Introduction

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Across time and space, the social fabric is woven differently. How do differences among societies affect the well-being of those who live in them? Are some types of societies more successful than others at promoting individual lives and the collective development of the community? How might the character of a society have such effects, and how are such societies built? These are large questions of classic interest to the social theorists of modernity, such as Comte, Tocqueville, Durkheim, Weber, and Marx, with a pedigree that stretches back to the utopian writings of Bacon, More, and Saint-Simon.

In recent years, however, social science has been more reluctant to tackle such questions. There are good reasons for caution. Post-Enlightenment thought observes that the success of a society is difficult to define independently of complex normative issues, not least because trade-offs must often be struck between goals or groups. Assessing the multifaceted web of social relations connecting members of society also poses major empirical challenges. Even the most promising studies in contemporary social science usually fasten onto one or two dimensions of it to the exclusion of others. Their formulations reflect a balkanization among disciplines that has seen some scholars focus on strategic interaction, while others concentrate on symbolic representations or psychosocial processes, each construing institutions and human motivation in different terms.

There is something becoming in the modesty of contemporary social science. It has made focused empirical inquiry more practicable. But something has also been lost. There are good reasons for believing that well-being is conditioned by many dimensions of social relations, but we do not know enough about how those dimensions interact with one another, whether some are substitutes or complements for others, and by what standards some societies can be said to be more successful than others.

This book steps into that breach. We define societies as patterns of social relations structured by institutional practices and cultural repertoires. We are especially interested in understanding how institutions and cultural structures

combine to advance (or limit) collective well-being. If this scope connects us to a classic literature, for conceptual tools we draw on contemporary arguments about social networks, identity, social hierarchies, collective action, boundaries, and social capital. Our objective is not to supersede such perspectives but to build on them. We are especially interested in understanding the effects of institutions, organizations, and available cultural repertoires and how they interact with one another.

Our premise is that some societies are more successful than others but, unlike some of the modernization theories of the 1960s, we do not claim there is a single path to success, and, precisely because institutions interact with local cultures, we are skeptical about proposals to identify "best practices" that can readily be transferred from one society to another. There may well be more than one way to solve similar problems. Nevertheless, the contributions the structures of society make to social welfare should be investigated.

A wide range of outcomes can be associated with successful societies, including nonviolent intergroup relations, open access to education, civic participation, cultural tolerance, and social inclusion. We see each as desiderata. However, the priority each should be assigned is open to debate, and engaging in that debate could easily absorb much of this volume, leaving little room to consider the issues that most concern us, namely, how institutional and cultural structures feed into such outcomes. Therefore, the empirical outcomes on which we have decided to focus the book are those of population health, taken as a proxy for social well-being. We concentrate on the health status of those living in a particular country, region, or community and what we sometimes describe as "health plus."[1]

This is an appropriate choice. On the one hand, a focus on population health fits well with our understanding of successful societies. A successful society is one that enhances the capabilities of people to pursue the goals important to their own lives, whether through individual or collective action, and, as we will argue later, population health can be seen as an indicator of such capabilities.[2] On the other hand, health is a relatively uncontroversial measure of well-being – longer life expectancies and lower rates of mortality can reasonably be associated with the success of a society – and it provides measurable outcomes to explain.

In these outcomes are many sets of puzzles for social scientists. Consider three examples. When the communist regimes of Eastern Europe fell after 1989 – in a set of developments some described as the "end of history" – one

[1] We owe this term to James Dunn who uses it to indicate that good health is usually accompanied by higher levels of self-esteem and associated with many other valued social outcomes, including fruitful employment and a satisfying family life.

[2] For an influential argument that associates development with the promotion of capabilities, see Sen (1999), although the meanings we associate with "capabilities" are more specific than his.

might have expected life to improve for those people who had been given new freedoms, and for some it did. After dipping amidst the transition, male life expectancy in the Czech Republic, for instance, began to improve more rapidly than under the previous regime, to reach 72 years by 2001. But male life expectancy in Russia dropped sharply during the transition and remained so low that it was barely 59 years in 2001. Why did a historic development improve collective well-being in one nation and erode it in another?

Recent gaps in the trend lines for life expectancy in the United States and Canada are equally puzzling. In the two decades after World War II, Canadians and Americans gained years of life at about the same pace. However, life expectancy has been increasing more slowly in the United States since the 1970s, such that the average Canadian now lives two years longer than his American neighbor. Moreover, women, who live longer than men, are losing their relative advantage at a faster pace in the United States than in Canada. These gaps translate into millions of years of productive life. Why are they occurring?

Some of these puzzles have policy implications. As sub-Saharan Africa copes with a devastating AIDS epidemic, some governments have had much more success than others. Uganda brought its rate of HIV infection down from about 20 percent of adults in 1992 to less than 8 percent a decade later, while Botswana has seen the rate of infection climb toward 38 percent. By most conventional measures, however, Botswana is much better governed than Uganda. How can one explain these differences in the success of AIDS prevention strategies? These are the types of puzzles this book tackles. For answers, we look to new ways of understanding the relationship between institutional frameworks, cultural repertoires, and population health.

From the Material to the Social in Population Health

What accounts for variation across countries and communities in the health of the population? Although they loom large in popular conceptions, variations in the quality and availability of medical care do not fully explain such differences. New vaccines, diagnostic procedures, and treatments have reduced the incidence and effects of many diseases, but comparisons over time and countries show that this type of innovation explains only a small portion of the variance in population health.[3] Much more can be attributed to the economic prosperity of a country or community and corresponding improvements in sanitation, housing or basic utilities.[4] But material factors alone do not provide complete explanations. Among the developed countries with annual per capita incomes greater than about US$11,000, there remain wide variations

[3] For a classic statement, see McKeown (1965) and the controversy published in the *American Journal of Public Health* (2002). Compare Cutler, Deaton, and Lleras-Muney (2006).
[4] Pritchet and Summers (1996).

in population health that bear no relationship to national income. The United States has the world's highest income per capita, for instance, and spends more on health care per person than any other country in the world, but it ranks only forty-first in terms of average life expectancy. Population health is clearly conditioned by factors that go well beyond the medical or material.

Much the same can be said about the distribution of health inside each society. The chapter in this book by Clyde Hertzman and Arjumand Siddiqi describes a familiar "health gradient." In all countries, people of lower socioeconomic status tend to have worse health than those in higher socioeconomic positions – a relationship so pervasive that some describe social inequality as the "fundamental cause" behind disparities in population health.[5] But how is this gradient to be explained? Some of it turns on the distribution of material resources: people with higher incomes are likely to be able to purchase the housing, health care, and opportunities for relaxation that contribute to better health. Nothing in our analysis disputes this basic point. However, there is more to one's position in a social structure than the material resources associated with it, and some of these other dimensions are likely to be consequential for health. Even studies of baboons show that position within a social hierarchy engenders physiological effects that impinge on health.[6] One of the objectives of this book is to explore how such dimensions of social relations can affect the distribution of health across the population. We are looking for the social sources of the health gradient.

Of course, this is a problem central to social epidemiology, a field on whose findings we build. One of our objectives is to integrate work in social epidemiology with the concerns of a wider range of social sciences, and to that task we bring a distinctive perspective, which emphasizes the impact on health of institutional structures and cultural repertoires. Many social epidemiologists share these concerns, but they tend to focus on a limited range of social relations and to conceptualize explanations based on them in terms of relatively undifferentiated categories, such as the "psychosocial." We look at the impact of a broader range of institutional structures and cultural repertoires with special emphasis on how they relate to one another.[7] This perspective allows us to identify a number of dimensions of social relations consequential for population health that

[5] Link and Phelan (1995; 2000). For overviews of the large literature on this topic, see Adler and Newman (2002); Lynch et al. (2004); Wilkinson (2005); Leigh and Jencks (2006).

[6] Sapolsky, Alberts, and Altmann (1997).

[7] Social relations broadly construed are the day-to-day interactions, informal (left to the subject's agency) or formalized (into structures, institutions, traditions), between individuals and groups, along with their various correlates: symbolic, material and social *stricto sensu* (hierarchies, networks, solidarities, and so on). Our analysis focuses on cultural structures and institutions rather than other dimensions of social relations. Cultural structures are representations (identities, scripts, frames, myths, narratives, collective imaginaries) that feed into behaviors and social boundaries. Institutions are defined as a set of regularized practices, whether formal or informal, with a rule-like quality in the sense that the actors expect those practices to be observed. (See footnote 52, in this chapter.)

deserve more attention than they have received and to deepen our understanding of the ways in which the effects of institutional structures can operate through the cultural frameworks they sustain. Although grounded in on-going research projects, all the chapters in this book are exploratory. Our objective is to widen the lens through which issues of population health can be seen.

Pathways from Institutions and Culture to Health

The chapters in this book approach population health from multiple angles. Some consider the challenges to health posed by contemporary developments. Others address problems associated with policies to improve health. Some focus on the impact of collective representations or symbolic boundaries. However, all are concerned with the roles played in such processes by institutional and cultural structures, which affect health through many routes.[8]

Among these routes, this book accords special importance to the health effects that follow from what is sometimes called the "wear and tear of daily life."[9] Although less dramatic than a virus that decimates the population, the toll taken by the stresses of everyday life may be just as great, given the number of people they affect. Many studies show that the emotional and physiological responses generated by the challenges people encounter in daily life condition not only their risk behaviors but also their susceptibility to many of the chronic illnesses that have become the dominant causes of mortality in the developed world, including stroke and heart disease.[10]

Daniel Keating's chapter describes the biological pathways linking the anger, anxiety, or depression generated in daily life to a person's health. Chronic exposure to high levels of stress has been associated with cumulative developments in the neuroendocrine system that inspire hypertension and poor health. Negative emotions such as depression, resentment, and anxiety appear to raise all-cause mortality, as well as the risk of coronary heart disease, through their effects on the sympathetic-adrenal-medullary (SAM) system, hypothalamic-pituitary-adrenocortical (HPA) system and immune system.[11] In many cases, these effects seem to operate, much as aging does, to induce progressive increases in the physiological costs of meeting new challenges from the social environment, thereby reducing resilience to health threats over time.[12] Moreover, there can be interaction along these pathways. The

[8] In this and subsequent sections, our argument has been shaped by ongoing conversations with the members of the successful societies program and influenced by joint work and discussion with Rosemary CR Taylor. See Taylor (2004).

[9] On the impact of the "wear and tear of daily life," see Hawkley et al. (2005). Also relevant is research on the allostatic load (for example, Szanton, Gill, and Allen 2005).

[10] For overviews, see Brunner (1997; 2000); Hertzman and Frank (2006); and Keating (Chapter 2, in this volume).

[11] Chrousos et al. (1995); Brunner (1997); Lovallo (1997); Sapolsky, Alberts, and Altmann (1997); Taylor, Repetti, and Seeman (1999); and Keating (Chapter 2, in this volume).

[12] See also Schoon (2006).

development of reflective consciousness, widely associated with the growth of the prefrontal cortex during adolescence, for instance, can condition the levels of stress experienced later in life.[13]

To understand how institutional practices and cultural frames impinge on health, we develop a particular conception of how the wear and tear of daily life is generated.[14] We suggest that wear and tear depends crucially on the balance between the magnitude of the *life challenges* facing a person and his or her *capabilities* for responding to such challenges. We use the term "life challenges" to refer to the tasks a person regards as most important to life, ranging from basic efforts to secure a livelihood and raise a family to others whose importance will vary across individuals – such as securing material goods, companionship, or social prestige in specific arenas of activity.[15]

We conceptualize "capabilities" in terms that borrow from psychology as well as sociology.[16] To some extent, these are constituted by basic attributes of personality associated with reflective consciousness and emotional resilience, which are conditioned by the experiences of childhood and refined in the contexts of adulthood.[17] But a person's capabilities depend on much more than personality. They include the ability to secure cooperation from others, which invokes a person's capacities for meaning-making and self-representation and the recognition he receives from the community, as well as the institutional frameworks that allow for recognition and effective cooperation.[18] Ultimately, they depend on access to the range of resources that can be used to resolve life's problems. The import of this equation should be apparent. As the life challenges facing a person loom larger relative to his or her capabilities for coping with them, we expect that person to experience higher levels of wear and tear in daily life, feeding into feelings of stress, anger, anxiety, and depression that take a toll on health.

The impact of material circumstances on health is readily captured by this model. In general, people with higher incomes face fewer – and generally different – challenges than those with low incomes. Even more important, however, is the contribution economic resources make to a person's capabilities. In

[13] One implication is that there are significant life course effects, as adult health is affected by childhood circumstances. Keating and Hertzman (1999b); Hertzman and Power (2006; Wheaton and Clarke (2003) advocate combining temporal and contextual perspectives to mental health.

[14] A more complete exposition of this model can be found in Chapter 3 and various dimensions of it are described in other chapters.

[15] In some psychological models, these challenges are described as "stressors." See Kubzansky and Kawachi (2000).

[16] Our formulation should not be confused with that of Sen (1983), although we find his work highly suggestive, and Evans makes use of it in his chapter for this volume.

[17] This model is a very basic one that should suffice here, although others may be able to refine the list of personality attributes constitutive of fundamental capacities. On stress throughout the life course, see Gotlib and Wheaton (1997).

[18] See Bourdieu and Wacquant (1992).

most societies, income is a multipurpose instrument that can be deployed to meet many kinds of challenges, ranging from securing housing to finding a partner. In short, the balance between life challenges and capabilities is a function of material resources. We acknowledge the important impact economic inequality has on the distribution of health across populations and nations.

However, the advantage of our model is that it also illuminates the role played by institutional practices and cultural frameworks in the determination of population health. The core point is that a person's capabilities can be augmented (or attenuated) not only by his access to material resources but also by his access to social (including symbolic) resources. A number of scholars have suggested that the correlates of social class constitute such resources.[19] However, existing attempts to enumerate them remain limited. Our analysis can be read as an effort to specify in more detail how resources are constituted and how they work their way into health. We focus on the ways in which institutional structures and cultural frames are constitutive of such resources, and we explore the ways in which those resources affect peoples' health by conditioning their capabilities for coping with life challenges.

The results are informative for comparisons across communities. Some societies seem to have more symbolic and social resources than others. However, the analysis also illuminates the familiar relationship between socioeconomic status and health, revealing pathways through which social inequalities impinge on health. Moreover, instead of assuming that the distribution of resources corresponds exactly to the distribution of economic resources, we look into that relationship, allowing for the possibility that social and symbolic resources may not be as tightly coupled to income inequality as some studies imply.[20]

These points are at the center of the collective analytical framework that has emerged from our collaborative research over the past five years. Building on our conversations, Hall and Taylor develop some of these ideas in their chapter. They argue that people's health is affected by capacities for coping with life challenges that depend on the character of the institutional and cultural frames in which they live. They suggest these frameworks supply "social resources" crucial to many people's health. Among the factors that contribute to these resources are a number that have been of interest to social epidemiologists, as well as a number of others, including: the character and density of social networks, associational life, a person's position within social hierarchies with a certain shape and dimensionality, and the collective narratives that specify symbolic boundaries and give meaningfulness to certain kinds of lives. Hall and Taylor contend that the distribution of these social resources may be as important to the health of an individual as the economic resources she commands.

[19] Giddens (1975); Pearlin and Schooler (1978); Weber (1978); Bourdieu (1984); Link and Phelan (1995, 2000); Kristenson (2006); among others.

[20] For a theoretical model spelling out the determinant role of semiotic practices in relation to material resources, see Sewell (2005).

Bringing Culture Back In

Social epidemiologists have shown, in repeated studies, that social relations matter to people's health. Broadly speaking, the field has emphasized three types of relationships. The first is the set of social networks to which people belong. There is substantial evidence that people with close ties to others, through marriage, friendship, or social networks, tend to enjoy better health and to recover more effectively from illness than those who have relatively few such ties. Research shows that the level and intensity of contacts with others affect all-cause mortality, self-rated health, and rates of recovery from illnesses such as myocardial infarction. Membership in networks offers resilience against depression, illness, and addiction.[21]

A second body of work emphasizes the secondary associations and trust in others they are said to promote, arguing that such associations provide a community with multipurpose "social capital" that can be used to mobilize collective action, especially to press governments to address the needs of the community.[22] Studies show relatively strong correlations between the density of membership in secondary associations and average levels of health across communities. Those who belong to such associations also appear to be healthier, even when factors such as age, income, and social class are controlled.[23]

If the concept of social capital highlights symmetrical relations among people, a third set of studies stresses the asymmetrical relationships found in hierarchies. Pioneering studies of British civil servants, for instance, have found differences in their health, corresponding to their rank within the employment hierarchy, and others find a relationship between the level of autonomy people enjoy in their job and their health.[24] Others suggest that society-wide status hierarchies may have health effects based, in particular, on the feelings of relative deprivation that high levels of income inequality may engender.[25]

This book is inspired by these lines of research.[26] They blaze important paths. However, we think those paths are still too narrow, notably in the range of social relationships they consider and how they construe the causal linkages to population health. One of the objectives of this book is to broaden prevailing conceptions of how social relations impinge on health, and we think one of the principal ways to do so is to bring the cultural dimensions of such

[21] See the pioneering work of Berkman and Syme (1979); Berkman (1995); Berkman et al. (2000); Smith and Christakis (2008).

[22] Putnam (2000). "Bridging social capital" that connects people across subgroup lines is said to be especially important.

[23] Kawachi, Kennedy, and Wilkinson (1999: Chapters 22 and 23).

[24] Marmot (2004).

[25] There is controversy about some of these points. See Wilkinson (1996; 2005); Kawachi (2000).

[26] We would like especially to thank Mel Bartley, Lisa Berkman, Martin Bobak, Katherine Frohlich, Arthur Kleinman, Michael Marmot, James Nazroo, Nancy Ross, Ingrid Schoon, Gerrg Veenstra, and David Williams for discussing their research with the participants in this project.

relationships into fuller focus. Doing so reveals new causal logics and enriches understanding of the pathways to which social epidemiology has pointed.

Scholars who look at the impact of social networks on health have been the most expansive in their formulations. They argue that networks provide logistical support for important tasks, such as rearing children, securing employment, and managing illness; information about how to approach these tasks; and social influence useful for securing the cooperation of others. Close contacts provide the emotional support that wards off feelings of isolation or depression.[27] This is congruent with our model. In each of these ways, membership in social networks can improve a person's health by enhancing her capabilities for meeting life challenges.

However, these formulations stop short of capturing the full meanings people give to their relations with others. What is missing is a sense of the moral valence people attach to people around them. Long ago, sociologist Max Weber made the point that there is no action and social relationship without meaning. Building on this insight, recent network analysts have observed that the social connectedness of a society is not specified simply by the structural properties of networks, such as their density or even the instrumental functions they serve, but by the meanings those networks produce and convey.[28] For those who belong to a network, membership is often associated, not only with arrangements of mutual convenience, but with value-laden judgments about the self and others, defined at its limits by a sense of who belongs, who should be defended and respected, and who is only at the margins.[29] People use these meanings to derive purposes for their actions as well as a sense of what they can reasonably expect in moral terms from each other. Those meanings constitute social resources. The research of Sampson and his colleagues underlines this point. They find that variations in the level of violence present across Chicago neighborhoods are best explained, not by the presence of social networks per se but by whether people in each neighborhood believe it appropriate for them to admonish their neighbors' children.[30]

Studies of the relationship between health and social capital take an even more restricted view of social relations and how they condition behavior. By and large, they emphasize relationships built on a logic of mutual exchange, whereby face-to-face encounters in associations or networks create generalized trust and a diffused reciprocity that can be mobilized for collective action.[31] There is evidence that relations of this sort can improve the

[27] See, for instance, the nice formulations in Berkman et al. (2000).
[28] See especially Emirbayer and Goodwin (1994). It should be noted that social epidemiologists often acknowledge, explicitly or implicitly, these dimensions of networks without always drawing out the full implications. For a more detailed critique of the place of culture in the literature on health and disparities, see the chapter by Lamont.
[29] For a classic article from this perspective, see Thompson (1971).
[30] Sampson, Raudenbausch, and Earls (1997).
[31] Putnam (1993).

ability of communities to press governments to address local problems. But this perspective misses many of the contributions that organizations make to a community's capacities for collective mobilization through the cultural frames they promote.[32]

Social organizations do not simply foster a diffuse sense of reciprocity. In many cases, they contribute important moral visions, identities, symbols, and historical narratives to the collective representations of a community, thereby influencing how individuals or groups see themselves and their relationship to the community as a whole. They convey information about the relative status of groups within the community. They communicate boundaries, defining inclusion or exclusion, and visions of what it means to belong to the community as a whole, which can promote specific models for action. These visions can be more crucial to mobilization, whether individual or collective, than the diffuse reciprocity engendered by associational life.[33] Cornell and Kalt, for instance, show how influential images of the "good Apache," derived from traditional collective narratives, could improve the well-being of bands of native peoples, and Oyserman and Marcus suggests that the models of "possible selves" presented to adolescents may influence their circumstances for years to come.[34]

The literature linking health to social status is especially important for its attentiveness to the distributional implications of social structure. However, there is no consensus in this literature about how social position affects health. Much of it relies on a vague concept of status or links status to health through a concept of relative deprivation that implies status derives mainly from income. In some instances, of course, status inequalities can give rise to a sense of deprivation, which affects a person's health by inspiring feelings of anger and resentment.

However, we think there is room for more multifaceted approaches to the relationship between status and health. On the one hand, differences in status may be grounded in a variety of sources. People may secure status in their local community and in their own eyes, not only from their material possessions but also from their commitment to collective solidarity or from their role in raising a family.

On the other hand, the effects of status may not operate entirely through feelings of relative deprivation. Hall and Taylor argue that social status conditions the toll daily life takes on people's health by affecting their capacities to secure the cooperation of others. Social status can condition a person's self-image in ways that increase the anxiety or stress he feels – what Giddens calls "ontological security" – without necessarily engaging feelings of relative deprivation.[35] Psychologists have noted that the stereotypes embedded in

[32] For an illustration of this point, see Small (2004). For relevant critiques, see Hall (1999) and Offe (1999).
[33] See Ann Swidler (Chapter 5, in this volume).
[34] Oyserman and Marcus (1990); Cornell and Kalt (1992).
[35] Giddens (1991).