Social capital and the third way in public health

CARLES MUNTANER* JOHN LYNCH† & GEORGE DAVEY SMITH‡

*Department of Behavioural and Community Health, School of Nursing, and Department of Epidemiology and Preventive Medicine, School of Medicine, University of Maryland-Baltimore
†The Institute for Social Research, University of Michigan
‡Department of Social Medicine, University of Bristol

ABSTRACT The construct of social capital has recently captured the interest of researchers in social epidemiology and public health. We review current hypotheses on the social capital and health link, and examine the empirical evidence available as well as its implications for health policy. With regard to theory, we contend that the construct as currently employed in the public health literature, lacks depth compared to its uses in social science. In addition, social capital presents itself as an alternative to materialist structural inequalities (class, gender and race) by bringing to the forefront of social epidemiology an appealing common sense idealist social psychology to which everyone can relate (e.g., good relations with your community are good for your health). The use of social capital invokes a romanticized view of communities without social conflict (e.g., Neo – Tocquevillian nineteenth century associationism) and favours an idealist psychology over a psychology connected to both material resources and social structure. We argue that the evidence on social capital as a determinant of better health is still scant or ambiguous – depending on the definition that is used. Even if confirmed, social capital hypotheses call for social determinants beyond the proximal realm of social psychology. We also maintain that social capital is used in public health as an alternative to both state-centred economic redistribution (e.g., living wage, full employment, and universal health insurance) and party politics (e.g., gaining control of the executive branch of the government). Social capital represents a ‘privatization’ of both economics and politics. Such uses of social capital mirror recent Third Way policies in Germany, UK and US. If Third Way policies end up losing support in Europe, its prominence there might be short lived. In the USA, where the working class is less likely to influence social policy, interest in social capital could be longer lived or, alternatively, could drift in the academic limbo like other psychosocial constructs which at one point were heralded as the next ‘big idea’.

Within the last few years, we have witnessed the rapid appearance of the concept of social capital in public health discourse. Before 1995, there was only one reference to the term ‘social capital’ in the Medline database and that was in regard to so-called...
‘family social capital’ and its effect on educational and occupational aspirations (Marjoribanks, 1991). Though the basic ideas encapsulated in the current use of social capital can be traced to the origins of classical sociology and political science, the appearance of the term itself in the mid 1990’s was largely stimulated by Robert Putnam’s work on civic participation and its effect on local governance (Putnam et al., 1993). He popularized this thesis by discussing the decline of social capital using the metaphor that America was ‘Bowling alone’ (Putnam, 1995a) – a powerful image that propelled Putnam to an audience with President Clinton to discuss the fraying of the social fabric in America. Since then, the concept of social capital has also appeared in other fields such as sociology (Portes, 1998) and development economics (Grootaert, 1997; Ostrom, 1999). In these fields, there has been a good deal of debate about the definition, operationalization, and the theoretical and practical utility of the concept for improving human welfare, especially in regard to alleviating poverty and stimulating economic growth in less industrialized countries (Collier, 1998; Knack & Keefer, 1997). In fact, the World Bank sponsors a website devoted exclusively to the topic of social capital, where information is exchanged and issues actively debated. Despite all this activity, one of the leading scholars in this field, Michael Woolcock, has argued that the concept of social capital ‘... risks trying to explain too much with too little’ (Woolcock, 1998, p. 155). He says that the term social capital is being ‘... adopted indiscriminately, adapted uncritically, and applied imprecisely’ (Woolcock, 1998, p. 196).

Social capital and its use in public health

We believe Woolcock’s critique is especially true for many of the ways that the term social capital has been used in relation to health. To date there has been very little systematic theoretical, empirical, or practical appraisal of the concept in the public health literature, although more critical accounts are beginning to appear. (Muntaner & Lynch, 1999a; Muntaner et al., 1999; Lynch et al., 2000; Hayes & Dunn, 2000 unpublished observations; Hawe & Shiell, 2000). Nevertheless, the term has slipped effortlessly into the public health lexicon as if there was a clear, shared understanding of its meaning and its relevance for improving public health. The term social capital and its close cousin, social cohesion, have been used as multi-purpose descriptors for all types and levels of connections among individuals, within families, friendship networks, businesses and communities (Wilkinson, 1996; Aneshensel & Sucoff, 1996; Kawachi & Kennedy, 1997; Kawachi et al., 1997a, b; Fullilove, 1998; Baum, 1997, 1999; Kennedy et al., 1999). In addition, it has been the subject of theme conferences (11th National Health Promotion Conference, Perth, Australia) and government sponsored discussion papers (Jenson, 1998; Lavis & Stoddart, 1999); it has been the topic of million dollar calls for research proposals funded by the Centers for Disease Control in the US, and on the basis of highly dubious comparisons between observational studies and clinical trials of such things as anti-thrombolytic therapy, it has even been proposed as an important avenue of public health intervention. Lomas has argued that ‘interventions to increase social
support and/or social cohesion in a community are at least as worthy of exploration as improved access or routine medical care. Certainly they are more worthwhile than public health’s traditional risk factor modification approach to cardiovascular disease’ (Lomas, 1998, p. 1184). These are impressive, yet completely untested claims.

Similarly, in a recent book, published by the Health Education Authority in Britain, the authors state that, ‘There is a consensus in recent literature that the construct of “social capital” may be usefully applied to the study of health and health-related behavior’. (Cooper et al., 1999, p. 4). They leave the impression that we know much more about the theoretical and practical value of social capital than an examination of the actual evidence would suggest. Furthermore, they go on to say that, ‘Researchers have measured social capital in terms of the social, collective, economic, and cultural resources available to a family, neighbourhood or community’. (Cooper et al., 1999, p. 4). There are a myriad of indicators of social, collective, economic and cultural resources across the levels of families, neighbourhoods and communities – are they all markers of levels of social capital? We are not concerned about the multi-dimensionality of the concept, but we are concerned that this multi-dimensionality has received so little theoretical exploration in regard to public health. Consequently it provides little guidance about the importance of the particular mechanisms that might link these different dimensions to health. Stated in this undifferentiated way, the laundry list of measurement strategies outlined above merely suggests that there may be a little something for everyone in social capital. Hawe & Shiell (2000) have commented that the health-related applications of social capital have often involved measuring ‘all that is good in a community.’ Conflating the political, cultural and economic aspects of a community under the one umbrella of social capital, may mask important conceptual distinctions as to the origins of those group resources and may obscure the fact that these dimensions are not necessarily equally important as determinants of health. It would seem that under this kind of undifferentiated approach to social capital, establishing an arts festival (the cultural dimension) and a job creation program (the economic dimension) are both interventions to improve social capital – are they likely to have an equal impact on public health? This in no way denies the importance of improving the cultural life of a community through programmes of arts and music. The question is whether tossing all these dimensions into the grab bag of social capital can inform strategies to improve public health.

The reasons for the easy and almost completely uncritical acceptance of social capital into public health discourse is of interest in itself. Discussion of the concept would appear to come from at least three main sources within the public health community – from those concerned with community-based health promotion (Baum, 1999; Cooper et al., 1999); from those in the social support field (Cooper et al., 1999; Tijhuis et al., 1995), and from those who have claimed that social capital and social cohesion are the main mediators of the link between income inequality and population health (Wilkinson, 1996; Kawachi et al., 1997a, b). One factor that perhaps links these diverse areas of public health research and practice is that they are all motivated to some extent, by the underlying idea that there is something
about the connections among individuals that is important for public health. Levels of population health may be more than the arithmetic sum of the health of the individuals in those populations, and the determinants of population health are both individual and contextual. In this view there is something inherently ‘social’ about improving public health that cannot be reduced to studying and changing discrete individuals. This idea is not new (Rose, 1985) and there have been many critiques of an overly individualistic approach to public health research and intervention (Krieger, 1994; Lynch et al., 1997; Muntaner & O’Campo, 1993). The concept and language of social capital has perhaps been seen as offering a new and exciting way to invigorate supra-individual public health research and to provide support for a non-individualized, social science approach to improving public health (Baum, 1999).

Public health and the connections among individuals

The goal of moving beyond individualistic theory and practice in public health is laudable and as one of us has recently argued, the connections among individuals are an important and neglected research area in epidemiology and public health. In that paper, Koopman & Lynch (1999) showed how the different arrangement of connections among individuals can produce very different patterns of infectious disease transmission in a population. Infectious disease transmission depends on who is connected to whom, and it is possible that other disease processes are also influenced by the pattern of connections within a population. This disease transmission perspective perhaps provides another language for understanding how social support has sometimes been found to protect against certain poor health outcomes. High levels of social support block the transmission of the pathogenic agent, in this case, usually hypothesized as stress.

Populations are not just unrelated heaps of individuals, whose patterns of connections can be ignored. However, overly simplistic interpretations of the pattern of connections among people may mask, not reveal determinants of population health. For example, strong links among individuals can both increase and decrease the risk of certain health outcomes. Tight connections among infants in a day-care centre may increase their risk of otitis-media. In one context, strong friendship networks of peers can increase the risk of smoking, drinking or use of illicit drugs, while in a different situation these same sorts of links may decrease the risk of suicide. Tight networks among the Mafia, neo-Nazi parties, or semi-clandestine business organizations such as the Trilateral Commission, the WTO or GATT increase health risks for other members of the population. Scratch beyond a superficial level and the public health consequences of how individuals and groups are connected rapidly becomes very complicated.

As we have stated above, we are advocates of the idea that the way individuals and groups get connected to form friendship networks, neighbourhoods, communities and populations can be important for public health. However, we are less convinced that the concept of social capital, in its present form, can provide an
adequate basis to understand how these connections may be linked to population health. We believe that social capital has been under-theorized in its public health usage, and that it is time to engage in serious debate about its definition, measurement, and application in public health research and practice. It is within this broader framework of appreciating how both the formal and informal connections among individuals, and the connections among population sub-groups are linked to population health, that we must critically evaluate the concept of social capital. We think that some of the issues for public health research and practice are 1) to explore the sources of the connections among different individuals and groups – i.e., what determines who gets connected to whom? 2) to understand what is transmitted over those networks that might be plausibly linked to health outcomes; and 3) to understand how the health relevant aspects of the connections among individuals and groups can be changed to improve public health.

**Theoretical differences with social science**

‘When I use a word’, Humpty Dumpty said, in a rather scornful tone, ‘it means just what I choose it to mean – neither more nor less’. ‘The question is’, said Alice, ‘whether you can make words mean so many different things’. ‘The question is’, said Humpty Dumpty, ‘which is to be the master that’s all’. (Lewis Carroll’s *Alice Through the Looking Glass*).

Because the scant empirical literature on social capital and health has been accompanied by enthusiastic expectations about social capital’s future relevance to public health (Kawachi *et al.*, 1997a, b; Marmot, 1998; Mustard, 1996), social capital often conveys the authoritarian arbitrariness of Alice’s famous exchange with Humpty Dumpty. Powerful institutions, actors and funding agencies have a lot to say about what a concept means and what concepts are considered legitimate for empirical research (Muntaner *et al.*, 1997; Muntaner, 1999a, b; Wing, 1998). Nevertheless, because public health is a science, and thus has adjacent disciplines, we can examine the compatibility of its social capital construct with regard to the social capital theories that have been developed in contiguous disciplines (e.g., sociology, demography, and international development). Almost exclusively, the construct of social capital adopted by public health researchers has been the most psychological, the communitarian view (Putnam *et al.*, 1993). This conception emphasizes civic engagement, as in membership in local non-governmental organizations, or norms of reciprocity and trust among community members. Communitarians, who often favour minimal government and self-reliance (Etzioni & George, 1999), present their position as a ‘third way’ between laissez-faire neoliberalism and social democracy (Etzioni & George, 1999), and have been supported by the New Labour and New Democrat administrations in the UK and USA (Muntaner & Lynch, 1999a). The ‘small government’ communitarian view, with its emphasis on civic organizations (third sector, not for profit institutions, and Non-Governmental Organizations), not only undermines government intervention in the social democratic European welfare state; but also undermines political representation,
since national class-based parties that strive for state control are substituted with idealized notions of small scale political organizing at the community level (Muntaner & Lynch, 1999a). Thus, it is possible that in public health, social capital may function as a health policy alternative to large scale government redistribution (i.e., dismantling or reducing the post-World War 2 welfare state) (Wainwright, 1996; Muntaner & Lynch, 1999a). In social epidemiology more specifically, social capital presents a model of the social determinants of health that does not include any analysis of structural inequalities (e.g., class, gender or racial relations) in favour of a horizontal view of social relations based on distributive inequalities in income (Muntaner & Lynch, 1999b). As a consequence, class, race or gender-based political movements are also ignored as explanations for reducing social inequalities in health (Muntaner & Lynch, 1999a).

In spite of the confusion regarding the referents of social capital (Coleman, 1990; Woolcock, 1998), there is no justification as to why public health scholars should restrict their conception of social capital to the communitarian notion of civic participation and its indicators (e.g., organization membership, newspaper readership). In social science, in particular in sociology, demography, and developmental economics, social capital has at least two other conceptualizations that have a larger sociological content: one is that of network analysis (Granovetter, 1973; Portes, 1998; Woolcock, 1998). This view of social capital derives from the Weberian tradition in sociology and acknowledges the existence of stratification as well as the negative effects of strong networks for communities (e.g., in Mafia ‘families’). For example, Granovetter showed the differences in the networks of professionals and non-professionals – weak ties among professionals facilitate access to information about job opportunities. Portes showed the conditions under which strong networks among immigrants have facilitated the enrichment of ethnic businessmen in the US. Another sociological approach to social capital emphasizes the role of institutions, including the state. Following the seminal work of Evans (1995) on economic development, this institutional approach considers both a communities’ social capital – its internal cohesion, ties and networks – as well as the type of relation that the state has with communities (Szreter, 1999). This ‘embeddedness’ or institutional support dictates how the state co-operates with civil society to foster economic development via interaction between private and public institutions, legal and democratic systems, and citizen rights (Woolcock, 1998). As we will show below, and have argued earlier (Lynch et al., 1999), this notion of social capital is the more encompassing and allows the greater explanatory potential and integration with other sociological traditions in social epidemiology and public health (e.g., the study of the health effects of class, gender and race relations).

**Idealist social psychology – ‘Bowling with de Tocqueville’and other exaggerations**

Social capital in public health is coined in terms of a lay/common sense social psychology that has great appeal in the US and elsewhere (Cooper et al., 1999; Baum, 1998; Kawachi et al., 1997b). Who would oppose the notion that civic
participation, trust in communities, good neighbourly relations are good for health? In the US, the ‘mom and apple pie’ idea that good community relations are desirable is part of the collective wisdom among communitarians, liberals and social conservatives alike (Putnam, 1995a, b; Etzioni & George, 1999).

Behind this conventional aspiration for achieving ‘healthy communities’ also lies an idealized view of past community life that is seldom-warranted (Lynch & Kaplan, 1997). A particular form of historical imprecision is the selective reading of Alexis de Tocqueville, a French aristocrat, known for his observations on the high degree of civic participation in American communities during his nineteenth century journey in the US (e.g., Kawachi et al., 1997a, b; Kawachi & Berkman, 2000). Leaving aside the contradictions in ‘Democracy in America’ (Elster, 1993), de Tocqueville displayed a sharp critical view, for example, when reflecting on the individualism and self-sufficiency that is so dear to communitarians: ‘Individualism is a calm and considered feeling which disposes each citizen to isolate himself from the mass of his fellows and withdraw into the circle of family and friends; with this little society formed to his taste and leaves the greater society to look after himself’ (de Tocqueville, 1835/1969). This sentence highlights the perils of narrow associationism, or a negative effect of social capital which is largely absent from current public health and social policy writings on the subject (Muntaner & Lynch, 1999a). A negative appraisal of vibrant, local associationism in the US is not new, however. Multiple local interest group associations are part of ‘American Exceptionalism’ (Muntaner, 1999a) and these strongly localized associations may be seen as both potential barriers and supports to creating public policies aimed to improve population health. For example, the failure of creating a broad working class political party capable of establishing a strong welfare state, including the lack of universal access to health care (Navarro, 1994), has been a barrier to improvements in public health in the US. Furthermore, a recent analysis of voter participation data in American cities circa 1880 lends no support to the social capital perspective whereby civic associations would have beneficial impact on broad-based political participation (Kaufman, 1999). Rather, these analyses reveal that civic associations functioned as powerful interest groups that lobbied for specific party platforms that were not necessarily in the broader public interest (Kaufman, 1999).

Another inaccuracy of the received wisdom in current public health accounts of social capital is the uncritical acceptance of Putnam’s ‘Bowling alone’ thesis on the decline of social capital in the US (Kawachi et al., 1997a; Kawachi & Kennedy, 1997; Kawachi et al., 1999; Wilkinson et al., 1998a, b). The available evidence in the US suggests that there has not been a decline in associations over the last two decades (Smith, 1997; Paxton, 1999). Furthermore, older forms of civic participation that have perhaps declined have been transformed over time (Fukuyama, 1999; Skocpol, 1999). In addition, Putnam’s analysis of social capital as the key factor underlying economic development in several Italian regions (e.g., Emilia-Romagna) has also been challenged (e.g., the neglect of class relations or 19th century socialist and catholic political traditions in the creation of contemporary social capital; Warren, 1994). The notion that social capital drives political and
economic performance has been refuted with new analyses of data from Italian regions and other industrial democracies (Jackman et al., 1996). Our overall point here is that the discourse around social capital in public health has tended to focus on its upside. We believe a more complete reading of the literature relevant to understanding the likely health effects of social capital reveals that the concept has been portrayed narrowly and has focused on more optimistic appraisals of its relevance to population health.

Communitarians of the world unite! Ignoring the class, gender and race structure

Given the scant support for the social capital hypotheses reviewed above, one would expect that policy makers and researchers alike would be more sanguine in their approach to the subject. At least, some acknowledgement of alternative mechanisms driving the political, economic and health performance of nations (e.g., political movements, and class relations) might be expected from objective scholars. Unfortunately, in the enthusiastic entourage of social capital, this is not the case (e.g., Kawachi et al., 1997a). The field is indeed inundated with paradoxes and omissions. For example, although communitarians such as Vaclav Havel accept the ‘end of the nation-state’ (Havel, 1999), that is, of its welfare policies (universal health care, public education, subsidized housing, poverty relief, unemployment compensation, etc.), they are often accepting of international military interventions under the umbrella of powerful nation–states (e.g., NATO’s war in the former Yugoslavia; Chomsky, 1999a).

Even the most erudite scholars seem to dismiss competing alternatives to social capital. For example, in the fields of comparative political sociology and economic development, dependency and world-system theories are far from exhausted, contrary to what Woolcock claims in his exhaustive review and integration of social capital studies (Woolcock, 1998). The early Dependency (e.g., Andre Gunder-Frank, Fernando-Henrique Cardoso) and world-system theories (e.g., Immanuel Wallerstein, Christopher Chase-Dunn), which were a spin-off of the Marxist tradition in sociology, have de facto evolved into stronger research programs that retain some of their ideas. This has happened for several reasons, including, 1) in recent years there has been a number of empirical articles on these theories in the leading sociological journals (American Journal of Sociology, American Sociological Review); 2) hypotheses arising from these theories of development (e.g., that receiving aid from the International Monetary Fund and the World Bank is associated with increased income inequality) have been confirmed by researchers coming from different perspectives (e.g., Boswell, who comes from the Marxian tradition, and Nielsen, who does not; see Muntaner & Lynch, 1999a); and 3) controversies in this field have reached such a degree of sophistication that the issue is less whether IMF or WB aid is associated with increases in a nation’s income inequality (it is), but rather the timing of these income inequalities (Dixon & Boswell, 1996; Kentor, 1998; Alderson & Nielsen, 1999). In other areas of social science,
social capital has been integrated with research on social inequalities (e.g., class, gender and race). For example, in historical sociology, Gould explains social class mobilization in the Paris Commune with network analysis and pre-existing levels of social cohesion (Gould, 1991, 1993). Another area of integration between stratification and social capital is the sociology of gender. Brines (1999) for example, has shown how earnings equality among cohabiting couples reinforces cohesion and stability, making couples more likely to remain together than in conditions where one of the members of the couple (most notably the woman in heterosexual couples) earns more than her male partner. In addition to class and gender (Erikson, 1996; Muntaner et al., 1999; Persell et al., 1992; Zweigenhaft, 1993), racial and ethnic segregation has also been linked to social capital (Borjas, 1992). Contrary to the ‘law and order’ view of social capital often portrayed in public health, Pattillo (1998) has showed the difficulty of separating networks of ‘law abiding’ and ‘criminal’ residents in cohesive African American neighbourhoods characterized by dense networks. Recently, researchers have also found that educational networks (Coleman’s original notion of social capital) are class and racially segregated (Schneider et al., 1997).

Thus, in social science the fields of class, gender and race/ethnic inequalities are often integrated with social capital (mostly its network and institutional versions). However, with few exceptions (Matthews et al., 1999) the mostly communitarian approach to social capital in public health shies away from these mechanisms (Muntaner & Lynch, 1999a, 1999b).

Familiar health policy implications – ‘The importance of subjectivity’

One implication of social capital in public health is the role of individual subjectivity in mediating the relation between inequality and health (Wilkinson, 1996, 1999). The breakdown in social cohesion occurs because individuals perceive their relative position in the social distribution of income, which creates anxiety and other psychosocial injuries which, in turn, affect health (Wilkinson, 1999). As no explanations for the causes of income inequalities are provided, this psychosocial mechanism becomes the central explanation of social cohesion models in public health (Muntaner & Lynch, 1999b; Lynch et al., 1999). This is not surprising as individuals look for explanations and they hold to those that are offered (Muntaner & Lynch, 1999b). The move towards psychosocial explanations on the effects of social cohesion (e.g., the culture of inequality; Wilkinson, 1996, 1999) is rather surprising, as just a few years ago the field of social inequalities in health was still materialist (Kaplan, 1995). Even researchers that had been relatively sympathetic to materialist explanations such as social class and working conditions (Marmot & Theorell, 1988), seem suddenly convinced by social capital/psychosocial environment explanations for health inequalities (Marmot, 1998).

The culture of inequality mechanism underlying the social capital – health association is not, however, all that innovative. For example, the culture of poverty hypothesis popularized by Oscar Lewis (1998/1963) is strikingly similar to the social capital/social cohesion formulations by Wilkinson and colleagues, albeit more
psychologically reductionist and ‘victim blaming’ than the latter (Muntaner & Lynch, 1999a). The culture of poverty states that some poor communities bring poverty onto themselves because of few community ties and little community heritage (i.e., social capital). Perceptions and subjectivity are all important, as it is not objective inequalities that ultimately determine the well being of populations but the subjective response to those inequalities.

One of the implications of the social capital/social cohesion hypothesis for public health is that communities may be seen as responsible for their crime rates (Sampson et al., 1997) or aggregated health rates, an idea that nicely justifies the privatization of health services, such as managed care (Stoto, 1999). Another possible direction for public health may be that we take a step back from the structural sources of health inequalities (‘the importance of subjectivity’, Wilkinson, 1999) – after all, if they are not an integral part of our theories of health inequalities and are so difficult to change, then perhaps an achievable alternative is to retreat to mass psychotherapy for the poor to change their perceptions of place in the social hierarchy (e.g., Proudfoot & Guest, 1997). Again, this idea is not new. In the 1960s the functionalist sociologist Warner revealed his hopes for his book called Social Class in America – ‘The lives of many are destroyed because they do not understand the workings of social class. It is the hope of the authors that this book will provide a corrective instrument which will permit men and women better to evaluate their social situations and thereby better adapt themselves to social reality and fit their dreams and aspirations to what is possible’. (Warner, 1960, p. 5). Elsewhere, we have labelled this new set of public health implications associated with the idea of a loss of social capital ‘blaming the community’ (Muntaner & Lynch, 1999a). The problem with subjectivity as an explanation for health inequalities is not only that it has little empirical support but also that it may yield anti-egalitarian public health policies (Muntaner & Lynch, 1999a, 1999b). Such anti-egalitarian public policy outcomes are not desired by any of the proponents of the social capital/psychosocial environment approach to health inequalities, or for that matter, anyone in the broader public health community. This is because social egalitarianism constitutes one of public health’s core values (Muntaner, 2000).

The ‘perceptions of relative inequality’ approach implies a psychophysical dualism that is at odds with scientific psychology since Sechenov and Pavlov (Muntaner & Lynch, 1999a). The culture of inequality view implies that culture is non-material (a subjective invention of people’s minds that is not tied to the material world), while economics is material (Wilkinson, 1999). There is no basis for this assumption in modern science: ideology, technology, and art are as material as political representation or production of goods and services. The process of writing an article on anarchism is a cultural activity, selling it is an economic activity and censoring it because of its content is a political activity – all of them material processes, as they take part in a social system, which is a material, albeit not physical, system (Muntaner & Lynch, 1999a).
Can social capital be saved from shallowness?

Why now? Explaining the growing interest in social capital

The literature on different approaches to social capital (e.g., communitarian, network, institutional) has been growing for the last three decades, from Loury, Bourdieu and Coleman, to Portes, Evans and Putnam (Coleman, 1990; Putnam, 1995b). However, not until the 1990s has the concept of social capital/social cohesion gained popularity in public health (e.g., Wilkinson, 1996) and development studies (Woolcock, 1998).

To understand the timely emergence of social capital from a psychosocial construct in the sociology of education (Coleman, 1990) to the next research ‘paradigm’ in developmental economics at the World Bank (Stiglitz, 1996, 1997), we need to understand the difficult position of international lending institutions in the current decade. After the demise of the Soviet Union, the so-called Washington Consensus rhetoric of minimal governments, austerity measures, debt repayment, and neo-classical (e.g., rational choice) economics pervaded unchallenged (Chomsky, 1999b). Maybe the clearest example of this attitude is the now famous 1991 Memorandum attributed to Lant Pritchett and Larry Summers, currently US Secretary of Treasury and then chief economist at the World Bank. This unique historical document provides a testimony of the policies of the Bank’s ideology that has been replaced by the language of social capital at the end of the decade (e.g, Stiglitz, 1996,1997; Woolcock, 1998). Following Summers:

‘Dirty’ Industries: Just between you and me, shouldn’t the World Bank be encouraging MORE migration of the dirty industries to the LDCs (Less Developed Countries)? I can think of three reasons: 1) The measurements of the costs of health impairing pollution depends on the foregone earnings from increased morbidity and mortality. From this point of view a given amount of health impairing pollution should be done in the country with the lowest cost, which will be the country with the lowest wages. I think the economic logic behind dumping a load of toxic waste in the lowest wage country is impeccable and we should face up to that. 2) The costs of pollution are likely to be non-linear as the initial increments of pollution probably have very low cost. I’ve always thought that under-populated countries in Africa are vastly UNDER-polluted, their air quality is probably vastly inefficiently low compared to Los Angeles or Mexico City. Only the lamentable facts that so much pollution is generated by non-tradable industries (transport, electrical generation) and that the unit transport costs of solid waste are so high prevent world welfare enhancing trade in air pollution and waste. 3) The demand for a clean environment for aesthetic and health reasons is likely to have very high income elasticity. The concern over an agent that causes a one in a million change in the odds of prostate cancer is obviously going to be much higher in a country where people survive to get prostate cancer than in a country where people obviously going to be much higher in a country where under 5
mortality is 200 per thousand. Also, much of the concern over industrial atmosphere discharge is about visibility impairing particulates. These discharges may have very little direct health impact. Clearly trade in goods that embody aesthetic pollution concerns could be welfare enhancing. While production is mobile the consumption of pretty air is a non-tradable. ‘The problem with the arguments against all of these proposals for more pollution in LDCs (intrinsic rights to certain goods, moral reasons, social concerns, lack of adequate markets, etc.) could be turned around and used more or less effectively against every Bank proposal for liberalization’. (Summers, as cited in Valette, 1999)

This economic ‘logic’ that if applied to interpersonal, rather than international relations, would be considered psychopathic, had to change once a series of economic crises in part fuelled by IMF and WB policies started to creep up around the globe (e.g., Mexico, Russia, Brazil, and East Asia; Galbraith, 1999). Criticism of IMF austerity policies escalated (Kolko, 1999) even at WB headquarters where the Bank’s new chief economist began using a more social democratic language where a positive role for governments was acknowledged, including references to social capital as a key factor in economic development (Stiglitz, 1996, 1997). The Bank’s interest in social capital thus marked a departure from economic imperialism, rational choice and public choice models, and a growing attention to integrating economics with sociology (Woolcock, 1998; World Bank, 1999a). Recent annual reports from the Bank also include the social dimension of economic development, including the need for government intervention in reducing international inequalities in science and technology (Stiglitz, 1997; World Bank, 1999b).

Sceptical observers argue that economic development happens precisely when countries do not follow IMF policies (Chomsky, 1999b); that countries that receive IMF and WB suffer increases in social inequalities (Kenton, 1998); and that social democracy has already been successfully tested in some European countries during part of the World War 2 period, without need for social capital explanations. On close scrutiny, now that communism and big bureaucratic states cannot be blamed, social capital allows for a different kind of criticism of debtor countries (e.g., Woolcock, 1998). Social capital allows for the characterization of countries as ‘corrupt’ or ‘developmental’ according to the character of the ties between state, private sector, and civil society (Evans, 1995). For example, after the crisis of 1997, South Korea, a country formerly praised for its Asian values and Confucian capitalism, became an example of ‘crony’ capitalism, while the role of the deregulation of Korean financial markets in the crisis was ignored (Galbraith, 1999).

In the case of Russia, the economic policy dictated by Harvard and the IMF (Wedel, 1998) are not to blame for its failure to develop, it is Russian corruption (The Economist, 1999). Thus, in the WB’s post-Washington Consensus documents, the interpretation of what happened to Russia in the 1990s is thought of as capitalism without proper social capital (i.e., deficient governmental regulation), rather than communism’s inevitable heritage (World Bank, 1999a, b). Russian events such as the 30% GDP decline and unregulated monopolies are explained as the outcome
of a deliberate hurry to privatize before any institutional capability to regulate could be put in place. Russian events are used as an example of social capital failure that provides a rationale for the Bank’s retreat from neo-liberalism and its attempt to build a new development theory. Social capital is used to inform a supposedly new comprehensive and participatory approach to development, which avoids small government and authoritarian top-down neoliberalsm (Stiglitz, 1997; Woolcock, 1998). The underlying notion is that with adequate levels of social capital (proper civil and state guidance and regulation), the internationalization of markets and private property are optimal for the welfare of nations (World Bank, 1999a, b). Social capital thus represents a leaner version of previous proposals on various degrees of state intervention in capitalist economies. There is thus a correspondence between the WB’s approach to social capital and its public health applications (less state interventions, emphasis on civic life, ‘blaming the community’, sharing responsibility with the community). This should not be surprising as there is a strong interdependence between the WB and the US government (Left Business Observer, 1999).

What is not to be done: a ‘third way’ for comparative health research

Social capital has been explicitly associated with Third Way social policies in the US and in the EU as well (Szreter, 1999). The Third Way, as in the New Labour or New Democrat governments and their intellectuals (Robert Reich, Anthony Giddens) has been associated with the reduced role of the state, privatization of social services, labour market flexibility, non-governmental organizations, modern philanthropy and the demise of the welfare state (Muntaner & Lynch, 1999a). Critics of the Third Way have argued that instead of representing a new set of policies by social-democratic parties, it represents a capitulation to the political right that leads to greater social inequalities (Albo & Zuege, 1999; Muntaner & Lynch, 1999a, 1999b). Albo & Zuege have argued that the failures of European social democracy in the seventies (e.g., Sweden’s Meidner plan) and early eighties (e.g., Mitterrand’s ‘U turn’) sent them into a path of retreat, accommodation and confusion from which they still have to recover. The Third Way rhetoric, more often defined by what it is not than by what it is (Giddens, 1994), would be part of a search for a ‘big idea’ that would ensure a durable political base for social-democratic parties in the new European capitalism. It is this potential role for social capital in public health that we think should be avoided (Muntaner & Lynch, 1999b).

In the wake of recent elections in Europe, some analysts are arguing that support for Third Way policies is fading, most notably in Germany (Singer, 1999). If that were to be the case, the fortunes of social capital in public health could follow, at least in the EU where governments have been more responsible to egaliitarian pressures from working class parties (Navarro, 1999). This is less likely to occur in the US where government is more insulated from egaliitarian working class politics (Navarro, 1994). Within public health, rather than discarding structural inequalities such as gender, race and class as outmoded materialism, in favour of psychosocial
constructs such as social cohesion (Wilkinson, 1999), a much more fruitful strategy would be to seize the opportunity that social capital brings to integrate sociology and economics into the field of social inequalities in health. For example, the Marxian tradition of class inequality (Wright, 1997) could be integrated with the Weberian tradition of institutional social capital (Evans, 1995). The institutional view of social capital stresses how states operate: some states are efficient or inefficient, others are strong or weak. The role of political institutions such as parties, the judicial system, how the executive and legislative branches of governments operate (e.g., the rationalization of state bureaucracies) become central to understanding how states are formed (Evans, 1995). From a Marxian perspective on the other hand, class inequality guides the analysis of the state. How does the capitalist class influence the legislative, administrative and executive branches of government? What are the class alliances (capitalist vs. working class) and splits among different segments of the capitalist class (financial vs. industrial) that affect government function or the relationship between the capitalist class and state elites? (Kadushin, 1995). At least the institutional approach to social capital favoured by Woolcock (1998) seems to be open to this kind of integration (e.g., Evans, 1995). But then, as public health scholars and activists, should we place false hopes on initiatives heralded by institutions (Amin, 1997) that have helped generate the health inequalities that we want to eliminate?

References


