ESSAY REVIEW

Social capital, class gender and race conflict, and population health: an essay review of Bowling Alone’s implications for social epidemiology

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Robert Putnam’s Bowling Alone (henceforth BA) serves as justification and support for one of the most influential hypotheses in contemporary social epidemiology, namely that the primary explanation for health inequalities in wealthy countries lies in low levels of social capital or social cohesion. For example, the major textbook of the sub-discipline includes two chapters on this topic. Putnam, and most social epidemiology, defines social capital as the norms of reciprocity and trustworthiness that arise from social connections among individuals. Although the social capital concept lacks closure and varies with authors and disciplines, Putnam uses a consistent set of indicators that have been readily adopted in epidemiology. Among these indicators we find community organization membership (clubs, civic or social organizations), engagement in public affairs (voting, town or school public meeting attendance), volunteering (number of non-profit organizations), informal sociability (entertaining, visiting friends), and norms of social trust.

Here we present an overview of Putnam’s claims, their supporting evidence, and we draw several consequences of the BA hypothesis for epidemiology and public health. We argue that the omission of class, race and gender relations and political variables from research on community trust and norms of reciprocity limits the usefulness of social capital as framework for social epidemiology. Next, we link the current theoretical emphasis on social cohesion to earlier social science attempts at advancing the beneficial effects of lack of conflict in Europe and the US.

Has ‘social capital’ declined in the US?

In order to build the argument that we should be concerned about social capital, Putnam reviews the evidence on a series of indicators showing a decline in community involvement in the US during approximately the last three decades. The author presents evidence on the decline of political participation, face-to-face involvement in community organizations, religious participation (in particular the ‘bridging’ or community building type), union membership (although the recent growth in the service sector organizing is ignored), informal social connections (e.g. entertaining or bowling), giving to philanthropic organizations, working in community projects, and social trust attitudes (although these later findings have been challenged by other researchers, see below). Putnam also presents trends on increased litigation, and guard labour (although no reference is made to the role of the state in using incarceration as a labour market institution or to the prison-industrial complex). On the other hand, Putnam presents data on trends in volunteering, crime rates, interpersonal telecommunication, small self-help and support groups, and social movements (e.g. environmentalism) that do not visibly support his claims that social capital has declined.

Putnam poses several possible causes for the supposed decline in social capital. Among them he lists work related time pressure, economic hardship, women’s access to the paid labour force and its effects on the family, residential mobility, suburban sprawl, technological revolution in communications, change in the structure and scale of the economy (chain stores, service sector...), and disruption of marriage. Interestingly, Putnam also includes growth of the welfare state, the civil rights revolution, and the sixties (anti Vietnam war movement, culture of revolt against authority) as potentially all playing a role in the decline of social capital in America (emphasis added). Several of these putative causes of declining social capital and health (e.g. welfare state) have been precisely associated with a reduction in social inequalities in health.

Putnam then reviews the empirical support for these alternative explanatory variables and concludes that, in order of importance, it is generational change, television, increased commuting, and time pressure (overwork) which explain US social capital decline. Putnam suggests that generational change accounts for 50% of the decline in social capital.
explanation is that for some reason, perhaps related to the
effects of World War II (WWII), this generation was highly civic
in terms of local associations and participation. Elsewhere in the
book, Putnam mentions that the WWII generation has different
values from boomer and later generations,—a psychological
explanation like the ‘psychology of inequality’ hypothesis that
has been proposed as a determinant of low levels of social
cohesion.3,4 Thus, even if we accept that there has been a decline
in trust and norms of reciprocity in US communities, we still
lack convincing explanations as to how this happened, other
than to somewhat vague references to ‘generational change’. In
addition, it should be recognized that there have been a number
of recent studies using data from the last decades that directly
challenge the BA hypothesis.9–12 Recent studies have found
stable levels of voluntary associations and voluntary association
participation,9–11 and stable levels of trust10,12 during the last
decades of the 20th century. The evidence on the decline of
social capital in America remains disputed by contradictory find-
ing and the use of different indicators of social capital across
studies. Thus, Putnam’s central claim about the decline of social
capital is far from resolved.

‘Social capital’ and health
Let us assume for the moment that Putnam’s claims concerning
the decline in US social capital during the last four decades of the
20th century are accurate. Putnam argues that these declines in
social capital have had negative effects on education, child well-
being, economic development (following Woolcock’s writings
at the World Bank13), neighbourhood safety, and democracy. In
addition, BA argues that social capital has important conse-
quences for the health of US populations. This inclusion of health
into the sphere of social capital actually represents quite a turn-
around from the position Putnam adopted in his heralded 1993
clearly that health should be excluded from consideration as
an outcome, since it is a contributor to social capital. Thus, in
Making Democracy Work, Putnam considered health is an input to
rather than an output of social capital. Perhaps the enthusiastic
acceptance of the idea of social capital by a wide variety of
health researchers convinced Putnam to change his mind and
consider how social capital might affect health. Indeed, by the
time BA was written in 2000 Putnam announced that, ‘Of all
the domains in which I have traced the consequences of social
capital, in none is the importance of social connectedness so
well-established as in the case of health and well-being’.1

Putnam builds the case for the health relevance of social capital
by drawing on the socio-psychological studies of social support
that typified 1980s US social epidemiology.1 During the 1980s
US epidemiology skewed social inequalities research, with few
exceptions such as the Alameda county study by Haan, Kaplan
and Camacho,14 in favour of social support and other psycho-
social constructs. Putnam also draws from recent studies on
social capital per se, conducted by Kawachi and colleagues and
directly inspired by Putnam’s own previous work.15–19 to voice
strong claims with regard to the beneficial health effects of
norms of reciprocity and trust in social networks. Putnam’s
position on the link between social capital and health is perhaps
best revealed where he states, ‘The bottom line from this multi-
tude of studies: as a rule of thumb, if you belong to no groups
but decide to join one, you cut your risk of dying over the next
year in half (emphasis in the original). If you smoke and belong
to no groups, it’s a toss up statistically whether you should stop
smoking or start joining. These findings are in some ways heart-
ening: its easier to join a group than to lose weight, exercise
regularly or quit smoking.’1 The reader can only assume that
Putnam is basing these wild claims on studies showing that the
relative risk of smoking on mortality was similar to the relative
risk found in some studies of low social support. These claims
seem to be based on rather naıve epidemiological interpretations
of relative risks across studies, which exclude considerations of
the population, study design and the important issues of residual
confounding. In addition, we are unaware of any study that has
shown that the act of joining a group conferred the same health
protective effect as not smoking.

Interpersonal relationships (e.g. social support, social isolation)
are associated with mortality, morbidity, and the progression of
disease, notably from chronic conditions such as cardiovascular
disorders.20 However, even if lack of social support or social
isolation had strong effects on a variety of health outcomes,
these psychosocial constructs cannot be equated with social
capital as defined above—which is as a community, not indi-
vidual, characteristic. Kawachi and Berkman have argued
cogently that, ‘A useful distinction can be drawn here between
social capital and social networks. Social networks are a charac-
teristic that can be measured at the individual level, whereas
social capital should be properly considered a characteristic of
the collective (neighbourhood, community, society) to which
the individual belongs. It makes no sense to measure an indi-
vidual’s social capital.’15 In this case Putnam’s argument for the
importance of social capital for health is based on analogies to
individual-level processes, rather than by more direct evidence.
At best one could hypothesize that social support at the indi-
vidual level might be enhanced by a community’s social capital.
In addition, when we examine social capital proper as an inde-
pendent community-level risk factor, the amount of empirical
evidence is drastically reduced to a few ecologic, cross-sectional
studies from the US, which are based on aggregated individual-
level data taken from the nationally representative General
Social Survey.16–18

The psychosocial explanations behind the putative health
effects of social capital (or social cohesion) await direct confirm-
atory evidence.21 The hypothesis that low social cohesion
(originating from individuals’ perceptions of their relative position
in the distribution of income) is more important than material
factors (e.g. the goods and services that can be purchased with
a given amount of income) rests on at least three shaky assump-
tions: (1) absolute levels of income are no longer relevant
in wealthy countries;22 (2) the strength of income inequality
effects, the alleged source of low social capital in cross-country
comparisons;22 and (3) the decline in social capital during the
last three decades in the US (Putnam’s own hypothesis1). There
is growing evidence that challenges each of these assump-
tions5,12,23 on which psychosocial explanations are built.
Furthermore, these claims also need to be considered against
the background of the dramatic improvements in health over the
last half-century. For instance, since 1950, cardiovascular
mortality in the US has been cut in half, precisely during the
period of alleged decline in social capital and public health.12

Problems with theory and measurement add another
dimension to the controversy surrounding the health effects of
social capital. The possibility of aggregation of individual attitudes about trust and reciprocity at the state or national level does not imply that trust is a state or national phenomena. Trust might as well occur only at the interpersonal level (a classical problem in sociology addressed by Simmel, 24 for instance). Social capital studies in (mostly non-white or poor) neighbourhoods 25,26 rely on investigator-designed questionnaires (with items on vandalism, broken windows, alcohol use, crime perception), pictures or videos, for the assessment of low social capital. But these measures do not provide social explanations, even when contextual effects are found. For example, media influenced perceptions of crime might not reflect actual crime rates and do not explain the social causes of local crime. 27 In fact, contrary to the BA hypothesis, a recent study from Florida shows that the rate of incarceration, a political variable, is a determinant of low ‘social capital’, rather than the reverse. 28 That is, the Florida police’s strategy of high incarceration prevents local households from creating social capital because continuous incarceration of family members disrupts attempts at maintaining stable community networks. Against the conventional wisdom on social cohesion, a study of successful single mothers living in a deprived community networks. Against the conventional wisdom on social cohesion, a study of successful single mothers living in a deprived and segregated neighbourhood suggests that a negative sense of community can lead to positive health outcomes. 29 Furthermore, social capital indicators of trust and norms of reciprocity are often biased against working class manifestations of these forms of social cohesion. 30 The likely consequence of using the above methods is a default attribution of social and health problems to some intrinsic property of the community (i.e. what elsewhere we have called ‘blaming the community’ 31,6). Thus, if the evidence for social capital’s effects on health is still scant, why is this construct considered central to social epidemiology? 29 In the remainder of the article we try to answer this question by analysing the underlying philosophy and the health policy implications of social capital. Table 1 summarizes the theoretical and philosophical differences between social capital and two alternative models in social epidemiology (class, gender and race, and income inequality). We conclude by linking current interest in social capital and social cohesion to previous social science attempts at finding the conditions that minimize conflict and preserve political and economic systems.

Table 1 The Social Capital hypothesis in contemporary epidemiology: a comparison with other research programmes namely Class, Gender and Race and Income Inequality. We compare several theoretical and philosophical features of these research programmes: the role of political conflict in population health; the features that generate new research (i.e. the positive heuristic of these research programmes); whether the epistemology is realist (includes a balance of theory and data), empiricist (‘let the data speak’), or pragmatist (‘whatever works is fine’); whether the ontology is idealist (‘the world is a subjective creation of people’s minds’) or materialist (‘the world is made of concrete things distinct from individual perceptions’); whether the values (ethics) inherent to the model are egalitarian (‘eliminate social inequalities in health’) or non-egalitarian; and whether the programme has implications for health policies at the macro level (e.g. universal health insurance, welfare state). The Class, Gender and Race programme appears more comprehensive and compatible with applied social science and technology than social capital, as it includes political factors and macro social policy, and is realist, materialist and egalitarian.

<table>
<thead>
<tr>
<th>Research programme</th>
<th>Class, race, gender</th>
<th>Income inequality</th>
<th>Social capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Role of political conflict</td>
<td>Includes social structure, political conflict</td>
<td>Indicator-driven, no politics</td>
<td>Favours psychosocial hypotheses, avoids politics, shuns conflict</td>
</tr>
<tr>
<td>Positive heuristic</td>
<td>Social mechanisms, origins of inequalities</td>
<td>More studies, better designs, data collection, or data analysis</td>
<td>Proximal psychosocial mechanisms (trust, cohesion)</td>
</tr>
<tr>
<td>Ontology/epistemology</td>
<td>Realism</td>
<td>Pragmatism, empiricism</td>
<td>Psychosocial realism</td>
</tr>
<tr>
<td>Ethics</td>
<td>Egalitarian (egalitarian or non-egalitarian)</td>
<td>Undetermined</td>
<td>Non-egalitarian</td>
</tr>
<tr>
<td>Public health policy</td>
<td>Welcomes specific national health policies</td>
<td>Undetermined</td>
<td>Avoids macro health policy, local emphasis</td>
</tr>
</tbody>
</table>

Theoretical and philosophical underpinnings of social capital

Although BA conceives social capital as an emergent property of social groups, it is supposed to originate in individual subjectivity (e.g. values). This is an assumption that links current social capital/social cohesion researchers with 19th French idealism (e.g. Saint-Simon Durkheim) and several later sociological traditions. 31 As it has been argued elsewhere, this assumption allows social capital researchers to discard neo-material explanations for social inequalities in health. 3,7 Psychological idealism precludes tracing the origins of social capital to a materialist social system (e.g. a class, gender or race structure involved in economic, political and ideological relations, see ref. 3 for an example). For instance, in Putnam’s US, lack of trust and civic engagement are determined by individual values, rather than by a surge in economic and political inequalities between the have and the have nots.

A recent article by Daniels et al. 32 illustrates the public health consequences of lacking a social structure and, in particular, of the absence of class and race inequalities among social capital researchers. Using Rawls’ theory of justice, the authors attempt to incorporate egalitarian goals into their social capital research programme. Nevertheless, there is an important oversight in the application of Rawls’ theory of justice to social inequalities in health: the precedence of property rights over any kind of social outcome including relief from poverty and disease. This endorsement puts Daniels et al. in a contradiction which is not uncommon among social capital researchers (e.g. World Bank’s poverty reduction and social capital initiatives): on the one hand they claim to work towards the reduction of social inequalities, while on the other they assert the precedence of property rights over any kind of egalitarian goal. As inequality in the distribution of property rights is the political base for generating inequality in income and wealth (for example see the empirical studies of Erik Olin Wright, 33 or the deductive work of John Roemer, 34), such proposals remain illusory. In addition, as others have already argued, 35 the goal of solving social inequalities exclusively with administration of justice is an explicit acceptance that inequalities are built in societies, that they are natural outcomes of public intervention.
social interaction, as in Rawls' theory. The view of human nature as essentially competitive is transmitted in Rawls' goal of equality of opportunity, that social capital researchers endorse, which implies that inequality of outcome is acceptable. There are still alternatives to that worldview, for instance, that a considerable equality of outcome is a more desirable agenda to improve population health than equality of opportunity. Thus, social justice implications that ultimately leave the origins of inequalities untouched (e.g. a private health care system) flow easily from social capital's individualist ontology (e.g. lacking a social structure).

'Keeping the rabble in line': the health policy implications of social capital research

Although there is a longstanding debate among epidemiologists as to whether they should be involved in policy (in the Weberian tradition of neutral social research), social epidemiologists are leading efforts to enter the health policy arena, and the civil rights movement fight against racism. Social capital, true to its psychosocial promotion of within- and between-group cohesion ('bonding' and 'bridging'), ignores class- or race-based political conflict. This is a serious omission as improvements in population health have followed class- and race-based political conflict (e.g. the central role of unions and social democratic parties in building European welfare states, and the civil rights movement fight against racism). Contrary to the social capital hypothesis, the conflict underlying class and race organizations is necessary to achieve positive population health change.

Figures 1a and b show moderate to strong associations between two class conflict variables (the rate of exploitation and years of social democratic government) and infant mortality among selected wealthy countries during the last decades of the 20th century. Years of social democratic government in the post-WWII period is used as an indicator of class conflict as it measures the success of working class (social democratic, labour or socialist) political parties in gaining access to power in capitalist economies. The wealthy countries selected closely correspond to the countries that have been used to generate the social capital/cohesion hypothesis in social epidemiology. In addition, social democratic governments have been often thwarted in other regions (e.g. Latin America). In brief, we define class exploitation by two forms of social relations: (1) an economic relation (the appropriation of the fruits of labour of the exploited by the exploiters); and (2) a political relation, domination (i.e. the exclusion of the exploited from ownership and control of productive resources by the exploiters usually by means of property
Towards a balanced view of social capital

Samuel Bowles has recently argued that social capital is appealing to liberal minded scholars because it asserts that co-operation and generosity are good for the welfare of populations while conservatives are attracted to it because it shuns state intervention. Thus, because of its emphasis on collectivism and co-operation, Durkheim’s oeuvre attracted the attention of some 19th century French socialists. Other scholars have been particularly caustic in their comments regarding the emergence of social capital as a research area and see it mostly as an academic diversion from more important political and economic problems. For example, Joseph Stiglitz chief economist at the World Bank was forced to resign after criticizing the International Monetary Fund (IMF) by pointing to the failure of the austerity, deregulation, and privatization policies that the IMF applies to poor countries. It is unlikely that Stiglitz would have aroused such harsh opposition if, instead of criticizing IMF economic policies, he had talked about the need to raise the social capital of poor ‘corrupt’ countries.

On the positive side, social capital may bring social factors (e.g. norms, trust, reciprocity, civic engagement, but also institutions) into fields that had been dominated by hyper-rationalist and reductionist rational choice models of economic behaviour. In strongholds of rational choice dogmatism, social capital might signal a welcome openness to include sociology and political science into disciplines such as development economics. However, social capital perpetuates the myth that physical and financial forms of capital are independent of social relations. The mere usage of term ‘social capital’ to differentiate it from physical and financial capital implies that the latter are not ‘social’.

Social capital could generate a positive heuristic in epidemiology if its relation to a society’s political, economic and cultural structure was made explicit, as in the original writings by Bourdieu and subsequent studies on social class and social capital. The notion of social capital that incorporates institutions (e.g. the state) is a potential area of growth that might correct some of the limitations of the communitarian notion criticized above. Several social epidemiologists and public health researchers have already begun to use more sociological notions of social capital.

Conclusion: manufacturing cohesion

Social integration will most likely remain an important question in social epidemiology. Nevertheless, social capital ignores the social determinants of trust and norms of reciprocity. For example, as presented in BA, social capital is the origin of economic inequality rather than its consequence. There is some evidence in public health that economic inequality is associated with lower levels of social trust attitudes. At the individual level, we know that a lower socioeconomic position can be strongly associated with cynical distrust. Contrary to Putnam’s view, this approach suggests that to increase social trust, societies need to reduce economic inequality. Thus BA avoids social democratic policies and favours cultural means to increase civic engagement, trust and reciprocity in the community.

The use of Putnam’s notion of social capital (and overlapping concepts such as community disorganization, social cohesion, or collective efficacy) in epidemiology and public health (e.g. refs 25,26) falls into an historical continuum of US (Coleman,
Merton, Parsons) and European (Spencer, Comte, and to some extent Durkheim) social science concerned with the prevention of social disintegration and maintaining social order. For example, Durkheim represented a conservative attempt at showing the benefit of avoiding conflict in a century ravaged by revolutionary movements. Some of today’s proponents of social capital and social integration, working in influential institutions, fulfill the role of advancing social theories where social cohesion and population health can be achieved without addressing structural inequalities, that is without political conflicts generated by class, gender or race relations. We can find such class-less, conflict-free utopia in BA as much as in openly conflicts generated by class, gender or race relations. We can find cohesion and population health can be achieved without
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