Successful Societies

How Institutions and Culture Affect Health

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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).

status systems can influence the self-confidence and competence people bring to particular tasks, even if they are not conscious of it doing so.[36] Recognition influences self-efficacy independently of access to material resources. Being defined as able to achieve or as a valuable member of the community has to be a component of how inequality penetrates under the skin. In short, we need a more expansive conception of the mechanisms through which status works its way into health, notably by affecting the capabilities people bring to life challenges.

We should also acknowledge that the status order is a cultural construct whose shape varies across societies. Status is not determined exclusively by material affluence or position within formal hierarchies. The extent to which status corresponds to income will depend on the available cultural frames. Michèle Lamont's comparison of the French and the American upper-middle class, for instance, shows how much these two societies vary with respect to the value or prestige attached to money, culture, and morality. In another study, she finds that French and American workers employ quite different matrices for assessing the value of various groups, such as blacks, immigrants or the poor, which means that blacks and the poor are regarded in more inclusive terms in the French than American context.[37] Because the status or social recognition accorded such groups varies across national contexts, the social opportunities available to them do so as well, with important implications for their health.

The study of population health can be enriched by taking into account the meaning-laden dimensions that permeate all social relations, even when the latter might seem solely interest-based. Those who belong to a society are tied together by ideas of who they are and what they can do that are as evaluative as they are factual. These ideas underpin the judgments we make about others and ourselves. They provide resources for our imagination and specify its limits.[38] In some respects, these "webs of meaning" constitute moral orders.[39] They are organized around group boundaries that have negative (exclusive) aspects as well as positive (identity-bearing) aspects and embodied in hierarchies that assign status or prestige. They find voice in collective narratives grounded in tales about the historic struggles of the tribe or nation, redolent with implications about what a member can or should do – providing definitions of "possible selves" for individuals and aspirations for the collectivity.

For the purposes of this book, we put special stress on three dimensions of culture, which are often embodied in institutional forms. The first is the set of *symbolic boundaries* that define who is at the center of the community and who is at its margins.[40] Boundaries of this sort construct ethnicity and

[36] Shih, Pittinsky, and Ambady (2002).
[37] Lamont (1992; 2000; 2006).
[38] See Swidler (1986) on strategies for action.
[39] The phrase is that of Geertz (1973).
[40] On the literature on boundaries, see Lamont and Molnár (2002).

the other social categories that structure the transactions of daily social life. They may be more or less permeable. Closely associated with them are sets of evaluative criteria, which attach more or less opprobrium to one side of a boundary and give rise to the stereotypes that influence views of ourselves as well as others.[41]

The second dimension consists in the *status hierarchies* of a society, understood as implicit sets of principles for distinguishing among social positions and a distribution that assigns varying amounts of social prestige to those positions. We are concerned with the steepness of the relevant status hierarchies, namely, the distance in status between positions at the top and bottom, and in the multidimensionality of status distribution.[42] As Max Weber argued, where status can be secured in several different ways, the social disadvantages experienced by those who lack status on one hierarchy may be offset by the status they gain through alternative means. Relevant to such processes are the terms on which a society assigns status, whether on the basis of citizenship, learning, income, or some other criteria.

Finally, we are attentive to the *collective imaginaries* that portray a society and its members in particular ways. If nations are "imagined communities," as Benedict Anderson has suggested, it matters how they imagine themselves.[43] Collective imaginaries are sets of representations composed of symbols, myths, and narratives that people use to portray their community or nation and their own relationship as well as that of others to it.[44] By virtue of their contributions to collective identity, these imaginaries condition the boundaries and status hierarchies to which we have just referred.[45] In addition, by presenting a community's past in a particular way, collective narratives influence the expectations of its members about the future, suggesting paths of collective development available to the community and "strategies of action" feasible for individuals within it.[46] The moral valence of such representations lends them influence, but they have cognitive and emotional impact as well, conjuring up templates for action from the past.

These cultural frameworks condition the health of individuals and its distribution across the population in multiple ways. As noted later, they provide blocks on which effective policies to promote healthy behaviors can be built and underpin the collective mobilization central to securing more healthy living

[41] See Steele (1988); Steele and Crocker (1998); Krieger (2000); Son Hing et al. (2002).

[42] This issue is complicated by the fact that the matrices used to measure worth can vary across groups. For instance, academics spontaneously privilege responsibility and authority as criteria of evaluation, whereas electricians privilege the usefulness of one's work. See Ollivier (2000).

[43] Anderson (1991).

[44] Note that our definition departs from that of Castoriadis (1987) who coined the term "social imaginaries." See also Gatens (2004). On this subject, our formulations are influenced by the work of Bouchard (2003b; 2005).

[45] On social identity, see Ashmore et al. (2004).

[46] Swidler (1986).

conditions in many societies. However, we want to emphasize the ways in which cultural frameworks affect health by conditioning peoples' capabilities for coping with life challenges and, hence, the amount of daily wear and tear they experience.

Social recognition can feed directly into capabilities.[47] As we have noted, it can affect a person's capacities for securing cooperation from others. Those who belong to low-status groups or occupy positions with low social respect may find it more difficult to secure such cooperation. Research on racial discrimination indicates that social recognition is also likely to affect self-confidence and the effectiveness with which tasks are performed.[48] Here, there are important life course effects: the recognition one achieves in childhood has durable importance for the self-concept and health.[49] Even with the most auspicious upbringing, however, in the absence of cultural templates that sustain a sense of social recognition, adults can rarely sustain the self-esteem that feeds directly into health.[50]

The predominant models of cultural citizenship, social boundaries, and status hierarchies of a society will influence whether social recognition is available and who will receive it. Where the status hierarchy is relatively flat or there are diverse paths toward status, those in the lower rungs of the social ladder should be healthier on average than their counterparts facing steeper or dominant hierarchies. Much may depend on whether status is driven by income. American workers have a greater sense of personal distress, for instance, than their counterpart in countries such as Poland and Japan, and Lamont argues that a quasi-consensus on income and success as sources of worth (epitomized in the collective myth of the American dream) may contribute to that.[51]

However, the process whereby people cope with issues of social recognition is double-sided. Michèle Lamont's chapter for this book suggests that social recognition emerges from an active process in which individuals work toward shaping the symbolic representations of their group. They also engage in boundary work to influence how members of their own group understand their collective identity (for example, by competing to define what it means to be African American in the contemporary United States). She charts the ways in which minority groups have used "destigmatization strategies" to bridge group boundaries and challenge the symbolic representations on which discrimination is based (such as the view that blacks are lazy or less able). In this respect, the widely available social representations of groups must be seen as a set of collective resources, multidimensional in nature, that contribute to well-being, and Lamont argues that the impact of discrimination

[47] On social recognition, see Taylor (1993) and Lamont and Bail (2005).

[48] Steele (1999). Also Steele and Aronson (1998).

[49] Keating (2004); Steinberg et al. (2006).

[50] Steele (1988); Pyszczynski et al. (2004). For a cultural-psychological theory of self-esteem, see Miller, Fung, and Mintz (1996).

[51] Kohn (1987); Lamont (2000: 247).

on a person's health is likely to depend on how low-status group members understand and respond to discrimination. The extent to which they are able to exercise control over self-representation is likely to influence mastery and self-efficacy – psychosocial "coping" and "buffering" factors that have been linked to depression and health more generally.

The connections between collective narratives and population health are similarly complex. As Gérard Bouchard's chapter indicates, we cannot always expect a one-to-one correspondence between the collective imaginary of a society and the health status of its population. His work on the role of myths in modern society is a pioneering effort. In the Québec case, he finds competing myths concerning the trajectory of Quebec society (one "modernist," the other "defeatist") and uses the trajectory of population health to assess their empirical verisimilitude. Even though the health of the Quebec population has increased dramatically throughout the twentieth century, the infant mortality curve (to mention only one example) does not correspond to either of the two widely available narratives about macro changes in Quebec society and its collective imaginary during this period. Bouchard's work reminds us that collective narratives often gain autonomy from lived experience to influence the meanings groups give to their collective identity.

Institutions, Public Policy Making, and Health

This book has much to say about the roles that institutions play in population health and the contributions governments can make to it. Here, our emphasis is on expanding the range of institutions considered relevant to health and on illuminating the ways in which cultural frameworks condition the policies of governments and effectiveness of institutions.[52]

Peter Evans's study of population health in the developing world feeds into exciting new lines of research that see institutions as crucial to international development. However, he questions conventional accounts that associate improvements in health in the developing world primarily with increases in per capita income and the latter primarily with the development of property rights regimes. Building on the contention that population health depends significantly on the wear and tear experienced by people in their daily lives, he argues that population health should be better where higher levels of education and a shallower socioeconomic hierarchy provide the mass of people with more capabilities. The implication is that population health depends not only on acquiring a certain kind of state, with effective administrative capacities and

[52] We conceptualize institutions as sets of regularized practices with a rule-like quality in the sense that actors expect those practices to be observed. They vary, according to how those expectations are established, from formal institutions backed by sanctions, as are many policy regimes, to informal institutions grounded in perceptions that they serve mutual interests or embody patterns of behavior widely seen as appropriate. See March and Olsen (1989); Hall and Taylor (1996); Hall and Thelen (2009).

secure property rights, but on the development of a wider range of institutions at the societal level that broaden the capabilities of ordinary people. Evans devises an indicator of "societal success" to represent such institutions and finds that it explains a good deal of cross-country variance in life expectancy across the developing world.

Our emphasis on enhancing peoples' capabilities to cope with life challenges parallels Amartya Sen's insistence that development should be construed, not simply as a matter of increasing national income but as a problem of enhancing peoples' capabilities understood in more general terms.[53] But Sen says little about how such capabilities are to be defined or enhanced, other than to argue for collective deliberation.[54] The next step, as Evans notes, is to join the "capabilities" approach to development to the "institutional turn" taken by development economics to ask: what sorts of institutions are required if the capabilities of people in the developing world are to grow?

Our answer, articulated by Evans, suggests that the deliberative processes fostered by democratic institutions have a role to play but are insufficient to generate large improvements in health. Population health has been advanced most effectively in places where deliberative institutions are accompanied by high levels of social mobilization that enable communities to press governments into action on a sustained basis over time. The problem is thus one of explaining how populations are mobilized – a topic on which there is a large literature, little of which is pointed directly at issues of population health.[55] Evans and Swidler (in her chapter) show that this is where cultural frameworks are an indispensible supplement to institutional structures. Even though rights-based institutions are often a precondition for such moblization, it is most effective at securing enduring reforms in settings, such as that of Kerala, where political organizations have promulgated collective imaginaries that challenge traditional hierarchies and provide ordinary people with new understandings of themselves that are inclusive and politically empowering.

In sum, for the purposes of advancing population health in the developing world, a well-configured state is not a substitute for an organized civil society. And the development of secure property rights provides, at best, an indirect route toward gradual improvements in health, many of which can be accelerated if effective social mobilization can be achieved.

Ann Swidler takes this a step further to consider how cultural frameworks condition the effectiveness of policy regimes. Her comparison of AIDS-prevention programs in Botswana and Uganda has important implications for the role of institutions in socioeconomic development. Most of those who assign importance to institutions as a tool for development favor the types of administrative structures that Botswana has established, built on Weberian

[53] As noted, Sen's use of the term is more general than ours. Compare Sen (1983; 1999).

[54] See Polletta's (2002) important contribution to this topic.

[55] For a notable exception, see Tendler (1997) and for reviews, see Polletta and Jasper (2001) and Snow, Soule, and Kriesi (2004).

bureaucracies that are relatively efficient and relatively uncorrupt.[56] By African standards, Botswana ranks high on most measures of good governance. But Swidler finds that those institutions were ineffective at reducing rates of HIV infection, while the government of Uganda, whose state lacks many of the features associated with good governance, was able to secure dramatic reductions in the incidence of HIV infection.

Swidler compares the public campaigns mounted to shift people away from behaviors that put them at risk of HIV infection. She finds those efforts were effective only when they mobilized the systems of meaning implicit in the everyday relations of local communities. To some extent, this was a matter of social organization. In Uganda, prominent clan structures, if less democratic than the local governments of Botswana, provided effective vehicles for reaching local communities. The implication is that indigenous organizations may provide a more effective base for reaching and motivating ordinary people than the organizations with more social distance operated by national bureaucracies or transnational organizations.

The core lesson for population health is that campaigns designed to alter behavior, so as to improve public health or reduce other threats, must do more than convey information. They will be more effective where they tap into the social imagery of the local community, invoking the obligations ordinary people feel to their friends and neighbors. To do so, they must resonate with the taken-for-granted frameworks through which people understand their lives.[57] Conceptions of everyday justice, of courtesy, and of communal responsibility are the foundation on which the response to new social risks can be built.

This means that governments interested in promoting more healthy behavior must work with existing cultural resources. Swidler conjectures that local culture in Uganda may have provided more fertile ground for moral appeals for AIDS testing and safe sex than the context in Botswana, which attaches high value to respect for privacy and a formal civic courtesy. However, she notes that effective cultural matches are not simply "found" but actively created, by appeals that can change, as well as leverage, available cultural frames.[58]

The overarching point is that those interested in improving population health or advancing its development should not assume that a common institutional form will work well in all cultural settings. International development agencies tend to look for institutional templates that reflect a "best practice" they can urge on all countries. Swidler's research reminds us that effective institutional design must take into account the cultural context in which institutions will be deployed because it is often only by tapping into that context that institutions become effective.

At the most general level, this means that policy makers should think of themselves as operating within a certain structure of social and cultural

[56] See also Evans (1995).
[57] On resonance, see Schudson (1989).
[58] See also Cornell and Kalt (1992).

relations. For some decades, it has been customary for policy makers to think of the economy in structural terms. Few officials would propose a new economic policy without considering not only the likelihood of meeting its immediate objectives but also its ancillary effects on the structure of market competition. But because governments rarely think of society in such terms, policy makers often miss the opportunity to leverage local social resources.

Hall and Taylor pursue this point. They note that governments can sometimes enhance the impact of a policy – securing a social multiplier effect – by considering how the delivery of a policy affects networks of social relations. Unemployment benefits can be delivered, for instance, in ways that strengthen the social ties between unemployed people and those who can provide leads to new jobs. Day care can be used to build the wider social relationships on which parents depend for support. The cultural frames governments deploy when making policy that bears on minority groups can feed back into the capacities of members of those groups to secure the cooperation of others.[59] In each of these cases, new social resources are being created that can amplify the effects of policy.

Conversely, if inattentive to the structure of social relations, governments can inadvertently erode the social resources available to the community, embodied in the networks to which people belong, the associational life available to them, the character of the social hierarchy, and the collective narratives that give meaningfulness to individual lives. Housing policies or zoning ordinances that inadvertently eliminate sites at which the elderly congregate can leave them socially isolated. Nationalist narratives that disparage some groups, even obliquely, can make local cooperation more difficult.

In sum, although we often think of public policy making as an endeavor that allocates material resources or devises sanctions and incentives to secure particular behaviors, it should also be seen as a process of social resource creation. And, as we have argued, social resources are consequential for population health. Therefore, governments can improve the health of the population not only with policies directly aimed at it but by configuring a much wider range of policies to promote or redistribute social resources.

Jane Jenson reverses this optic to consider how the broader ambit in which policy is made conditions the types of policies that governments will adopt to promote health. Her chapter shows how key elements of the collective imaginary – encapsulated in the prevailing "citizenship regime" – affect the reception given to alternative medical paradigms. Using the case of the sanitarian movement in nineteenth century Britain, she argues that the enthusiasm governments develop for particular medical paradigms and the interventions they undertake to implement them are deeply affected by prevailing ideas about the responsibilities of governments and the rights of different groups of citizens.

[59] Soss (2008). Also see Steensland (2006).

epidemiology can gain from such comparisons. Studies of how position in a social hierarchy affects health, for instance, are likely to produce more robust results if they can examine its effects across cases in which the shape of the hierarchy differs. Many important features of social relations are structural attributes of society, whose effects cannot be ascertained without comparison across societies. To date, such research has been limited by the availability of good cross-national data – about health, cultural frameworks, and social relations. There is a strong case here for the collection of such data.

The perspective advanced in this book has similar import for how the causal processes that connect social relations to health are construed. In some instances, those may be relatively direct: higher levels of social status or membership in a denser set of social networks may provide individuals with social resources that enhance their health status. Even here, we need to be attentive to the time lags that may be associated with cause and effect. In other instances, however, the causal structures may not be so straightforward. As Clyde Hertzman observes, a set of social relations developed long ago or gradually over time, via a set of path-dependent processes in which subsequent developments depend on the character of previous ones, may affect population health only at a later point in time or in the presence of a specific kind of challenge. The resilience of population health in the Czech Republic in the wake of the collapse of communism may be attributable to this kind of causal process. The collective imaginary and social networks of the Czech Republic, for instance, may have provided the population with sources of resilience in the face of this shock, even though they may have had no discernible effects on health during the communist period. We do not know this for sure because research often focuses on effects that operate consistently across time and space rather than on those that may become important only in the context of specific junctures.

A useful analogy is to studies of well-being over the life course, which find that a person's resilience in adulthood, encompassing both physiological and mental responses, can depend on the experiences of childhood. The latter may operate in a number of ways – by engendering effects that lower one's subsequent resistance to health threats, by inducing a sequence of experiences or behaviors that cumulatively threaten health, or by producing latent effects triggered only in the presence of later experiences. There is some reason to think that social developments may operate on societies in analogous ways, drawing them into cumulative spirals that gradually enhance or erode population health or equipping them with characteristics that condition collective resilience in the face of subsequent challenges.[62] Although one must be cautious about drawing parallels between organic entities and social ones, there is a case for more research into the sources of social resilience.

Therefore, when considering the relationship between health and social relations, it is important to look for what Pierson calls "large, slow-moving processes" – the incremental shifts in tectonic plates that precede the

[62] Compare Schoon (2006).

earthquake – rather than seeking the causes for a health outcome entirely in that last set of events that precipitate it.[63] We do not need to go back to the Battle of Hastings to explain the English Civil War of the 1640s, but no adequate account of the causes of that war would stop with the king's effort to dissolve Parliament.[64] These injunctions apply with special force to studies focused on the social determinants of population health. Because many of those determinants are the product of historical processes, without looking into those processes, we can have at best incomplete explanations for health. Our perspective suggests that social factors should always be seen as the artifacts of historical processes. To study the latter can be revealing not only about the causal dynamics that lie behind population health but also about the wider implications of socioeconomic development.

William Sewell's chapter for this volume is a contribution to this kind of inquiry. He observes that many of the conditions associated with population health, including income inequalities, the level of provision of public goods, and the intensity of market insecurity, are deeply affected by developments on a transnational scale. To understand population health, he suggests, we need to look, not only at its immediate determinants, but at long-term shifts in the cultural and institutional frameworks governing global capitalism. In a highly suggestive essay, he traces the decline of a state-centric paradigm for economic governance and the rise of a neoliberal paradigm with attendant cultural as well as economic implications. His inquiry draws attention to factors impinging on population health that narrower studies miss, suggesting that health depends on some basic elements in the constitution of societies that are malleable over time. He reveals that population health is as much historically, as biologically, determined.

This perspective calls for more longitudinal analysis of the social determinants of health. Social epidemiology tends to concentrate on cross-sectional comparisons of cases observed at a single point in time. This emphasis is eminently understandable, given the available data, and we have called for more such comparisons. However, our perspective suggests that some of the most important causal processes associated with the social determinants of population health may be ones that operate dynamically over time, in ways that will be illuminated only by longitudinal studies of how they develop.

Conclusion

This book is addressed to social scientists, social epidemiologists, and the informed public. It is designed to promote several sets of dialogues. We have tried to show how fascinating the puzzles of population health are for many disciplines and how much social science can gain from turning more of its attention to them. By example as well as precept, we encourage analysis of

[63] Pierson (2004).
[64] See Stone (1972).

the large issues associated with how "successful societies" are constituted and more interchange between those interested in the role of institutions and those interested in the role of culture in social life. Both sides can benefit from that conversation.

Social epidemiologists long interested in the social determinants of health will find here new perspectives that broaden the range of determinants considered relevant to health and deepen our understanding of the role cultural frameworks play in them. Investigating some of the social processes identified here may be challenging, but we think there is room for empirical progress and no point in looking only at the lighted side of the street, if what must be found lies on the other side.

There are clear implications for policy in many of the chapters that follow. We suggest that governments can improve population health through a range of measures that extend well beyond conventional efforts at health promotion. Governments enhance population health by conserving social resources, much as the conservation of natural resources improves the environment. Against the view that population health is best advanced in developing countries by increasing gross domestic product, we argue that measures to improve skill levels and redistribute resources can have significant effects. We suggest that prevention policies will be more effective when they tap into the moral solidarities animating local networks.

This book is an exercise in interdisciplinary exploration. The objective of the chapters is not to resolve issues but to open up new ways of thinking about them. However, all advance an approach to population health that emphasizes the contributions cultural frameworks interacting with institutional structures make to the wear and tear people experience in daily life and to the effectiveness of public policy making. In this perspective, we see exciting agendas for further research.