education and individual income to revisit the effect of these class-related variables.

The results from Model 1 are not unusual findings. Unsurprisingly,



**TABLE 2**  
**ORDERED LOGIT REGRESSION ON SELF-REPORTED HEALTH BY SOCIO-  
 DEMOGRAPHIC ATTRIBUTES AND SOCIAL CAPITAL DIMENSIONS**

|                                            | Model 1             | Model 2             | Model 3             | Model 4             |
|--------------------------------------------|---------------------|---------------------|---------------------|---------------------|
| Age                                        | -0.082**<br>(0.025) | -0.074**<br>(0.025) | -0.075**<br>(0.025) | -0.084**<br>(0.027) |
| Age squared                                | 0.000<br>(0.000)    | 0.000<br>(0.000)    | 0.000<br>(0.000)    | 0.001†<br>(0.000)   |
| Sex (base=female)                          |                     |                     |                     |                     |
| Male                                       | 0.143†<br>(0.076)   | 0.138†<br>(0.077)   | 0.107<br>(0.077)    | 0.004<br>(0.081)    |
| Hukou                                      |                     |                     |                     |                     |
| Non-agricultural                           | 0.031<br>(0.095)    | -0.043<br>(0.097)   | -0.056<br>(0.100)   | -0.011<br>(0.107)   |
| Marital status (base=Divorced/Widowed)     |                     |                     |                     |                     |
| Single                                     | 0.460*<br>(0.196)   | 0.455*<br>(0.196)   | 0.465*<br>(0.197)   | 0.530**<br>(0.204)  |
| Married                                    | 0.581***<br>(0.154) | 0.552***<br>(0.154) | 0.554***<br>(0.154) | 0.559***<br>(0.157) |
| Employment status<br>(Base=Non/Unemployed) |                     |                     |                     |                     |
| FT employed                                | 0.415***<br>(0.111) | 0.353**<br>(0.113)  | 0.351**<br>(0.113)  | 0.147<br>(0.137)    |
| PT employed/Retired                        | -0.179<br>(0.137)   | -0.188<br>(0.137)   | -0.180<br>(0.137)   | -0.312*<br>(0.150)  |
| Non/Unemployed (base)                      |                     |                     |                     |                     |
| Class (base=Non-middle class)              |                     |                     |                     |                     |
| Middle class (core/semi-)                  |                     | 0.305***<br>(0.087) | 0.249**<br>(0.095)  | 0.255*<br>(0.121)   |
| Network diversity                          |                     |                     |                     |                     |
| High-status networks                       |                     |                     | 0.008<br>(0.015)    | -0.007<br>(0.016)   |
| Low-status networks                        |                     |                     | 0.073**<br>(0.023)  | 0.088***<br>(0.024) |
| Network diversity                          |                     |                     | -0.002<br>(0.004)   | -0.000<br>(0.005)   |

TABLE 2  
(CONTINUED)

|                                   | Model 1              | Model 2              | Model 3              | Model 4              |
|-----------------------------------|----------------------|----------------------|----------------------|----------------------|
| Civic engagement                  |                      |                      | 0.062<br>(0.034)     | 0.031<br>(0.036)     |
| Education (base=Junior secondary) |                      |                      |                      |                      |
| University+                       |                      |                      |                      | -0.098<br>(0.159)    |
| College                           |                      |                      |                      | -0.145<br>(0.146)    |
| Senior secondary                  |                      |                      |                      | 0.021<br>(0.111)     |
| Income (base=bottom)              |                      |                      |                      |                      |
| Top quartile                      |                      |                      |                      | 0.687***<br>(0.152)  |
| 2nd quartile                      |                      |                      |                      | 0.474***<br>(0.131)  |
| 3rd quartile                      |                      |                      |                      | 0.172<br>(0.120)     |
| Intercept 1                       | -3.966***<br>(0.545) | -3.778***<br>(0.547) | -3.543***<br>(0.562) | -3.546***<br>(0.611) |
| Intercept 2                       | -1.816***<br>(0.543) | -1.624**<br>(0.545)  | -1.378*<br>(0.561)   | -1.380*<br>(0.610)   |
| Pseudo R <sup>2</sup>             | 0.082                | 0.084                | 0.088                | 0.092                |
| N                                 | 2971                 | 2971                 | 2971                 | 2775                 |

NOTE.—Standard errors in parentheses; \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$

people tend to feel less healthy when they grow older. Furthermore, keeping a mainstream lifestyle (for example, staying married and being employed full-time) seems to keep one fit. Apart from that, the results of Model 1 point to a gender advantage in health for men, although the effect is marginally significant. This is consistent with findings of gender inequality in health indicated by previous studies (Zheng and Zeng 2016).

Model 2 provides a test of our hypothesis that people's perception of health is affected by their class positions. As anticipated, being in the middle class, either in the core middle or semi-core middle class, significantly boosts

one's health status. Living in metropolitan areas, the distinction between the middle class and those in less advantaged class positions may mean whether or not one has access to health care resources that often are attached to occupations and income. On the other hand, I may also understand middle class positions are more likely to be associated with a healthier lifestyle or work environment. At the same time, I may notice that all the significant effects of personal attributes that are found in Model 1 remain significant when class is added, albeit of a smaller magnitude.

Model 3 reveals the relationship between social capital and self-reported health. The results, however, do not support our Hypothesis 2, i.e. the size of social networks and network diversity positively affects people's health status. Contrary to our hypothesis, low-status social network is the only social capital measure in Model 3 that is positively associated with health. At first glance, the results are hard to interpret. Yet, this is to some extent consistent with what Zhao (2008) found regarding the impact of network size on health. Comparing the rural sample with urban sample, Zhao (2008) indicated that while social networks exert a crucial impact on rural residents' health, the effect of network size and structure is markedly less significant for urban residents. It is important to note in Model 3 that, when social capital variables are included, class still matters, while the marginal positive effect of being male no longer remains.

It is also important to note that I have used household income as one of the defining criteria for middle class. Having confirmed the impact of class, I turn to Model 4 to reexamine the effect of education and individual income on self-reported health, since these two variables are closely connected to one's class position. From the results, I can see that although education does not play a role in determining one's self-reported health, earning an income above the median level strongly affects people's assessments of their own health. When social background variables are all controlled for, a low-status network is still positively associated with health status. However, it is pertinent to note that, compared with the strongly significant impact of advantaged class positions as well as individual income, the effect of social networks on health is merely moderate.

In sum, the results I find in Table 2 suggest that what function as crucial social determinants for health are those that are closely linked to access to health resources and a quality lifestyle. Moving on from here, do class and social capital affect people's social attitudes in the same way? And how is health associated with people's perceptions of fairness? The next section reports what I find regarding Hypotheses 3-5.

*Class, social networks, health, and perception of fairness*

Table 3 presents the results from a set of ordinal logit regression models on perceptions of fairness. Like Table 2, I start off by examining the general effect of social demographic characteristics. Of all the personal attributes included in Model 1, however, marriage is the only variable that shows a significant association with perceptions of fairness, confirming the positive meaning of marriage in Chinese society.

In Model 2, I test Hypothesis 3. In order to probe into the differences within the middle class, I have added the four-way class variable to distinguish the core middle class and semi-core middle class from the marginal middle class. From the results, I can see that among the socio-economic-demographic characteristics being examined, nothing seems to matter except people's class positions. Compared with the non-middle class, the entire middle class is significantly more likely to perceive the society as a fair one. The coefficients for the class effect in Model 2 indicate that the core middle class, which makes up less than 10 percent of the class structure of our three cities under study, feels most contented with society.

Model 3 tests the impact of social capital on perceptions of fairness. Unlike what is revealed when social capital measures were included for the analysis of health, Model 3 reports positive associations among three out of the four social capital variables and people's perceptions of fairness. The more diverse one's high-status social network is, the more likely he or she is to consider society a fair one. Similarly, the greater one's network diversity, the better perception of fairness one is likely to report. In other words, building bridging capital helps boost one's confidence in society as a fair place. Meanwhile, civic participation also positively affects people's impression of social justice. As far as personal attributes are concerned, being a member of the core middle class is still significantly and positively associated with perceptions of fairness, whereas higher education is likely to reduce one's satisfaction with society in terms of fairness. This is consistent with some of the earlier findings on education's complicated role in determining social attitude (Li 2015).

To understand the relationship of health to perceived fairness, I add self-reported health status to Model 4. In addition, I also include the self-reported negative experience in the year prior to the SLCM survey. The results reconfirm the significant positive association between perceived fairness and the core middle class position, social capital (except low-status networks), as

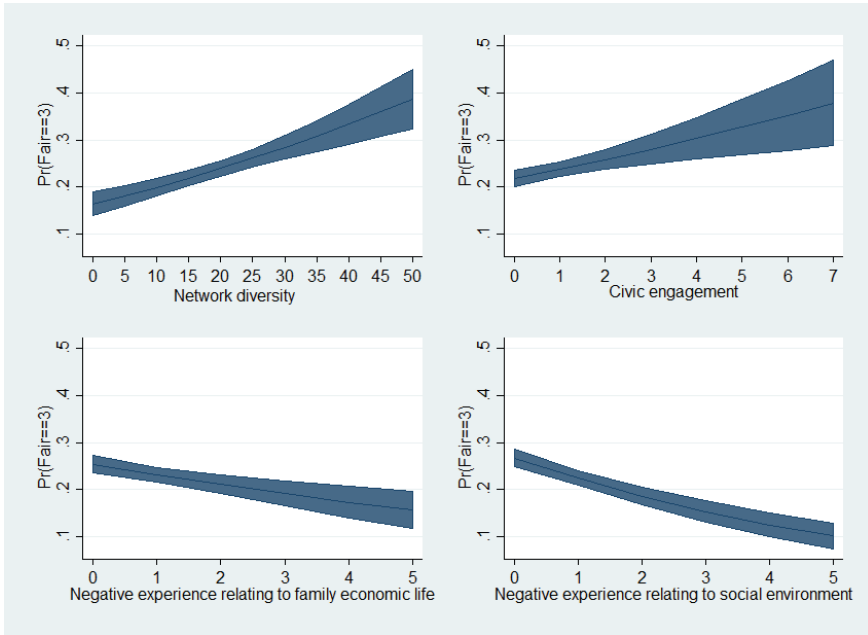
**TABLE 3**  
**ORDERED LOGIT REGRESSION MODELS ON PERCEIVED FAIRNESS**

|                                            | Model 1                        | Model 2           | Model 3                        | Model 4                        |
|--------------------------------------------|--------------------------------|-------------------|--------------------------------|--------------------------------|
| Age                                        | -0.039 <sup>†</sup><br>(0.023) | -0.020<br>(0.025) | -0.018<br>(0.025)              | 0.004<br>(0.025)               |
| Age squared                                | 0.000<br>(0.000)               | 0.000<br>(0.000)  | 0.000<br>(0.000)               | 0.000<br>(0.000)               |
| Sex (base=Female)                          |                                |                   |                                |                                |
| Male                                       | 0.046<br>(0.070)               | -0.019<br>(0.074) | -0.020<br>(0.075)              | 0.027<br>(0.076)               |
| Hukou (base=Agricultural)                  |                                |                   |                                |                                |
| Non-agricultural                           | 0.051<br>(0.088)               | -0.049<br>(0.099) | -0.028<br>(0.100)              | -0.082<br>(0.103)              |
| Marital status<br>(base= Divorced/Widowed) |                                |                   |                                |                                |
| Single                                     | 0.220<br>(0.186)               | 0.146<br>(0.192)  | 0.152<br>(0.192)               | 0.043<br>(0.195)               |
| Married                                    | 0.308 <sup>*</sup><br>(0.152)  | 0.245<br>(0.156)  | 0.235<br>(0.156)               | 0.148<br>(0.159)               |
| Employment status                          |                                |                   |                                |                                |
| FT employed                                | 0.065<br>(0.103)               | 0.176<br>(0.130)  | 0.203<br>(0.131)               | 0.164<br>(0.132)               |
| PT employed/Retired                        | -0.107<br>(0.131)              | 0.065<br>(0.145)  | 0.078<br>(0.146)               | 0.146<br>(0.147)               |
| Education (base=Junior secondary)          |                                |                   |                                |                                |
| Senior secondary                           |                                | -0.160<br>(0.107) | -0.198 <sup>†</sup><br>(0.108) | -0.238 <sup>*</sup><br>(0.109) |
| College                                    |                                | -0.179<br>(0.168) | -0.190<br>(0.170)              | -0.215<br>(0.172)              |
| University degree and above                |                                | -0.258<br>(0.171) | -0.319 <sup>†</sup><br>(0.175) | -0.358 <sup>*</sup><br>(0.177) |
| Income (base=Bottom)                       |                                |                   |                                |                                |
| Top quartile                               |                                | 0.014<br>(0.141)  | -0.084<br>(0.142)              | -0.270 <sup>†</sup><br>(0.146) |
| 2nd quartile                               |                                | 0.038<br>(0.124)  | -0.012<br>(0.124)              | -0.119<br>(0.127)              |

**TABLE 3**  
(CONTINUED)

|                                                 | Model 1            | Model 2                       | Model 3             | Model 4                        |
|-------------------------------------------------|--------------------|-------------------------------|---------------------|--------------------------------|
| 3rd quartile                                    |                    | -0.155<br>(0.116)             | -0.144<br>(0.116)   | -0.220 <sup>†</sup><br>(0.118) |
| Class (base=Non-middle class)                   |                    |                               |                     |                                |
| Core middle class                               |                    | 0.657**<br>(0.205)            | 0.422*<br>(0.210)   | 0.410 <sup>†</sup><br>(0.214)  |
| Semi-core middle class                          |                    | 0.417*<br>(0.162)             | 0.257<br>(0.165)    | 0.234<br>(0.168)               |
| Marginal middle class                           |                    | 0.230 <sup>†</sup><br>(0.124) | 0.146<br>(0.125)    | 0.130<br>(0.127)               |
| Network diversity                               |                    |                               |                     |                                |
| High-status networks                            |                    |                               | 0.030*<br>(0.015)   | 0.035*<br>(0.015)              |
| Low-status networks                             |                    |                               | -0.020<br>(0.022)   | -0.024<br>(0.022)              |
| Network diversity                               |                    |                               | 0.021***<br>(0.004) | 0.024***<br>(0.004)            |
| Civic engagement                                |                    |                               | 0.092**<br>(0.032)  | 0.116***<br>(0.033)            |
| Self-reported health (base=Fair/Poor)           |                    |                               |                     |                                |
| Good                                            |                    |                               |                     | 0.185<br>(0.123)               |
| Excellent                                       |                    |                               |                     | 0.346**<br>(0.125)             |
| Negative experience                             |                    |                               |                     |                                |
| Family economic negative experience             |                    |                               |                     | -0.125***<br>(0.035)           |
| Negative experience relating to external causes |                    |                               |                     | -0.239***<br>(0.034)           |
| Intercept 1                                     | -1.055*<br>(0.489) | -0.570<br>(0.537)             | -0.030<br>(0.551)   | 0.163<br>(0.566)               |
| Intercept 2                                     | 0.662<br>(0.489)   | 1.163*<br>(0.538)             | 1.725**<br>(0.552)  | 1.969***<br>(0.568)            |
| Observations                                    | 2976               | 2781                          | 2781                | 2770                           |
| Pseudo R <sup>2</sup>                           | 0.003              | 0.007                         | 0.014               | 0.033                          |

NOTE.—Standard errors in parentheses; \*  $p < 0.05$ , \*\*  $p < 0.01$ , \*\*\*  $p < 0.001$



NOTE.—Based on the results of Model 4, Table 3.

FIG. 4.—Predictive margins with 95% CI for the effects of network diversity, civic engagement and negative personal or family experience on perception of fairness

well as the negative impact of higher education. As for the impact of health, although ordinary self-assessment of health does not show a significant effect, feeling oneself in excellent health significantly enhances one's perception of fairness. At the same time, I can see that people's satisfaction with society can be significantly harmed by negative experience, either family-related or social-related. To clearly visualize the impact of social capital measures and negative experience, Figure 4 presents the marginal effects of network diversity, civic engagement and the two types of negative experience.

## Conclusion

Based on the most updated survey data of the three megacities in China, this article has examined social determinants of both self-reported health and perception of fairness. The analysis has built a link between health inequity

and people's perceptions of their social environment. In terms of contribution of empirical evidence, I find that while class has emerged as the strongest determinant of urban people's self-assessed health, social networks and civic engagement play a significant role as they affect people's perceptions of how fair our society is. I also emphasize that in the burgeoning academic and policy discussions of the middle class in China, it may be risky to view the middle class as a homogeneous social group that share values and socio-political attitudes. Through the analysis in this article, I see that the middle class in urban China is composed of individuals of differing social and economic situations. Moreover, their perception of the society and other social attitudes vary depending on their actual social positions, e.g. how central or marginal they are in the middle class. Given the wide variety of definitions applied in academic and policy research on the middle class, one implication is that the middle class be viewed as a heterogeneous share of the population, each group having their own actual needs and attitudes.

Another implication of this study lies in the link it builds among health inequality, social capital and perception of fairness. Much of the existing literature on health inequality in China is focused on urban-rural disparity, which is mainly a consequence of uneven distribution of wealth and health resources. With the increasingly expanding population and complicated demographic structure in megacities such as Beijing, Shanghai and Guangzhou, the regional and urban-rural inequality in health may gradually turn into health inequity within urban areas. By establishing the connection between health and perceptions of fairness, this article argues that health inequality is an issue that bears political significance and may affect social safety. While the middle class expands in urban areas in China, sufficient attention should be paid to the simultaneously widening class gap in health outcomes, and, in turn, the possible social outcomes it can lead to. Our findings of the positive effects of particular types of social capital imply that policies such as community development and those that may generate opportunities of boosting individual and community social capital may contribute to overall city development.

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