Health, Social Relations, and Public Policy

Peter A. Hall and Rosemary CR Taylor

Minda de Gunzburg Center for European Studies
Harvard University
27 Kirkland Street
Cambridge MA 02138
phall@fas.harvard.edu

Department of Sociology / Community Health Program
Tufts University
112 Packard Avenue
Medford MA 02155
rtaylor@tufts.edu

October 2006

Prepared for *Successful Societies: Institutions, Cultural Repertoires and Health*, a volume edited by Peter A. Hall and Michèle Lamont for the Successful Societies Program of the Canadian Institute for Advanced Research.

Governments are often urged to take steps to improve the health of their citizens. But there is controversy about how best to achieve that goal.[1] Popular opinion calls for more investment in medical care and the promotion of behaviors associated with good health. But, across the developed countries on which we focus here, variations in the health of the population do not correspond closely to national levels of spending on medical care, and there remain many uncertainties about how governments can best promote healthy behavior.[2] Expanding access to health care offers greater promise but, as many chapters in this book note, health care is only the tip of the iceberg of population health.

The objective of this chapter is to explore how governments affect the health of their populations. We develop a distinctive perspective on this topic that suggests governments often do so by creating or eroding social resources when they make public policy. Our analysis turns on a contention at the heart of this volume, namely, that the structure of social relations in which people are embedded conditions their health. In social epidemiology, there is substantial evidence to back up this claim, but continuing controversy about which aspects of social relations impinge on health and through what causal mechanisms.[3] We shed light on these issues by proposing a model that links social relations to some kinds of health outcomes and then using it to identify dimensions of social relations likely to impinge on health. Our approach goes beyond many current formulations to incorporate a fuller appreciation for how components of culture, such as collective imaginaries, matter to variations in population health.

We then employ this model to identify a set of pathways through which public policies condition population health, including some that have not received enough attention. The wider significance of our argument lies in the portrait it draws of public policy-making. In contemporary accounts, policy is often said to have effects on collective well-being by virtue of how it redistributes economic resources or alters the material sanctions and incentives embodied in regulatory regimes. Many policies work this way. However, we argue that public policy also conditions the structure of social relations, and we see those relations as social resources on

For insightful comments on earlier versions of this chapter, we are grateful to the members of CIAR's Successful Societies Program, its advisory committee, Bo Rothstein and Michèle Lamont. For research and logistical assistance, we thank Marius Busemeyer, and Emily Putnam.

[1] For synoptic statements, see Acheson (1998); and Adler and Newman (2002).

[2] Variations in population health over time may be more closely related to spending on medical technology or health care Cf. Cutler (2004); McKeown (1965). For discussion of how governments do or do not promote healthy behavior, see the chapter by Swidler in this book as well as Taylor (1982).

[3] For recent overviews of these controversies, see Wilkinson (2005); Carpiano *et al*. (2006); Berkman and Kawachi (2000).

which individuals draw to advance their well-being. In short, we see public policy-making as a process of social resource creation.

Linking Population Health to Economic and Social Relations

We begin by developing a specific perspective on the problem of how the structures of economic and social relations feed into health. Our analysis speaks to two explanatory problems of wide interest to scholars in social epidemiology. One is the problem of explaining the basic gradient that links health to socioeconomic status, measured by income, occupation or educational level. In all of these countries, people with lower levels of socioeconomic status tend to have poorer levels of health. The other problem is one of explaining differences in the shape of this gradient across countries. In some places, this gradient is much flatter than in others. That is to say, the differences in health that correspond to socioeconomic status are not as large in some countries or communities as they are in others, for most or all of the population.[4] These cross-national differences in the shape of the gradient are large enough to represent millions of years of healthy lives foregone.

There is a vast literature in epidemiology devoted to explaining the basic gradient and a smaller but significant literature devoted to explaining differences in its shape across nations or regions. Many analysts attribute the gradient to differences in the material resources available to people at different income levels. Some attribute it to social factors, such as differences in status or membership in social networks among different segments of the population.[5] However, this literature is not always clear about precisely how social factors impinge on population health. One of the objectives of this chapter is to explore how they do so.

Moreover, epidemiology has had difficulty disentangling social factors from economic factors. Link and Phelan argue that the 'fundamental cause' of the gradient lies in 'socioeconomic status', but whether there is an operative social force adequately captured by that term remains an open question.[6] Many analysts treat cross-national differences in social factors as if they are largely rooted in material factors.[7] Of course, social factors often do have economic

[4] For discussion of these gradients, see the chapters by Hertzman and Keating in this volume. For an especially powerful illustration of them, see Banks *et al.* (2006).
[5] For recent overviews, see Kawachi *et al*. (1999); Berkman and Kawachi (2000); and Heymann *et al*. (2006).
[6] Link and Phelan (1995, 2000). For a recent effort to identify some of the mechanisms through which 'socioeconomic status' might work, see Carpiano *et al*. (2006). Within wider literatures, this engages issues of how 'social classes' are constituted.
[7] Cf. Wilkinson 2005; Link and Phelan 1995.

roots. But we try to delineate the dimensions of social relations relevant to population health in terms that are conceptually separate from economic relations, so that their own impact can be appreciated and subsequent work can investigate, rather than assume, how much they depend on economic relations. One advantage of this approach is that it reveals that governments affect the provision of social resources in ways that do not depend entirely on how they distribute material resources.

Seen from a broad perspective, the health of a population turns on many factors, including the incidence of infectious as well as chronic diseases, and it is affected by many kinds of policies, such as efforts to contain inter-group violence, to provide housing or sanitation, and to limit environmental risks. Our objective is not to review every way in which social relations impinge on health, but to concentrate on a specific, and important, set of causal chains. Our focus is on the affluent democracies, where population health is not closely correlated with political stability or gross domestic product per capita. We also concentrate on the impact that the 'wear and tear of daily life' takes on a person's health.[8] This is an appropriate focus for the affluent democracies. Chronic diseases that have been linked to such wear and tear make an especially large contribution to life expectancy in these countries, and national differences in rates of mortality there turn primarily on differences in mortality in the working age population, namely, among people exposed to many pressures in their working lives.[9]

Our perspective emphasizes the impact on health of experiences of stress and the emotional states often associated with them, such as anxiety, resentment and frustration.[10] Although these are not the only causes of ill health, a substantial body of research shows that they are closely associated with a person's health. Daniel Keating's chapter for this volume reviews some of this research and traces the biological pathways whereby such experiences produce negative physiological effects.[11] Considerable evidence suggests that experiences in daily life that consistently evoke feelings of, anxiety, anger or frustration adversely affect health.

Therefore, in order to consider how the structure of social relations conditions health, we deploy a simple, but relatively general, model designed to explain how much stress and

[8] This model influences many of the essays in this book. See McEwen (1998, 2005); Taylor *et al.* (1999).
[9] See the chapter in this volume by Clyde Hertzman.
[10] We follow a substantial literature in conceptualizing stress as an experience associated with systematic physiological responses. Its level depends on the magnitude of the stressors one encounters and on attributes of personality that affect how much stress one feels in the face of such experiences. A person's physiology, conditioned by past experience, also affects his physiological reactions to subsequent stressors. See Haslam *et al.* (2005). As we construe them here, a person's capabilities condition both the degree to which any particular task constitutes a stressor and the degree to which a stressor of given magnitude results in feelings of stress.
[11] See also Brunner (2000); Chrousos (1995); Lovallo (1997); Brunner, (1997); Sapolsky *et al*. (1997); Taylor *et al*. (1999).

accompanying negative feelings a person is likely to experience in daily life. There are two main components to it. The first is the magnitude of the *life challenges* facing individuals, namely of the tasks associated with reaching goals they consider important, such as finding a companion, raising a family, or securing a livelihood. We assume that the happiness of people depends heavily on the effectiveness with which they accomplish these tasks, and we identify two ways of doing so, through individual and collective action, defining the latter as group-based endeavor to secure changes in public policy or to improve the community in ways that also serve the goals of the actors.

The second component of this model is the set of *capabilities* a person has for taking effective action to cope with these life challenges.[12] These are constituted, first, by the quality of key attributes of personality, including emotional resilience, reflective consciousness, and self-esteem. These attributes are established initially in childhood but refined in later life. Evidence shows that they condition a person's ability to complete many kinds of tasks successfully and to control behaviors associated with ill-health, such as smoking, exercise and diet.[13] The second important element of a person's capabilities rests in her capacity to elicit the cooperation of others. Performing many of the tasks of daily life, associated with child care, work or housing, requires the cooperation of other people. Where it is difficult to secure, those tasks become more onerous. Finally, some challenges can be addressed only or best by collective action. In such cases, people need the capability to act in concert, whether to pressure governments to provide better access to health care and a safer environment or to clean up the neighborhood.

Our core contention is that the amount of 'wear and tear' a person suffers in daily life turns on the *balance* between these life challenges and capabilities. Those who experience more difficult life challenges or do so with fewer capabilities will consistently experience higher levels of stress and feelings of anxiety, anger and frustration that tend to lead to poorer levels of physical or mental health. Everyone experiences some challenging moments, but we are referring to life challenges and capabilities that tend to be relatively durable over time. Thus, they condition many experiences in a person's life and do so relatively consistently over time. It is the consistent quality of such experiences that works its way most perniciously 'under the skin'.[14]

Social and economic relations enter this model as factors that condition the balance between challenges and capabilities found at typical positions in a given society. Of course, life challenges and capabilities vary considerably across individuals. However, we are interested in

[12] Our concept of 'capabilities' is narrower than the influential formulation of Sen (1999). For analogous formulations inspired by his, see also Bartley (2006).
[13] Grembowski *et al.* (1993); Berkman *et al.* (2000).
[14] Taylor *et al*. (1999).

systematic variation in population health across societies and in how it might be affected by the structure of economic or social relations. In the following sections, we use this model to derive propositions about the dimensions of economic and social relations likely to affect population health and consider evidence for whether they do so, before turning to the effects governments can have on social relations.

The Impact of Economic Relations

We begin by discussing the impact of economic relations in order to situate the analysis of social relations that follows. As many analysts have noted, the economy can be seen as a collection of individual and collective actors endowed with particular sets of material resources (in the form of wealth, income or skills) and politically-established rights (extending from property rights through civil, and political rights), who are linked together in relations structured by markets, hierarchies, and institutions supporting specific kinds of cooperation.[15] These views of the economy draw attention to a range of material resources that are important to the health of the population from the perspective of our model because their supply and distribution conditions the magnitude of the life challenges facing people and their capabilities for meeting those challenges. Access to material resources makes it easier for people to cope with the challenges associated with finding a good job, securing a decent residence, taking care of children, and the like.

In short, our model accepts that the distribution of material resources provides at least part of the explanation for the familiar gradient, namely for why the poor are likely to suffer more health problems than the wealthy. The implication is that governments can mitigate the effects of inequalities of wealth and income on the health of the poor by redistributing income, providing public services, such as daycare, social insurance and healthcare, or promoting education to enhance marketable skills.[16] Considerable evidence supports these propositions. Up to some point of diminishing marginal returns, income certainly conditions the health of individuals. There is more contestation about whether distributing income more equally improves the health of most or all of the population, but there is evidence to support that contention.[17] The public provision of services is also associated with better population health and may sometimes be a

[15] Williamson (1985), Greif (2006), Hall and Soskice (2001). In these models, political, as well as economic, relations are often construed in market terms. For alternative views of the economy, see Smelser and Swedberg (1994).

[16] The public provision of daycare has special importance. If it is not merely custodial but stimulating and supportive, daycare can have durable effects on children's health that last through adulthood, as well as relieving parents. See Keating and Hertzman (1999).

[17] For recent overviews, see Wilkinson (2005), ch. 4, Lynch *et al*. (2004). Cf. Beckfield (2004). At issue in this debate is not only whether income distribution conditions population health but why it does so.

substitute for income redistribution.[18] A number of analysts have argued that wider access to education can improve the health of the population.[19]

Another dimension of the structure of economic relations that might affect the health of the population is the intensity of competition, especially in labor markets, and the corresponding insecurity it introduces into the employment relationship. Relatively little is know about how the intensity or scope of market competition affects population health. On the one hand, it may improve the opportunities available to some people.[20] On the other hand, by increasing insecurity, it may generate more stressful experiences, which, according to our model, could lead to poorer health, especially among segments of the population endowed with few marketable assets. The precipitous declines in health in Eastern Europe following the transition to capitalism, to which Clyde Hertzman draws attention, indicate such risks are real. But the impact on health of increasing market competition may be mediated by other features of the context, such as overall levels of unemployment, the character of social benefits provided to the unemployed and the like. This issue deserves more study based on comparisons across time as well as space.

Social Relations as Social Resources

One of the strengths of economics since Adam Smith has been its inclination to construe the economy as a set of relations structured by markets, hierarchies and institutions. As a result, when governments make economic policy, they usually consider not only whether policy will secure a specific set of goals but also how it will affect the overall structure of market relations. Tax policy is designed, not only with an eye to the revenues it will raise, but with a view to how it will alter incentives for actors in the economy more generally.

A core contention of this chapter is that societies should be seen in analogous terms, namely, as a structured set of social relations. Another is that this structure of social relations impinges directly on population health. In subsequent sections, we will ask whether governments can affect these social relations. For the moment, our task is threefold. We begin by trying to identify the dimensions of social relations that impinge on population health, with an emphasis on those that are comparable across societies. Second, we deploy the model developed in this

[18] Ross *et al*. (2006).
[19] See the chapter by Peter Evans in this volume and Keating and Hertzman (1999).
[20] Increasing market competition might also lead to higher levels of GDP per capita but, across the developed democracies, population health is not closely related to those levels. Some perspectives suggest that economies with high levels of strategic coordination as well as those with high levels of market competition can perform well in economic terms; see Hall and Soskice (2001).

chapter to identify a set of causal paths whereby these dimensions of social relations affect the health of the population.[21] Third, we adduce some evidence drawn from the existing literature in support of the contention that these dimensions affect population health.

Notwithstanding the value of its structural approach, the drawback of economics is its restricted view of *how* relations among people are structured. Alongside market relations and cooperative equilibria are other sets of social relationships important to health. We are trying to draw out the importance of these quintessentially social relations.

Most views of them follow one of two traditions in the study of society.[22] The first has roots in the conceptions of Emile Durkheim, who saw societies as interconnected wholes joined by personal relations and a collective consciousness. This perspective emphasizes the importance of social connectedness. From their connections with others, people are said to derive not only logistical support but emotional sustenance and a sense of self. A second approach to society is reflected in the formulations of Max Weber, who put more emphasis on relations of domination. On this view, individuals are deeply affected by asymmetries in their relations with others, construed in terms of class, status or power.

From a Weberian perspective, if differences based on class, rooted in economic relations, are aligned in many societies with distinctions of status rooted in cultural frameworks, they are not so aligned in all. Thus, Weber directs our attention to the importance of understanding the impact of status, relative to material factors, on well-being and of analyzing its roots. He notes that the shape of status hierarchies can vary across societies. Accordingly, our analysis explores the impact on population health, first, of *social connectedness* and, then, of *social hierarchy*. Together, these constitute key features of social structure.

At the foundation of our causal analysis is the contention that many of these features of social relations constitute *social resources*, analogous to the economic resources, on which people draw to cope with life challenges.[23] Social resources condition people's capabilities in several ways. In many cases, social relations provide multipurpose instruments used by ordinary people to cope with the challenges confronting them. When required to care for children or sick relatives, for instance, people call upon the social networks in which they are embedded and the sense of moral obligation fostered by such networks. To secure the cooperation of others, they draw on their social status and on levels of social trust in the community. To mobilize support for collective action to improve their community, they tap the collective purposes and ideals defined

[21] As noted, we are not claiming these are the only paths through which social relations condition health.
[22] See Berkman (1995); Berkman *et al*. (2000).
[23] Link and Phelan (2000) imply this as well when they use the term 'social resources'.

by prevailing social imaginaries. Like economic resources, social resources can often be put to multiple uses. However, what people attempt to do and the confidence or competence they bring to various tasks is also conditioned by the stereotypes and templates for feasible or socially appropriate actions present in prevailing cultural frameworks.[24] The institutional practices and cultural frameworks that structure social relations can affect the capabilities of people and of communities in fundamental ways.

In short, compared to economic views that associate a person's capabilities with a set of endowments, seen as possessions or attributes of the individual, we contend that capabilities are intrinsically relational, i.e., constituted by the quality of a people's relations with others.[25] Although a person can influence some aspects of such relationships, others are determined by institutional practices and cultural frameworks that are collective features of a society. Moreover, while some of these relations can be understood in the rationalist terms of strategic interaction and cooperative behavior, we will argue that social relations are also constitutive of social resources in ways that such perspectives do not capture.[26]

The Impact of Social Connectedness

We use the term 'social connectedness' to refer to the character of the ties that individuals have to others in society. It is reflected in people's contacts with others, whether frequent and familiar or more distant, and in the images people have of the community to which they belong, whether or not they have personal contact with each other. The social cohesion of a society turns on the quality of these attachments. However, several different dimensions of social relations bear on social connectedness, and many analysts put more emphasis on some than others. We will consider a number of dimensions in turn.

One of the most prominent contemporary perspectives construes social connectedness in terms of 'social capital', seen in Robert Putnam's influential formulation as generalized capacities for cooperation that are said to arise from repeated face-to-face interaction in social encounters or secondary associations. These capacities for cooperation turn on relations of mutual reciprocity

[24] These characteristics are sometimes described as a person's 'self-efficacy'; see Grembowski *et al*. (1993); Steele (1988, 1999); Steele *et al.* (1998). See also Swidler (1986); Oyserman and Markus (1990); Oyserman *et al*. (2006).

[25] This formulation parallels contemporary understandings of the firm. At one point, a firm's competencies were thought to depend on its assets, namely, on the capital, technology and skills it possessed. But recent analyses suggest that the competencies (and success) of a firm depend even more heavily on the quality of the relationships it is able to form with other actors, including its clients, employees, and suppliers of goods or finance. See Dosi and Teece (1998).

[26] See also Hall and Taylor (1996).

that are built on relatively rationalist exchanges and the social trust that is said to accompany them.[27] The account views 'social capital' as a multipurpose social resource of such singular generality that even those who do not participate in this associational life are said to benefit from it.

From the perspective of our model, social capital contributes to population health through two causal pathways. Higher levels of social trust make it easier for everyone to secure the cooperation of others, thereby enhancing their capabilities for coping with life challenges. The networks of reciprocity encouraged by personal contact in civic associations or social networks also facilitate collective action either to address the challenges facing the community directly or to pressure governments to do so. Accordingly, the health of a community can be improved by building secondary associations and social networks, especially across racial or ethnic boundaries that might otherwise limit social trust. There is some evidence for these propositions. On a variety of measures, average levels of health across communities are correlated with the levels of social trust and numbers of secondary associations found there.[28] The concept of social capital provides one way of understanding how the structure of social relations generates resources that underpin population health.

As many analysts have observed, however, the effects that social networks and civic associations have on population health may not flow entirely through the generalized mechanisms of social capital. Analysts have identified a number of more direct ways in which membership in social networks or associations enhances people's capabilities for coping with life challenges, thereby contributing to population health.[29] Networks can provide *logistical support* for important life tasks, such as child rearing, securing employment, and managing illness, *information* about how to cope with such challenges, and *social influence* useful for securing the cooperation of others in life tasks or collective action. As a source of *emotional support*, some kinds of networks condition the psychological resilience of individual in the face of challenges.

---

[27] Putnam (1993; 2000). Social trust refers to the general willingness of people to trust others in the community. For a critical discussion, see Cook *et al*. (2005).

[28] Kawachi *et al*. (1997; 1998); Kawachi *et al*. (1999), chs. 22 and 23. Of course, these correlations may reflect mechanisms other than those posited by this general conception of social capital, including the support provided directly to individuals by social networks, as noted in subsequent paragraphs; and levels of social trust are not always closely correlated with the density of associational membership.

[29] We use the term 'social networks' to refer to the contacts people have with other people. These formulations are influenced by the analysis of Berkman *et al*. (2000), which covers such pathways in more detail. There is a large literature based on various psychological models about how social networks impinge on physical and mental health.

Of course, networks vary along several dimensions, and the contribution a network makes to the resolution of particular kinds of challenge depends on its character.[30] Social networks may be dense, linking people to many others, or relatively thin. They can be based on frequent or infrequent contact, on face-to-face or more distant relations. They can embody strong ties that reflect intimacy or weak ties based on passing acquaintance. Networks may be deeply intertwined or segmented by social group. These dimensions are consequential. People seeking work, for instance, may benefit more from weak ties to many others, while people recovering from illnesses may benefit more from deep attachments to a few individuals.[31]

How the dimensions of a network affect its value for meeting particular kinds of challenges is a matter deserving of even more research. However, convincing evidence now links a person's health to the overall density of the social networks in which s/he is embedded. Studies show that the level and intensity of a person's contacts with others are related to all-cause mortality, self-rated health, and rates of recovery from a variety of illnesses, such as myocardial infarction. The emotional attachments provided by close relationships seem to improve resilience against depression, illness and addiction.[32]

Membership in associations underpins people's capabilities in analogous ways, thereby reducing the stress and anxiety that is associated with meeting important challenges. Day care cooperatives help parents cope with the demands of a family. Sports clubs provide companionship and opportunities for exercise. Self-help groups oriented to the control of risky behaviors constitute one of the fastest-growing segments of the non-profit sector. Not surprisingly, studies find that those who belong to such associations are likely to be healthier, even when factors such as age, income and social class are controlled.[33]

Because membership in social networks and associations varies across social groups, however, these dimensions of social connectedness can affect the distribution of health across the populace as well overall health in a society. As Putnam posits, some of the effects of social networks and civic associations may be society-wide. The benefits of social trust, for instance, may be available to all on relatively equal terms.[34] However, social connections of this sort are rarely distributed evenly across the population. Some studies suggest that people with lower incomes and lower-status occupations tend to belong to fewer associations and have smaller

[30] See Erickson (1996, 2002).
[31] Granovetter 1974; Case *et al.* (1992).
[32] Syme and Berkman (1979); For broad reviews, see Berkman (1995)and Berkman *et al*. (2000).
[33] Kawachi *et al*. (1999): chs. 22 and 23.
[34] If so, the health of most of the populace should be better in societies with higher levels of social trust.

social networks based on closer attachments to a smaller number of friends.[35] Therefore, discrepancies in social connections may be one of the factors contributing to the gradient observed between income or occupational status and health. The poor may have worse health because they lack the social resources such connections provide. If the relationship between income (or occupational status) and membership in social networks (or associations) varies systematically across countries (or communities), it may also help to explain cross-national variation in the shape of this health gradient.

However, the social connectedness of a society is not specified simply by the density or character of its social networks but by the content of the messages about meaningfulness and morality that those networks convey.[36] The concept of social trust is too thin to capture such dimensions fully. Social relations are structured by a set of collective representations that contribute to the social cohesion of a society, not only by fostering social trust, but by specifying a meaningful set of purposes individuals can use to guide their actions, a vision of what it means to belong to the community as a whole, and a sense of what can reasonably be expected in moral terms from others. As a short form, we refer to these dimensions of social relations as features of a society's collective imaginary.[37]

The key point here is one anthropologists have argued for some time.[38] Social relations are central to the meanings people assign to their lives and actions, and that meaningfulness is often important to a person's health. People have more psychological resilience, against depression, anxiety and other adverse emotional states, when their lives appear to them as purposeful, and for this sense of purpose, people draw on the collective imaginary of the community. Within it, they find collective representations of the community and of their place within it, one that allows them to define individual purposes for themselves and to link their actions to collective purposes assigned to the community as a whole. As such, collective imaginaries are also constitutive of feelings of belonging.

Moreover, at this level, the social order is also a moral order – marked by customary attitudes with normative force. Those attitudes are important for specifying what individuals can expect of one another. They go well beyond the relations of mutual reciprocity founded on

[35] For the British case, see Allan (1990); Oakley and Rajan (1991); Goldthorpe (1987). See also Carpiano *et al*. (2006).
[36] Emirbayer and Goodwin (1994).
[37] For related formulations, see Bouchard (2000, 2003) and Castoriadis (1987) whose concept of the social imaginary differs in some ways from ours.
[38] See Geertz (1978); Kleinman (1981). Although this perspective is appreciated by social epidemiology it is less well-represented there because it references variables that are difficult to measure systematically across communities.

reciprocal exchange on which conceptions of 'social capital' focus to approach what Thompson called the 'moral economy' of a community.[39] They define the informal obligations people in a community feel towards others and the standards of behavior to which individuals believe they can hold each other.[40]

From the perspective of our model, there are a variety of ways in which these dimensions of the social imaginary feed into people's capabilities and hence into the health of the population. On the one hand, they affect our willingness to turn to others for help and the likelihood they will supply it. When individuals call on others for help with life tasks, they do not simply engage in exchange relations; they also call upon moral conceptions of the forms of respect and aid people are believed to owe others. This also applies to collective action. In order to motivate others to join with them in such endeavors, individuals call upon collective representations of the purposes and standards of the community. They make moral as well as material appeals.

On the other hand, as Durkheim noted, collective representations of society also condition the emotional resilience of individuals in the face of challenges. By virtue of how they define the community, these visions can enhance or erode a person's feelings of social isolation. They contribute to feelings of belonging that are important to human beings and the level of optimism people feel about the fate of their community and their own future. These feelings are generally seen as important to health.

Collective imaginaries also specify the range of behaviors that will be seen as appropriate in a variety of contexts. As Gatens notes, for instance, they usually define a specific set of gender roles.[41] Social imaginaries help to define what Swidler calls the 'strategies for action' on which individuals in various social positions draw to cope with life challenges. As she notes, when confronted with a challenge, one tends to ask 'what can someone like me do about that?' Although any one person's answer will be conditioned by personal experience, it will also be influenced by how 'someone like me' is construed in the collective imaginary.[42] In such respects, collective imaginaries are both enabling and constraining. They are constitutive of people's capabilities, and they encourage or discourage a range of behaviors relevant to health. When social imaginaries shift, they can affect the health of large numbers of people.

Evidence about the impact of social imaginaries on population health is obviously difficult to gather. It exists for some links in the causal chain. At the individual level, there is statistical evidence that the attitudes and emotions we have just referenced affect mental and

[39] Thompson (1971).
[40] See Ann Swidler's chapter in this volume, also (Taylor, 2004).
[41] Gatens (2004).
[42] Swidler (1986).

physical health. At the communal level, most evidence is based on case studies. Erikson's careful investigation of the traumatic symptoms that followed a flood in Buffalo Creek found that many were a reaction, not to the physical disaster itself, but to loss of the sense of communality that had characterized the tight-knit community swept away by the flood.[43] Eberstadt associates some part of the decline in the population health of the Soviet Union just prior to *perestroika* with the demoralization that set in as the values once promoted by the Soviet leadership lost resonance for ordinary people, leaving them uncertain about what their nation promised or what the future would hold.[44]

However, Gérard Bouchard's chapter for this volume shows that there may not always be a one-to-one correspondence between the collective imaginary and the overall health of the population. His cautionary tale reminds us that a society's imaginary is made up of many different images, myths, and collective representations on which individuals can draw differently. It constitutes a repertoire, whose overall contours may be constraining, but which enables many types of actions. Some groups create counter-cultures that are conditioned by a mainstream imagery, and individuals can adopt a variety of strategies to offset some of the effects of that imagery.[45]

Social Hierarchy

As Weber has emphasized, there are also asymmetries in the structure of social relations associated with social hierarchy. Some arise from formal hierarchies that assign a delimited range of power and autonomy to each position in them. Others are the informal hierarchies that assign people different levels of social status or prestige. All societies have such hierarchies, and they are usually considered a defining feature of the social structure. The concept of status also figures prominently in studies of population health.[46]

Although some argue that, as a basic phenomenon, social hierarchy is biologically embedded, we view the *shape* such hierarchies take in any society as an artifact of its collective imaginary. To whom status is assigned, in what measure, and by what criteria are ultimately

[43] Erikson (1976).
[44] Eberstadt (1981). This is a controversial claim since there is debate about the timing and sources of declining health in the former Soviet Union, but it highlights the contribution a collective imaginary makes to community capabilities and individual resilience. See also Garrett (2000) and Field (1986).
[45] Willis (1977); Crocker and Major (1989). See also Lamont's chapter in this volume.
[46] For synoptic works, see Wilkinson (2005); Marmot (2004). We use the terms 'status hierarchies' and 'social hierarchies' as synonyms to denote these informal hierarchies. By social status, we mean the level of general social prestige a person enjoys.

features of a cultural framework.[47] Social hierarchies vary substantially across societies. Here, we are interested in understanding how they affect population health and how to characterize variations in them that are relevant to health.

As others have observed, formal hierarchies can affect health by restricting a person's autonomy or control at work, and social hierarchies may do so by engendering feelings of relative deprivation.[48] From the perspective of our model, however, two other causal channels are more important. Both operate through the effects of status on a person's capabilities for coping with life challenges. One turns on the problem of securing cooperation, the other on the problem of self-recognition. To meet life challenges, a person requires the cooperation of others, and people of lower social status are likely to have more difficulty securing it. Status is an all-purpose social lubricant conditioning the respect and cooperation one receives from others. As a result, people with low status tend to experience more wear and tear as they attempt to meet the challenges of daily life.[49]

As we have noted, the levels of stress or anxiety experienced by a person depend, not only on the magnitude of the tasks confronting her, but on the level of confidence or self-esteem she brings to them. People with low levels of self-esteem are less likely to attempt challenging tasks, less likely to succeed at them, and more likely to find them stressful.[50] Self-esteem is initially established in childhood, but it can be influenced by subsequent experiences.[51] Our image of ourselves is reflected in the mirror society holds up to us. Where that image is more negative, our self-esteem is likely to suffer. In short, social recognition is crucial to self-recognition, and higher social status is likely to confer more favorable social recognition. As a result, higher status individuals should have higher levels of self-esteem or self-efficacy that reduce the amount of stress and anxiety they experience in daily life, promoting better health.

If this perspective is correct, societies that deprive larger numbers of people of social status should have worse levels of population health than those that assign status more evenly. Variations in population health should follow variations in the social hierarchy. But what are the relevant dimensions along which a society's social hierarchy can vary? This problem has not received sufficient attention. Many analysts seem to assume that a person's status corresponds to his occupation or that this is the only dimension of social status that matters to health. However,

---

[47] Bourdieu (1983).
[48] Marmot *et al*. (1997); Wilkinson (1996).
[49] For more general discussion of this point, see Marmot (2004).
[50]; Steele (1988); MacLeod (1987).
[51] A similar analysis applies to 'self-efficacy', a concept associated with the confidence an individual brings to a specific set of tasks, rather than self-esteem understood as a variable with more general application. See Grembowski *et al*. (1993).

sociological research reveals that there are multiple sources of status or social recognition and that the precise shape of the status hierarchy is likely to vary across societies.[52] We need ways of characterizing that variation.

We suggest that three dimensions of social hierarchy are likely to be consequential for population health. The first is the steepness of the status hierarchy associated with income or occupational position, understood as the size of the status differentials between typical positions. That might be reflected, for instance, in the levels of social prestige enjoyed by those at each decile in the income distribution. But the shape of this curve is also important. If, as Runciman notes, feelings of relative deprivation are usually based on comparisons made with others in proximate social positions, the poor may be more affected by the shape of the curve for the bottom half of the income distribution than for its top.[53]

Equally important is the multidimensionality of status attribution, reflected in the number and variety of social roles that confer prestige in any given society. People live in social settings defined by the overlapping circles of family, workplace, neighborhood, and nation, each associated with distinctive components of the collective imaginary. In principle, a person may secure status from his role or performance in any of these settings. In societies where people derive status, not only from their occupation, but from their roles as a fathers, citizens or consumers, the overall distribution of status may be more even, generally to the advantage of those in lower-status occupations.[54] Of special significance here is the degree to which status depends on income. Where it does, the status hierarchy will reinforce the health effects of income. In those cases, the distribution of social resources parallels the distribution of economic resources. However, in other societies, income and status may not be so closely coupled.

Social hierarchies also vary in the status they assign to readily identifiable groups in society, such as men, women, racial or ethnic groups. One should not assume that such effects are small relative to those of the status hierarchy rooted in income or occupation.[55] The status accorded members of such groups is frequently based on stereotypes that are familiar features of collective imaginaries, and evidence from psychology suggests that such stereotypes can have a powerful influence, sometimes unconscious, on the efficacy with which people perform various tasks. It can affect their self-esteem and capacities to secure the cooperation of others.[56] Status

[52] Lamont (2000); Boltanski and Thévenot (1999).
[53] Runciman (1964).
[54] See Steele (1988); Sieber (1974); Thoits (1983).
[55] Williams (1999, 2005); Krieger (2000).
[56] Steele (1998); Steele *et al*. (1998); Cf. Pyszczynski *et al*. (2004); Elmer (2001).

differences are associated with the social boundaries discussed in Michèle Lamont's chapter for this volume.[57].

Empirically, it is difficult to separate the effects of status from those of income, and to date there are relatively few measures that allow one to assess the health effects of cross-national differences in status hierarchies. However, three streams of evidence converge to suggest that status affects health. The studies of British civil servants conducted by Marmot and others found that, even when other risk factors were controlled, those in lower status positions in this occupational hierarchy suffered from more health problems than officials of higher status.[58] Studies of humans and other primates show that those with low status in their tribes display a range of physiological effects associated with poor health, such as atherosclerosis, obesity, worse cholesterol profiles, and behavioral depression.[59] And, although the interpretation is hotly contested, studies the finding that the health of the average person is worse in countries or regions where the income distribution is more unequal may indicate that the distribution of status is also less equal there and adversely affecting overall levels of health.[60] Of course, none of these studies evaluates our conception of the channels through which status affects population health against alternative formulations but, taken together, they offer substantial support for the proposition that social hierarchies condition population health.

The Capabilities of Communities

This discussion has emphasized how the structure of social relations affects the health of a population by altering the balance between the capabilities of individuals and the life challenges facing them, thereby conditioning the amount of 'wear and tear' they experience in daily life. We have adopted this emphasis in order to focus the analysis and to concentrate it on a set of pathways that connect social relations directly to physiological reactions associated with physical and mental health. However, it is important to note that some of the aspects of social relations we have been discussing contribute, not only to the capabilities of individuals, but to what might be thought of as the capabilities of communities. Through other pathways, these, too, feed into population health.

[57] See also Lamont (2000). As she points out, members of identifiable groups can use various strategies to offset the effects the status order might otherwise have on their endeavors.
[58] Marmot (2004).
[59] See the chapter by Keating in this volume and Shively *et al*. (1994, 1997); Sapolsky and Share (1994); Sapolsky *et al*.(1997); Brunner (1997).
[60] For overviews, see Berkman and Kawachi (2000); Wilkinson (1997, 2005: ch. 4); Lynch *et al*. (2004).

We have in mind two broad sets of capabilities. The first refers to the capabilities members of the community have for helping each other in ways that advance everyone's health. Some of these operate by reducing the wear and tear of daily life. But others may operate through other pathways. Members of a community can cooperate to reduce rates of violence, to improve local housing, or to clean up the environment.[61]

The second refers to the capabilities of governments, understood as instruments of the community, to advance health. Those turn both on the capacities of governments to implement effective policies and on the capabilities members of the community have for ensuring that governments pursue such policies. Governments make many contributions to public health, through policies that address infectious as well as chronic diseases, including efforts to improve sanitation, regulate food and occupational safety, and otherwise provide a healthy environment.[62]

Of course, many kinds of factors condition the capabilities of governments and communities.[63] Here, we are interested in how the structure of social relations affects those capabilities. Several other essays in this volume touch on this topic, and we will address it here only briefly. However, we want to highlight how some of the dimensions of social relations emphasized in this essay condition such capabilities.

Central to them are the capacities members of a society have for mobilizing either to improve the conditions affecting health or to press governments to do so. Analyses of social capital suggest that such capacities turn on the density and activism of civic associations and on levels of social trust, which are conditioned by how well those associations and social networks bridge ethnic or religious divisions in society. There is evidence that this is the case.[64] However, capacities for effective mobilization may well turn on more than the relatively thin relations of reciprocity that this type of social capital provides. As Peter Evans points out, mobilization requires more than civil rights and the capacities for deliberation represented, for instance, by town meetings.[65] We want to emphasize that they depend not just on the presence of social networks but on the content of the moral messages those networks convey, since the latter are constitutive of local solidarities.[66] In short, capacities for mobilization are conditioned by the

[61] Other examples could be given. See Sampson *et al*. (1997; 2002).
[62] For overviews, see McKeown (1965); Adler and Newman (2002); Acheson (1998).
[63] These factors include the structure of the state and the rules of the political system. The factors most important to mobilizational capacities in particular may also be different at the national level than they are at the local level. Cf. Wilkinson (2005: 227 ff.).
[64] Putnam (2000); Warren (2001).
[65] There is a large literature on the conditions that allow for effective mobilization citing factors we do not cover here, including different views of the resources required for mobilization. For examples, see McAdam *et al*. (1996, 2001).
[66] See especially the chapter by Ann Swidler in this book.

collective imaginaries of a community, which specify what people owe one another, why they should band together to improve their lives and, in some instances, how to improve them.[67]

The capacities of governments to implement various kinds of policies effectively also depend on social organization. Many studies have shown that, at the national level, the effective implementation of income, industrial or agricultural policies turns on the presence of organizations that mobilize particular segments of society.[68] However, measures required to protect vulnerable citizens or to persuade people to change behaviors that harm their health are often depend on the peculiarities and particularities of intensely local arrangements. Ann Swidler shows that the capacities of governments to implement policies promoting more healthy behaviors can also depend on the character of local relations, including the social solidarities that structure them.[69] In his analysis of a devastating heat wave in Chicago, Eric Klinenberg describes why existing social protection systems could not shield elderly, isolated residents from its effects. One of the reasons for this failure is that they could not reach many elderly men who refused support rather than admit dependence in a culture that idealizes self-sufficiency.[70] One implication of this argument is that different types of social relations at the local level may make some types of policy more effective than others.

Jane Jenson goes farther to suggest that the likelihood governments will adopt particular kinds of policies to promote health, in the first place, will be conditioned by the shapes of citizenship regimes that are defined both by institutional practices and the collective imaginary. Other studies written from a variety of perspectives also indicate that governments are predisposed toward certain approaches to policy by wider cultural frameworks that can be seen as components of the collective imaginary.[71]

In short, the organizations, social networks, social hierarchies, and collective imaginaries that structure social relations condition the capabilities of communities, as well as those of individuals, that can be important to the health of the population.

---

[67] Recent declines in the capacities of socialist parties or organizations to mobilize the European working class and of Catholic organizations to mobilize their constituencies reflect this point. In many cases, the relevant organizations continue to exist and membership in civic associations remains relatively high in Europe, but collective imaginaries have changed in ways that deprive the left and political Catholicism of much of their mobilizing power. See Valle (2003); Putnam (2002).

[68] For examples, see Keeler (1987); Golden (1993); Atkinson and Coleman (1989).

[69] See her chapter.

[70] Klinenberg (2002).

[71] See Jenson's chapter and Dobbin (1997).

Social Resources and Public Policy-Making

We have argued that, over the course of a lifetime, people's health depends on the balance between the life challenges facing them and their capabilities. We suggest that people's capabilities, as well as the life challenges they confront, are affected by their positions within the structure of social relations, and we have identified several features of this structure that constitute social resources conditioning the capabilities of individuals and communities. Where social resources are in short supply, people will find it more difficult to cope with life challenges. Where they are plentiful, a variety of purposes are better served. In this respect, the social resources available to a society are much like its economic resources. They can be put to multiple uses. If carefully husbanded, they can be invested and grow over time. The more people use some social networks, for instance, the stronger those networks become. Used to increase the fruitfulness of individual endeavors, social resources also augment the well-being of society as a whole.[72]

This approach to population health has important implications for governments and policy-making. It invites the question: what are governments doing when they make policy? One answer is that governments are redistributing material resources among social groups.[73] Another is that they are deploying legal sanctions or financial incentives to induce specific patterns of behavior. Policy-makers often see their own actions in these terms. However, these answers do not capture the full effects of policy on aggregate social welfare. Our analysis raises the possibility that public policies may affect the well-being of the community by altering the structure of social relations. Governments may be redistributing social, as well as material, resources.

Many governments are inattentive to this dimension of policy-making. As a result, social resources are frequently generated or eroded as an unintended consequence of policies adopted for other purposes. When introducing an economic policy designed to achieve particular goals, officials often consider its ancillary effects on the structure of economic competition as a whole. More rarely do they consider the effects of policy on the structure of social relations. Several factors may lie behind this reluctance. Although policy-makers are accustomed to thinking of the economy as a set of relations structured by markets, recent developments have discouraged them

[72] This point follows, for instance, from Putnam's (2000) formulations about social capital.
[73] The most famous definition in political science is that public policy is the 'authoritative allocation of resources' and social transfer programs now consume close to half of public budgets.

from seeing society in analogous structural terms.[74] In the developed democracies, the prosperity of the decades following the Second World War inspired a decline in class-based conflict and organization that has shifted the political focus away from class structures.[75] The neo-liberal era that William Sewell describes in this volume has been marked by an enthusiasm for the economic benefits of markets that emphasizes their centrality to society and downplays other dimensions of social relations.

Of course, there is something counterintuitive about the proposition that public policy can influence the structure of social relations. Social structure is usually seen as the immutable product of long-term socioeconomic processes impervious to the actions of governments, and there is some truth to this view.[76] But to say that social structure is not putty in the hands of governments does not mean they cannot mold it at all. Some types of social resources may persist only in the presence of supportive public policies, and there is an important temporal dimension to such matters. The effects of actions, often seemingly inconsequential at the time, can cumulate into major changes in social structure over the long run.[77] For instance, the shifts in class structure observed in some nations over the past fifty years owe much to the expansion of public employment.[78]

Whether public policy can affect the dimensions of social relations we have identified as pertinent to health is, therefore, an open question. In the following sections, we consider that issue and what types of policies might sustain or erode social resources. The available evidence is limited, but we review it to consider each of the components of social resources we have outlined.

Social Connectedness

In his influential work, Putnam associates social capital with participation in voluntary associations and high levels of social trust. Early accounts of social capital saw it as a resource created by long-term social developments largely independent of public policy.[79] But recent studies suggest that governments play an important role in sustaining social capital. One of its

[74] By contrast, the impact of policy on class relations was often discussed in nineteenth century Europe. See Chevalier (1973).
[75] See Graubard (1964); Goldthorpe *et al*. (1969); Dalton *et al*. (1984).
[76] Cf. Skocpol's (1979) contention that only a few revolutions actually change the social structure.
[77] See the chapter in this volume by Clyde Hertzman and Pierson (2004).
[78] Goldthorpe (1987)
[79] Putnam (1993); Coleman (1990).

core components is the set of voluntary associations and the active participation of people in such associations.

Comparison shows that, while levels of social capital in the U.S. have recently declined, Britain has retained dense networks of civic associations. That success can be traced, in part, to two sets of public policies: those expanding access to higher education and ones that rely on voluntary labor to deliver social services. Higher education has encouraged civic engagement, and government support for charitable associations employing volunteers has sustained them.[80] Similar effects have been found in the Nordic nations, where moves to professionalize the delivery of social services seem to have eroded social capital, while efforts to support the organizations of civil society preserved it. In the terms of Jenson and Saint-Martin, social capital can be sustained by a 'social investment state.'[81]

Historically, governments have helped to construct (or destroy) a wide array of civic organizations. For many decades, for instance, most European regimes have subsidized and orchestrated the development of trade unions, churches and agricultural associations that developed into the basis for important social networks. Officials did so to facilitate wage coordination, modernize agriculture, or reduce religious conflict, but these organizations became resources used by people for many different purposes. Although mass membership organizations with a political hue are declining, those governments now encourage associations devoted to recreation, sports and culture. Neighborhood groups – a quintessentially American phenomenon – are flourishing even in France, where republican ideals have traditionally been hostile to civic association.[82]

Because governments often support such organizations for specific purposes, rather than as multi-purpose resources, however, they are not always attentive to the distributive effects of this support. In the early twentieth century, governments of various complexions, supported organizations designed to recruit members of the working class. In recent years, as these trade unions, fraternal societies, cooperatives, and religious organizations have declined, the civic associations that remain, in Europe at least, are more likely to have a middle class membership.[83] As a result, rather than offsetting the distribution of economic resources, the distribution of social resources is more likely to reinforce it. Governments interested in enhancing social welfare and

[80] Hall (1999). For overviews of social capital, see Warren (1999); Edwards *et al*. (2001); Stolle and Hooghe (2003).
[81] Selle (1999); Torpe (2003); Jenson and Saint-Martin (2003).
[82] Worms (2002). The Communist regimes of east central Europe provide a bleak counter-case, showing how fully governments can erode civic organization if they set out to do so (Howard 2003).
[83] People with lower levels of education and income tend to join fewer associations and have smaller social networks (Hall 1999).

population health need to be attentive to the social composition of the organizations and networks they support

There is also evidence that the actions of governments influence levels of social trust. As might be expected, repressive acts seem to diminish it. Booth and Richard find a significant correlation between the repressiveness of central American regimes and levels of trust among their citizenry, and Inglehart argues that is not because democracy creates trust but because repression erodes it.[84] However, there is still a great deal of variance to be explained: the proportion of people expressing trust in others varies from about 25 percent to 65 percent across democracies.

There, as elsewhere, political corruption seems to affect social trust adversely. Wuthnow argues that social trust is conditioned by political trust and declined in the U.S. as a result of the Watergate scandal of the 1970s.[85] Where officials commonly engage in petty corruption, they encourage distrust among the citizenry.[86] Thus, policies reinforcing the even-handedness of public administration may enhance levels of social trust.

The design of policy may also affect trust. Kumlin and Rothstein find that the recipients of benefits assigned via a means test are less likely to be trusting of others than the recipients of universal benefits going to all citizens. Since those eligible for means-tested benefits may be less trusting in the first place, it is tempting to ascribe these effects to a selection bias, but they show up even when for income, class and other attributes associated with the propensity to trust others are controlled.[87] The implication is that, if the design of a policy implies benefit recipients cannot be trusted, they may become less trusting.

Social trust is also correlated with the safety and prosperity of the community and the optimism people feel about the future.[88] Where governments can enhance those aspects of communal life, they may build social capital indirectly as well. Although these studies indicate that governments can affect their country's social capital, however, how much they do so, relative to other factors, remains uncertain. Given the many other factors conditioning it, few would claim that social capital depends primarily on public policy.[89]

---

[84] Booth and Richard (2001); Inglehart (1999).
[85] Wuthnow (2002). See also Freitag (2003).
[86] Sztompka (1999). See also Rothstein (2003, 2005)
[87] Kumlin and Rothstein (2004). See also Murray (2000); Svensson and Von Otter (2002); Wallis and Dollery (2002).
[88] Sampson *et al*. (1997); Kennedy *et al*. (1998).
[89] See Putnam (1993) who argues that the causal lines run mainly the other way round – from the level of social capital to the quality of policy, and Kawachi *et al*. (1998).

As we have noted, however, civic organizations and social networks do not simply generate social capital. They also connect people in ways that enhance their capabilities more directly, and many policies have networks effects that may be consequential, even if they are not themselves a central object of policy. Accordingly, governments interested in enhancing social resources would also be well advised to consider the effects of their policies, not only on the density of social networks, but on the character of these networks. As we have noted, the value of a network often depends on the type of support an individual needs. As Granovetter has famously argued, for instance, a person seeking a new job needs a large network of relatively weak ties to others who already have jobs so as to secure references and information about openings.[90] But policies that require the recipients of unemployment benefits to appear regularly at manpower centers tend to give the unemployed precisely the wrong sort of ties, namely ties to other individuals who are also unemployed. By contrast, policies that provide temporary work or training in firms put the unemployed in touch with people with jobs.

The key point here is that, by designing policies with an eye to their network effects, governments can achieve a 'social multiplier' effect. Many policies have network effects that can be leveraged to enhance the value of that policy. Day care centers, for instance, can be designed to enhance the social networks among parents that serve as further sources of support for child rearing. Care for the elderly can be designed to reinforce the support networks to which they belong rather than separate them from those networks.[91] In many cases, such strategies not only increase the impact of policy, but also augment generalized social resources.

Status and Social Recognition

Can governments mitigate the effect of status differentials, thereby shifting the shape of social hierarchies? To the extent that status derives from income, of course, they can do so by redistributing material resources. In some cases, there may be no substitute for that. But governments also influence the status, or social prestige, available to people, even at the low end of the income spectrum, by what they do, how they do it, and what they say. Although direct evidence for such effects is scanty, we should not discount them.

Citizenship regimes are a fundamental component of such processes.[92] As Marshall observed many years ago, the provision of civil, political and social rights constitutes a form of

[90] Granovetter (1973, 1974).
[91] Jacobstone and Jenson (2005).
[92] See Jenson's chapter for this volume and Jenson and Phillips (2003).

'class abatement'.[93] He emphasized education and social benefits, but his analysis was framed to indicate that something could be gained by establishing them as fundamental rights of citizenship. Concepts of citizenship strike at status differentials. They provide even those with little else a fundamental claim to equality.

However, other kinds of social recognition also matter. In the realm of the status order, which is defined by collective imaginaries, symbolic actions have real effects, and the symbols governments employ are especially authoritative.[94] Political leaders occupy positions that give them special social influence and, with sufficient effort and auspicious circumstances, their rhetoric and actions can shift elements of the social imaginary.[95] By celebrating the sacrifices ordinary people make in their daily lives and the multiple kinds of contributions an individual can make to society, governments can valorize a wide range of endeavors, accord recognition to those who might otherwise have little, and undercut the monotonicity of the status order. By articulating national narratives that are inclusive, politicians can enhance the status of groups that might otherwise be marginalized.

Of special importance is the recognition governments accord identifiable racial and ethnic minorities. Of course, as Lamont observes, the images that define group stereotypes and social boundaries are deeply embedded in imaginaries that governments influence only at the margin.[96] And governing parties are often tempted to exploit those stereotypes to enhance their chances of securing reelection rather than take on the more difficult task of shifting them. However, there are success stories. Kymlicka argues that Canadian governments have successfully promoted a new national image based on multiculturalism that accords status to many ethnic minorities. Moreover, rather than eroding the sense of national purpose or identity, multiculturalism has become defining features of them.[97]

However, there are limits to how much rhetoric and ritual can shift social recognition or status without accompanying material and institutional support. Much is likely to depend on whether the ideals and idioms promoted by leaders are subsequently institutionalized.[98] Where governments are concerned, this is especially important, as it would be in any large organization represented by many agents. In such contexts, cultural frameworks and institutions are two sides of the same coin. The respect or social recognition accorded people turns not only on what

[93] Marshall (1949).
[94] Kertzer (1989); Lukes (1975).
[95] On these processes, see Kingdon (1984); and Jones and Baumgartner, (1993).
[96] Lamont (2000).
[97] See Kymlicka's essay in this volume and the references there.
[98] On institutionalization, see Jepperson (1991).

politicians say but on what 'street-level bureaucrats' do.[99] This is why 'racial profiling' has an importance that extends beyond crime.[100] The behavior of public officials sends important signals to society. If the public authorities treat individuals even-handedly, others in society are more likely to do so as well. That, in turn, increases social resources. The respect shown a person feeds into his self-respect, and hence into his capabilities for coping with life challenges

Communal Capabilities

The actions of governments can affect the capabilities of communities as well as those of individuals. As we have described them, those capabilities turn partly on the ease with which members of a community can join together to improve conditions that affect their health and partly on their capacities as citizens to mobilize in order to pressure governments into policies that promote population health. Therefore, public policies that support civic associations and social networks should enhance such capabilities.

Those capabilities can also be affected by the collective narratives politicians deploy to define the aspirations or ideals of a nation and the terms in which they characterize its national identity. By attaching value to a set of collective aspirations, these narratives make some issues meaningful enough to inspire social or political mobilization, and they supply rationales for mobilization on behalf of such issues. By evoking particular sets of social boundaries, these narratives help define who is likely to band together. Edward Miguel's research provides evidence that concerted rhetorical efforts to downplay the differences between race and tribe in favor of a common national belonging can enhance the capabilities of ethnically divided communities. Comparing closely matched communities in Tanzania and Kenya of mixed ethnicity, he found that the communities in Tanzania were more effective at cooperating across ethnic lines, in this case to promote education, than those in Kenya; and he traces the origins of this cooperation to the ideology of national unity promoted for three decades in Tanzania, without an analogue in Kenya.[101]

In these cases, governments did not simply exploit local social solidarities and the moral meanings they comprehend to make many kinds of policies more effective, as Swidler argues they can. They actually created new social solidarities and gave new meanings to national identity. This is one of many ways in which politics can be a creative process.

[99] Lipsky (1980); Bartley (2006): ch. 10; Canvin *et al*. (2006).
[100] Tyler and Blader (2000).
[101] Miguel (2004).

This analysis does not imply that efforts to shape the collective imaginary are costless or without trade-offs. The ideology of national identity that Tanzania pursued in the 1960s may have enhanced local cooperation in the 1990s, but it was achieved at the cost of repressing many local cultures, much as the attempt to turn 'peasants into Frenchmen' did during the nineteenth century.[102] The influential efforts of successive governments to promote a national view of Sweden as 'the people's home' seems to have fostered egalitarian attitudes, as intended, but it has not equipped the nation to cope with the ethnic diversity resulting from recent waves of immigration.[103] From the perspective of social recognition, a comparison of French and American versions of republicanism would reveal that each has some advantages and corresponding disadvantages.[104]

Conclusion

Building on research which suggests that the experiences of stress in daily life and associated emotional states have a substantial impact on population health, we have explored the ways in which the structure of social relations conditions those experiences and emotional states, using a model that associates the latter with the balance between the life challenges facing a person and her capabilities. We have argued that the structure of social relations conditions both these challenges and capabilities, notably through the social resources it supplies to people in different social positions. Based on this model we have identified some of the dimensions of social relations most likely to contribute to social resources and thus to population health.

Nothing in this argument suggests that the structure of material relations is unimportant. Income and access to material resources contribute to a person's capabilities. However, we take seriously the possibility that the distributions of material and social resources do not correspond exactly to one another in all societies. That allows us to explore a wide range of causal mechanisms linking socioeconomic conditions to population health and to identify some that have not received sufficient attention to date.

We pay particular attention to the cultural dimensions of social relations embodied in collective imaginaries, on the premise that they often structure social relations as forcefully as institutions or organizations do. We consider social status to be dependent, in the first instance, on cultural frameworks and only contingently on economic relations. We regard social networks

[102] Weber (1976).
[103] Berman (1998).
[104] Higonnet (1988); Lamont (2000).

as important for the meaningful messages they convey as well as for the informational or logistical support they provide.

These formulations point to the value of comparing the structure of social relations across countries or communities, rather than deducing them from the structure of economic relations, and provide conceptual tools for doing so. Of course, this is empirically difficult and the range of available evidence limited. However, we think there is much to be learned from devoting more attention to such issues.

In contrast to some accounts, we contend that governments need not take the structure of social relations as immutable, and we have examined a number of routes through which public policies might influence it. We conclude that policy conditions social relations, just as it does economic relations. By nurturing dimensions of social relations on which the capabilities of many people depend, governments sustain social resources. Moreover, policies that create or sustain social resources have unusually widespread and powerful effects. Like policies that open up market opportunities, they create resources that many people then use for multiple purposes.[105] The result can be significant improvement in population health as well as aggregate social welfare.

The analysis suggests governments should pay as much attention to the conservation of social resources as they do to the protection of natural resources and look for ways to augment them. We are not suggesting this is easy. Building networks, new collective narratives, and neighborhood organizations can require the institutionalization of new practices and material resources as well as inventive policy design. But we have also suggested that designing policies or the delivery of benefits with an eye to leveraging existing social resources can enhance the effectiveness with which those policies address their immediate objectives, while nurturing social resources. In this respect, if they are attentive to social relations, governments can secure a social multiplier effect.

Of course, we are not suggesting that the structure of social relations depends entirely or even primarily on the actions of governments, simply that those actions condition the shape of that structure sufficiently to affect population health. Further study of this subject will have to consider the temporal dimensions of such issues.[106] Like Rome, social structures are not built in a day. In some cases, public policies may have immediate effects on the viability of a social organization or network. However, collective representations of society or local solidarities may

[105] This is a characteristic of 'structural' reforms, whether directed at the structure of economic or social relations.
[106] See the chapter by Hertzman; Pierson (2004); Thelen (2004); Streeck and Thelen (2005).

shift slowly in response to a series of incremental interventions. They may become effective only when institutionalized in a variety of ways; and, as Thelen points out, institutions themselves are often reinterpreted over time. The structure of social relations is built up through the accumulation of developments over long periods of time. Public policies are important in this process but they often have effects that materialize much later.

As Clyde Hertzman's essay for this volume notes, this means that the impact of public policy on population health will not necessarily show up in cross-national snapshots taken at one point in time, however well framed. More may be learned from longitudinal analyses. However, this perspective also demands more intensive examination of the *processes* through which policy works its way into social relations and from there into health. Comparative case studies can be used to advantage in this type of inquiry.[107]

Our analysis has implications for governments as well as researchers. It provides confirmation for the view that many types of policies can affect the health of the population and suggests sets of mechanisms through which they may do so. Without denying that the promotion of healthy behaviors has a role to play in policy, we suggest that governments can achieve far-reaching effects in other ways. Our goal has been to outline some of those ways and to stimulate further research into them.

[107] See Hall (2003).

Acemoglu, Daron and James A. Robinson (2005). *Economic Origins of Dictatorship and Democracy*. Cambridge University Press.

Acheson, Donald. (1998). *Inequalities in Health: Report of an Independent Inquiry*. London: HMSO.

Adler, Nancy E. and Katherine Newman. (2002). "Socioeconomic Disparities in Health: Pathways and Policies," *Health Affairs*, 21, 1: 60-76.

Allan, Graham. (1990) `Class Variation in Friendship Patterns', *British Journal of Sociology*, 41, 389-92.

Almedon, Astier M. (2005). "Social Capital and Mental Health: An Interdisciplinary Review of Primary Evidence," *Social Science and Medicine*.

Atkinson, Michael and William D. Coleman (1989). *The State, Business and Industrial Change in Canada.* Toronto: University of Toronto Press.

Banks, James, Michael Marmot, Zoe Oldfield, James P. Smith. (2006). "Disease and Disadvantage in the United States and England," *Journal of the American Medical Association*, 295, 17: 2037-2045.

Bartley, Mel. ed. (2006). *Capabilities and Resilience: Beating the Odds*. Department of Epidemiology and Public Health, University College, London.

Baumgartner, Frank R. and Bryan D. Jones. (1993). *Agendas and Instability in American Politics*. Chicago: University of Chicago Press.

Beckfield, Jason. (2004). "Does Income Inequality Harm Health? New Cross-National Evidence," *Journal of Health and Social Behavior*, 45, 3: 231-248.

Behrman, Jere, Hans-Peter Kohler, Susan Cott Watkins and Eliya Zulu. (2003). *Social Interactions and HIV/AIDS in Rural Malawi*. Demographic Research
Special Collection #1.

Berkman, Lisa F.. (1995). "The Role of Social Relations in Health Promotion," *Psychosomatic Medicine*.

Berkman, Lisa F., Thomas Glass, Ian Brissette, Teresa E. Seeman. (2000) "From Social Integration to Health: Durkheim in the New Millennium," *Social Science and Medicine*. 51: 843-57.

Berkman, Lisa F. and Ichiro Kawachi, eds. (2000) *Social Epidemiology*. New York: Oxford University Press.

Berkman, Lisa F. and S. Leonard Syme. (1979) "Social Networks, Host Resistance and Mortality: A Nine Year Follow Up Study of Alameda County Residents," *American Journal of Epidemiology*: 109-186.

Berman, Sheri. (1998). *The Social Democratic Moment*. Cambridge: Harvard University Press.

Booth, John A. and Patricia Bayer Richard. (2001). "Civil Society and Political Context in Central America" in Bob Edwards and Michael W. Foley, eds., *Beyond Tocqueville: Civil Society and the Social Capital Debate in Comparative Perspective*. Hanover, NH: University Press of New England: 43-54.

Boltanksi, Luc and Laurent Thévenot (1999). "The Sociology of Critical Capacity," *European Journal of Social Theory*, 2, 3: 359-377.

Bouchard, Gérard. (2000). *Genèse des nations et cultures du nouveau monde. Essai d'histoire comparée*. Montréal: Boréal.

Bouchard, Gérard (2003). *Raison et contradiction*. Montréal, Boréal.

Bourdieu, Pierre. (1983). `The Forms of Capital', in John G. Richardson, ed., *Handbook of Theory and Research for the Sociology of Education*. New York: Greenwood

Brunner, Eric J. (1997). "Stress and the Biology of Inequality," *British Medical Journal*, 314: 1472-6.

Brunner, Eric J. (2000). "Toward a New Social Biology" In Lisa Berkman and Ichiro Kawachi, eds., *Social Epidemiology*. New York: Oxford University Press: 306-31.

Bulmer, Martin. (1986). *Neighbours: The Work of Philip Abrams* (Cambridge: Cambridge University Press

Canvin, K, C. Jones, M. Whitehead. (2006). "Avoiding Social Welfare Services in Britain: Causes and Consequences for Health and Well-Being." Working Paper 3, University of Liverpool.

Carpiano, Richard M., Bruce G. Link and Jo C. Phelan. (2006). "Social Inequality and Health: Future Directions for the Fundamental Cause Explanation. Working Paper.

Case, R. B, A. J. Moss, N. Case, M. McDermott, and S. Eberly. (1992). "Living Alone After Myocardial Infarction," *Journal of the American Medical Association*: 267-515.

Castoriadis, Cornelius (1987). *The Imaginary Institution of Society*. Cambridge, UK: Polity Press.

Chevalier, Louis. (1973). *Labouring Classes and Dangerous Classes in Paris during the First Half of the Nineteenth Century*. London: Routledge and Kegan Paul.

Chrousos, G.P, McCarty, R, Pacak, K., Cizza, G., Sternbery, E. Gold, P.Wl., Kvetansky, R, Eds. (1995). "Stress: Basic Mechanisms and Clinical Implications," *Annals of the New York Academy of Sciences*. Vol. 771.

Coleman, James. (1990). *Foundations of Social Theory* Cambridge, Mass.: Harvard University Press

Cook, Karen, Russell Hardin and Margaret Levi. (2005). *Cooperation Without Trust?* New York: Russell Sage.

Crocker, Jennifer and Brenda Major. (1989). "Social Stigma and Self-Esteem: The Self-Protective Properties of Stigma," *Psychological Review*, 96, 4: 608-30.

Culpepper, Pepper D. (2003). *Creating Cooperation: How States Develop Human Capital in Europe*. Ithaca: Cornell University Press.

Cutler, David M. (2004). *Your Money or Your Life: Strong Medicine for America's Health Care System*. New York: Oxford University Press.

Cutrona, C. and B. Troutman. (1986). "Social Support, Infant Temperment and Parenting Self-Efficacy: A Mediational Model of Postpartum Depresseion," *Child Development*, 57: 1507-1518.

Dalton, Russell J., S. C. Flanagan, Paul A. Beck and James E. Alt, eds., (1984). *Electoral Change in Industrial Democracies: Realignment or Dealignment?* Princeton: Princeton University Press.

Deaton, Angus. (2001). "Relative Deprivation, Inequality, and Mortality." Working Paper. MacArthur Network on Poverty and Inequality in a Broader Perspective, Center for the Study of Health and Well-Being, Woodrow Wilson School.

Dobbin, Frank. (1997). *Forging Industrial Policy: The United States, Britain and France in the Railroad Age*. New York: Cambridge University Press.

Dosi, Giovanni and David Teece. (1998). eds. *Technology, Innovation and Competitiveness*. Oxford: Oxford University Press

Dunn, James R. Bill Burgess and Nancy A. Ross. (2005). "Income Distribution, Public Service Expenditures and All-Cause Mortality in U.S. States," *Journal of Epidemiology and Community Health*, 59:768-774

Eberstadt, Nick. (1981). "The Health Care Crisis in the USSR," *New York Review of Books* (February 19): 23-31.

Edwards, Bob, Michael W. Foley and Mario Diani, eds. (2001). *Beyond Tocqueville: Civil Society and the Social Capital Debate in Comparative Perspective*. Hanover, N.H.: University Press of New England

Elmer, N. (2001). *Self-Esteem: The Costs and Benefits of Low Self-Worth*. New York: Joseph Rowntree Foundation.

Emirbayer, Mustafa and Jeff Goodwin (1994). "Network Analysis, Culture, and the Problem of Agency," *American Journal of Sociology*, Vol. 99 (6); 1411-54.

Erickson, Bonnie H. (1996). "Culture, Class and Connections," *American Journal of Sociology* 102 (July): 217-51

Erickson, Bonnie H. (2001). "Good Networks and Good Jobs: The Value of Social Capital to Employers and Employees." In Nan Lin, Karen S. Cook and Ronald S. Burt, eds. *Social Capital: Theory and Research*. New York: Aldine de Gruyter: 127-58.

Erickson, Bonnie H. (2002). "Knowing Men and Women" Working Paper, Department of Sociology, University of Toronto.

Erikson, Kai T. (1976). *Everything in its Path: Destruction of Community in the Buffalo Creek Flood*. New York: Simon and Schuster.

Evans, Peter (1995). *Embedded Autonomy: States and Industrial Transformation*. Princeton, NJ: Princeton University Press.

Field, Mark. G. (1986). "Soviet Infant Mortality: A Mystery Story," In Jelliffe and Jelliffe, eds., *Advances in International Maternal and Child Care*, Vol 6: 25-65..

Fraser, Nancy and Axel Honneth. (2003). *Redistribution or Recognition*. London: Verso.

Freitag, Markus. (2003). "Beyond Tocqueville: The Origins of Social Capital in Switzerland," *European Sociological Review*, 19 (2): 217-232.

Garrett, Laurie. (2000). "Bourgeois Physiology," In *Betrayal of Trust: The Collapse of Global Public Health*. New York: Hyperion, ch. 3.

Gatens, Moira. (2004). "Can Human Rights Accommodate Women's Rights? Towards an Embodied Account of Social Norms, Social Meaning, and Cultural Change," *Contemporary Political Theory*, 3: 275-99

Geertz, Clifford (1973). *The Interpretation of Cultures*. New York: Basic Books

Golden, Mirian. (1993). "The Dynamics of Trade Unionism and National Economic Performance," *American Political Science Review*, 87 (June): 439-54.

Goldthorpe, John A. (1987). *Social Mobility and Class Structure in Modern Britain*. Second edition. Oxford: Oxford University Press.

Goldthorpe, John A., Frank Beckhofer, David Lockwood (1969). *The Affluent Worker in the Class Structure*. Cambridge: Cambridge University Press.

Granovetter, Mark. (1974). *Getting a Job*. Cambridge, MA: Harvard University Press.

Granovetter, Mark. (1973). "The Strength of Weak Ties," *American Journal of Sociology* 78: 13260-80.

Graubard, Stephen. (1964). *A New Europe?* Boston: Houghton Mifflin.

Greif, Avner. (2006). *Institutions and the Path to the Modern Economy*. New York: Cambridge University Press.

Grembowski, D., D. Patrick, P. Diehr, M. Durham, S. Beresfors, E. Kay. (1993). "Self-Efficacy and Health Behavior among Older Adults," *Journal of Health and Social Behavior*, 34: 89-104.

Hall, Peter A. (1999). 'Social Capital in Britain,' *British Journal of Political Science* 29, 3: 417-61.

Hall, Peter A. (2003) “Aligning Ontology and Methodology in Comparative Research” In James Mahoney and Dietrich Rueschemeyer, eds. *Comparative Historical Analysis: New Approaches and Methods*. New York: Cambridge University Press: 373-406.

Hall, Peter A., and David Soskice eds. (2001). *Varieties of Capitalism - The Institutional Foundations of Comparative Advantage*. Oxford: Oxford University Press.

Hall, Peter A. and Rosemary C. R. Taylor (1998). "Political Science and the Three 'New Institutionalisms,'" *Political Studies* (December 1996)

Hall, Peter A. and Kathleen Thelen (2006). “Institutional Change in Varieties of Capitalism.” Paper presented to the Conference of Europeanists, Chicago.

Haslam, S. Alexander, Anne O’Brien, Jolanda Jetten, Karine Vormedal and Sally Penna. (2005) “Taking the Strain: Social Identity, Social Support and the Experience of Stress,” *British Journal of Social Psychology*, 44: 355-70.

Hawkley, Louise C., Gary G. Berntson, Christopher G. Engeland, Phillip T. Marucha, Christopher M. Masi, and John T. Cacioppo (2005). “Stress, Aging, and Resilience: Can Accrued Wear and Tear Be Slowed?” *Canadian Psychology/Psychologie canadienne*, 2005, 46:3, 115-125.

Helliwell, John. F. (2005). “Well-Being, Social Capital and Public Policy: What’s New?” National Bureau of Economic Research Working Paper 11807, Cambridge, Ma.

Helliwell, John F. and Haifang Huang (2006). “How’s Your Government? International Evidence Linking Good Government and Well-Being.” National Bureau of Economic Research Working Paper 11988, Cambridge, Ma.

Hertzman, Clyde and John Frank. (2006). "Biological pathways linking social environment, development, and health." In *Healthier Societies: From Analysis to Action*, edited by Jody Heymann, Clyde Hertzman, Morris L. Barer, and Robert G. Evans. New York: Oxford University Press.

Hertzman, Clyde and Chris Power. (2006). "A life course approach to health and human development." In *Healthier Societies: From Analysis to Action*, edited by Jody Heymann, Clyde Hertzman, Morris L. Barer, and Robert G. Evans. New York: Oxford University Press.

Heyman, Jody, Clyde Hertzman, Morris L. Barer and Robert G. Evans, eds. *Healthier Societies: From Analysis to Action*. New York: Oxford University Press.

Higonnet, Patrice. (1988). *Sister Republics: The Origins of French and American Republicanism*. Cambridge, Ma.: Harvard University Press.

Howard, Marc. (2003). *The Weakness of Civil Society in Post-Communist Europe*. New York: Cambridge University Press.

Inglehart, Ronald. (1999). “Trust, Well-Being and Democracy” In Mark Warren, ed., *Democracy and Trust*. New York: Cambridge University Press: 88-120.

Jacobstone, Stephane and Jane Jenson. (2005). Care Allowances for the Frail Elderly and their Impact on Women Care-Givers. Canadian Family Network. Discussion Paper.

Jenson Jane and S. Phillips. (2003). "The Changing Canadian Citizenship Regime" In *Experiments in Citizenship*, edited by Colin Crouch, Klaus Eder, and D. Tambini. London: Oxford University Press.

Jenson, Jane and Denis Saint-Martin. (2003). "New Routes to Social Cohesion? Citizenship and the Social Investment State," *Canadian Journal of Sociology*. 28 (1): 77-99.

Jepperson, Ronald L. (1991). "Institutions, Institutional Effects and Institutionalization." In Walter W. Powell and Paul J. DiMaggio, eds., *The New Institutionalism in Organizational Analysis*. Chicago: University of Chicago Press.

Johnson, James. (2002). "How Conceptual Problems Migrate: Rational Choice, Interpretation and the Hazards of Pluralism," *Annual Review of Political Science*, 5: 223-248.

Kawachi, Ichiro (2000) "Income Inequality and Health." In *Social Epidemiology*, edited by Lisa Berkman and Ichiro Kawachi.. Oxford University Press: New York, pp. 76-94.

Kawachi, Ichiro and Bruce P. Kennedy (1999). "Health and Social Cohesion." In *The Society and Population Health Reader: Income Inequality and Health*, edited by I. Kawachi, B. P. Kennedy and R. G. Wilkinson. p.195-202. New York: The New Press.

Kawachi, Ichiro, Bruce P. Kennedy, Kimberly Lochner, Deborah Prothtrow-Stith. (1997). "Social Capital, Income Inequality and Mortality," *American Journal of Public Health*

Kawachi, Ichiro, Bruce P. Kennedy and Roberta Glass. (1998). "Social Capital and Self-Rated Health: A Contextual Analysis," *American Journal of Public Health*.

Kawachi, Ichiro, Bruce P. Kennedy and Richard G. Wilkinson, eds. (1999). *The Society and Population Health Reader: Income Inequality and Health*, Vol. I. New York: The New Press.

Keating, Daniel (2004). "Cognitive and brain development." In *Handbook of Adolescent Psychology*, edited by Richard Lerner and Laurence Steinberg. New York: Wiley & Sons.

Keating, Daniel P. and Clyde Hertzman. (1999). *Developmental Health and the Wealth of Nations. Social, Biological, and Educational Dynamics*. New York: Guilford Press.

Keeler, John T. S. (1987). *The Politics of Neo-Corporatism in France*. New York: Oxford University Press

Kennedy, Bruce P., Ichiro Kawachi, Deborah Prothrow-Stith, Kimberly Lochner, and Vanita Gupta. (1998). "Social Capital, Income Inequality and Firearm Violent Crime," *Social Science and Medicine*.

Kertzer, David. (1989). *Ritual, Politics and Power*. New Haven: Yale University Press.

Kingdon, John. (1984). *Agendas, Alternatives and Public Policy*. Boston: Little Brown.

Klinenberg, Eric. (2002). *Heat Wave*. Chicago: University of Chicago Press.

Kleinman, Arthur (1981). *Patients and Healers in the Context of Culture*. Berkeley: University of California Press.

Kohn, Melvin L., Atsushi Naoi, Carrie Scoenbach, Carmi Schooler, and Kazimierz Slomczynski. (1990). "Position in the Class Structure and Psychological Functioning in the United States, Japan and Poland." *American Journal of Sociology* 95 (4): 964-1008.

Krieger, Nancy (2000). "Discrimination and Health" In *Social Epidemiology*, edited by Berkman Lisa and Kawachi Ichiro. New York: Oxford University Press, pp 36-75.

Kubzansky LD and I. Kawachi (2000). "Affective states and health." In *Social Epidemiology*, edited by Berkman Lisa and Kawachi Ichiro. New York: Oxford University Press, pp. 213-241.

Kumlin, Staffan and Bo Rothstein. (2004). "Making and Breaking Social Capital: The Impact of Welfare Institutions. Mimeo.

Kymlicka, Will. (1996). *Multicultural Citizenship: A Liberal Theory of Minority Rights*. New York: Oxford University Press

Kymlicka, Will. (forthcoming). *The Diffusion of Liberal Multiculturalism*.

Lamont, Michèle (1998). *Money, Morals and Manners: The Culture of the French and the American Upper-Middle Class.* Chicago: University of Chicago Press (Morality and Society series, ed. by Alan Wolfe). (2nd edition: 1999).

Lamont, Michèle (2000).*The Dignity of Working Men: Morality and the Boundaries of Race, Class, and Immigration*. Cambridge: Harvard University Press and New York: Russell Sage Foundation.

Lin, Nan, Karen S. Cook and Ronald S. Burt, eds. (2001). *Social Capital: Theory and Research*. New York: Aldine de Gruyter.

Link BG and JC Phelan (1995). "Social conditions as fundamental causes of disease." *Journal of Health and Social Behavior*. :80–94.

Link BG and JC Phelan (2000). "Evaluating the fundamental cause explanation for social disparities in health." In *Handbook of Medical Sociology*, edited by CE Bird, P Conrad, A Fremont, Upper Saddler River, NJ: Prentice Hall, pp. 33-46.

Lipsky, Michael. (1980). *Street-Level Bureaucracy*. New York: Basic Books.

Lovallo, W. R., (1997*). Stress and Health: Biological and Physiological Introduction*. London: Sage.

Lukes, Steven (1975). "Political Ritual and Social Integration," *Sociology*, 9, No. 2, 289-308

Lynch, John and George Kaplan. (2000). "Socioeconomic Position" In Lisa Berkman and Ichiro Kawachi, eds., *Social Epidemiology*. New York: Oxford University Press: 13-35.

Lynch, John, George Davey Smith, Sam Harper, Marianne Hillemeier, Nancy Ross, George A. Kaplan, and Michael Wolfson. (2004). "Is Income Inequality a Determinant of Population Health? Part 1. A Systematic Review." *The Milbank Quarterly* 82 (1), 5-99.

MacLeod, Jay. 1987. *Ain't No Making It*. Boulder: Westview.

March, James G. and Johan P. Olsen (1989). *Rediscovering Institutions. The Organizational Basis of Politics*. New York: Free Press.

Marmot, Michael. (2004). *The Status Syndrome*. NY: Henry Holt and Co.

Marmot, Michael, H. Bosma, H. Hemingway, E. Brunnere and S. Stansfeld. (1997). "Contribution of Job Control and other Risk Factors to Social Variations in Coronary Heart Disease Incidence," *Lancet* 350: 235-9.

Marshall, T. H. (1949). "Citizenship and Social Class" in Marshall, *Class, Citizenship and Social Development* New York: Anchor. 1965 Edition, ch. 4.

McAdam, Douglas, J.D. McCarthy and Mayer N. Zald. (1996). *Comparative Perspectives on Social Movements*. New York: Cambridge University Press.

McAdam, Douglas, Sidney Tarrow and Charles Tilly. (2001). *Dynamics of Contention*. New York: Cambridge University Press.

McEwen, B.S. (1998). "Protective and Damaging Effects of Stress Mediators," *New England Journal of Medicine* 338: 171-9.

McEwen, Bruce S. 2005. "Stressed or stressed out: what is the difference?" *Journal of Psychiatry and Neuroscience*,. 30(5): 315-318.

McFarlane, A, A. Bellissimo, G. Norman. (1995). "The Role of Family and Peers in Social Self-Efficacy: Links to Depression in Adolescence," *American Journal of Orthopscychiatry*, 65: 402-10.

McKeown T. (1965). *Medicine in Modern Society*. London, England: Allen & Unwin.

Miguel, Edward. (2004). "Tribe or Nation? National-Building and Public Goods in Kenya versus Tanzania," *World Politics* 56 (3): 327-62.

Murray, Michael. (2000). "Social Capital Formation and Healthy Communities: Insights from the Colorado Health Communities Initiative," *Community Development Journal* 35 (2): 99-108.

Oakley, Ann and Lynda Rajan.. (1991) `Social Class and Social Support: The Same or Different?' *Sociology*, 25:31-59.

Offe, Claus (1999). "How Can We Trust Our Fellow Citizens." In Mark E. Warren, ed., *Democracy and Trust*. New York: Cambridge University Press: 42-87.

Ostrom, Eleanor. (1990). *Governing the Commons*. New York: Cambridge University Press.

Oyserman, Daphna, Deborah Bybee and Kathy Terry. (2006). "Possible Selves and Academic Outcomes: How and When Possible Selves Impel Action," *Journal of Personality and Social Psychology*.

Oyserman, Daphna and Hazel R. Markus (1990). "Possible selves and delinquency." *Journal of Personality and Social Psychology*. 59, 1 (July):. 112-125.

Pierson, Paul (2000). "Increasing Returns, Path Dependence and the Study of Politics," *American Political Science Review* 94 (June): 251-67.

Pierson, Paul (2004). *Politics in Time: History, Institutions, and Social Analysis*. Princeton University Press.

Pritchett, L. and Lawrence Summers (1996). "Wealthier is Healthier." *Journal of Human Resources*, Vol. 31, No. 4 (Autumn, 1996), pp. 841-868. doi:10.2307/146149.

Putnam, Robert D. (1993). *Making Democracy Work*. Princeton, NJ: Princeton University Press.

Putnam, Robert D. (2000). *Bowling Alone: The Collapse and Revival of American Communities*. New York: Simon and Schuster.

Putnam, Robert. D. ed. (2002). *Democracies in Flux: The Evolution of Social Capital in Contemporary Society*. Oxford: Oxford University Press

Pyszczynski, Tom, Jeff Greenberg, Sheldon Solomon and Jamie Arndt (2004). "Why Do People Need Self-Esteem? A Theoretical and Empirical Review," *Psychological Bulletin* 130, 3: 435-68.

Ross, Nancy, D. Dorling, James R. Dunn, G. Hendricksson, J. Glover and J. Lynch. (2006) "Metropolitan Income Inequality and Working Age Mortality: A Five Country Analysis Using Comparable Data," *Journal of Urban Health*.

Ross, Nancy, Michael Wolfson, George A. Kaplan, James R. Dunn, John Lynch, and Claudia Sanmartin (2006). "Income inequality as a determinant of health." In Healthier Societies: From Analysis to Action, edited by Jody Heymann, Clyde Hertzman, Morris L. Barer, and Robert G. Evans. New York: Oxford University Press.

Rothstein, Bo. (2001). "Social Capital in the Social Democratic Welfare State," *Politics and Society* 29 (2): 207-41.

Rothstein, Bo. (2003). "Social Capital, Economic Growth and Quality of Government: The Causal Mechanism," *New Political Economy* 8 (1): 49-71.

Rothstein, Bo. (2005). *Social Traps and the Problem of Trust*. New York: Cambridge University Press.

Rothstein, Bo and Eric M. Uslaner. (2004). "All for All: Equality and Social Trust". Center for European Studies Working Paper. No. 117. Harvard University.

Runciman, W. G. (1964). *Relative Deprivation and Social Justice*. Harmondsworth: Penguin.

Sampson, Robert J., Stephen W. Raudenbush, and Felton Earls (1997). "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy." *Science* 277 (15 August 1997):. 918 - 24.

Sampson, Robert J., Jeffrey D. Morenoff and Thomas Gannon-Rowley. (2002). "Assessing Neighborhood Effects: Social Processes and New Directions in Research". *Annual Review of Sociology* 28:443-478.

Sapolsky, R. M. and L. J. Share. (1994). "Rank-Related Differences in Cardiovascular Function among Wild Baboons: Role of Sensitivieity to Glucocorticoids," *American Journal of Primateology*, 32: 261-75.

Sapolsky, R. M., S. C. Alberts, J. Altmann (1997). "Hypercortisolism Associated with Social Subordinance or Social Isolation among Wild Baboons," *Archives of General Psychiatry*, 54, 12: 1137-1143.

Schnittker, Jason and Jane D. McLeod. (2005). "The Social Psychology of Health Disparities." *Annual Review of Sociology* 31:10.1-10.29.

Sayer, Andrew. (2005). "Class, Moral Worth and Recognition," *Sociology*, 39, 5: 947-63.

Schudson, Michael (1989). "How Culture Works," *Theory and Society*, 18: 153-80.

Selle, Per. (1999). "The Transformation of the Voluntary Sector in Norway: A Decline in Social Capital?" In. Jan W. Van Deth, Marco Maraffi , Kenneth Newton and Paul F. Whiteley, eds. *Social Capital and European Democracy*. London: Routledge: 144-66.

Sen, Amartya (1999). *Development as Freedom*. Oxford: Oxford University Press.

Shively, C.A. and T.B. Clarkson. (1994). "Social Status and Coronoary Artery Atherosclerosis in Female Monkeys," *Arteriosclerosis and Thrombosis*, 14: 721-6.

Shively, C.A. K. Laer-Laird, R.F. Anton. (1997). "Behavior and Physiology of Social Stress and Depression in Female Cynomolgus Monkeys," *Biological Psychiatry*, 41: 871-82.

Sieber, S. (1974). "Toward a Theory of Role Accumulation, " *American Sociological Review*, 39: 567-78.

Skocpol, Theda. (1979). *States and Social Revolutions*. New York: Cambridge University Press.

Smelser, Neil and Richard Swedberg. (1994). *Handbook of Economic Sociology*. Princeton: Princeton University Press.

Stacey M. et al. (1975). *Power, Persistence and Change* London: Routledge and Kegan Paul.

Steele, Claude M. (1988). "The Psychology of Self-Affirmation: Sustaining the Integrity of the Self" In *Advances in Experimental Social Psychology, Vol. 21: Social Psychological Studies of the Self: Perspectives and Programs*. San Diego: Academic Press, pp. 261-302.

Steele, Claude. M. (1999). "Thin ice: "Stereotype threat" and black college students." *The Atlantic Monthly*, 284(2), 44-47, 50-54.

Steele, Claude .M. and J Aronson (1998). "Stereotype threat and the test performance of academically successful African Americans." In *The Black-White Test Score Gap* edited by Christopher Jencks and Meredith Phillips. Washington, DC: The Brookings Institution Press.

Steensland, Brian (2006). "Cultural Categories and the American Welfare State: The Case of Guaranteed Income Policy." *American Journal of Sociology*, 111: 1273 – 1326.

Steinberg, Lawrence, Ronald Dahl, Daniel P. Keating, David Kupfer, Anne Masten, and Daniel Pine. (2006). "Adolescent psychopathology." In *Handbook of Developmental Psychopathology*. New York: Wiley & Sons.

Stolle, Dietlind and Marc Hooghe, eds. (2003). *Generating Social Capital: Civil Society and Institutions in Comparative Perspective*. Houndmills: Palgrave Macmillan.

Streeck, Wolfgang and Kathleen Thelen. Eds. (2005). *Beyond Continuity: Institutional Change in Advanced Political Economies*. New York: Oxford University Press.

Svensson, Lennart and Casten Von Otter. (2002). "Strategies for Regional Regeneration: Learning from the Bergslagen Regional Research Center," *Economic and Industrial Democracy* 23 (2): 421-39.

Swidler, Ann. (1986). "Culture in Action: Symbols and Strategies." *American Sociological Review* 51: 273-286.

Sztompka, Piotr (1999). *Trust: A Sociological Theory*. New York: Cambridge University Press.

Taylor, Charles. (1993). *Multiculturalism and the Politics of Recognition*. Princeton: Princeton University Press.

Taylor, Rosemary CR (1982). "The Politics of Prevention," *Social Policy*, 13, 1 (1982): 32-41.

Taylor, Rosemary CR. (2004). "What's Culture Got To Do With It? Public Health and 'Foreign Bodies'." Paper presented at the Institute for Advanced Study (Wissenschaftskolleg), Berlin.

Taylor, Shelley E., Rena L. Repetti and Teresa Seeman. (1999). "What is an Unhealthy Environment and How Does it Get Under the Skin," in Ichiro Kawachi, Bruce P. Kennedy and Richard G. Wilkinson, eds. *The Society and Population Health Reader*. I. New York: The New Press: 351-78.

Thelen, Kathleen (2004). *How Institutions Evolve: The Political Economy of Skills in Germany, Britain, the United States and Japan*. New York: Cambridge University Press.

Thoits, P. 1983. "Multiple Identities and Psychological Well-Being: A Reformulation of the Social Isolation Hypothesis," *American Sociological Review*. 48: 174-87.

Thompson, E. P. (1971), "The Moral Economy of the English Crowd in the Eighteenth Century," *Past and Present*, 50, (February): 76-136.

Torpe, Lars. (2003). "Social Capital in Denmark: A Deviant Case?" *Scandinavian Political Studies* 26 (1): 27-48.

Tyler, Tom R. and Steven Blader. (2000). *Cooperation in Groups: Procedural Justice, Social Identity and Behavioral Engagement*. London: Psychology Press.

Valle, Carla (2003). Political Catholicism in Post-War Italy: How Social Organizations Respond to Political Change. Ph.D. Dissertation. Department of Government, Harvard University.

Van Kemenade, Solange, Sylvain Paradis and Erik Jenkins. (2006). "Can Public Policy Address Social Capital?" *Policy Research,* 6 2. Health Canada.

Wallis, J. and B. Dollery. (2002). "Social Capital and Local Government Capacity," *Australian Journal of Public Administration*,

Warren, Mark. Ed. (1999). *Democracy and Trust*. New York: Cambridge University Press.

Warren, Mark. (2001). "Power and Conflict in Social Capital." In. Bob Edwards, Michael W. Foley and Mario Diani, eds., *Beyond Tocqueville: Civil Society and the Social Capital Debate in Comparative Perspective*. Hanover, N.H.: University Press of New England, pp. 169.

Weber, Eugen (1976). *Peasants Into Frenchmen: The Modernization of Rural France, 1871-1914*. Stanford: Stanford University Press.

Wheaton, Blair (1985). "Models for the Stress-Buffering Functions of Coping Resources." *Journal of Health and Social Behavior*, Vol. 26, No. 4 (Dec., 1985), pp. 352-364. doi:10.2307/2136658

Wheaton, Blair and Philippa Clarke (2003). "Space Meets Time: Integrating Temporal and Contextual Influences on Mental Health in Early Adulthood." *American Sociological Review*, Vol. 68, No. 5 (Oct., 2003), pp. 680-706.

Wilkinson, Richard. (1996). *Unhealthy Societies: The Afflictions of Inequality*. London: Routledge.

Wilkinson, Richard. (1997). "Health Inequalities: Relative or Absolute Standards?" *British Medical Journal* 314: 591-95.

Wilkinson, Richard G. (2005). *The Impact of Inequality: How to Make Sick Societies Healthier*. New York: Free Press.

Williams, David R. (1999). "Race, Socioeconomic Status, and Health. The Added Effects of Racism and Discrimination." *Annals of the New York Academy of Sciences* 896: 173-188.

Williams, David R. (2005). "The Health of U.S. Racial and Ethnic Populations," *Journal of Gerontology*.

Williamson, Oliver. (1985). *The Economic Institutions of Capitalism*. NY: Free Press.

Willis, Paul. (1977). *Learning to Labour: How Working Class Kids Get Working Class Jobs*. Farnborough, Hants.: Saxon House.

Worms, Jean-Pierre. (2002). "Old and New Civic and Social Ties in France." In. Robert D. Putnam, ed., *Democracies in Flux*. New York: Oxford University Press: 137-88.

Wuthnow, Robert. (2002). "United States: Bridging the Privileged and the Marginalized." In. Robert D. Putnam, ed., *Democracies in Flux*. New York: Oxford University Press: 59-102.