THE CONCEPTUAL AND EMPIRICAL UTILITY OF SOCIAL CAPITAL FOR PUBLIC HEALTH

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Abstract

This thesis evaluates the utility of 'social capital' for public health in four dimensions (communication, explanation, practice and measurement) and at two levels (macro and micro), using interviews with public health workers and a theoretical analysis of social capital. It concludes that the concept is potentially useful for public health but that there are limitations to its utility, arising from the presence of two competing discourses or world views identified in the social capital literature: the rational choice discourse and the political economy discourse.

This thesis argues that although social capital is widely perceived to have rhetorical leverage in macro-level policy debates, its contested meaning draws into question the value of any consensus built on the glossing over of different world views. The concept has no value for communication at the micro level.

The rational choice theory of social capital appears useful for explaining the social determinants of health although it does not adequately account for the power structures which shape and constrain access to social capital, and it undervalues many aspects of social relationships. The political economy approach is more useful in these respects but is far more complex and difficult to quantify. It is unclear whether either of these theories adds much value to the existing literature which social capital tends to eclipse.

The concept has limited value for public health practice, as the dual world views embedded in it can be used to support widely varying policy directions. It is also limited by its inability to describe the dynamics of change or to identify levers for initiating change.

The meaningfulness of social capital indicators is compromised by the reductionism of the rational choice paradigm. The political economy

discourse renders the development of quantitative indicators far more problematic but may be useful for informing qualitative research.

Statement of Authorship

Except where reference is made in the text of this thesis, this thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

A preliminary report of the material presented in Chapter 3 was published in the *Health Promotion Journal of Australia*, 1999, Volume 9, No. 3, pp. 183-187.

No other person's work has been used without due acknowledgment in the main text of the thesis.

This thesis has not been submitted for the award of any degree or diploma in any other tertiary institution.

The research procedures reported in the thesis were approved by the La Trobe University Faculty of Health Sciences Human Ethics Committee.

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Chapter 1: Public Health Interest in Social Capital

The aim of this thesis is to evaluate the concept of social capital for explaining the historical dynamics which create ill health, for understanding current patterns of health and illness and as a strategic target of health development programs and policies. The utility of the concept of social capital for public health is evaluated using a theoretical analysis of the social capital literature and interviews with public health policy makers and researchers.

Chapter 1 traces the emergence of the concept of social capital and its rising popularity in public health policy making, practice and research and explores the contemporary usage of social capital in public health in four broad areas. The chapter concludes with a discussion of the contested meaning of social capital and concerns with its usage in public health.

1.1 The emergence of the concept of social capital

Social capital is a notion that has increasingly gained currency over the last decade as a means of describing the value of social resources which cannot be easily measured in economic terms.

The concept gained currency in America after Robert Putnam used it to explain the differential success of democratic institutions in Italy, in his book *Making Democracy Work* (1993). The terminology of social capital quickly gained currency and is now commonly used in a range of different disciplines, spheres of public life and policy arenas. Eva Cox popularised the concept in Australia, when she introduced it in the 1995 Boyer Lectures on Radio National, in a series of lectures entitled *A Truly Civil Society*.

There is no commonly agreed definition of social capital, but all theorists seem to agree that social capital is a resource which resides in social

networks, and can be transformed into something of use (Wall et al, 1998: 304, Cox and Caldwell, 2000). Putnam's definition is perhaps the most generally accepted and used definition. Putnam (1993: 167) defined social capital as "…features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions."

The capital metaphor implies that social processes and relationships constitute an asset which can accumulated, stored and used to generate a flow of resources (Wall et al, 1998: 302). Like economic capital, it requires investment; there are costs involved in generating and maintaining social capital in terms of time and labour (Hawe and Shiell,2000: 873). The term 'capital' also suggests that social resources facilitate the production of a public good; something which is essential for the well-being of societies.

1.2 Rising interest in social capital in public health circles

The concept of social capital is being used more and more commonly in public health policy, practice and research. When work began on this project in 1997, many public health workers in Australia had never heard of the concept, and very few had a working knowledge of it.

The first empirical data linking health and social capital per se was published in the *American Journal of Public Health* in 1997 (Kawachi et al). Four years later, the term has become part of public health lexicon. Many seminars and conferences are structured around the theme of social capital. Social capital is now explicitly used as the basis for many funding programs and there are even health promotion programs structured around building social capital.

Despite often voiced concerns about the use of the concept of social capital in public health (Labonte, 1999; Baum, 1997; Leeder and Dominello, 1999), its popularity appears to be increasing.

1.3 Reasons for increasing interest in social capital

Preliminary analysis of contemporary usage of the term 'social capital' in public health discussion and commentary suggested four broad ways in which social capital is being used. These were as follows:

- **As rhetoric:** It seems to offer potential for capturing the attention of politicians and economists (Leeder and Dominello, 1999);

- **As explanation:** A number of commentators have suggested that it promises new insights into the relationship between the social environment and health (Leeder and Dominello, 1999; Baum, 1997; Legge, 1999);

- **To inform public health practice:** Interest has been expressed in its potential for explaining and supporting public health practice (Labonte, 1999: 431); and

- **To contribute to the development of indicators:** Social capital raises the possibility of developing better indicators of the social level outcomes of health development policies and programs (Legge, 1999).

1.3.1 Social capital as rhetoric

The concept of social capital focuses attention on the links between health and social relationships. For most researchers, practitioners and policy makers in areas of public health such as health promotion and primary health care, it is well-accepted that social relationships, both

between individuals and between groups in society, are vitally important to health. In a society increasingly dominated by economic rationalism and neo-liberalism, however, this has become a point which needs to be made (Borthwick, 1999: 161). As Baum et al (2000: 252) point out:

> Social capital has provided an opportunity to look beyond the funding demands of community structures to consider the contribution they make to the building of healthy communities, and the benefits these offer to all aspects of society.

Speaking about social goods (including social relationships) in terms of capital, which implies that they have productive value and are worth investing in, may be strategic in the current political environment to draw the attention of politicians and policy makers toward the conditions which foster healthy populations and communities.

Lomas (1998) suggests that using the concept of social capital may also be strategic in the public health field, which is dominated by individualistic, biomedical approaches (see also Diez-Roux, 1998).

Despite the interest focused on using social capital rhetoric, concerns have increasingly been expressed in public health circles about the consequences of adopting this concept (Labonte, 1999, Baum, 1997, Leeder and Dominello, 1999).

1.3.2 Social capital as explanation

Social capital may well represent an important explanatory construct for understanding the distribution of health and illness.

There has been a resurgence of interest in recent times in the social determinants of health. Much of this renewed interest has focused on the widening of inequalities in health in spite of overall population health improvement (Hawe et al, 1997: 30).

Epidemiological studies in the 1970's – 80's demonstrated a strong relationship between socioeconomic status and health (see for example, Townsend and Davidson, 1982; Broom, 1984; and Broadhead, 1985).

In the last few years there has been renewed interest in the effects of income inequality on population health (see Wilkinson, 1992; Lynch and Kaplan, 1997; Kennedy et al, 1998; Kennedy et al 1996; and Judge et al, 1998). Evidence is accumulating that individual income alone cannot explain the link between income inequality and health differentials across societies. This has led to a search for other explanations.

Richard Wilkinson's (1996) controversial book, *Unhealthy Societies: The Afflictions of Inequality*, argues that it is relative inequality rather than absolute income level which is most closely related to mortality (in rich countries). Wilkinson (1996) observed that among developed countries, more egalitarian societies have better health, and that societies which are both egalitarian and healthy are also more socially cohesive.

Social capital is one construct which has been posited as an explanation for this observed relationship (Wilkinson, 1996, Kawachi et al, 1997). Kawachi et al (1997) produced the first empirical evidence linking social capital with mortality. Strong cross-sectional correlations were found between indicators of social capital (group membership and trust) and mortality rates between U.S. states, after adjusting for state median income and poverty rates. The study concluded that social capital mediates the effect of income inequality on health (Kawachi et al, 1997). In a further study, Kawachi et al (1999) used the same indicators to demonstrate a relationship between social capital and self-rated health, after adjusting for individual socio-economic status.

There has been vigorous debate in the literature about the utility of this particular concept for understanding the social determinants of health (see, for example, Wilkinson, 1997; Muntaner and Lynch, 1999;

Wilkinson, 1999). Some researchers have argued that the link between income inequality and health is the result of material deprivation resulting from systematic underinvestment in social infrastructure, rather than psychosocial factors and perceived inequality (Muntaner and Lynch, 1999; Kaplan et al, 1996).

Rising interest in social capital as an explanatory construct is part of a broader movement in public health away from individualistic theories towards theories which aim to make sense of contextual and macro-level determinants of health:

> Critical reflection on our methods and theories is mounting in part because of evidence that higher-order variables, properties of context and the relations that arise within them may have independent effects on health and well-being (Hawe, 1998).

Theories explaining the relationship between 'the social' and health abound. Initially, the literature explaining social determinants of health tended to focus on either material factors or cultural/psychological factors. Materialist theories explain health differentials in terms of the unequal distribution of material resources (Townsend and Davidson, 1982: 114). Cultural and psychosocial theories explain health inequalities in terms of differences in beliefs, attitudes and behaviour between social groups, such as consumption patterns, lifestyle and use of preventive services (Townsend and Davidson, 1982: 118).

Later theorising has given greater recognition to the complexity of the relationship between behavioural and structural factors. There are many theories which have been found useful for understanding the social determinants of health. Concepts such as alienation, powerlessness, and locus of control (see for example Seeman, 1959, 1975; Wallston and Wallston, 1978; Wallerstein, 1992) have helped us to understand how structural and psycho-social factors work in concert to shape people's health and life chances. A thorough review of this literature is

beyond the scope of this thesis. Hawe and Shiell (2000), however, give a comprehensive overview of the multitude of ways in which social relationships and the social environment have been theorised and measured.

The key question is whether the concept of social capital is able to illuminate further the relationship between social processes and health in a way which adds value to existing theories.

1.3.3 Social capital in public health practice

Social capital is seen as potentially useful as a strategic construct (or intermediate objective) for planning public health policies and programs.

Social capital has been hailed as "...one important new framework for organising our thinking about the broader determinants of health and how to influence them through community-based approaches to reduce inequalities in health and well-being" (Gillies, 1998: 99).

Whether social capital is useful for informing practice depends very much on its value as an explanatory framework. If it does not illuminate exactly what it is about social relationships and structures that leads to better health, the concept will not be useful as a guide to action.

The sociological concepts of alienation and powerlessness, as mentioned above, have led to the strategies of empowerment and community development which have been demonstrated as successful in improving the health of disadvantaged people (Wallerstein, 1992; Wallerstein and Bernstein, 1988):

> Empowerment becomes the avenue for people to challenge their internalized powerlessness while also developing real opportunities to gain control in their lives and transform their various settings (Wallerstein, 1992: 198).

Whether social capital can similarly lead to effective strategies for social change, however, remains unclear.

If social capital is to be truly useful in the public health sphere, it needs to be more than simply rhetoric. The key questions here are: Does it assist us in creating the conditions for better health? Does it suggest a clear course of action?

1.3.4 Social capital indicators

Increasing emphasis on outcomes as the basis for resource allocation has lead to a search for ways to measure the outcomes of health policies and programs.

The health outcomes of public health policies and programs which address the social determinants of health are often difficult to measure, as they are not simply improvements in the health status of individuals, but also changes in the capacity of communities and populations to work cooperatively towards better health.

In the absence of useful indicators for determining the impact of public health policies and programs on the social and cultural determinants of health, funding agencies have had to use measures of individual health status instead.

A review of the published literature in health promotion found that evaluations overwhelmingly used individual behaviour change as the outcome measure (Gillies, 1998: 114). There is a well-recognised need for indicators to measure community level effects rather than just aggregating individual outcomes:

> Indicators for success which focus only on benefits for individuals cannot capture adequately the extent of the impact of the many and varied collective, collaborative

> health promotion initiatives, alliances or partnerships currently underway around the world (Gillies, 1998: 99).

Where accepted techniques of outcome measurement and economic evaluation are not adequate for measuring the outcomes of public health programs and policies, they may be undervalued and under-resourced (Legge, 1999: 117, Shiell and Hawe, 1996: 243).

There has been some interest in social capital as the basis for 'intermediate indicators'. Where health outcomes are not demonstrable for health development programs, one argument is that intermediate indicators can be used instead (Nutbeam, 1998: 29).

Notions of social capital have been at the centre of a call for the development of better social and health indicators – indicators which reflect the health of society in more than economic terms (see for example, Cox, 1998).

A number of instruments have now been developed for measuring social capital. At the time these interviews were conducted, there were only two published studies which measured social capital (Putnam, 1993 and Kawachi et al, 1997).

Putnam (1993) used several indicators of the 'civicness' of regional Italy. He measured the 'vibrancy of associational life' (ie. the number of groups, clubs and organisations), participation in public life (by newspaper readership), concern for public issues (by turnout in referenda), and preference voting, which was an indicator of a lack of social capital (Putnam, 1993: 91-4). These indicators are all measured as features of communities, rather than individuals.

Kawachi et al (1997) used existing data on social trust and organisational membership from the General Social Survey to measure social capital in their study of the relationship between social capital and

mortality in the USA. The civic engagement component of social capital was measured by the number of groups and organisations that people belonged to. The social trust component was measured using three survey questions: “Do you think most people would try to take advantage of you if they got a chance, or would they try to be fair?”, “Generally speaking, would you say that most people can be trusted or that you can’t be too careful in dealing with people?” and “Would you say that most of the time people try to be helpful, or are they mostly looking out for themselves?” (Kawachi et al, 1997). These sorts of measures, derived from secondary sources and aggregated to represent features of societies, have been widely criticised for their individualism and lack of conceptual soundness (Diez-Roux, 1998; Stone, 2001).

More recently, there has been a great deal of international research conducted to develop indicators and instruments for measuring social capital. Many national surveys now include measures of social capital (see for example, Rose, 2000 and Health Development Agency, 2001).

The World Bank has also generated a range of projects to define and measure social capital, which are using increasingly complex methodologies including ‘…quantitative methods in formal research designs with use of control groups, econometric analyses calling on instrumental variables and principal component approaches, as well as case studies, qualitative and inductive methods’ (World Bank, 1998).

For example, the Social Capital Assessment Tool (Krishna and Shrader, 1999) uses a community profile based on group interviews, household surveys, and organisational profiles to build up a picture of the social capital available to communities.

A number of Australian organisations, such as the Centre for Australian Community Organisations and Management and the Australian Institute of Family Studies have developed measures of the local level social

capital of communities and neighbourhoods (Onyx and Bullen, 1997, Stone, 2001).

In the public health field, there have been a number of studies undertaken which measure local level social capital in relation to health, such as the Adelaide Health Development and Social Capital Project (Baum et al, 2000), which explored the relationship between community participation, health and social capital in the western suburbs of Adelaide. This study used four different methods drawing on both individual and community level data including a mailed survey, in-depth interviews, a survey of community groups and organisations and case studies of some of these groups.

There are, however, persistent concerns about the adequacy of the concept of social capital as a basis for the development of indicators and outcome measures.

1.4 Conclusion

Despite the growing popularity of the concept of social capital in public health circles, many commentators have noted the problematic nature of the concept and expressed concerns about the utility of the concept in public health (Leeder and Dominello, 1999, Labonte, 1999, Baum, 1999). These concerns seem to centre around the problems with social capital theory itself and also with the uses to which the concept has been put. There are many different definitions and explanatory frameworks employed in speaking about social capital. Often these are not explicit (Wall et al, 1998: 302). As a consequence, the concept has been put to very different uses depending on the meaning ascribed to it by the user (Wall et al, 1998: 300). The way in which it is often used, however, assumes a common understanding of the meaning of social capital. A number of commentaries in the public health literature have pointed out the dangers involved, particularly its potential misuse

(Labonte, 1999; Leeder and Dominello, 1999; Paul, 1998; Baum, 1999; Erben et al, 1999).

Several authors, however, point out the heuristic value of the concept for stimulating debate and furthering understanding of the relationship between social networks and the health of communities and societies, and caution against abandoning the concept prematurely (Wall et al, 1998: 301; Flora, 1998: 503, Leeder and Dominello, 1999: 429). There is clearly a need to evaluate the utility of the concept for public health.

Chapter 2: Methodology

This chapter describes the project goal and objectives, data collection and data analysis.

2.1 Goal and Objectives

The goal of this research project was to support public health strategies by contributing to a clearer understanding of the social determinants of health, and therefore contributing to developing more effective policy and program strategies and better methods to measure outcomes and evaluate different public health strategies.

The objectives were:

- To evaluate the conceptual and empirical usefulness of social capital and social capital measures from the perspectives of public health policy makers and researchers.

- To evaluate the usefulness of the concept of social capital:

(i) for describing historical pathways to present patterns of ill health;
(ii) as a social level construct which helps to make sense of current patterns of health and illness; and
(iii) as a strategic target for policy, programs and management in a social change process towards better health.

- To evaluate the potential of social capital as the basis for creating indicators for measuring the social level effects of public health policy and programs.

2.2 Data collection

Two types of data were collected in this research project:

- Social capital literature and literature on the social determinants of health; and
- Interviews with public health researchers and policy makers.

2.2.1 Review of the literature

The review included:

- Examination of the origins of the concept of social capital in sociological and economic theory;
- The theoretical foundations of social capital;
- Insights offered by social capital theory into the social determinants of health;
- Other bodies of theory for understanding the social determinants of health; and
- Elements of social capital (trust, reciprocity and networks) and other ways of theorising them.

Databases scanned for references to social capital included AustHealth, Health and Society, Sociofile, Sociological Abstracts, EconLit and Medline. Indexes of online journals were scanned electronically for more recent references. The social capital database hosted by the World Bank website was also used in the bibliographic search. These databases were scanned again at a later date for any papers relating to social capital and health, social capital and indicators/measurement, social capital and theory.

The literature reviewed for the social determinants of health began with the social epidemiology and social psychology literature and diverged widely into the sociological and anthropological literature as leads were followed.

2.2.2 Interviews with public health researchers and policy makers

In-depth interviews were conducted with five public health policy makers and five public health researchers chosen according to the following criteria:
a) their policy/research work is concerned with the social determinants of health; and
b) the two groups of interviewees each collectively represents a broad range of perspectives and disciplines.

The interviews were semi-structured. An interview schedule was used to guide the interviews (see Appendix A). The questions on the schedule were open-ended and exploratory.

A pilot study was conducted with one researcher and one public health worker with policy experience. This study was used to refine the interview questions.

Profiles of the interviewees

Public health researchers:

Dr. Ron Borland
Dr. Borland is the Deputy Director of the Centre for Behavioural Research in Cancer at the Anti-Cancer Council of Victoria. He is a quantitative methodologist and behavioural researcher/social psychologist whose research interests centre around the effects of social structure on health behaviour and the ways in which risk factors are socially located.

Dr. Anne Kavanagh

Dr. Kavanagh is an epidemiologist with the Centre for Sex, Health and Society, La Trobe University, with interests in social theory and the social determinants of health.

Dr. Damien Jolley

Dr. Jolley is a social epidemiologist and quantitative methodologist from Deakin University.

Dr. Sandy Gifford

Dr. Gifford is an anthropologist and qualitative researcher from Deakin University with a particular interest in health inequalities. She is a teacher of qualitative research methods, and has extensive experience in public health, particularly in the area of blood-borne viruses.

Dr. Fran Baum

Dr. Baum is a public health researcher in public health and primary health care. She is Professor and Head of the Department of Public Health at Flinders University, South Australia and Director of the South Australian Community Health Research Unit.

Public health policy makers:

Dr. Ian Anderson

Dr. Anderson has extensive experience in Aboriginal health policy. His interests lie in the social determinants of health and in particular, the political and economic factors which shape the health of Aboriginal people.

Dr. Rob Moodie

Dr. Moodie is Chief Executive Officer of the Victorian Health Promotion Foundation (VicHealth). He has also been involved in research in refugee health care and Aboriginal health.

Dr. Ralph McLean

Dr. McLean is a rural health policy maker from the Victorian Department of Human Services, who also has a long history of involvement in the community sector and local government.

Dr. Vivian Lin

At the time of the interviews, Dr. Lin was a policy maker with the National Public Health Partnership. Her work primarily has a policy focus but she is also well-versed in social epidemiology.

Dr. Hal Swerissen

Dr. Swerissen has a long history in policy making. He is currently the Director of the Australian Institute for Primary Care, La Trobe University.

It is important to note that while the interviewees were categorised as either researchers or policy makers for the purposes of the research, in reality these categories were arbitrary and there was considerable overlap. Participants were told which category they were placed into for the interview but invited to comment on issues other than those associated with their research or policy making roles if they wished to.

Interviewees were contacted by telephone or email to request an interview. At this initial contact they were asked about their knowledge of social capital theory and were given the option of being sent a range of papers on social capital (including Bourdieu, 1986; Coleman, 1988; Harriss and De Renzio, 1997; Kawachi et al, 1997; Lomas, 1998 and Portes, 1998).

All interviewees were sent a chapter of Robert Putnam's (1993) book *Making Democracy Work*, entitled 'Social Capital and Institutional Success' to read prior to the interview unless they indicated that they had already read it.

Individual interviews were used so that the utility of social capital could be explored within the context of the participants' own work. Face to face interviews were conducted in the participant's workplace with the exception of one participant who was interviewed by telephone as distance did not permit a face to face interview.

Interviews were tape-recorded and transcribed. Interviewees were sent a copy of the transcript and permitted to edit it or add comments unless they indicated that they did not wish to.

Ethics

Ethics approval was granted by the La Trobe University Faculty of Health Sciences Human Ethics Committee.

Interviewees were asked for their permission to have their names included in written reports of the project's findings. They were sent an information and consent form (Appendix B) prior to the interview and asked to sign it at the time of the interview. They were given a copy of the information and consent form to keep.

2.3 Data Analysis

The social capital literature was analysed by looking for the theories, discourses or world views underpinning the theoretical origins of the concept. Two different (and contesting) discourses that reflect different world views were identified within the social capital literature and have been used in analysing the interview data.

Interview data were described using a cross-case analysis (Patton, 1990: 376). The research objectives were used as a basis for developing themes which were progressively refined during the data collection

process according to analytic insights and interpretations that emerged (Patton, 1990: 378). Care was taken to look for ‘alternative explanations and patterns that would invalidate initial insights’ (Patton, 1990: 379).

Using the theoretical analysis, an inductive thematic analysis of the interview data was performed:

> Inductive analysis means that the patterns, themes, and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis (Patton, 1990: 390).

The data analysis involved iteration between the theory and interview data, using the two discourses identified in the theoretical analysis, which were used as ‘sensitising concepts’ to interpret the data (Patton, 1990: 390).

Themes used to categorise the data were:

- Four 'dimensions of usefulness': communication, explanation, practice and measurement. These categories were largely indigenous (arising from the data itself).
- Two levels of analysis (macro - the level of whole populations or societies; and micro - the level of specific programs and communities); and
- Two underlying discourses or world views identified in the social capital literature.

The data analysis involved a process of working ‘back and forth between the data and the classification system to verify the meaningfulness and accuracy of the categories and the placement of data in categories’ (Patton, 1990: 403). Themes and categories were checked for inclusiveness following data analysis.

Dr. David Legge assisted with the analysis of the interview transcripts.

Chapter 3: Social Capital Theory and its Implications for Public Health

This chapter provides an overview of the social capital literature, focusing on the two main theorists, James Coleman and Pierre Bourdieu. The remainder of the chapter explores the theoretical foundations of these two contrasting concepts of social capital. The chapter argues that two underlying (and contesting) discourses can be identified in the social capital literature: the rational choice discourse and the political economy discourse.

3.1 An overview of the social capital literature

A thorough discussion of the history of the concept of social capital is beyond the scope of this thesis. Several good reviews of social capital appearing in the sociological literature cover this in detail (Portes, 1998; Wall et al, 1998; Flora, 1998; Harris and De Renzio, 1997). It is worthwhile, however, to briefly examine the origins of the concept and its trajectory in contemporary discourses.

Although the concept of social capital is often hailed as a new idea, the ideas behind it are not new. The conditions under which cooperation occurs, the benefits of group membership both for the individual and the wider society, and the characteristics of social networks have been the subject of investigation by sociologists since the beginning of the discipline (Portes, 1998: 2; Wall et al, 1998: 303-4). In spite of this rich history of thought, many of the ways in which the concept of social capital is now employed are significantly atheoretical.

Both Coleman and Putnam record that the economist Glenn Loury was the first to use the term social capital, although his treatment was not highly theoretical. Loury, an economist with particular interests in education and racial inequality, used the term social capital to describe

resources available to children from their family and community networks which assist in their development (Loury in Coleman, 1990: 300). Loury (1995: 103-4) also argued that disparities in social capital are important in creating and maintaining inequalities between groups, as are disparities in access to financial capital. Wall et al (1998: 302-3), however, point out that a limited definition of social capital has been used in economics for decades, to describe various collective forms of capital such as physical infrastructure and social expenditure by the state.

Pierre Bourdieu (1986) and James Coleman (1988, 1990), both educational sociologists, have been particularly influential in theorising contemporary concepts of social capital. Their definitions of social capital are deceptively similar. Bourdieu and Coleman both define social capital as a resource residing in social networks which accrues to its members (Bourdieu, 1986; Coleman, 1988, 1990). Social networks and forms of social exchange and obligation (such as reciprocity) are central ideas to both theorists. Their theories, however, are underpinned by very different perspectives.

Coleman's concept is based on rational choice theory, where social capital is seen as the aggregation of self-interested (and mutually beneficial) behaviour of interconnected individuals (Flora, 1998: 486). The assumption underlying Coleman's theory of social capital is that individuals are rational agents, who choose actions according to their goals and purposes; who accept the norms of reciprocity and the disciplines of trustworthiness in return for access to the resources of the wider community (Coleman, 1990: 13, 17).

Bourdieu's theory, in contrast, takes a more structural (or political economy) approach which examines how people's access to resources shapes (and is shaped by) their position in society (Wall et al, 1998: 306). The distribution of different types of capital, according to Bourdieu

(1986: 242), is shaped and constrained by social structures. These two theories are based on contrasting views of the relationship between the individual and society and the basis for social relationships. The contradictory nature of these two theories is not recognised in much of the later social capital literature.

Robert Putnam popularised the concept when he used social capital as an explanatory framework in his 1993 study of the performance of democratic institutions in Italy (Putnam, 1993). Putnam (1993) explored the relationship between social capital and the success of democratic institutions, using the Italian government's 1970 decision to implement regional governments. The governments in each region were virtually identical in organisation and resources, but the social and economic contexts were very different (Putnam, 1993: 10). Putnam (1993: 81, 83) found marked differences in institutional performance between the regions, with northern regional governments showing consistently greater effectiveness than those in southern regions. He found a poor correlation between the affluence of the regions and their institutional performance, but identified a strong relationship between institutional performance and the extent of participation in civic life (Putnam, 1993).

Social capital, according to Putnam (1993), is characterised by three inter-related, mutually reinforcing features: social trust, norms of reciprocity and networks of civic engagement. Social trust is a less direct form of trust than personal trust between individuals, and enables people to predict the actions of others (Putnam, 1993: 171). Social networks, or 'networks of civic engagement', enable trust to diffuse through communities by making information available about reputations (Putnam, 1993: 169, 174). Networks of civic engagement include membership of a range of political and non-political associations, which provide horizontal interactions amongst community members (Putnam, 1993: 173). Norms of generalised reciprocity entail '...a continuing relationship of exchange that is at any given time unrequited or

imbalanced, but that involves mutual expectations that a benefit granted now should be repaid in the future' (Putnam, 1993: 172). Such norms are both created within and reinforced by social networks (Putnam, 1993: 172). Networks restrain opportunism by increasing the 'potential costs to a defector in any individual transaction' (Putnam, 1993: 173).

Putnam's (1993) analysis draws heavily on Coleman's concept of social capital with its ideas of individual agency. Putnam, however, incorporated an extra dimension of functionalist thought to make claims about the nature of cooperation and about social capital as a 'public good' (Wall et al, 1998: 313). The social capital literature which follows Putnam's analysis is heavily influenced by functionalist notions of social cohesion with its overtones of consensus, social stability and harmony.

Some commentators have argued that the theories of Coleman and Bourdieu are essentially similar in their focus on social capital as a resource that accrues to individuals, in contrast to Putnam's theory which applies the concept on a far broader scale, where social capital is seen as a public good for the benefit of regions or nations (Winter, 2000; Cox and Caldwell, 2000). Whilst it is recognised that Putnam applied the theory on a different scale, this chapter will argue that there are distinct and contesting discourses underlying Coleman's and Bourdieu's perspectives which are not well recognised in the literature.

Putnam's analysis has been criticised on both theoretical and methodological grounds, including his failure to sufficiently take into account structural and environmental differences between the regions of Italy (see Levi, 1996; Sabetti, 1996; Lenci, 1997 and Harriss and De Renzio, 1997). Critique also focuses on the role of participation in non-political associations such as soccer clubs and choirs in creating social capital. It is unclear how these networks contribute to social change at a broader level (Levi, 1996: 48). The power of communities, even if rich in social capital, to change the structural constraints which affect their lives may be limited (Levi, 1996: 49).

In spite of these criticisms, Putnam's treatment of social capital has captured the imagination of people from a broad range of areas (Paul, 1998, 54). Most of the current usage of social capital draws on Coleman's and Putnam's work (Labonte, 1999: 431).

The concept of social capital has undergone much theoretical refinement since Putnam's 1993 study. Much of this theoretical work has been stimulated by the World Bank. Some of this theorising has focused on distinguishing between sources and benefits of social capital (Portes, 1998) and defining different types of relationships which produce social capital (such as bonding, bridging and linking ties) (Woolcock, 2000). In most of this literature, however, the theoretical dichotomy discussed below is not acknowledged.

Putnam's analysis of social capital, and indeed much of the subsequent literature, suffers from the risks associated with Coleman's theory (Wall et al, 1998). Although Putnam's work is influential, this chapter will focus on Coleman and Bourdieu, two leading and contrasting theorists of social capital, and examine the assumptions and world views which underpin their theories.

3.2 James Coleman's concept of social capital

Coleman's concept of social capital is based on rational choice theory (Coleman, 1990). The key assumption of rational choice theory is that social relationships, structures and institutions are based on the instrumental rationality of individuals (Coleman, 1990, Elster, 1986). This assumption results in a number of vulnerabilities.

James Coleman's concept of social capital is modelled on Weber's theory of social action (Coleman, 1990: 13). Weber takes the position that social institutions are the product of the actions of individuals and

the interactions between them (Cheek et al, 1996: 110; Collins, 1986: 45). Weber takes the orientations of individual actors as a starting point in his analysis of social relationships:

> Action in the sense of subjectively understandable orientation of behavior exists only as the behavior of one or more *individual* human beings (Weber, 1968: 13).

Coleman (1990) interprets Weber's position as reducing social life to the actions or decisons of individuals. Coleman (1990: 2) explores the relationship between the individual and society by examining how the actions of individuals contribute to the functioning of society as a whole.

There are inevitable risks in using this starting point in the analysis of social structures and institutions (Hindess, 1987: 143). Many theorists argue that social life is comprised of much more than the sum of the actions of individuals (Hindess, 1987: 138; Warfield Rawls, 1992). Hindess (1987: 146) argues for a broader, more inclusive definition of the actor as 'a locus of decision and action', where actors can be groups, agencies and institutions where decisions are made and acted upon, as well as individuals. The decisions of these 'social actors' are not reducible to the sum of the decisions of the individuals of which they are comprised.

Rational choice theory explains collective action in terms of the 'maximising actions of individuals' (Green and Shapiro, 1994: 16), and does not acknowledge collective identity as a factor in decision-making processes:

> According to the principle of methodological individualism, there do not exist collective desires or collective beliefs (Elster, 1986: 3).

Some sociologists (for example Lenci, 1997 and Dawes et al, 1990) argue that rational choice theory is too limited to explain the nature of

cooperation, which often arises from a sense of group identity which overrides individual self-interest:

> Such identity – or solidarity – can be established and consequently enhance cooperative responding in the absence of any expectation of future reciprocity, current rewards or punishment, or even reputational consequences among other group members (Dawes et al, 1990).

The individualism of Coleman's concept means that he ignores the possibility of structural impediments to individuals' 'maximisation of utility'. The assumption is that people have the freedom of will to act as they choose, rather than choices being primarily determined by external forces (Coleman, 1990: 5, 17). It is concerning that the concept on which Putnam and most contemporary social capital theorists and researchers base their arguments '...ignores the socioeconomic and political influences which affect the accessibility of social capital' (Paul, 1998: 57). In this respect the rational choice concept of social capital fits quite comfortably with neoliberal discourses which emphasise individual responsibility for health.

Coleman's theory, and in fact much of rational choice theory, is based on Weber's idea of rationality. Weber distinguished between four ideal types of social action: instrumentally rational (zweckrational) action, value-rational (wertrational) action, affectual and traditional action. Weber describes the first two types of action as rational, because they are based on conscious reflection. (Weber, 1968: 25). *Instrumentally rational (zweckrational) action* is calculated, rational, purposive and goal-oriented (Weber, 1968: 26).*Value-rational (wertrational) action* is motivated by an ultimate value or belief. Value-rational action is '...determined by a conscious belief in the value for its own sake of some ethical, aesthetic, religious or other form of behaviour, independently of its prospects of success' (Weber, 1968: 25). This type of action is rational in the sense that it is a conscious, planned choice of action according to the ultimate value (Weber, 1968: 25), however it is not

goal-oriented in the same sense as instrumentally rational action, as fulfilling the value is, in itself, the goal (Cheek et al, 1996: 90). *Affectual action,* which is produced by powerful emotions, and *traditional action*, which is habitual, Weber describes as 'close to the borderline of what can justifiably be called meaningfully oriented action, and indeed often on the other side' (Weber, 1968: 25).

Weber was well aware of the limitations of his abstract typology. He notes that in reality, action is rarely totally rational, or totally oriented to one of these ideal types (Weber, 1968: 21, 26). Rather, social action is usually the product of a number of types, which may be in conflict with each other (Cheek et al, 1996: 92). Weber emphasized that many social problems involve conflict between ends and values, and are not amenable to the unproblematic application of instrumental rationality (Brubaker, 1984: 5). He cautioned against allowing instrumental rationality to dominate all spheres of social life at the expense of value-rational action, which he saw as critical for a healthy society (Cheek et al, 1996: 92). Interestingly, rational choice theory, although based on Weber's ideas, appears to have discarded Weber's cautions along with the subtle but important distinctions between types of social action.

Two fields of thought about rationality can be distinguished in the rational choice literature. The traditional narrow Hobbesian definition describes a choice as rational if it promotes the individual's self-interest (Frank, 1990: 91). The alternative more inclusive definition describes rationality as 'the efficient pursuit of whatever aims one has at the moment of deliberation and action' (Frank, 1990: 91). Accepting the second definition enables the labelling of any choice as rational provided it is the consistently preferred choice (Frank, 1990: 91; Sen, 1990: 29).

Coleman's theory of social capital is based on the second of these approaches, the idea that all action is instrumentally rational. Coleman (1990: 14) adapts the concept of rationality used in economic theory, in

which actors choose actions which will 'maximise utility'. Even if the action does not appear rational to the observer, Coleman (1990: 18) argues that in the actor's terms, it is always rational.

Rational choice theory has been criticised for its limited conception of rational action, narrow conceptions of human motivations and relationships, and the poverty of its theory in comparison with other bodies of theory within sociology and anthropology which provide a much richer understanding of the social world (Mansbridge, 1990: 11). It is questionable whether Coleman's concept of social capital is able to capture sufficiently the complexity and heterogeneity of the relationship between the social environment and health (Leeder and Dominello, 1999: 424).

An example of this is Coleman's notion of reciprocity as a rational contract between individuals seeking to maximise their self-interest. Elster (1990) argues that there are many motives involved in social exchange which cannot be explained in terms of the maximisation of utility, including love, duty and altruism. Many forms of giving are not motivated by (or even rationalised in terms of) self interest or expectations of reciprocity (Elster, 1990: 45). Every parent knows this intuitively. The resource intensive caring which parents invest in their children's futures cannot be explained in terms of expected future returns. Another example of exchange which is not easily accounted for by Coleman's explanation of reciprocity is blood donation, an autonomous gift given with no expectation of future return (Titmuss, 1970).

Coleman's and Putnam's analyses of social capital have also been criticised for their inadequate theorisation of trust. From a rational choice perspective, trust is treated as a commodity that lubricates economic exchange by reducing transaction costs, and is understood to be produced by the rational calculation of individual actors seeking to

maximise utility (Lenci, 1997: 11, Misztal, 1996). Trust and social exchange have been theorised in far more complex and less instrumental terms in the sociological and anthropological literature (for a review of the concept of trust, see Misztal, 1996). Mauss (1966) and Titmuss (1970), in particular, describe gift exchange in terms of its symbolic meaning; return of the gift is usually not consciously calculated or expected. The rational choice theory on which Coleman's concept of social capital is based ignores much of this rich existing body of theory.

The rational choice discourse of social capital is limited in its emphasis on individual choice and its failure to account for enabling and constraining social structures, its lack of recognition of group identity, and its narrow conception of social action as the product of instrumental rationality.

3.3 Pierre Bourdieu's concept of social capital

The French sociologist Pierre Bourdieu undertook the first contemporary theoretical analysis of social capital (Bourdieu, 1986). Bourdieu (1986) describes three different but inter-convertible types of capital: economic capital (money and property rights), cultural capital (education, cultural goods and qualifications) and social capital. Bourdieu describes social capital as:

> ...the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition - or in other words, to membership in a group - which provides each of its members with the backing of the collectivity-owned capital, a "credential" which entitles them to credit, in the various senses of the word (Bourdieu, 1986: 248-9).

Bourdieu is heavily influenced by both Weberian and Marxist sociological traditions. His analysis draws on Marxist ideas of social life as characterised by competition and conflict, shaped by social structures as well as individual agency (Wall et al, 1998: 307). Where he differs from

Marx, however, is in his rejection of Marx's economic determinism and his materialist portrayal of class (Wilkes, 1990; Mahar et al, 1990: 4). Bourdieu's understanding of the factors which shape people's position in society is more complex than that of Marx, and includes symbolic and personal facets of life which are more characteristic of Weber's thought (Wilkes, 1990: 109).

Bourdieu uses the three key interrelated concepts of *habitus*, *field* and *capital* in a theoretical framework which attempts to overcome the classic sociological dichotomy between structure and agency (Mahar et al, 1990: 21). Bourdieu perceives the social space as structured by *fields* of forces within which struggles for dominant positions take place (Mahar et al, 1990: 8; Wilkes, 1990: 129). The concept of *habitus* refers to personal qualities, dispositions, knowledge and understandings of the world, which although influenced by social structures, cannot be fully explained by them (Mahar et al, 1990: 10). Both field and habitus are intimately linked with capital. The distribution of capital shapes the struggles which take place in the field; particular habitus can increase or reduce access to capital, or even embody a form of capital in themselves (Mahar et al, 1990: 12-13). The theoretical framework within which Bourdieu introduces the concept of social capital is unique in accounting for the influence of both social structures and more personal, individual qualities.

Most importantly, Bourdieu's analysis includes an examination of the unequal distribution of the various types of capital according to power and the control of production. Bourdieu insists on the ultimate reducibility of other types of capital to economic capital (Portes, 1998: 4), although he notes that social capital is never entirely reducible to economic capital because there are transformation costs involved (Bourdieu, 1986: 252). Bourdieu's theory of social capital is clearly underpinned by a political economy perspective.

Economic capital is seen to be at the root of all the other types of capital, although the very purpose of these other types is to disguise this fact (Bourdieu, 1986: 252). Cultural and social capital are dependent on economic capital, as they require the investment of both time and money, although this is often indirect (Bourdieu, 1986: 250). For example, a collection of artworks (a form of cultural capital) requires the expenditure of economic capital; strengthening networks of connection requires time and possibly the giving of gifts (Bourdieu, 1986). These forms of capital are used by those in powerful positions in society to reinforce their access to resources. One's access to social capital can increase or reduce access to other forms of capital:

> Throughout, Bourdieu's emphasis is on the fungibility of different forms of capital and on the ultimate reduction of all forms to economic capital, defined as accumulated human labor. Hence, through social capital, actors can gain direct access to economic resources (subsidized loans, investment tips, protected markets); they can increase their cultural capital through contacts with experts or individuals of refinement (i.e. embodied cultural capital); or, alternatively, they can affiliate with institutions that confer valued credentials (ie. institutionalized cultural capital) (Portes, 1998: 4).

According to Bourdieu (1986: 256), people gain unequally from economic or cultural capital depending on how well they can 'mobilise by proxy' the capital of the groups to which they belong. Bourdieu's theory of social capital may therefore offer insights into how differences in people's ability to mobilise resources from social networks shapes their position in society. This analysis resonates with discourses of community development and social justice. Ron Labonte (1999: 432) highlights the role of community development as a strategy for helping disadvantaged people and communities to 'mobilise resources' and gain access to opportunities and information, as well as working with them to change the power relationships which create disadvantage in the first place.

3.4 Conclusion

Two competing discourses reflecting two different world views can be seen to underpin the concepts of social capital theorised by Coleman and Bourdieu. For the purposes of this research, we have labelled these discourses as the ‘rational choice discourse’ and the ‘political economy discourse’. The two underlying discourses in the social capital literature which this analysis describes are used to interpret the research findings presented in Chapter 4.

Chapter 4: Research Findings

Introduction

This chapter describes the findings from interviews with ten Australian public health workers (five policy makers and five researchers) in which they were asked about their opinions of the utility of the concept of social capital in the public health sector.

The data have been organised into four 'dimensions of usefulness', or areas of public health work in which social capital might prove useful. These dimensions are communication, explanation, practice and measurement.

Within each dimension of usefulness, the utility of social capital is considered at two levels of analysis: macro - the level of whole populations or societies; and micro - the level of specific programs and communities. The nature of social capital is qualitatively different at these different levels (Hawe and Shiell, 2000).

For each of these categories, the research findings have been analysed according to the two different (and contesting) discourses or world views underpinning the various theories of social capital which have been identified in Chapter 3: the rational choice discourse and the political economy discourse.

The rational choice discourse is implicit in the concept of social capital as it is most often used. The rational choice perspective is based on the assumption that people will cooperate if it is rationally in their best interests to do so. This perspective down-plays or ignores the role of economics and government in creating the conditions for a healthy society. The less prominent political economy discourse, in contrast,

situates the emergence of social capital within the political, economic and historical context. From this perspective, the distribution of social capital is intimately linked with the distribution of economic capital and shaped by many of the same forces.

For each dimension of usefulness, the utility of social capital has also been compared with pre-existing theories which have been found useful in public health.

The findings have not been analysed according to the 'jobs' of policy making and research, as both groups commented on the utility of social capital more broadly, rather than confining their responses to their areas of work. Responses, however, have been attributed to policy makers or researchers where appropriate.

Quotations from the interviews have been presented in italics. Ellipses have been used to indicate where text has been omitted for the purpose of clarity. Text in square brackets indicates where pronouns have been replaced by the term that they refer to.

4.1 The utility of social capital for communication

4.1.1 The utility of social capital for engaging in macro-level inter-sectoral policy debates

There was agreement among most of the interview participants that 'social capital' has rhetorical leverage which can be useful for inter-sectoral communication and policy advocacy. The majority of policy makers and researchers recognised the potential of social capital to capture the attention of politicians and economists by adopting the language of economics. As one policy maker said:

It's a good insight in a time when policy discourse is increasingly focused around economic rationalist ideas, so that it becomes a counter, and in that sense, a very good one, because it draws on economic concepts but resituates them, and that way, creates parallels in people's minds, particularly from the more conservative end of policy, with concepts and ideas that they're familiar with.

In the current economic and political environment, with the rising popularity of economic rationalism, conceptualising social relationships and structures in terms of capital has a certain currency:

If it has any value, it is a term that's probably recognisable by the economic rationalist...that is the kind of discourse that's controlling where the world is going…it actually seems like it must be worthwhile because it's capital, and…we live in a capitalist society, so capital must be good. So as a rhetorical debating term it might be a good idea.

Many of the public health workers interviewed believed that the concept of social capital is useful for drawing attention to the importance of the social environment for health. The value of this concept seems to be its focus on social relationships as crucial for healthy societies:

It focuses people's attention on the notion that the way we relate to each other has an impact on health.

As well as drawing the attention of policy makers from other sectors to the relationship between 'the social' and health, social capital may also attract public health researchers who have been taken with biological determinants. One researcher suggested that the emergence of debate about social capital has corresponded closely with, and to some extent stimulated, a refocussing of public health on the social determinants of health.

Several interviewees discussed the utility of social capital for raising the profile of community development in policy discourses, by re-packaging existing ideas in more attractive language:

…I'd see social capital as in the continuum of the development of notions of community development and investment in communities and participation…I think it's very useful in those terms.

To some extent the notion of social capital can be appropriated for increasing recognition of the social determinants of health and to support programs which address these. Ron Labonte (1999: 433) describes social capital as a Trojan horse, which can be packed with the meaning we choose to give to it. One researcher suggested that the reason for increasing interest in social capital in the health sector is partly pragmatic, as funding opportunities may be tied to research and programs which use social capital rhetoric.

There are, however, some significant limitations to the capacity of social capital theory to be appropriated for furthering public health aims. Its utility for meaningful communication is compromised by the presence of two opposing world views underlying social capital theory and rhetoric.

Social capital is a term which can have very different meanings according to the context and the theoretical basis (or lack thereof). Some interview participants found that the utility of social capital was doubtful or unclear:

… I think it's going to be one of those terms that means a whole lot of different things to different people, and thus, probably comes to confuse arguments…

Policy makers pointed out that people tend not to explain what they mean by the term, and common meaning may be assumed:

…people talk about social capital and they never talk about what they're talking about....And this is particularly dangerous in a policy sense, because policy itself suffers a lot from the production of concepts which can be very, very useful depending on their interpretation.

As people begin to use the term without understanding the implications and the different meanings with which it is loaded, it tends to lose its meaning and lend itself to misinterpretation:

...the danger is that it becomes empty of meaning, or that it's actually used in a way which is wrong, or arguable, or that doesn't reflect the intention, or what the person's trying to say.

…people construct it as something much more than what it might be, or people put different slants on it.

The danger in this, both policy makers and researchers warned, is that the rhetoric can be distorted or co-opted to support a conservative agenda. This is demonstrated clearly by the World Bank's treatment of social capital as a means of increasing economic productivity (Leeder and Dominello, 1999: 427). For example, one researcher said:

I think there's a danger of hopping on the bandwagon and playing into the hands of the World Bank, for example, where the World Bank is definitely using it as a cheap and easy way of not investing economic capital.

It is the rational choice perspective, in particular, which lends itself to misinterpretation. The individualism inherent in Coleman's concept of social capital sits comfortably alongside the discourses of neo-liberalism and economic rationalism, and it is arguable that this accounts for its broad appeal. For this reason, it can easily be subverted - it can and has been used to construct arguments justifying the withdrawal of state

support in favour of reliance on community resources, because it ignores the role of social structures and power relationships in creating inequality (Leeder and Dominello, 1999: 427). For example Lindsay Paul (1998) describes the potential for a discourse of social capital to be appropriated by politicians to shift the responsibility of caring of the frail and disabled onto the community.

The potential for social capital rhetoric to be interpreted in a neo-liberal light means that it is often not strategic for public health policy makers to adopt this metaphor. Policy makers reported that they need to be strategic in the way in which health issues are constructed in order to get them on the political agenda. They need to be able to engage with different sectors, establish a dialogue with diverse interests, and build coalitions. Issues need to be constantly re-framed to maintain their political currency:

…you've got to construct the policy discourse in different ways in order to make sure that some things stay on the agenda, and that you can actually move it forward rather than backward.

Two policy makers in particular questioned the rhetorical value of social capital. They expressed concerns that public health workers can allow themselves to become "pegged into a particular hole" by identifying too closely with particular theories or concepts. Using the language of social capital in policy debates is not always strategic; it depends very much on the policy discourses at any particular point in time:

…if you really want to have an influence then you have to learn the language of the people who are in power…to engage in the debate and to try and use the tools and the rhetoric…because that's the dominant policy paradigm at the moment.

Adopting a concept like social capital (where the meaning is contested and ambiguous) and using it in public policy arenas introduces the risk of being marginalised in policy debates:

…there's a deep suspicion about what it means in public policy areas…you start using that language and you're immediately marginalised… So what you end up doing is basically using language which is useful only for the converted.

The political economy discourse of social capital situates the generation of social capital within the political and economic context. Bourdieu's approach to social capital, with its analysis of power and structure, appears to offer promise in contributing to our understanding of how access to social resources shapes inequality. This discourse is more compatible with that part of the public health tradition concerned with empowerment and social justice. For these very reasons, however, Bourdieu's theory does not possess the same ability to capture the imagination of politicians and economists. Adopting this concept may mean losing some or all of the rhetorical power of the currently accepted meaning.

The challenge for policy makers who choose to adopt social capital rhetoric is to be very clear about the discourse they are drawing on when using the term. Some policy makers reported that clarity and precision are crucial in policy making. It is important to be able to describe the meaning of concepts:

...the thing about a good insight is protecting what's good about it. And if that insight becomes embedded within a concept that has a very diverse range of connotations, then you can lose the precision in your communication. And precision in communication is really important in policy.

Some public health workers have resolved the problem of the connotations attached to the term social capital by instead using the term “social connectedness”. The Victorian Health Promotion Foundation (VicHealth) has deliberately adopted this term for its more precise and less value-laden meaning. As one policy maker described:

...[social connectedness] reflects more what we’re really talking about…if you have someone to trust, to depend on, to talk to, a group to belong to, then your health is much better.

Some policy makers suggested using investment rhetoric rather than adopting the term ‘social capital’ exclusively, because it incorporates ideas of broader investment and focuses more on the role of government:

I think the language to use is the language of investment...I think that’s the language to use if you’re going to have an influence on policy at the moment, because that shifts the debate subtly away from just purchasing things, to the notion of investing in the infrastructure of society and building the capacity of society and so on and so forth.

4.1.2 The utility of social capital for facilitating micro-level communication with communities and individuals

None of the policy makers or researchers identified any benefits in using the concept of social capital to communicate with lay people or communities. The consensus was that social capital is not so good for facilitating communication between public health professionals and communities, as it does not reflect the diversity of people’s experiences and relationships.

Public health workers pointed out that to the lay person, social capital jargon tends to be incomprehensible and over-intellectualised.

Interviewees said that they need to take care to relate to people in their own terms. In some contexts, social capital jargon would be very incongruous and even alienating. For example, a rural health policy maker said:

It is almost oppositional to notions of effective and clear communication of ideas and principles to rural and remote communities.

Another policy maker commented that notions of social capital are hardly likely to inspire and politicise people. People are more interested in fundamental quality of life issues that are meaningful to them. Mainstream political approaches, he suggested, are more useful for driving health improvement.

4.2 The utility of social capital for explaining the social determinants of health

4.2.1 For explaining the macro-level relationship between social processes and the health of populations and societies

Participants drew attention to the need for better theories for exploring inequalities in population health:

There are so many unexplained differences in disease that we observe in our society, that we have to continually be looking for the causes...

Existing theories do not fully elucidate the pathways through which social differentials create inequalities in health. One social epidemiologist explained:

Trying to find...what is the mechanism whereby those social differentials give rise to...higher disease rates is a difficult problem…it's multi-

faceted. It's an area which is intriguingly complex, and difficult to work out.

In this context, any new theory that promises to illuminate the social determinants of health is worth exploring.

Much of the social epidemiology literature still reduces social determinants to the level of the individual and does not take the broader social context into account. There was interest among the interview participants in the potential of social capital to, as one interviewee said, 'bridge the political with the individual'.

Several participants believed that the concept of social capital may increase understanding of the effects of relative inequality:

...the social capital stuff is right in saying that societies with less relative poverty have better outcomes.

One researcher also found the concept useful for understanding how position in the social hierarchy affects health. He quoted animal research[1] that demonstrates biological mechanisms associated with social position:

...the determinants are largely to do with people's sense of their position in society. There's a huge amount of animal research which shows that subordinate animals in a group are much more stressed, much more likely to die early, suffer all sorts of consequences. So there are real biological mechanisms that you can fit onto human society.

[1] Sapolsky (1993) demonstrated that for primates, rank in the social hierarchy produces changes in the level of stress hormones, and it has been hypothesised that social position is also a predictor of stress in humans. Brunner (1997) found similar physiological and metabolic differentials in a hierarchy of white collar civil servants, which are believed to predict susceptibility to cardiovascular disease and a range of other diseases.

While some of the effects of relative inequality may be attributed to direct biological mechanisms, this researcher argued, there are also indirect effects that are mediated by behaviour such as smoking. These mechanisms are poorly understood, however it makes sense to understand them in terms of social capital. In this explanatory framework, social exclusion and 'failure to fit' are seen as risk factors, whereas:

There is social capital associated with having a social structure that gives you a clear position in it.

Whether or not these theories are found to be useful, most interviewees believed the concept of social capital is more broadly useful for locating determinants of health beyond the individual:

...it's actually saying something about the supportive social systems and institutions in which people live.

The emerging evidence on social capital seems to be indicating that the way people cooperate, the way they network, and the way they participate in society are all crucial to population health.

The predominant theoretical approach to social capital is surprisingly uninformed by much of the body of sociological literature. One policy maker commented:

…the other thing I'm conscious about the social capital debate in public health is that it's so atheoretical. It's almost like it lives outside of social theory. You would swear these people had never heard of a Marxist or neo-Marxist analysis, or the concept of power or structural interests…

In particular, noted another participant, the concept of social capital is impoverished by a lack of recognition of Bourdieu's theory:

I think forgetting Bourdieu's stuff is really a real risk, and not reading Durkheim or some of the older studies.

The concept of social capital based on Coleman's and Putnam's theories fails to adequately account for the 'bigger picture' political and economic dimensions which shape the health of populations. The concept of social capital which has gained currency sits comfortably within the sort of individualistic world view which has given rise to neoclassical economics.

Participants questioned the functionalist assumptions of consensus upon which much social capital theory seems to be based:

…what we perceive as the betterment of the community might not be the same for everybody. And so what you perceive as being a move toward the betterment of community may not be the same as the way I perceive it. So it's difficult for there to be a rational overview of gains in community wealth, commonwealth, if we can't agree what's the currency.

There's a sense that there's either an absolute value on sameness, or an absolute value on heterogeneity. And I get nervous when there's the notion of an ideal community.

One of the drawbacks associated with using the concept of social capital is that it tends to focus exclusively on the positive effects of sociability (Portes, 1998). Two of the researchers criticised the concept for this reason, noting that some groups which could arguably be seen to have high social capital (such as Nazi Germany) can have negative effects on society. One researcher situated this danger of social capital firmly within the middle class, individualistic paradigm upon which popular notions of social capital are based.

For Bourdieu, by contrast, the so-called ‘dark side’ of social capital is less problematic (Hawe and Shiell, 2000: 874), since he conceived social capital as disguised economic capital, which is distributed according to power inequities (Bourdieu, 1986).

Both policy makers and researchers cautioned that a concept based on individualistic notions of rational choice may lead to a separation between the economic and the social. The problem becomes defined as improving the health of poor communities by fostering spontaneous cooperation, without creating necessary social infrastructure or re-distributive measures. The responsibility for change is shifted from governments to communities and individuals.

The political economy discourse of social capital, with its insights about the interchangeability of different types of capital and the ultimate reducibility of social capital to economic capital, may be more useful in terms of understanding the social context of health and illness.

Both policy makers and researchers stressed the importance of economic factors in shaping health and believed that the social determinants of health could not be understood outside of the economic and political context:

...without investment of other kinds of capital, social capital will not alleviate poverty.

For example, a rural health policy maker referred to economic factors as crucial for understanding how the health of rural communities is shaped. The health of rural communities can be understood in terms of a decline in the farming population as a result of the aggregation of farms, increases in technology and increased productivity and a gradual decline in community infrastructure such as banks and schools.

Policy makers in particular stressed the importance of addressing economic factors and social infrastructure in the project of health improvement:

I think that the literature would suggest that societies which are more affluent and which have a better standard of education and more organised service delivery systems and a more equal distribution of opportunities and power, tend to have healthier populations in the classic morbidity/mortality stakes...

Public health systems themselves, some policy makers pointed out, are an important part of the infrastructure which leads to improvements in population health.

Several interviewees described the inter-relationship between social, economic and cultural capital, and the way in which the distribution of social capital is structured by power relations:

There will always be unequal access to social capital as well as economic capital.

Each of the participants emphasised the need for theoretical frameworks which take into account material, physical and environmental factors like housing, economic participation, deprivation and access to health services. The interviewees described a multiplicity of richer frameworks for placing social capital alongside other, 'bigger picture' political, economic, cultural and historical issues which shape people's health.

Each participant demonstrated an understanding of social determinants of health that extended beyond those facets of social relationships which social capital is customarily used to describe.

One policy maker described social determinants in terms of upstream and downstream factors. Upstream factors, he explained, are the “big picture” issues such as political, social and cultural marginalisation; whereas downstream factors refer to such as risk factors and individual behaviour. This policy maker situated social capital towards the “downstream” end of the scale, although one step up from individual factors:

...membership, trust and reciprocity, then that’s further downstream than a lot of these other social and economic determinants. It’s not synonymous.....So even though it’s further upstream than the risk behaviours of whether you smoke or drink or drive your car too fast or have unsafe sex...it’s not the political and economic and social determinants.

Other interviewees used a range of other frameworks such as Maslow's hierarchy of needs or an analysis of proximate, contributory and underlying factors which influence health issues.

A common thread in the understanding of the interviewees of social determinants was ideas of power and control. For example, one researcher described the effects of gambling in terms of people's control over their lives:

It takes away decision-making from the individuals that are involved in it, and they commit their success or failure to the throw of a die, or the pull of a lever, or the push of a button. And to that extent it takes away from people their ability to control their own destiny.

One researcher described how the research problems which he encountered in his work, such as the physical health of people with mental health problems, could not be understood outside of the complex social structures in which people live:

Now that particular group are marginalised in society, and so a lot of the reasons for this differential risk profile that they have is due to their social position within our community.

It appears that one of the primary difficulties which public health workers have with social capital is its claim to universality - to encapsulating the relationship between health and society. Overall, the participants were interested in using social capital to enrich their understanding, in so far as it is useful, slotting it into their broader frameworks for understanding the social determinants of health.

One policy maker described her eclectic approach to theories about the social determinants of health:

…there's quite a vast literature you draw on, which comes out of different disciplines….I don't think there's one way of understanding it.

The public health worker needs to be able to use and integrate ideas from a range of different theories and disciplines (Baum, 1998). Participants clearly thought that social capital is worth exploring for the particular insights that it might offer (particularly into understanding the effect of relative inequality on population health) but cautioned that it needs to be placed alongside, rather than replace, other ways of understanding.

4.2.2 For explaining the micro-level relationships between social processes and the health of individuals and communities

There was some evidence that social capital and its elements (trust, reciprocity and networks of engagement) might add to current understandings of social processes within communities and groups. Some participants thought that social capital had some unique insights to offer:

I think social capital – the little I know about it – does offer a new way of looking at the processes whereby communities decide upon their actions and their ways of tackling common problems, of which health is a major one.

For example, one researcher found it useful to describe the success of cancer support groups, which depend on people's preparedness to give with no necessary expectation of receiving, in terms of reciprocity:

What that is doing is building social capital. That's actually helping people engage, providing opportunities for other people to help others, and it's directly an exercise in creating social capital.

Although some participants thought that social capital had new insights to offer, others disagreed, arguing that it simply re-packages existing concepts:

...I don't think social capital's anything new. I think it's been around for yonks, for ages and ages...it's one of these concepts that's just been sort of re-labelled with sort of an economic rationalist label.

A number of interviewees pointed out that social capital is a concept which values some kinds of social relationships and exchanges at the expense of others. This is a result of the rational choice view, which is inherently reductionistic and individualistic. Many of the interviewees raised general questions about the capacity of social capital to capture the richness and variety of human relationships, and pointed to other bodies of literature which have more insights to offer:

No, it can't capture [the complexity of interpersonal relationships]. It can gloss over it....So complexity is embedded in two words.

Participants mentioned that there are many other features of social relationships apart from the circumscribed notions of trust, reciprocity and networks that contribute to health. One researcher, a social anthropologist, pointed out that the ethnographic literature deals with the complexities of social exchange and the meaning inherent in relationships in a much more satisfying way:

…I think that a lot of the social capital literature has failed to actually understand some of the nuances and differences in terms of reciprocity and sharing and giving.

This anthropologist criticised social capital as being a very middle class model of social connections and institutions:

…*when you think about social capital, it's come out of capitalist, middle class societies that I think are very, very blinkered by our ethno-centric points of view…it's not useful for marginalised communities, communities that are other than us.*

These issues are being increasingly recognised in the published research. Rose (2000: 30), for example, notes the problematic nature of trust and civic engagement in repressive regimes such as the former Soviet Union, where belonging to formal organisations and networks does not improve health, and may in fact increase stress and negatively affect health. Morrow (1999: 749) notes that Coleman's concept is 'gender blind, ethnocentric, and arguably a concept imported from the USA without due attention to cross- and inter-cultural differences'.

By contrast, the political economy discourse of social capital appears to be useful in terms of thinking about how disadvantaged individuals and groups can mobilise resources from social networks.

Only one of the public health workers interviewed had thought about social capital in these terms. Although he did not specifically refer to Bourdieu's theory, he discussed social capital in terms of the re-emergence of Marxist ideas, and used many terms and ideas from Bourdieu's work. He described social capital in terms of the group resources which provide people with leverage to exert greater control over their lives and circumstances:

...social capital is also implying that that knowledge, understanding and cultural competencies are something which provide people with leverage that is capital, something which they can draw on as a resource in effecting change.

This social capital discourse resonates strongly with theories of empowerment and community development:

…it's about a set of relationships through which one can be empowered, individually and collectively, through the application of knowledge and practice.

It is also able to add a new dimension to these theories:

We've tended to think about empowerment as being driven just by knowledge, but it's also driven by relationships…

The sorts of resources which social capital might provide, said this policy maker, ‘may be access to a service, maybe knowledge, might be access to data, might be access to a certain response out of the system, a certain product’. He found it useful to describe Aboriginal health in terms of social capital:

It's about building relationships, the knowledge that builds and sustains those relationships, the social connectedness to mobilise them and having a sense of those broad informal networks...

The social epidemiology and social psychology literature explores the relationship between social ties and individual health using a variety of constructs such as 'social support', 'social strain', 'social networks', 'social cohesion', 'social integration' and 'social isolation' (Mittelmark, 1999; Schwarzer and Leppin, 1989; Rosenfeld, 1997; Bloom, 1990; Berkman, 2000 and House et al, 1988). Extensive research has established that participation in supportive social networks promotes both physical and emotional health (see, for example, Matt and Dean, 1993; Olsen, 1993; and Berkman, 1984, 2000).

The community development and empowerment literature (Wallerstein, 1993, 1992; Wallerstein and Bernstein, 1988) has been particularly useful in theorising and understanding how people can improve their health and life chances by cooperating to change the environment in which they live:

> In its broadest definition, empowerment is a multi-level construct that involves people assuming control and mastery over their lives in the context of their social and political environment; they gain a sense of control and purposefulness to exert political power as they participate in the democratic life of their community for social change (Wallerstein, 1992: 198).

Interest has focussed on the potential for social capital to identify more contextual, indirect influences on the health of individuals than those which are measured in social support studies (Veenstra, 2000: 620). It is unclear at this stage, however, whether social capital adds much value to the existing literature. As one researcher noted:

I don't think it's very useful in terms of looking at individual health.

Some studies have attempted to establish a relationship between social capital and individual health with mixed results. Veenstra (2000) for example, found only a weak relationship between social capital and self-rated health, compared with the strong relationship identified between socioeconomic status and health.

Similarly, it is unclear whether social capital brings new insights to current understandings of community-level determinants of health. Lochner et al (1999) describe four existing constructs which have been used to describe and measure the community level social processes which shape health. These are collective efficacy, sense of community, neighbourhood cohesion and community competence. These concepts all attempt, like social capital, to capture the collective features of social structures rather than attributes of individuals. Lochner et al (1999) note that these constructs all overlap with the sorts of community features that social capital has been used to describe, although some (for example, community competence) focus more explicitly on collective political skills and capacity. These authors conclude that insufficient theoretical and empirical work has been done to determine whether social capital adds value to these existing notions (Lochner et al, 1999: 269).

4.3 The utility of social capital for public health practice

4.3.1 For macro-level (population based) programs and policies

The public health workers interviewed generally agreed that the focus of social capital on broader social processes rather than individual risk factors is useful for directing programs and policies toward changing the conditions which shape the health of populations. For example, one researcher said:

…it provides the potential for evidence based population public health strategies that aren't reduced to individual risk factors or individual social capital factors.

The concept of social capital raises questions about the nature of societies and how well they foster the conditions for collective action:

...it begs the question of what is society doing to make sure people can trust each other? What's society doing to make sure people can belong, or can look after each other?

Whether social capital can actually provide a useful framework for action, however, was seen as far more problematic.

The concept of social capital raises questions about the role of government in providing resources for these preconditions for health. The investment metaphor, in particular, draws attention to role of government:

…I think there's a very important question, especially for public health, but not limited to public health, about the role of government in longer term investment, in terms of the issues about what is the nature of society/economy.

There has been vigorous debate in policy circles and in the literature about the role of government in 'building social capital'. Notions of social capital based on different world views have been used to support widely varying policy directions. One argument advocates the so-called 'Third Way', where public policy is directed toward developing trust and civil society through the 'devolution of public governance to the institutions of civil society' (Latham, 2000). The 'Third Way' is posed as an alternative to the traditional dichotomy between the competing ideologies of libertarianism and socialism. It advocates the retention of the state's regulatory, funding and social insurance functions, while giving the

responsibility of service provision to the non-state public sector (Latham, 2000).

Other commentators argue against this proposed devolution of governance toward informal community based structures, arguing that the re-distributive function of government is vital for ensuring the equitable distribution of resources (Cox and Caldwell, 2000).

The rational choice discourse in the social capital literature was seen by some interviewees as undermining its utility, as it reinforces individualistic values:

I think that one of the dangers of social capital is that it's implicitly mostly based on rational choice...And I think it runs a real risk of reinforcing a public health... that ends up reducing everything to individual choice and responsibility. And you can see that in gambling, you can see that in the heroin policy debate, where basically the state is absolved of any responsibility whatsoever for what actors do. And I think it runs the real risk of actually re-configuring social determinants in such a way that it becomes victim blaming.

Notions of reciprocity and mutual obligation can result in a heavier burden being placed on people further down the socio-economic ladder, without changing the power structures which create inequalities:

…I'm very conscious that what we tend to be talking about is that the poor should be mutually obligated to do things, but I don't see a whole lot of obligations being placed on the rich.

As one policy maker explained, people at the bottom of the power structures are generally unable to shift the dominant structural interests which shape their health and life chances.

Notions of social capital are sometimes used to imply that the role of government should be limited to fostering the conditions in which reciprocity, networks and trust can flourish:

…the social capital agenda can be a bit corrupted towards saying that the role of the state is only to facilitate, only to intervene. So what it does is just creates opportunities, not actually make something happen…it vacates the field and facilitates community action, community development and so on and so forth….I still think that there is a very strong role for nation states and government to intervene on behalf of its citizens to protect them against the aberrations.

Participants recognised that there is a danger in social capital rhetoric being used to justify the withdrawal of infrastructure or resources and promote reliance on community social capital. The dominant discourse of small government in the social capital literature is antipathetic to the aims of public health, and may actually reinforce inequalities rather than alleviate them.

Another very real limitation of the rational choice concept of social capital is that it does not provide policy makers or practitioners with a clear course of action. Although the social capital literature may raise questions about how well societies foster the conditions for collective action, it does not identify points of intervention or practical pathways and levers for initiating change.

As it is commonly defined and used, the concept of social capital is deterministic. Putnam's (1993) theory, in particular, accounts for a society's stock of social capital in term of historical processes. Lenci (1997: 1-2) questions the possibility of creating social capital given that social capital stores are attributed to historical accumulation. Putnam's (1993) account does not provide much indication that it is possible to

intervene in these processes, and the interview participants noted that there is no theory for how social capital emerges or is created:

What I found particularly fascinating about this is the notion that those cooperative civic tendencies actually, you know, have been maintained over thousands of years, and it's very difficult to change.

One researcher commented on the similarity of notions of social capital to ideas from anarchist literature, which '…questions the capacity of institutional policy makers to do anything too clearly defined to actually facilitate [the way individuals in societies operate together]'.

Rhetoric about building social capital abounds in policy circles, but participants were sceptical whether it is possible to 'build' social capital. Even if it is possible to do this, respondents questioned the ability of the social capital literature to provide direction for bringing about social change:

...we know on aggregate that social capital, if you like, seems to be related to better health outcomes, but I don't know that we really know how to do that. So I don't know that it has much implication for policy.

...it doesn't give any guide in how to get there. Making observations about social capital at one point in time leaves you little understanding of the very particular historical, cultural factors that you need to work with in order to actually build or develop social capital.

The inability of the rational choice concept of social capital to explain the dynamics of change is also noted in the social capital literature. Morrow (1999: 752) argues that it is a '"catch-all" to describe rather than explain the effects of inequality (it cannot explain change, or social mobility)…'.

Even assuming that it is possible to build social capital, there are problems inherent in attempting to build social capital for its own sake.

One policy maker pointed out that social capital is often a by-product arising from social processes which are not focussed on increasing social capital, which draws into question the entire project of building social capital.

Attempting to 'build social capital' may also have unintended consequences. One researcher recounted her experience in India where high levels of social capital in a community experiencing 'rapid upheaval, social change, mass deaths through disease and civil unrest' are actually causing great stress on people, because of all the obligations resting on them.

The political economy discourse of social capital offers insights relating to its consideration of the political and economic forces which shape people's access to social capital, and the importance of government taking a re-distributive role. Policy makers, in particular, emphasised the importance of government taking a strong role in creating supportive institutional structures, rather than placing responsibilities on individuals and communities:

So I think it's very important that we don't lose sight of the very important role of government. Government should be seen as more than a facilitator; it is an intervener, and it should try to shape the institutions of society in the interests of justice and equity as well as efficiency and wealth and so on.

Government is needed to create opportunities and social processes in which people can participate and provide institutional structures through which debate can be influenced. Policy makers also believed that the re-distributive function of government was vital for addressing inequalities in health. Bourdieu's insights predict that giving responsibility to communities with few resources and limited access to other types of

capital is unlikely to alleviate inequalities or even to enable the generation of social capital (Baum, 1999: 176).

This finding is supported in some of the more recent social capital research. The Adelaide Health Development and Social Capital Project (Baum et al, 2000), for example, found that people's ability to participate in formal organisations and community life is stratified by income and education. Baum et al (2000) argue that support is required to improve income and education levels and provide the structures which enable participation in community life. Two British qualitative studies (Campbell and Gillies, 2001 and Macintyre and Ellaway, 1999) also found that people's ability to create and mobilise social capital varied according to their level of material deprivation.

The literature on empowerment and community development remains useful for understanding the dynamics of change and indicating points of intervention and leverage. Syme (1989: 10) argues that the concept of control is particularly 'amenable to intervention and application not only at the individual level but at the community and environmental level'. Social justice and equity are also concepts that indicate clearly the action that needs to be taken to achieve social change and reduce inequalities in health. These theories appear to have been eclipsed by the concept of social capital in some circles.

Capacity building, one policy maker suggested, may be a more useful, specific and focused concept than social capital, for conceptualising social change to improve health.

Policy makers appealed for a balanced approach to thinking about the project of social change which draws on a range of conceptual frameworks, rather than limiting the construction of policy discourse to social capital:

I think it has something useful to offer, but I think social capital needs to be seen sitting alongside a lot of other investment questions. And it's important to think about what is an investment portfolio in human capital, social capital, intellectual capital, cultural capital and so forth, rather than say this is the new magic bullet, in the same way that many other things get seen as the magic bullet, when you actually need a balanced portfolio.

4.3.2 For micro level (local and community based) programs and policies

Many of the interview participants found that the concept of social capital is not very useful for identifying specific interventions or strategies. Social capital is found to be too vague and broad to be useful as a policy or program objective:

…it's like having the objective of building a better society. This is too general. We need to get it down to things which are more concrete and which people will vote for and understand.

Likewise, the elements of social capital (trust, reciprocity and networks) were seen as too broad to use as objectives but can be used to underpin program development:

They're fine as broad statements of intent, but you couldn't possibly operationalise it into a program objective. How do you make trust a program objective?

Social capital was not perceived to offer much in terms of evaluating programs and policies, as it is too complex and long term. However some researchers used elements of social capital theory in evaluating programs, or used intermediate markers such as participation.

There have been some attempts to operationalise social capital. The Victorian Health Promotion Foundation (VicHealth), for example, based its mental health promotion strategy on ideas drawn from the social capital literature (VicHealth 1999). However this strategy, while broadly based on social capital (or social connectedness), uses these ideas as underlying themes rather than as specific objectives or expected outcomes (VicHealth, 1999).

At the micro level, the rational choice discourse suffers from the same flaws as those identified at the broader population level, particularly its inability to describe the dynamics of change or to identify interventions. At the community level, it is also difficult to operationalise 'building social capital':

… how do you break down trust into something you can do something about? It's not all that easy.

Some researchers in particular found that talking about building social capital made sense in terms of planning programs and policies. There are certainly similarities between the language of social capital and the themes of community development in terms of building trust.

In rural health, for example, notions of social capital can support policies which value community participation and investment in local communities. A rural health policy maker pointed out that when social processes have been accorded value along with more material and monetary issues, and governments have invested in building participatory processes, rural communities have benefited. Notions of social capital along with other concepts (such as 'sustainability') have contributed to this shift.

One policy maker, who drew on a political economy discourse of social capital, found building social capital a useful concept in Aboriginal health:

...in Aboriginal health you identify people who are providing community leadership, who have got good networks and relationships with their own communities, so they've got some symbolic capital. You work out a way to build a relationship between them and the key policy or the key practice people; you work out a process through which people come together around some common issues, allow them to work out some of their differences, and broker their relationships to a certain extent.

Once again, there are many other bodies of theory, notably the community development and empowerment literature, that may be better able to indicate where change in the social determinants of health needs to take place.

The concepts of empowerment, community development and capacity building provide a number of insights which are lost in much of the social capital literature, in particular the centrality of power and control. Ideas of power and powerlessness also highlight the political nature of working with communities and the place of the public health practitioner in the power structures that maintain inequality (Hawe and Shiell, 2000: 878-9).

4.4 The utility of social capital for measuring social and health outcomes

4.4.1 For the development of macro-level social and/or health indicators

Interviewees believed that measuring progress on the social determinants of health was very important:

…without measurement, in present day policy contexts, there's very little credibility.

There is clearly a need for better social indicators which measure the health of society in terms other than financial:

I think that we do need indicators which are more than just GDP growth and morbidity, mortality. I think we do need to have a social index…the quality of our society being tied more to indices of sustainability and equity and fairness and those sorts of social outcomes.

I think it's really critical to develop some generalisable and rigorous and robust way of looking at how social justice gains are implemented, how they're effective and how they're maintained – and how that's actually associated with health outcomes across all the world's communities.

There was considerable interest in the potential of social capital for contributing to the development of indicators of social progress:

I think it's one thing in a movement towards trying to be able to come up with some global indicators that are universally adopted as being meaningful and being connected to a better way of living, and better health outcomes.

The vast majority of indicators which have been developed to measure social capital at the population level draw on the rational choice discourse embedded in the theories of Coleman and Putnam.

The meaningfulness of social capital indicators is compromised by the theoretical limitations of this paradigm discussed in Section 4.2 of this chapter, including its failure to recognise the political, economic and historical context, and its over-simplification of the complexity of social determinants of health.

The researchers interviewed stressed the complexity of social determinants and the dangers of using simplistic indicators to describe them:

…you're talking about an immensely complicated, multi-dimensional complex phenomenon, which is the social environment...But how can we talk about "it" as an object, when we're really talking about a phenomenally complicated range of experiences and exposures and of histories that impact on individuals?

Quantitative indicators tend to be reductionistic and as one participant said, 'lose the political dimensions of the debate'. This is a common problem with social indicators, which are always surrogate or proxy measures of complex social phenomena (Carley, 1981: 2).

The concept of social capital does not describe all aspects of social relationships. Measures of social capital may well leave out important aspects of the relationship between social processes and health:

What's not measured is almost important as what's measured.

Researchers expressed concern that attempting to reduce a concept like social capital to quantitative measures may well mean that it loses a lot of its meaning in the process. For example, Kawachi's (1997) measures of perceived fairness and perceived trust reduce the notion of social capital itself to a bare skeleton, 'kind of leaving out a broader sense of social capital', as one researcher said. Like all such measures (for example 'quality of life'), it is partial and simplistic.

Many of the interviewees were sceptical about the claims made for social capital as an all-encompassing explanation for the association between social disadvantage and mortality:

Somehow it kind of seems a bit limited in some way, and not quite the full story. And I don't know whether we can get the full story…I think every study will be partial evidence. I don't believe any theory is going to give us full evidence of the way things happen.

Some of the interview participants expressed reservations with the attempts to produce universal, generalisable measures:

Is there a way of being able to distil the essence in a sort of community wide, multi-community application? I don't know. I mean, do we want to do that? Do we want to distil out the differences between communities so that we can compare them using common measures? I'm not sure.

There is a tendency for epidemiologists to seize on certain concepts which may be easier to measure than other ways of understanding social processes:

…we kind of want to grab hold of these concepts that seem like we can somehow measure them, because it resolves our empirical difficulties if we can actually measure these, so well let's grab hold of this concept and let's run with it, use it in research and try and look at something different.

The theoretical problems discussed in section 4.2.1 also affect the utility of social capital as a basis for the development of social indicators. Social indicators require an explicit theoretical framework which specifies the relationships between variables and clearly relates the surrogate or proxy measures to the unmeasurable concept (Carley, 1981). The lack of clarity in the social capital literature presents obvious problems for the development of meaningful measures.

There are also significant methodological difficulties, including the problem of aggregating individual measures to represent collective features, and the specificity of measures to culture, time and context.

Several of the researchers noted that the quantitative studies reported in the literature (such as Kawachi et al,1997) largely measure trust, reciprocity and social connections at the individual level and then aggregate them to represent general features of the society:

So if you look at all that social epi stuff, it's actually based on questionnaires looking at individual factors that then have been theorised at a collective level.

This approach is consistent with the rational choice paradigm with its assumption that social processes are based on the instrumental rationality of individuals. Most of the researchers, however, described this as an important methodological issue which needed to be resolved:

…I think it's important to try and do more than just aggregate measures and say that's actually a group level measure of something.

Concerns have also been raised in the literature about the ability of indicators based on measurements at the individual level to reflect change processes within communities (Shiell and Hawe, 1996). Social indicators must treat communities not just as settings or collections of individuals, but also describe processes, relationships and networks (Shiell and Hawe, 1996: 242-3; Wallerstein, 1993). As Shiell and Hawe point out:

> …when one is concerned with social systems such as communities, the whole is essentially *different* from the sum of its parts (1996: 244).

There was recognition amongst the researchers, however, that trust and reciprocity are very difficult to measure collectively and at this stage we

are unable to do so, in which case aggregate measures are better than nothing:

…we can't measure health by just looking at individuals and adding up the individuals. You have to look at the degree of interaction that's going on between them. But measuring that and intervening, and finding suitable interventions is a huge challenge.

Another significant methodological issue is the specificity of social capital to culture, time and place.

Participants recognised that social capital is a culturally framed and influenced determinant and therefore measures of social capital are culturally specific. One researcher pointed out that Putnam's (1993) explanation of social capital is specific to the particular cultural context in parts of Italy, and may not be useful if taken to another culture.

A number of participants also pointed out that social capital is context-specific according to both time and place:

I mean [social capital indicators] are context dependent both in time as well as in geographical and cultural contexts.

The meaning of social capital also depends on the scale of the population or group:

…trying to apply the same principle in every circumstance at every degree of localisation (or globalisation) is absurd.

These problems limit the generalisability of social capital indicators:

It's a problem with all instruments of this nature….there's a danger in its generalisability. I mean, in what way would you develop a social capital

instrument that measured all of those things in Australia, if you're going to take into account the wide variety of ethnic backgrounds, and indigenous versus non-indigenous Australians, and how do you get a measure that's actually going to capture what's meant by social capital in all of those different groups of people?…And then never mind actually trying to get one that goes over countries and time periods….The more I talk about it, the less I feel convinced of it as an instrument that you could develop to use universally.

These methodological issues, however, were not believed to be insurmountable:

I think most things are measurable. Some are incredibly complex to measure. But if there's a will, there's a way.

Researchers described a number of strategies for dealing with these issues.

One researcher described the approach he would take to social capital in his research as describing domains of social capital variables which include different types of relationships:

I wouldn't do a study of social capital, I'd do a study of a kind or several kinds of social capital….as a generic concept it's too broad, It's talking about a range of different things, some of which may be mutually exclusive.

This researcher believed that it might be possible to define and quantify some of the types of social capital, although he alluded to some methodological difficulties which this would pose. But he thought that measures could be developed:

And as you start to measure it and start to progress you'll find ways to refine it, which is what science is all about. You never start with perfect measures. You always start with cruddy measures and make them better and better.

Another researcher mentioned emerging techniques for quantifying networks which might improve our ability to capture some of the complexity of social networks:

…there are some newer techniques of measurement…which are using immensely complex iterative computer algorithms…numerical network models that are able to measure very complex organisations.

Another suggested combining quantitative measures with ethnographic research in order to enrich the indicators.

Interviewees generally believed that there was much work that needed to be done before indicators could be developed:

...I think we need to start to get much more complex in the way that we define the terrain, and for those different sets of relationships, it may well be different processes and different structures.

Still, it is important to continue to struggle with ways of measuring the social processes that lead to health improvement:

I find [social capital] complicated and difficult. But at the same time, I struggle as a researcher, to say well, we need to actually measure these things, to be able to get at some of the social processes that actually affect people's health.

The crucial question, participants emphasised, is not so much whether we can measure social capital, but whether what we are measuring is real and useful.

For social capital indicators to be useful, they must be able to inform policy making. If the concept of social capital cannot provide us with useable policy directions, as section 4.3.1 of this chapter suggests, then social capital indicators are not likely to be useful:

…I think these things ought to be things you can actually influence, not stuff that you don't have any notion about how it might be influenced.

Bourdieu's insights about the inextricability of social capital from the broader political and economic context make the development of indicators far more problematic. A search of the literature did not locate any macro/population studies or indicators which used Bourdieu's perspective. Bourdieu's concept does not so easily lend itself to quantitative research, which may in part account for the fact that it has been relatively ignored in the literature.

Unfortunately, despite the concerns public health workers expressed about the conceptual and empirical issues with developing national or population-based indicators of social capital, there are few promising alternatives.

4.4.2 For the micro-level collection of qualitative data about social determinants of health

Qualitative data gathering at the local level might be enhanced by the inclusion of indicators of social capital. There is considerable interest among some social researchers in adapting the concept in ethnographic studies.

The published social capital indicators, however, which are largely based on the rational choice paradigm, tend to be middle class and individualistic. For example, one researcher found that in trying to apply the concept of social capital to survivors of torture, the measures were irrelevant:

…the very people that they've trusted have raped their mothers and killed their families. And how do you think about building social capital in communities that are extremely marginalised…the very social capital they may have built was used against them.

As with the development of broad social indicators, there are methodological issues but these were perceived to be resolvable, and some of the newer modelling techniques may be able to overcome some of these issues.

Once again, the critical question is how meaningful social capital indicators based on the rational choice paradigm (given the theoretical issues previously discussed) can be.

Bourdieu's notion of social capital indicates that any measures of social capital would need to take into account the broader social context in which groups and individuals live. There seem to have been some attempts to do this in public health research.

Qualitative studies seem to offer greater potential than quantitative cross-sectional research for integrating an understanding of social and economic constraints into the application of social capital. Indeed, some qualitative studies seem to have been largely informed by a rational choice model of social capital but have drawn conclusions which are more consistent with Bourdieu's concept (for example, Campbell and Gillies, 2001; Baum et al, 2000; Macintyre and Ellaway, 1999). The

inclusion of a careful analysis of the links between social capital and socio-economic disadvantage seems to make this transition possible.

Two of the researchers interviewed were actively drawing on the concept of social capital to inform their research program. Both researchers built in measures of social capital into a broader research design and adapted notions of social capital to be more appropriate for the research problem under investigation. They tended to measure some of the constituent parts of social capital, and used social capital as an explanatory framework, along with the generalist literature.

One of these researchers wanted to build some measures of social capital into her research on what helps communities of refugees settle well and re-establish healthy, fulfilling and hopeful lives, however she found that all of the published measures were completely irrelevant. Work is being done on understanding “indigenous” forms of social capital (for example, in drug using communities) where the measures reported in the literature do not make sense and concepts like trust have very different meanings.

It seems that the concept of social capital may useful in this context but requires significant development.

Campbell and Jovchelovitch (2000: 261-2) note the importance of the research literature on empowerment and related constructs such as ‘sense of community’, ‘community competence’ and ‘community capacity’ for studying community level determinants of health, although they note that these concepts also tend to suffer from a lack of conceptual and theoretical coherence.

Hawe and Shiell (2000: 876-7) describe a broad range of research models based on other theories (such as social support) which may be able to differentiate more precisely between the types of benefit generated by different sorts of networks in different contexts. However

Hawe and Shiell (2000: 877) also point out that the social capital literature has drawn important links between social epidemiology and some of these more obscure theoretical traditions. This suggests that the value of social capital may rest on what it *brings together* rather than what it *adds* to existing literature.

Chapter 5: Conclusions

The findings of this research project suggest that social capital is potentially useful for public health, but there are boundaries and limitations to its utility. The two discourses or world views which have been identified in the social capital literature have important ramifications for its utility.

The study reports the views of a small number of public health policy makers and researchers who were selected firstly because their policy/research work is concerned with the social determinants of health and secondly to include a broad range of perspectives and disciplines in public health. The sample was not intended to be representative of the general public health workforce and it is likely that the interviewees had a more extensive knowledge of social capital and related concepts than most public health workers.

The study was conducted in 1999 when social capital was a relatively new term in public health circles in Australia. Whilst some of the interviewees were familiar with the social capital literature, others were not. This places limitations on the quality of the data and draws into question the value of making recommendations based on the findings of the study. There are, however, some general conclusions which can be drawn from the research findings.

The popularity of ‘social capital’ in public health circles arises to a large extent from its perceived rhetorical leverage in inter-sectoral policy debates. The capital metaphor has broad appeal and brings people together from different disciplines, interests and political positions to focus on the common goal of creating a better (or healthier) society. This rhetoric is very attractive for public health workers who wish to increase recognition of the social determinants of health and build an inter-sectoral movement for change.

The meaning of social capital, however, is contested and ambiguous, and the opposing world views which are represented by the concept are rarely understood or acknowledged. Common meaning is often assumed; this is both the promise and the danger of the concept of social capital. Public health workers who enter the debate with a political economy interpretation of social capital (aligned with ideas such as empowerment, equity and social justice) may be misunderstood by those who use social capital rhetoric to support arguments for a conservative or neoliberal agenda of small government and reliance on community networks. Any consensus built on such tenuous grounds may well be illusory and even dangerous.

The connotations with which the label ‘social capital’ is loaded may also result in marginalisation in some policy debates. Nor is it useful for communicating with individuals and communities, where the jargon can be alienating.

Interest in social capital also centres on its potential for illuminating the relationship between the social environment and health. It appears to be useful for the quantitative measurement of social processes in large-scale cross-sectional studies. The concept of social capital which has been used in this type of research, however, is based on rational choice theory which does not adequately account for the power structures which shape and constrain access to social capital, and therefore lends itself to individualistic interpretations. The political economy discourse includes an analysis of these broader social forces in its insight regarding the interchangeability of different types of capital and the ultimate reducibility of social capital to economic capital, however there seem to have been no attempts to apply or quantify it at this level, probably because of its greater complexity.

The basis of the rational choice discourse of social capital on the instrumental rationality of individuals also limits its capacity for elucidating the social determinants of health, particularly at the micro level. Conceiving social relationships in terms of instrumental rationality (using the circumscribed notions of trust, reciprocity and networks) omits or undervalues many dimensions of social exchange, such as the way in which a sense of collective identity enables cooperation when individual benefit is not guaranteed.

The political economy discourse of social capital, by contrast, appears to be useful for thinking about how disadvantaged individuals and groups can mobilise resources from social networks which can be used as leverage to effect changes in social position.

The concept of social capital may be tending to eclipse the existing literature on the social determinants of health. At best, it seems to offer relatively little in terms of added value to this literature, and at worst, it neglects important insights from other theories such as the importance of power and control, and the intricacies of social exchange.

The concept of social capital is of limited value for guiding policy and programs that aim to address inequalities in health. Although it raises questions about how well societies foster the conditions for collective action and the role of government in investing in these conditions, the dual world views embedded in the concept mean that it can be used to support widely varying policy directions. The rational choice discourse lends itself to individualistic interpretations which suggest policies such as small government and the devolution of responsibility of public provision to the institutions of civil society. The political economy discourse (which is better aligned with social justice and equity) suggests strengthening the redistributive function of government and increasing investment in social infrastructure.

The utility of the concept for public health practice is also limited by its determinism. The rational choice model, in particular, does not adequately describe the dynamics of change or identify pathways and levers for initiating change. It is difficult to operationalise in meaningful ways for developing program objectives or outcome measures. Social capital theory must be situated alongside other theories, such as empowerment and community development, which have been found useful for understanding the action that needs to be taken to produce social change and reduce inequalities in health.

As a basis for macro-level social indicators, social capital has received a great deal of attention, largely due to the lack of promising alternatives for measuring social progress. However the meaningfulness of social capital indicators is compromised by the limitations of the rational choice paradigm, including its failure to recognise the political, economic and historical context of social capital and its over-simplification of social processes, which results in reductionistic measures. The political economy discourse, in which social capital is seen as inextricable from the broader social context, renders the development of quantitative indicators far more problematic. Bourdieu's concept may be very useful, however, for informing qualitative research, particularly when used along with the generalist literature.

All of the public health workers interviewed struggled with using the concept of social capital in their work. They thought that it was important, however, to continue grappling with the ideas it presents:

...concepts like social capital are quite dense concepts, so that to have a suspicion about their value is very important, because it means that we're challenging ourselves to actually articulate what we're talking about, and articulate how we effect that.

They believed that it was important to use social capital strategically rather than 'throwing the baby out with the bath water', but also to be aware of the dangers involved in using it:

…maybe what we need to do if we're going to use it is actually somehow think through what are the limitations of it a bit more clearly, and what are the consequences of understanding this in a particular way, and the kind of actions we're going to take…..So if I choose to understand these social processes in terms of social capital, what are the consequences for public policy, health policy, and what does it facilitate, and what does it actually leave out?

The debates which the concept of social capital has stimulated may well be as important as the application of the concept, for they raise important questions about the way in which social determinants of health are conceived and the sorts of interventions which might reduce inequalities. As one researcher said:

I always find the uncomfortable places are the best places to be in terms of research and policy.

Appendix A: Interview Schedule

Public Health Policy Makers

1. Can you tell me about how you think about the social determinants of health? By social determinants I mean the political, economic, cultural and historical factors which affect health.

2. In your policy work, what are the sorts of policy jobs you might expect to be involved in, where you would need to have an understanding of the social determinants of health?

3. What does the concept of social capital add (if anything), to the considerations you draw upon in working through that kind of problem?

4. Would it make sense to frame social health policy in terms of ‘building social capital’ (trust, reciprocity and networks)?

5. How would you operationalise this? (How would you go about 'building' trust, reciprocity and networks?)

6. How important do you think the measurement of progress on the social determinants of health is in policy terms? How useful would the various instruments for measuring social capital be, do you think?

Public Health Researchers

1. Can you tell me about how you think about the social determinants of health? By social determinants I mean the political, economic, cultural and historical factors which affect health.

2. What are the kinds of research problems that bring you to addressing questions about the social determinants of health? Can you talk a bit about how your research program touches upon the role of social determinants of health?

3. What does the concept of social capital add to your thinking about these sorts of issues? What does it add to your research design?

4. Do you think social capital has the potential to provide generalisable, widely valid, reliable measures of the outcomes of policies and programs?

5. If you don't think social capital is useful for public health research, how would you monitor the effects of policies and programs in ways which take into account the social determinants of health?

Appendix B: Information and consent form

Project Title:	THE CONCEPTUAL AND EMPIRICAL USEFULNESS OF SOCIAL CAPITAL FOR HEALTH DEVELOPMENT
Senior Investigator	DR DAVID LEGGE, ASSOCIATE PROFESSOR, SCHOOL OF PUBLIC HEALTH, LA TROBE UNIVERSITY
Researcher	MS DEBORAH GLEESON, POSTGRADUATE STUDENT, SCHOOL OF PUBLIC HEALTH, LA TROBE UNIVERSITY

The aim of this research project is to evaluate the concept of social capital for explaining the historical dynamics which create ill health, for understanding current patterns of health and illness and as a strategic target of health development programs and policies.

This research is being conducted as part of the requirements for Ms Deborah Gleeson's Master of Public Health. The results of this project will appear in a thesis to be written by Deborah Gleeson, in journal publications and in presentations at conferences.

If you agree to participate in this project you will be asked to:

(i) participate in an audio tape recorded in-depth interview of approximately one hour's duration;

(ii) give your consent for your name to be identified in the text of reports and publications.

You will have the opportunity to scan a transcript of the interview and identify any material which you would like to modify or delete from the records.

During the research the data will be stored in a locked filing cabinet at the home of the researcher. After the project has been completed, records will be stored in the research data archives maintained by the School of Public Health, La Trobe University. Audio tapes of the interviews will be destroyed immediately after they are transcribed.

You will not directly benefit from participating in this project, but your participation will contribute to better population health by improving understanding of the social determinants of health.

You may decide not to participate or to withdraw from the project at any time.

Any questions regarding this project titled 'The conceptual and empirical usefulness of social capital for health development' may be directed to the Senior Investigator, Dr. David Legge, of the School of Public Health at La Trobe University, Bundoora, Victoria 3083 on the telephone number (03) 9479 5849.

If you have any complaints or queries that the Senior Investigator has been unable to answer, you may contact the Secretary of the Faculty Human Ethics Committee, Faculty of Health Sciences, La Trobe University, Bundoora, Victoria 3083, telephone (03) 9479 3574.

I, ……., have read and understood the information above, and any questions I have asked have been answered to my satisfaction. I agree to participate in this project, realising that I may withdraw at any time. I agree that research data collected during the project may be included in a thesis, presented at conferences and published in journals. I give consent for my name to be identified in the text of reports and publications.

NAME OF PARTICIPANT (in block letters):

…….

Signature: …….. Date: ……..…

NAME OF SENIOR INVESTIGATOR (in block letters): ……

Signature: …….. Date: …….

NAME OF RESEARCHER (in block letters): ……..

Signature: …… Date: ……..

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