HEALTH, SOCIAL RELATIONS, AND PUBLIC POLICY

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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 extend our understanding of how governments affect population health. We develop a distinctive perspective on this topic that suggests governments 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 support this claim but continuing

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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 nutrition and sanitation, 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).

controversy about which aspects of social relations impinge on health and through which causal mechanisms.[3] We shed light on these issues by proposing a particular model linking social relations to health and then use that model to identify the dimensions of social relations most likely to impinge on health. Our approach goes beyond many current formulations to incorporate a fuller appreciation for the ways in which cultural frameworks matter to variations in population health.

The wider significance of our argument lies in the portrait it draws of public policy-making. Policy is often said to affect collective well-being by redistributing economic resources. Many policies work this way. However, we argue that public policies also affect collective well-being through their impact on the structure of social relations, because those relations are social resources on which individuals draw to advance their own welfare. In short, we see public policy-making as a process of social resource creation and social resources as central to population health.

A Basic Model Linking Population Health to Economic and Social Relations

We begin by developing a general model designed to capture some of the important ways in which economic and social relations feed into health. It has special relevance for the gradient that links health to socioeconomic status, measured by income, occupation, or educational level. As the opening chapters in this book indicate, in all developed and most developing countries, people with lower levels of socioeconomic status tend to have poorer levels of health. The problem is to explain both the existence of this gradient and why variations in its shape, that indicate disparities in health across socioeconomic

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

groups, are greater in some communities or countries than in others.[4] Such variations are large enough to represent millions of years of healthy lives foregone.

Although well documented in epidemiology, the health gradient is not well explained. 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 variation in the presence of social networks among different segments of the population.[5] However, the 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 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 of such generality adequately captured by that term remains an open question.[6] Many studies treat cross-national differences in social factors as if they are rooted in material factors.[7] Of course, social factors often have economic roots. But we try to delineate the dimensions of social relations relevant to population health in terms that separate them 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.

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[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.

Our focus is on the affluent democracies, where population health is not closely correlated with political stability or gross domestic product per capita, and our objective is not to review every way in which social relations impinge on health, but to concentrate on a specific set of causal chains. We attribute particular importance to the toll taken on health by the 'wear and tear of daily life'.[8] This is appropriate for the OECD countries where chronic diseases that have been linked to such wear and tear make a large contribution to life expectancy, and national differences in rates of mortality turn primarily on differences in mortality in the working age population, namely, among people exposed to the pressures of working lives.[9]

This perspective emphasizes the impact of experiences of stress and the emotional states associated with them, such as anxiety, resentment and frustration.[10] Although these are not the only causes of illness, a substantial body of research shows they are closely associated with a person's health. Daniel Keating's chapter for this volume traces the biological pathways whereby such experiences produce negative physiological effects.[11]

We deploy a simple, but relatively general model to identify how much stress and accompanying emotional pressure a person is likely to experience in daily life. At its heart are two main components. On one side is the magnitude of the *life challenges*

[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).

facing individuals, namely the tasks associated with reaching goals they consider important, such as finding a companion, raising a family, or securing a livelihood. We assume that life satisfaction depends heavily on the effectiveness with which people 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.

On the other side of the model are a person's *capabilities* for taking effective action to cope with these life challenges.[12] These are constituted, first, by key attributes of personality, including emotional resilience, reflective consciousness, and self-esteem. These attributes are established in childhood but refined in later life. Evidence shows they condition a person's ability to complete many kinds of tasks successfully and to control behaviors associated with poor health, such as smoking, exercise and diet.[13] The second constitutive element of a person's capabilities lies in her capacity to elicit the cooperation of others. Performing many of the tasks of daily life, associated with finding child care, work or housing, requires the cooperation of other people. Where cooperation is difficult to secure, accomplishing such tasks becomes more onerous. Finally, some challenges can be addressed best by collective action. In such cases, people need the capability to act in concert, whether to pressure governments to provide better 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

[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).

experience higher levels of stress and feelings of anxiety, anger and frustration that lead to poorer levels of physical and mental health. Everyone experiences some challenging moments, but we are referring to life challenges and capabilities that tend to be durable 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 across individuals. However, we are interested in systematic variations in population health across social groups and societies. 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 review the evidence for whether they do so, before turning to the effects governments can have on social relations.

The Impact of Economic Relations

One of the advantages of this model is that it captures the effects of economic as well as social relations on population health. 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), linked together in relations structured by markets, hierarchies, and other institutions supporting

[14] Taylor *et al*. (1999).

cooperation.[15] From the perspective of our model, the economy is important to the health of the population because the distribution of material resources conditions the magnitude of the life challenges facing people and their capabilities for meeting challenges. Access to material resources makes it easier for people to find a good job, secure a decent residence, take care of children, and the like. In short, our model incorporates the contention that the distribution of material resources provides part of the explanation for the familiar health gradient.

The implication is that governments can mitigate the health effects of material inequality 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. Disagreement existsas to whether a more equal income distribution improves the health of the population as a whole, but some evidence supports thatclaim.[17] The public provision of services is associated with better population health and may sometimes be a substitute for income redistribution.[18] A number of analysts have argued that wider access to education can improve the health of the population.[19]

However, our model suggests that the structure of economic relations may affect the health of the population in other ways as well, notably through the intensity of labor

[15] Williamson (1985), Greif (2006), Hall and Soskice (2001). In these models, both political and 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.
[18] Ross *et al*. (2006).
[19] See the chapter by Peter Evans in this volume, Cutler et al. 2007, and Keating and Hertzman (1999).

market competition it promotes and corresponding insecurities in the employment relationship.[20] Relatively little is known about how the intensity of market competition affects population health. On the one hand, it may improve the opportunities available to some people.[21] On the other hand, by increasing insecurity, it may generate more stressful experiences that can lead to poorer health, especially for segments of the population endowed with few marketable assets. The precipitous declines in health following the transition to capitalism in Eastern Europe, to which Clyde Hertzman draws attention, suggest such risks are real. But the impact on health of increasing market competition may be mediated by other factors, such as overall levels of unemployment and the character of social benefits, raising issues that deserve more study.

Social Relations as Social Resources

Since Adam Smith, it has been customary to construe the economy in structural terms. One of our core contentions is that societies should be seen in analogous terms, namely, as structured sets of social relations that impinge on population health. To establish this point, we pursue three lines of analysis. First, we try to identify the principal dimensions of social relations that affect population health, with an emphasis on those comparable across societies. Using the model we have just described, we then outline a set of causal paths whereby each of these dimensions might affect the health of the population.[22]

[20] Bartley et al. 2005

[21] 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).

[22] As noted, we are not claiming these are the only paths through which social relations condition health.

Finally, we adduce some evidence drawn from the literature in support of the argument that each of these dimensions affects population health.

Most views of the social relationships important to health follow two traditions in the study of society.[23] 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 and Karl Marx, 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. Weber directs our attention to the importance of separating the impact of status from the impact of material inequality because differences of social class rooted in economic relations are aligned with distinctions of status rooted in cultural frameworks in some societies but not in all. Accordingly, we explore the impact on population health of *social connectedness* and *social hierarchy*, taken as constitutive features of social structure.

At the foundation of our analysis is the contention that many dimensions of social relations constitute *social resources*, analogous to economic resources, on which people can draw to cope with life challenges.[24] When required to care for children or aging parents, for instance, people call upon the social networks in which they are embedded and the concepts of moral obligation fostered by particular networks. To secure the

[23] See Berkman (1995); Berkman *et al*. (2000).
[24] For analogous formulations that use the term 'social resources' slightly differently, see Link and Phelan (2000); Kristensen (2006); and Pearlin and Schooler (1978).

cooperation of others, they draw on their social status and levels of generalized trust in the community. To mobilize support for action on behalf of the community, they tap the collective purposes defined by prevailing social imaginaries. Like economic resources, social resources can often be put to multiple uses. What individuals attempt to do and the confidence brought to those tasks can also be conditioned by the templates for action present in predominant culturalnarratives.[25]

Rather than seeing a person's capabilities as a set of attributes or endowments possessed by the individual, we see social resources as intrinsically relational, i.e., constituted by the quality of a person's relations with others.[26] While some of these relationships can be understood in the rationalist terms of strategic interaction, others are given by institutional practices and cultural frameworks that are collective features of a society.[27] Let us consider the relevant dimensions in more detail.

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, regardless of their personal contacts. The social

[25] 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).

[26] 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).

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

cohesion of a society turns on the quality of such attachments. Existing analyses emphasize some dimensions of social connectedness more than others.

Social Capital

One of the most prominent 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 that are built on relatively rationalist exchanges and the social trust that is said to accompany them.[28] This account views 'social capital' as a multipurpose social resource of such singular generality that even those who do not participate in associational life are said to benefit from it.

From the perspective of our model, social capital contributes to population health through two 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 – to address the challenges facing the community directly or to pressure governments to do so – especially when these networks run 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

[28] 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).

numbers of secondary associations found there.[29] The concept of social capital provides one way of understanding how the structure of social relations generates resources that underpin population health.

Social Networks

As many analysts have observed, however, the effects of social networks on population health may not flow entirely through the generalized mechanisms of social capital. There are a number of more direct ways in which membership in social networks enhances people's capabilities for coping with life challenges, thereby contributing to their health.[30] 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 sources of *emotional support*, some kinds of networks condition the psychological resilience of individual in the face of challenges.

Of course, the contribution a network makes to the resolution of particular kinds of challenges depends on its character.[31] 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

[29] 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.

[30] 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.

[31] See Erickson (1996, 2002).

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.[32]

More research is needed to establish the value of networks with specific kinds of dimensions for meeting particular kinds of challenges.[33] However, convincing evidence now links a person's health to the overall density of the social networks in which she 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.[34]

Membership in associations underpins people's capabilities in analogous ways, thereby reducing the stress associated with 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.[35]

There is a distributive side to social connectedness. As Putnam posits, the benefits of social trust may be available to all on relatively equal terms.[36] However, people with lower incomes and lower-status occupations tend to belong to fewer

[32] Granovetter 1974; Case *et al.* (1992).
[33] However, see Lin et al. (2001).
[34] Syme and Berkman (1979); For broad reviews, see Berkman (1995) and Berkman *et al*. (2000).
[35] Kawachi *et al*. (1999): chs. 22 and 23.
[36] If so, the health of most of the populace should be better in societies with higher levels of social trust.

associations and smaller social networks based on closer attachments to fewer friends.[37] Therefore, discrepancies in social connections may be one of the factors contributing to the gradient observed between social class and health, and, if the relationship between income (or occupational status) and membership in social networks (or associations) varies systematically across countries, it may help to explain cross-national variation in the shape of the health gradient.

Collective Imaginaries

The social connectedness of a society is specified not simply by the density or character of its social networks, but by the content of the messages about meaning and morality those networks convey.[38] Social relations are structured by a set of collective representations that contribute to the social cohesion of a society by specifying a 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.[39] The concept of social trust is too thin to capture such dimensions fully.

The key point here is one anthropologists have advanced for some time.[40] Social relations are central to the meanings people assign to their lives and actions, and that meaningfulness can often be important to their health. People have more psychological resilience – against depression, anxiety and other adverse emotional states – when their

[37] For the British case, see Allan (1990); Oakley and Rajan (1991); Goldthorpe (1987). See also Carpiano *et al*. (2006).
[38] Emirbayer and Goodwin (1994).
[39] For related formulations, see Bouchard (2000, 2003) and Castoriadis (1987) whose concept of the social imaginary differs in some ways from ours.
[40] 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.

lives appear to them as purposeful, and, within the collective imaginary, people find representations of the community and their place within it that are constitutive of feelings of belonging and allow them to define individual purposes for themselves.

Moreover, the social order is also a moral order – marked by customary attitudes with normative force that specify what individuals can expect of one another. As factors of social cohesion, these go beyond the relations of reciprocal exchange emphasized in conceptions of 'social capital' to approach what Thompson called the 'moral economy' of a community.[41] They define the informal obligations people feel toward each other and the standards of behavior to which they can hold others.[42]

There are a variety of ways in which these dimensions of the collective imaginary feed into people's capabilities and hence into their health. They affect an individual's willingness to turn to others for help and the likelihood it will be supplied. In order to motivate others to join in collective action, people also call upon collective representations of the purposes and standards of the community, making moral as well as material appeals.

As Durkheim noted, collective representations of society 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 people's feelings of social isolation, as well as their levels of optimism about their own fate and that of their community – feelings generally seen as important to health.

Collective imaginaries also specify a range of behaviors seen as appropriate for particular contexts or types of people. They usually identify a set of gender roles and

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

help define what Swidler calls the 'strategies for action' on which individuals in various social positions draw to cope with life challenges.[43] When confronted with a challenge, a person tends to ask 'what can someone like me do about that?' The answer will be influenced by personal experience, but also by the conceptions of 'someone like me' available in the prevailing collective imaginary.[44] In such respects, collective imaginaries are both enabling and constraining. They encourage or discourage a range of behaviors relevant to health and are constitutive of people's capabilities.

Evidence about the impact of social imaginaries on population health is difficult to gather. However, a number of cases establish some of these causal links. Attitudes toward risky behaviors vary systematically with social position in ways that suggest they do not simply reflect the general skills conveyed by education but also the dispositions associated with a particular 'habitus'.[45] At the communal level, Erikson's investigation of the traumatic symptoms following a flood in Buffalo Creek found that many were a reaction, not to the physical disaster itself, but to a loss of the sense of communality once fostered by the tight-knit community swept away by the flood.[46] Eberstadt associates part of the decline in population health in the Soviet Union 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.[47]

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[43] Gatens (2004).
[44] Swidler (1986), see also Oyserman *et al.* (2006).
[45] Veenstra (2005); Frohlich *et al*. (2001); Cockerham (2007). Cf. Cutler and Lleras-Muney (2008).
[46] Erikson (1976).
[47] 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).

However, Gérard Bouchard's chapter in this book reminds us that a society's imaginary is made up of many different images, myths, and collective representations on which individuals draw differently. It constitutes a repertoire that can enable many types of action, even if its overall contours are constraining. Some groups create counter-cultures that take them in different directions, albeit conditioned by a mainstream imagery, and, as Michèle Lamont suggests, individuals can develop strategies to offset some of the effects of a dominant imagery.[48]

Social Hierarchy

As Weber has emphasized, the structure of social relations is also characterized by the asymmetries of social hierarchy. Some arise from formal hierarchies that assign a delimited range of power and autonomy to each position inside them. Others stem from informal hierarchies allocating levels of prestige or social status – a concept that figures prominently in studies of population health.[49]. How do the shapes of social hierarchies and relative positions within them impinge on health?

There is substantial evidence that the formal hierarchies associated with employment affect health by restricting a person's autonomy at work. Those with less control available to meet the demands of the workplace experience more stress and daily anxiety, with corresponding effects on their health.[50] Some argue that steep social hierarchies engender feelings of relative deprivation.[51] However, our model suggests two

[48] See Lamont's chapter in this volume. Also Willis (1977); Crocker and Major (1989).
[49] 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.
[50] See Karasek (1979); Collins et al. (2005); Marmot et al. (1997); Bartley (2005).
[51] Wilkinson (1996).

other pathways from social hierarchy to health, operating through the effects of status on capabilities for coping with life challenges. One turns on the problem of securing cooperation. 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 cooperation one receives from others. As a result, people with low status should experience more wear and tear as they attempt to meet the challenges of daily life.[52]

The other pathway turns on problems of recognition. The levels of stress or anxiety a person experiences depend, not only on the magnitude of the tasks confronting her, but on the confidence 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.[53] Self-esteem is established initially in childhood but influenced by subsequent experience, and our images of ourselves come from those reflected in the mirror society holds up to us.[54] Where those images are more negative, self-esteem is likely to suffer. In short, social recognition is crucial to self-recognition, and higher social status confers more favorable social recognition. As a result, higher status individuals should have higher levels of self-efficacy that reduce the amount of stress they experience in daily life and promote better health.

These observations have important implications for cross-national analysis. Although some view social hierarchies as biologically embedded, the *shape* of such hierarchies is manifestly different across societies and ultimately an artifact of cultural

[52] For more general discussion of this point, see Marmot (2004).
[53]; Steele (1988); MacLeod (1987).
[54] 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).

and institutional frameworks.[55] If we are correct, these differences, in turn, condition the distribution of health across the population. Societies that deprive large numbers of people of social status should have worse levels of population health than those that assign status more evenly. National variations in population health should follow variations in the social hierarchy.

However, we need ways of characterizing that variation. Many analysts assume a person's status simply corresponds to his occupation, generating a similar curve for advanced industrial societies. But sociological research reveals more diverse sources of status and wider variation in the shape of such curves.[56] With this in mind, we suggest three dimensions of social hierarchy likely to be consequential for population health.

The first is the steepness of the status hierarchy associated with income or occupational position in any given country, understood as the size of the status differentials between typical positions along it, reflected, for instance, in the levels of social prestige enjoyed by those at each decile in the income distribution. But this relationship may not be unilinear, and the shape of this curve is 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.[57]

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 overlapping circles of family, workplace, neighborhood, and nation, each associated with distinctive components of the collective imaginary. In

[55] Bourdieu (1983).
[56] Lamont (2000); Boltanski and Thévenot (1999); Sing-Manoux *et al*. (2005).
[57] Runciman (1964).

principle, a person may secure status from his role in any of them. In societies where people typically derive status, not only from their family origins or occupation, but from their roles as fathers, citizens or consumers, the overall distribution of status may be more even, to the advantage of those in lower-status occupations.[58] 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 inequality. Here, the distribution of social resources parallels the distribution of economic resources. In some societies, however, income and status may not be so closely coupled.

Social hierarchies can also be characterized by the status they assign to readily identifiable groups in society, such as men, women, racial or ethnic groups. Status differences of this sort may be as large as those rooted in income or occupation.[59] Typically, they are reflected in the stereotypes that are familiar features of collective imaginaries, and constitutive of the social boundaries discussed in Michèle Lamont's chapter for this volume.[60] Evidence from psychology suggests that such stereotypes can have powerful effects on the efficacy with which people perform certain tasks. They can affect self-esteem and a person's capacity to secure the cooperation of others.[61]

Empirically, it is difficult to separate the effects of status from those of income, and there are few studies 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

[58] See Steele (1988); Sieber (1974); Thoits (1983).
[59] Williams (1999, 2005); Krieger (2000).
[60] 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.
[61] Steele (1998); Steele *et al*. (1998); Cf. Pyszczynski *et al*. (2004); Elmer (2001).

positions in this occupational hierarchy suffered from more health problems than officials of higher status.[62] Studies of other primates as well as human beings show that those with low status display a range of physiological effects associated with poor health, such as atherosclerosis, obesity, worse cholesterol profiles, and behavioral depression.[63] And, although the interpretation is hotly contested, the finding that average levels of health are worse in countries where the income distribution is more unequal may indicate the adverse health effects of a steeper status hierarchy.[64] Taken together, these studies offer tentative support for the contention that social hierarchies condition population health.

The Capabilities of Communities

Of course, the structure of social relations affects, not only the capabilities of individuals, but what might be called the capabilities of communities. Some of these reside in the capacities of members of the community to cooperate to advance everyone's health, through efforts to reduce rates of violence, improve local housing, clean up the environment, and the like.[65] Others reside in the capabilities of governments to address community health issues, reflected in policies to cope with infectious as well as chronic diseases and efforts to improve sanitation, regulate food or occupational safety, and otherwise provide a healthy environment.[66]

[62] Marmot (2004).
[63] See the chapter by Keating in this volume and Shively *et al*. (1994, 1997); Sapolsky and Share (1994); Sapolsky *et al*.(1997); Brunner (1997).
[64] For overviews, see Berkman and Kawachi (2000); Wilkinson (1997, 2005: ch. 4); Lynch *et al*. (2004).
[65] Other examples could be given. See Sampson *et al*. (1997; 2002).
[66] For overviews, see McKeown (1965); Adler and Newman (2002); Acheson (1998).

Many factors condition the capabilities of communities and their governments, but these include various features of the structure of social relations. [67] As Peter Evans observes, mobilization requires more than civil rights and the existence of town meetings.[68] Capacities for collective mobilization turn on the density of existing social networks and the quality of the local solidarities animating them. [69] Those capacities are conditioned by the collective imaginaries of a community, which specify what people owe one another, why they should band together, and just how to improve their lives.[70]

The capacities of governments to implement various kinds of policies also depend on the nature of social organization and the cultural frameworks associated with it. Many studies have shown that the effective implementation of industrial or agricultural policy turns on how those segments of society are organized.[71] However, measures to protect vulnerable citizens or to shift people away from behaviors that put their health at risk can also depend on the character of local arrangements. Eric Klinenberg analyzes why existing social protection systems could not shield elderly, isolated residents from the effects of a devastating heat wave in Chicago. He found, for example, that many refused offers of support in order to avoid admitting dependence in the context of a culture that

[67] 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.).
[68] 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).
[69] Putnam (2000); Warren (2001); Swidler's chapter in this volume.
[70] Recent declines in the capacities of socialist or Catholic organizations to mobilize their European constituencies reflect this point. In many cases, the relevant organizations continue to exist but collective imaginaries have changed in ways that deprive the left and political Catholicism of much of their mobilizing power. See Valle (2003).
[71] For examples, see Keeler (1987); Golden (1993); Atkinson and Coleman (1989).

idealizes self-sufficiency.[72] In such cases, cultural, as well as institutional, frameworks at the local level made some types of policy more or less effective.

As Ann Swidler's chapter indicates, this is an important part of the story underlying the AIDS epidemic in various African countries: Helen Epstein argues that differences in HIV infection rates in South Africa and Uganda can be explained in large part by the destabilization of the family in South Africa engendered by apartheid and a migrant labor system, both of which eroded a sense of trust and community, whereas Ugandans who are more likely to live in enduring rural communities have a greater capacity to take care of one another that allowed for a more open response to AIDS.[73] Philip Setel shows how the transformation of the Chagga in Tanzania into a migrant group whose regulated domestic life was undermined created new aspirations and a loosened control over sexuality – in effect, a "reordering of desire" that set the stage for transmission of HIV.[74] Catherine Campbell, Paul Farmer and others have argued that governments and donor agencies who do not understand these changing ways of life and patterns of belief cannot speak to them in their prevention strategies.[75]

Public Policy-Making as Social Resource Creation

Over the course of a lifetime, a person's health depends on the balance between the life challenges confronting him and his capabilities, which feed into the amount of wear and tear experienced in daily life. We have argued that a person's position within the structure of social relations provides social resources that condition those capabilities.

[72] Klinenberg (2002).
[73] Epstein (2007)
[74] Setel (1999)
[75] see in particular Farmer (2005) and Campbell (2003)

Like economic resources, many of these social resources can be put to multiple uses. Moreover, like some kinds of economic resources, if investments are made in them, they can grow over time. The more some networks are used, for instance, the stronger they become. By increasing the effectiveness of individual and collective endeavors, these social resources also enhance the well being of societies.[76]

This approach to population health has important implications for public policy-making. It invites the question: what are governments doing when they make policy? Typically, governments are said to redistribute material resources and to deploy legal sanctions or fiscal incentives to induce prescribed patterns of behavior.[77] Many policy-makers see their actions in these terms. However, our analysis suggests that public policy-making can also be seen in another light – as a process in which social resources are eroded or created – with important consequences for the well being of the community

In many cases, governments are inattentive to this dimension of policy-making, and social resources are eroded as an unintended consequence of policies adopted for other purposes.[78] Why might this be so? Consider the case of economic policy-making. Because officials think about the economy as a structured set of market relations, when formulating a tax or industrial policy, they consider not only whether the policy will secure its intended goals but its side-effects on the overall structure of market competition. By contrast, policy-makers rarely consider the ancillary impact of policies on social relations, because they are less accustomed to thinking about society as a structure of social relations.

[76] This point follows, for instance, from Putnam's (2000) formulations about social capital.
[77] 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.
[78] Cattell (2004).

This was not always the case. In nineteenth century Europe, where social classes were a prominent feature of politics, officials often considered the impact of policies on class relations. [79] But the prosperity of the second half of the twentieth century reduced class conflict and, as William Sewell's chapter notes, the turn of the century saw the rise of a neo-liberal paradigm that made market relations much more central than social relations to policy-making.[80]

Of course, there is also something counterintuitive about the proposition that public policy can influence the structure of social relations. Social structure is often seen as the immutable product of long-term socioeconomic processes independent of the actions of government.[81] But to say that social structure is not putty in the hands of government does not mean policy is without effect on it. Over the long run, the impact of actions seemingly inconsequential at the time can cumulate into major changes in social relations.[82] The shifts in class structure after World War II owe much, for instance, to the expansion of public employment in that period.[83]

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

[79] See Chevalier (1973).
[80] See Graubard (1964); Goldthorpe *et al*. (1969); Dalton *et al*. (1984).
[81] Cf. Putnam 1993, Tarrow 1996, Skocpol and Fiorina (1999).
[82] See the chapter in this volume by Hertzman, and Pierson (2004).
[83] Goldthorpe (1987)

Social Connectedness

Although it is only one of several dimensions of social connectedness, social capital has been the subject of more cross-national empirical work focused on the impact of public policy on social relations than most other dimensions. As Putnam defines it, 'social capital' entails participation in voluntary associations and high levels of social trust. Early accounts saw social capital as a resource created by long-term socioeconomic developments largely independent of public policy. But recent studies suggest that the character of public policies can have important effects on it. [84]

Comparisons between the United States, where levels of social capital have recently declined, and Britain, which has retained more substantial civic networks, indicate that social capital was sustained in Britain by post-war policies that expanded access to higher education and deployed voluntary associations to deliver social services. At the individual level, higher levels of education encourage more intense civic engagement, and governmental support for the volunteer work of charitable associations seems to sustain a country's associational life.[85] 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. Social capital can be sustained by a 'social investment state.'[86]

These findings are consistent with the history of public policy. For more than a century, the development of trade unions, religious organizations and agricultural associations in both Europe and the United States has been tied to governmental support

[84] Cf. Putnam (1993); Coleman (1990); Mettler (2002); Field (2004), ch. 5.
[85] Hall (1999); Glatzer (2008). For overviews of social capital, see Warren (1999); Edwards *et al*. (2001); Stolle and Hooghe (2003).
[86] Selle (1999); Torpe (2003); Jenson and Saint-Martin (2003).

for their endeavors, and Skocpol finds that the growth of associational activity in the U.S. was linked to the structural development of government.[87]

Governments can also influence the levels of generalized trust associated with social capital. Although the presence of a democratic regime does not guarantee social trust, repression almost certainly erodes it. Booth and Richard find a significant correlation between the repressiveness of central American regimes and levels of trust among their citizenry, as Inglehart also argues, not because democracy creates trust but because repression undermines it.[88] Political corruption also seems to affect social trust adversely. Wuthnow argues that social trust declined in the U.S. as a result of a drop in political trust linked to the Watergate scandal of the 1970s, and even petty corruption encourages distrust among the citizenry.[89] Thus, policies that reinforce the even-handedness of public administration may enhance levels of social capital.

Kumlin and Rothstein argue that the design of specific policies can also influence levels of social capital. They find that the recipients of benefits distributed 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 selection bias, but they show up even when income, class and other attributes associated with the propensity to trust are controlled.[90] The implication is that, if the design of a policy implies benefit recipients cannot be trusted, they may become less trusting.

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[87] Skocpol and Fiorina (1999).
[88] The proportion of people expressing trust in others varies from about 25 percent to 65 percent across democracies. Booth and Richard (2001); Inglehart (1999); Uslaner (2003); Howard (2003).
[89] Wuthnow (2002). See also Freitag (2003); Sztompka (1999). See also Rothstein (2003, 2005).
[90] Kumlin and Rothstein (2004). See also Murray (2000); Svensson and Von Otter (2002); Wallis and Dollery (2002).

However, there are distributive dimensions to such policies that deserve more attention. Although Putnam views social capital as a resource that enhances the well being of everyone in society, the networks that underpin it also offer direct benefits to those within them. Therefore, it matters whose networks policy is sustaining. Although associational life remains relatively vibrant in Britain, for instance, it has become an increasingly middle-class phenomenon – as the trade unions, cooperatives and religious organizations that were once pillars of working class life have suffered precipitous declines and movement away from traditional working-class communities as people seek work in the wake of deindustrialization has eroded the informal social networks to many workers once belonged.[91] As a result, although levels of social capital remain substantial in Britain, it is being redistributed and, in this respect, the distribution of social resources now reinforces, rather than offsets, the distribution of economic resources.

At issue here is not only the creation of social resources but the success of public policies. Since many policies have network effects, the latter can be leveraged to enhance the impact of policy. Unemployment policy provides a classic example. As we have noted, a person seeking a new job benefits most from a large network of weak ties to others who already have jobs in order to secure references and information about openings.[92] But policies that require the recipients of unemployment benefits to appear at manpower centers tend to give the unemployed precisely the wrong sort of ties, namely to the other people they meet there who are also unemployed, whereas policies that provide temporary work or training in firms put them in touch with people with jobs.[93]

[91] Hall (1999).
[92] Erickson (2000).
[93] 6 (1997)

In much the same way, day care centers can be designed to enhance the social networks among parents that serve as further sources of support for child rearing, and care for the elderly can be designed to embed them in support networks rather than separating them from such networks.[94] In short, by designing policies with an eye to their network effects, governments can sometimes achieve a 'social multiplier' effect that improves the impact of policy and augments social resources more generally.[95]

Social Hierarchy

Can public policy have analogous effects on social hierarchies? There is plenty of historical evidence that it can. The process whereby governments expanded the conception of citizenship to encompass civil, political and social rights was, as Marshall observed, a form of 'class abatement'.[96] Measures to encourage collective bargaining and support trade union organization can improve job security and the control ordinary people have over their working conditions– factors associated with their health. In countries where status is closely linked to income, policies to reduce income inequalities may also reduce status inequalities.

Whether governments will take such steps is, of course, another question. In many of these cases, the redistribution of status was contingent on a redistribution of power and material resources that emerged only from political struggles conducted over long periods of time. However, it is worth noting that material gains secured as rights of citizenship improved the status as well as the economic situation of those on the lower

[94] Keating *et al*. (2005); Jacobstone and Jenson (2005).
[95] Policy Research Institute (2005).
[96] Marshall (1949).

rungs of the economic ladder. Rights-based regimes often shift the status order, as well as the economic and political orders.

In this realm, political rhetoric can also matter. The status order is defined by collective imaginaries, and the symbolism governments deploy is a constitutive element of those imaginaries.[97] By celebrating the sacrifices ordinary people make in their daily lives and their contributions to society, governments can valorize a wide range of endeavors, according recognition to those who might otherwise have little and undercutting the monotonicity of a status order that might otherwise be based exclusively on wealth.

The recognition governments accord identifiable racial and ethnic minorities is especially important. By articulating national narratives that are inclusive, politicians can enhance the status of groups that might otherwise feel marginalized. Kymlicka argues that the multicultural policies adopted by some governments effectively shifted the social imaginary, according a new status to ethnic minorities.[98] There is similar evidence that the rights-based policies adopted in the wake of the civil rights movement in the United States improved both the situation and the health of African Americans.[99]

In each of these cases, however, the results turned not simply on what politicians said but on what governments did. This is an instance in which cultural frameworks and institutional procedures are closely intertwined. If recognition is to shift social hierarchies, the ideals and idioms promoted by leaders must also be effectively

[97] Kertzer (1989); Lukes (1975).
[98] See Kymlicka's essay in this volume and the references there.
[99] Kaplan *et al*. (2008).

institutionalized at multiple levels of governance.[100] The social recognition accorded people turns not only on what politicians say but on what 'street-level bureaucrats' do.[101]

This is why 'racial profiling' or practices that allow the police to treat members of minorities differently from other people has an importance that extends beyond crime.[102] The behavior of public officials sends important signals. If the public authorities treat individuals even-handedly, others in society are more likely to do so as well, thereby enhancing their social resources, and, when a person is shown respect, that experience feeds into his self-respect, which also conditions his capabilities for coping with life challenges

Communal Capabilities

Governments can also influence the capabilities of communities. Public policies that support civic associations and social networks tend to enhance the capacities of the community to mobilize. By evoking particular sets of ideals and social boundaries, the collective narratives politicians deploy to define the nation also affect the likelihood groups will band together. Comparing closely matched communities in Tanzania and Kenya, Edward Miguel found, for instance, that the Tanzanian communities were more effective than the Kenyan at cooperating across ethnic lines to promote local education; and he traces the origins of this cooperation to the ideology of national unity promoted in Tanzania, without an analogue in Kenya.[103]

[100] On institutionalization, see Jepperson (1991).
[101] Lipsky (1980); Bartley (2006): ch. 10; Canvin *et al*. (2006).
[102] Tyler and Blader (2000); see also Soss (1999).
[103] Miguel (2004). See also Wallerstein (2002).

Ann Swidler's chapter shows that public policies can also be more effective when they exploit local social solidarities. She argues that AIDS prevention policies in Uganda were more successful than those in Botswana because they spoke directly to the types of obligations characteristic of the moral imagery of social networks in Uganda.

However, efforts to shape the collective imaginary are not costless, and there are often trade-offs to the adoption of any particular imagery. The ideology of national unity pursued in Tanzania during the 1960s, for example, was achieved at the cost of repressing many local cultures, as were antecedent attempts to turn 'peasants into Frenchmen'.[104] The efforts of successive governments to promote a view of Sweden as 'the people's home' encouraged egalitarian attitudes, but it has not equipped the nation to cope with the ethnic diversity that results from recent waves of immigration.[105] Even different versions of republicanism of the sort found in France and the United States foster distinctive types of social recognition with corresponding advantages and disadvantages for particular groups.[106]

Conclusion

We have argued that population health and its distribution across social groups are dependent on the wear and tear ordinary people experience in their life, which is conditioned, in turn, by the balance between the life challenges facing those people and their capabilities for coping with them. We contend that this balance is determined, not only by economic resources, but by the social resources available to individuals and communities, and we have identified a series of dimensions of social relations

[104] Weber (1976).
[105] Berman (1998).
[106] Higonnet (1988); Lamont (2000).

constitutive of those resources. Nothing in this argument suggests that income is unimportant. But we believe that the distribution of social resources is likely to be equally important to the health of the population, and, in keeping with the themes of this volume, our conception of social resources includes the cultural frameworks closely bound up with social connectedness and hierarchy. In short, we argue that population health is determined as much by the structure of social relations as by the structure of economic relations.

Against the view that social relations are determined entirely by long-term socioeconomic developments, we have argued that they are conditioned as well by public policy. Public policy-making should be seen, at least in part, as a process of social resource creation. This is not to say that it is easy for governments to create social resources, and in some cases efforts to do so entail costs and complex trade-offs. Like policies that open up market opportunities, however, policies that create social resources have widespread effects, because people use those resources for multiple purposes. Governments should pay as much attention to the conservation of social resources as they do to the protection of natural resources and, by designing policies to leverage existing social resources, governments can enhance their effectiveness through social multiplier effects.

Although our analysis draws on a wide range of literatures, it is obviously suggestive, rather than dispositive, about many issues. Our objective has been to show that there is real value in pursuing research that asks how the structure of social relations impinges on health and what governments can do to enhance social resources. Because social relations often vary at the national level, this calls for more intensive cross-national

empirical inquiry and the gathering of data to make such an inquiry possible. Ourreview of the issues and evidence indicates that there is promise in such research and implications for policy that should concern all governments.

References

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. (2005). "Job Insecurity and its Effect on Health," *Journal of Epidemiology and Community Health*, 59: 718-19.

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

Campbell, Catherine. (2003). *'Letting Them Die': Why HIV/AIDS Prevention Programmes Fail.* The International AIDS Institute in association with Oxford: James Currey; Bloomington & Indianapolis: Indiana University Press; Cape Town: Double Storey.

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.

Cockerham, William C. (2007). *Social Causes of Health and Disease*. Cambridge: Polity Press.

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. and Adriana Lleras-Muney, (2008). "Education and Health: Evaluating Theories and Evidence." In *Making Americans Healthier: Social and Economic Policy as Health Policy*, edited by Robert F. Schoeni, James S. House, George A. Kaplan and Harold Pollack. New York: Russell Sage Foundation, pp. 29-60.

Cutrona, C. and B. Troutman. (1986). "Social Support, Infant Temperment and Parenting Self-Efficacy: A Mediational Model of Postpartum Depression," *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.

Epstein, Helen. (2007) *The Invisible Cure: Africa, The West, and the Fight against AIDS.* New York: Farrar, Straus and Giroux.

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.

Farmer, Paul. (2005). *Pathologies of Power: Health, Human Rights and the New War on the Poor.* Berkeley: University of California Press.

Field, John. (2003). *Social Capital*. London: Routledge.

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.

Frohlich, Katherine L., Ellen Corin and Louise Potvin. (2001). "A Theoretical Proposal for the Relationship between Context and Disease," *Sociology of Health and Illness*, 23, 6: 776-97.

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

Glatzer, Miguel. (2008) "Fostering Civil Society: The Portuguese Welfare State and the Development of a Non-Profit Sector." In Michael Baum, ed. *Portugal's Democracy: Thirty Years after the Transition*. Xxx: Lexington 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.

Kaplan, George A., Nalini Ranjit and Sarah A. Burgard. (2008). "Lifting Gates, Lengthening Lives: Did Civil Rights Policies Improve the Health of African American Women in the 1960s and 1970s." In *Making Americans Healthier*, edited by Robert F. Schoeni *et al*.: 145-70.

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.

Keating, Norah, Jennifer Swindle and Deborah Foster. (2005). “The Role of Social Capital in Aging Well.” In *Social Capital in Action: Thematic Policy Studies*. Policy Research Institute. Government of Canada.

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.

Kristenson, Margareta. (2006). “Socio-economic Position and Health: the Role of Coping.” *Social Inequalities in Health,* edited by Johannes Siegrist and Michael Marmot. Oxford: Oxford University Press, pp. 127-52.

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. (2007). *The Diffusion of Liberal Multiculturalism*. New York: Oxford University Press.

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.

Mettler, Suzanne. (2002). "Bringing the State Back in to Civic Engagement: Policy Feedback Effects of the G.I. Bill for World War II Veterans," *American Political Science Review*, 96:351-65.

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.

Nash, Vicki (2004). "Public Policy and Social Networks: Just how 'Socially Aware' is the Policy-Making Process." In Chris Phillipson, Graham Allen and D. J. Morgan, eds.,

Social Networks and Social Exclusion: Sociological and Policy Perspectives. London: Ashgate: 219-235.

O'Dea, Kerin and Mark Daniel. (2001). "How Social Factors Affect Health: Neuroendocrine Interactions." In *The Social Origins of Health and Well-Being*, edited by Richard Eckersley, Jane Dixon and Bob Douglas. Cambridge: Cambridge University Press, pp. 231-44.

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.

Pearlin, L. I. and C. Schooler (1978). The Structure of Coping," *Journal of Health and Social Behavior*, 19: 2-21.

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.

Policy Research Institute. (2005). *Social Capital as a Public Policy Tool: Project Report*. Government of Canada.

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.

Schoon, Ingrid. (2006). *Risk and Resilience: Adaptations in Changing Times*. Cambridge: Cambridge University Press.

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.

Setel, Philip. (1999). *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania.* Chicago: University of Chicago Press.

Shively, C.A. and T.B. Clarkson. (1994). "Social Status and Coronary 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.

Singh-Manoux, A., M. G. Marmot, and N. E. Adler. (2005). "Does subjective social status predict health and change in health status better than objective status?" *Psychosomatic Medicine*, 67: 855-861.

6, Perri. (1997). "Social Exclusion: Time to be Optimistic," *Demos Collection*, 12: 3-9.

Skocpol, Theda and Morris P. Fiornia. Eds. (1999). *Civic Engagement in American Life*. Washington: Brookings Institution.

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

Soss, Joe. (1999). "Lessons of Welfare: Policy Design, Political Learning and Political Action," *American Political Science Review* 93: 363-80.

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.

Uslaner, Eric M. (2003). "Trust, Democracy and Governance: Can Government Policies Influence Generalized Trust?," In *Generating Social Capital*, edited by Dietlind Stolle and Marc Hooghe. Houndmills: Palgrave Macmillan, pp. 171-90.

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.

Veenstra, Gerry. (2005). "Social Space, Social Class and Bourdiue: Health Inequalities in British Columbia, Canada," *Health and Place*:

Wallerstein, Nina. (2002). "Empowerment to Reduce Health Disparities," *Scandinavian Journal of Public Health*, 30, 2: 72-77.

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.