

Health, Social Relations, and Public Policy

Peter A. Hall and Rosemary CR Taylor

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. However, 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 controversy about which aspects of social relations impinge on health and through which causal mechanisms this occurs.³ We shed light on these issues by proposing a model linking social

¹ For synoptic statements, see Acheson (1998); 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. Compare Cutler et al. (2006) and McKeown (1965). For discussion of how governments do or do not promote healthy behavior, see Swidler (Chapter 5, in this volume) as well as Taylor (1982).

³ For recent overviews of these controversies, see Berkman and Kawachi (2000); Wilkinson (2005); Carpiano et al. (2008).

An earlier version of this chapter was presented at the annual meeting of the American Sociological Association, Montreal, Quebec, Canada, August 10, 2006. For insightful comments on various drafts we are grateful to the members of CIFAR's Successful Societies Program, its advisory committee, Susan Bell, Michèle Lamont and Bo Rothstein. For research assistance, we thank Marius Busemeyer and, for logistical assistance, Emily Putnam.

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 variations in its shape, indicating that disparities in health across socioeconomic 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 captured by that term remains an open question.⁶ Many

⁴ For discussion of these gradients, see Hertzman (Chapter 1, in this volume) and Keating (Chapter 2, in this volume). For an especially powerful illustration of gradients, see Banks et al. (2006).

⁵ For recent overviews, see Kawachi, Kennedy, and Wilkinson (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. (2008). Within wider literatures, this engages issues of how social classes are constituted.

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.

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. In [Chapter 2](#) of this volume, Daniel Keating 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* 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

⁷ Compare Link and Phelan (1995) and Wilkinson (2005).

⁸ This model influences many of the chapters in this book. See McEwen (1998, 2005) and Taylor et al. (1999).

⁹ See [Chapter 1](#) in this volume by Clyde Hertzman and Arjumand Siddiqi.

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 Chrousos et al. (1995); Brunner (1997); Lovallo (1997); Sapolsky et al. (1997); Taylor et al. (1999); Brunner (2000).

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 those involving 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 simply to clean up the neighborhood.

Our core contention is that the amount of wear and tear a person suffers in daily life turns on the *balance* between these life challenges and capabilities. Those who experience more difficult life challenges or do so with fewer capabilities will consistently experience higher levels of stress and feelings of anxiety, anger, and frustration that 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 set of individual and collective actors endowed

¹² Our concept of capabilities is narrower than the influential formulation of Sen (1999). For analogous formulations inspired by his, see also Bartley (2006).

¹³ Grembowski et al. (1993); Berkman et al. (2000).

¹⁴ Taylor et al. (1998).

with particular levels of material resources (in the form of wealth, income, or skills) and politically established rights (notably property rights) linked together in relations structured by markets, hierarchies, and other institutions supporting 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 day care, social insurance, and health care, 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 exists as to whether a more equal income distribution improves the health of the population as a whole, but some evidence supports that claim.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 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

¹⁵ Williamson (1985); Hall and Soskice (2001); Greif (2006). 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 day care has special importance. If it is not merely custodial but stimulating and supportive, day care can have durable effects on children's health that last through adulthood, as well as relieving parents. See Keating and Hertzman (1999b).

¹⁷ For recent overviews, see Lynch et al. (2004); Wilkinson (2005; Chapter 4). Compare 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 Keating and Hertzman (1999b); Cutler et al. (2008); Evans (Chapter 4, in this volume).

²⁰ Bartley et al. (forthcoming).

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).

poorer health, especially for segments of the population endowed with few marketable assets. The precipitous declines in health in some states following the transition to capitalism in Eastern Europe, to which Clyde Hertzman draws attention, suggest that 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 likely to condition 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 these dimensions affect the health of the population.²² Finally, we adduce some evidence drawn from the literature suggesting that each of these dimensions impinges on 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 closely 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

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

²³ See Berkman (1995); Berkman et al. (2000).

²⁴ For analogous formulations that use the term “social resources” slightly differently, see

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 communities. To secure the cooperation of others, they draw on their social status and levels of generalized trust in local networks or society as a whole. 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 cultural narratives.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, that is, constituted by the quality of a person's relations with others.²⁶ Whereas 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 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

²⁵ These characteristics are sometimes described as a person's self-efficacy; see Steele (1988; 1999); Grembowski et al. (1993); Steele and Aranson (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).

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 numbers of secondary associations found in them.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 rearing children, securing employment, and managing illness, as well as *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 individuals 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

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).

²⁹ Kawachi et al. (1997); Kawachi, Kennedy, and Glass (1998); Kawachi, Kennedy, and Wilkinson (1999: Chapters 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. For a review regarding mental health, see Almedom (2005).

³¹ See Erickson (1996; 2002).

on frequent or infrequent contact, on face-to-face, or more distant, relations. They can embody strong ties that reflect intimacy or weak ties based on passing acquaintance. Networks may be deeply intertwined or segmented by social group. These dimensions are consequential. People seeking work, for instance, may benefit more from weak ties to many others, whereas 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 he is embedded. Studies show that the level and intensity of a person's contacts with others are related to all-cause mortality, self-rated health, and rates of recovery from a variety of illnesses such as myocardial infarction. The emotional attachments provided by close relationships seem to improve resilience against depression, illness, and addiction.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 nonprofit 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 in relatively equal amounts.³⁶ However, people with less income and lower-status occupations tend to belong to fewer associations and smaller social networks that are 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, that 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

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); Berkman et al. (2000).

³⁵ Kawachi et al. (1999: Chapters 22 and 23).

³⁶ If so, the health of most of the populace should be better in societies with higher levels of social trust.

³⁷ For the British case, see Goldthorpe (1987); Allan (1990); Oakley and Rajan (1991). See also Cappano et al. (2008).

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 individuals 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 lives appear to them as purposeful; and within the collective imaginary people find representations of the community and their place in it that are constitutive of feelings of belonging and allow them to define larger 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 other people.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. 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

³⁸ Emirbayer and Goodwin (1994).

³⁹ For related formulations, see Bouchard (2000; 2003b) and Castoriadis (1987) whose concept of the social imaginary differs in some ways from ours.

⁴⁰ See Geertz (1973); 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.

⁴¹ Thompson (1971).

⁴² See Swidler (Chapter 5 in this volume); see also Taylor (2000).

gender roles and 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 they are ultimately 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 those attitudes do not simply reflect the general skills conferred 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 of those symptoms 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

However, there are limits to the effect of a collective imaginary. In [Chapter 7](#) of this volume, Gérard Bouchard reminds us that a society’s imaginary is made up of many different images, myths, and collective representations on which diverse individuals draw differently. It constitutes a repertoire that can enable various types of action, even if its overall contours are constraining. Some groups create countercultures that take them in different directions, albeit conditioned by mainstream imaginary, and, as Michèle Lamont suggests, individuals can develop strategies to offset some of the effects of a dominant imagery.⁴⁸

⁴³ Gatens (2004).

⁴⁴ Swidler (1986); see also Oyserman et al. (2006).

⁴⁵ Bourdieu uses the concept of the “habitus” to indicate the sets of norms and practices embodying views about appropriate behavior that are associated with particular positions in the structure of social relations. See Frohlich et al. (2001); Veenstra (2005); Cockerham (2007). Compare 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 Field (1986); Garrett (2000).

⁴⁸ See Lamont (Chapter 6 in this volume). Also Willis (1977) and Crocker and Major (1989).

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 steeper social hierarchies engender more intense feelings of relative deprivation.⁵¹ However, our model suggests two 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 such cooperation. 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 him but also on the confidence he 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 such tasks stressful.⁵³ Self-esteem is established initially in childhood, but it is influenced by subsequent experiences, during which our images of ourselves are affected by 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 greater levels of self-efficacy that reduce the amount of stress they experience in daily life, promoting better health.

⁴⁹ For synoptic works, see Marmot (2004); Wilkinson (2005). 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); Marmot et al. (1997); Collins et al. (2005); Bartley (2005).

⁵¹ Wilkinson (1996).

⁵² For more general discussion of this point, see Marmot (2004).

⁵³ MacLeod (1987); Steele (1988).

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. (1992).

These observations have important implications for cross-national analysis. Although some analysts think social hierarchies are biologically embedded, the *shape* of such hierarchies is manifestly different across societies and ultimately an artifact of cultural and institutional frameworks.⁵⁵ If we are correct, these differences condition, in turn, the distribution of health across populations. Societies that deprive large numbers of people of social status should have lower overall levels of 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 status curve in 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. This relationship may not be linear, and the shape of the 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 at the bottom half of the income distribution than at 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 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 also from their roles as fathers, consumers, or citizens, 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 distribution of social resources parallels the distribution of economic resources, and the status hierarchy will reinforce the health effects of income inequality. 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 gender and ethnic groups.

⁵⁵ Bourdieu (1983).

⁵⁶ Boltanski and Thévenot (1991); Lamont (2000); Sing-Manoux et al. (2005).

⁵⁷ Runciman (1964).

⁵⁸ See Sieber (1974), Thoits (1983), Steele (1988).

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 by Michèle Lamont in Chapter 6 of 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 positions in this occupational hierarchy suffered from more health problems than officials of higher status.⁶² Studies of primates other than 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, to improve sanitation, regulate food or occupational safety, and otherwise to provide a healthy environment.⁶⁶

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 (1988); Steele and Aronson (1998). Compare Elmer (2001); Pyszczynski et al. (2004).

⁶² Marmot (2004).

⁶³ See Shively and Clarkson (1994); Sapolsky and Share (1994); Brunner (1997); Sapolsky et al. (1997); Shively, Laer-Laird, and Anton (1997); Keating (Chapter 2, in this volume).

⁶⁴ For overviews, see Wilkinson (1997, 2005: Chapter 4); Berkman and Kawachi (2000); Lynch et al. (2004).

⁶⁵ Other examples could be given. See Sampson et al. (1997; 2002).

⁶⁶ For overviews, see McKewon (1965); Acheson (1998); Adler and Newman (2002).

Many factors condition the capabilities of communities and their governments, but among these are various features of the structure of social relations.⁶⁷ As Peter Evans observes, an effective civil society requires more than civil rights and the existence of town meetings.⁶⁸ It depends on sustained mobilization, and capacities for collective mobilization turn on the density of existing social networks and the quality of the local solidarities animating them.⁶⁹ Such capacities are also 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 how society is organized and the cultural frameworks that impinge on that. Studies have shown that the effective implementation of industrial or agricultural policies turns on how the relevant segments of society are organized.⁷¹ However, measures to protect the health of citizens and to shift people away from behaviors that put their health at risk can also depend on the character of local arrangements. Eric Klinenberg considers why existing social protection systems failed to shield elderly residents from the effects of a devastating heat wave in Chicago. He found, for example, that many refused offers of support because, in the context of a culture that idealizes self-sufficiency, they were reluctant to admit dependency.⁷² In cases such as these, cultural as well as institutional frameworks at the local level make some types of policies more or less effective.

As Ann Swidler indicates in Chapter 5 of this volume, this is an important part of the story underlying the AIDS epidemic in various African countries, and others confirm this point. Helen Epstein argues that differences in HIV infection rates in South Africa and Uganda can be explained in large part by a destabilization of the family in South Africa that was engendered by apartheid and a migrant labor system that eroded a sense of trust and community. Ugandans, on the other hand, are more likely to live in enduring rural communities that confer on them greater capacities to take care of one another, allowing for a more open response to AIDS.⁷³ Philip Setel shows how

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. Compare Wilkinson (2005: 227ff.).

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 (Chapter 5, 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); Atkinson and Coleman (1989); Golden (1993).

⁷² Klinenberg (2002).

⁷³ Epstein (1997).

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 that 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

We have argued that, over the course of a lifetime, a person’s health depends on the balance between his life challenges and capabilities, which feed into the amount of wear and tear experienced in daily life. We suggest that a person’s position within the structure of social relations provides social resources that condition those capabilities. 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, social resources 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? It is conventional to say that governments redistribute material resources and 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 of social resource creation or erosion – 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 also the side effects of that policy on the overall structure of market competition. By contrast, policy makers rarely consider the ancillary effects their policies might have on social relations because they are less accustomed to thinking about society as a structure of social relations.

⁷⁴ Setel (1999).

⁷⁵ See in particular Campbell (2003); Farmer (2005).

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. Currently, social transfer programs now consume close to half of public budgets.

⁷⁸ Phillipson et al. (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 such perspectives shifted over time. The prosperity of the second half of the twentieth century reduced class conflict and, as William Sewell notes in Chapter 10 of this volume, the end of the century brought to the fore a neoliberal paradigm that made market relations much more central to policy making and relegated social relations to its sidelines.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 However, 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, for instance, owe much to the gradual 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 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.

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 than most other dimensions of social relations. As Putnam defines it, “social capital” entails participation in voluntary associations and high levels of social trust. Although early accounts saw social capital as a resource created by long-term socioeconomic developments largely independent of public policy, recent studies suggest that public policies can have important effects on it.⁸⁴

Comparisons between the United States where levels of social capital have declined and Britain, which retains more substantial civic networks, indicate that social capital was sustained in Britain by postwar 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

⁷⁹ See Chevalier (1973).

⁸⁰ See Graubard (1964); Goldthorpe et al. (1969); Dalton et al. (1984).

⁸¹ Compare Putnam (1993); Tarrow (1996); Skocpol and Fiorina (1999).

⁸² See Pierson (2004); Hertzman (Chapter 1, in this volume).

⁸³ Goldthorpe (1987).

⁸⁴ Compare Coleman (1990); Putnam (1993); Mettler (2002); Field (2002; Chapter 5).

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 have preserved it. Some argue that 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 Europe has been tied to governmental support for their endeavors. Skocpol finds that the growth of associational activity in the United States was also linked to the structural development of government.⁸⁷

Governments also seem to be able to 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 seems to affect social trust adversely. Wuthnow argues that social trust declined in the United States 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 specific features of the design of policies can also affect 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 such findings 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.

Moreover, there are distributive dimensions to such policies that deserve attention. Although Putnam views social capital as a resource enhancing the well-being of everyone in society, the networks that underpin it offer even more

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).

⁸⁷ Skocpol and Fiorina (1999).

⁸⁸ The proportion of people expressing trust in others varies from about 25 percent to 65 percent across democracies. Inglehart (1999); Booth and Richard (2001); Howard (2003); Uslaner (2003).

⁸⁹ Wuthnow (2002). See also Sztompka (1999); Freitag (2003); Rothstein (2003; 2005).

⁹⁰ Kumlin and Rothstein (2005). See also Murray (2000); Svensson and Von Otter (2002); Wallis and Dollery (2002).

direct benefits to those within them. Therefore, it matters whose networks are sustained by public policy. 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 declined. Movement away from traditional working-class communities by people seeking work in the wake of deindustrialization has eroded the informal social networks to which many workers once belonged.⁹¹ As a result, although levels of social capital remain substantial in Britain, as a social resource it is being redistributed in ways that reinforce, rather than offset, the unequal distribution of economic resources.

At issue here is not only the creation of social resources but also the success of public policy. Many policies have network effects that can be leveraged to enhance the impact of policy. Unemployment policy provides a classic example. As we have noted, a person seeking work 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 gather at manpower centers tend to give the unemployed precisely the wrong sort of ties, namely to other people who are also unemployed, whereas policies that provide temporary work or training in firms put them in touch with people with jobs.⁹³

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 aged can be designed to embed the elderly in support networks rather than separating them from such networks.⁹⁴ In short, by designing policies with an eye to their network dimensions, 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 improve job security and the control ordinary people have over their working conditions – factors closely associated with their health. In countries where status is closely linked to income, policies to reduce income inequalities may also reduce status inequalities.

⁹¹ Hall (1999).

⁹² Erickson (2001).

⁹³ 6 (1997).

⁹⁴ Jacobstone and Jenson (2005); Keating et al. (2005).

⁹⁵ Policy Research Institute (2005).

⁹⁶ Marshall (1965 [1849]).

Whether governments will take such steps is, of course, another question. In many historical cases, the redistribution of status was contingent on a redistribution of power that emerged only from political struggles conducted over long periods of time. However, it is worth noting that gaining rights of citizenship improved the status as well as the economic situation of those on the lower rungs of the economic ladder. Rights-based regimes often shift the status order, as well as the distribution of economic and political resources.

In this realm, political rhetoric also matters. 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, governments can valorize a wide range of endeavors and accord recognition to those who might otherwise have little, thereby undercutting the monotonicity of a status order that might otherwise be based exclusively on wealth.

The recognition governments afford to identifiable racial and ethnic minorities is especially important. By articulating national narratives that are inclusive, politicians 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, affording 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 status and 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. These are instances 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 institutionalized at multiple levels of governance.¹⁰⁰ The social recognition accorded people turns not only on what politicians say but also on what “street-level” bureaucrats do.¹⁰¹ This is why racial profiling, for instance, 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. When a person is shown respect, that experience also feeds into his self-respect, conditioning his capabilities for coping with life challenges.

⁹⁷ Lukes (1975); Kertzer (1989).

⁹⁸ See Kymlicka (Chapter 9, in this volume) and the references therein.

⁹⁹ Kaplan et al. (2008).

¹⁰⁰ On institutionalization, see Jepperson (1991).

¹⁰¹ Lipsky (1980); Bartley (2006: Chapter 10); Canvin et al. (2006).

¹⁰² Tyler and Blader (2000). See also Suss (1999).

Communal Capabilities

In similar ways, governments can influence the capabilities of communities. Public policies that support civic associations and social networks enhance the capacities of communities to mobilize. By evoking particular sets of ideals and social boundaries, the collective narratives politicians deploy to define the nation also affect the ease with which groups will band together. Comparing closely matched communities in Tanzania and Kenya, for instance, Edward Miguel found 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 analog in Kenya.¹⁰³

In Chapter 5, Ann Swidler also shows that public policies can 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 trade-offs to the adoption of any particular imaginary. The ideology of national unity pursued in Tanzania during the 1960s, for example, was achieved at the cost of repressing many local cultures, much like 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 this conception has not equipped the nation to cope with the ethnic diversity that accompanies recent waves of immigration.¹⁰⁵ Even different versions of republicanism of the sort found in France and the United States, for instance, foster distinctive types of social recognition with corresponding advantages and disadvantages for particular groups.¹⁰⁶

CONCLUSION

We have argued that the overall health of a population and its distribution across social groups are dependent on the wear and tear ordinary people experience in daily 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 several dimensions of social relations constitutive of those resources. Nothing in this argument suggests that income is unimportant. But we believe that the distribution of social resources is also important to

¹⁰³ Miguel (2004). See also Wallerstein (2002).

¹⁰⁴ Weber (1976).

¹⁰⁵ Berman (1998).

¹⁰⁶ Higonnet (1988); Lamont (2000).

the health of the population, and, in keeping with the themes of this volume, our conception of social resources includes the cultural frameworks 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 they can be conditioned as well by public policy. Public policy making should be seen 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 or complex trade-offs. Like policies that create market opportunities, however, policies that create social resources have deep and diffuse effects because people use those resources for many purposes. The clear implication is that governments should pay as much attention to the conservation of social resources as they do to the protection of natural resources. By designing policies to leverage existing social resources, governments can secure social multiplier effects that enhance the effectiveness of policy.

Although our analysis draws on a wide literature, it is obviously suggestive, rather than dispositive, about many of these 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 vary at the national level, this calls, in particular, for more intensive cross-national empirical inquiry and the development of new data sets to make such inquiries possible. Our review of the issues and evidence indicates there is genuine promise in such research and there are issues at stake that should be of concern to all governments and their citizens.