Chapter 15
Implications and Implementations

Recommendations

At the Sixty-second World Health Assembly, the WHO urged the member states to pursue to reduce health inequities through action on the social determinants of health (WHO 2009). Social capital, at its best, serves as a measure of social determinants that has been accepted to promote public and population health and well-being (Cox 1997, OECD 2001, World Bank 2009, WHO 2009).

In many Western countries, national statistics offices have taken the leading role in surveying social capital and promoting it for welfare and well-being, as discussed in Chapters 2 and 3. However, statistical reviews of social capital are far more frequent than actual recommendations or implementations of any measures. In Canada, special recommendations concerning the promotion of social capital for the purposes of public health policy and population health have been published within the Policy Research Initiative (PRI 2005). They may well be are suitable as general recommendations in the developed and rich Western world but not necessarily valid or relevant in developing or non-democratic countries.

The Canadian recommendation is very preliminary and theoretical by nature, perhaps due to the deductive orientation towards the concept of social capital. First, it demands that the Government should adopt a social capital approach to developing research plans, data and policy analysis and evaluation. Second, it suggests as reasonable to adopt a social capital approach that documents and examines existing social networks to better identify the presence and manifestations of social capital. Third, it is recommended to examine social capital in terms of different health policy areas, such as populations at risk of exclusion, community development, migration and rural revitalization, and major life transitions in general. Social capital studies may give answers to questions regarding the types of social networks for healthy aging, childhood development, integration into the labor market, and cultural integration (PRI 2005).

Despite the recommendations of the major global organizations and extensive empirical literature that speak for social capital as a measure of social well-being, several critical comments have been made during the early days of the social capital and health debate. Mostly, hesitation or criticism has been based on limited

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conceptualization and lack of longitudinal empirical evidence concerning the utility of the concept of social capital for public health (Baum 1999, Lynch et al. 2000, Muntaner et al. 2000, Forbes and Wainwright 2001, Shortt 2004, Folland 2007, Moore et al. 2009). As shown in this book, the longitudinal empirical evidence accumulated since the early critical reports indicates that social capital may be a good investment strategy for public and population health. In other words, the confidence in the utility of existing social capital for community health has been proved in challenging tests. The real problem is the question how to build social capital and to implement it for the benefit of public and population health.

Can Social Capital Be Built?

It has come clear to me personally that communities with an abundant stock of social capital exhibit better health outcomes. The obvious question is "How can we build up social capital?" so as to promote population and public health, which actually can be quite poor in some communities and countries. There are theorists, health researchers and health policy makers anchoring on the prospects for social capital, but practically nobody seems to know how to create it or how it comes into existence. Warner (2001) discussed shortly various matters and obstacles concerning the constructability of social capital. She referred to the role of investment costs and returns in building and maintaining social capital in the Bourdieuan sense. Social capital includes activities of autonomous individuals, and calls for both horizontal and vertical linkages between local actors. At the community level these ties are formed through interactions which emerge as extensions of school, workplace, or play. If these ties do not occur naturally, specific forums for interaction must be intentionally designed and created to encourage development of social capital (Warner 2001). This, of course, is easier said than done, presuming that the state and the government authorities are not inherently suited to help construct social capital. In contrast to the horizontal grass-root character of social capital, some social capital scholars argue for a central role of state or government and speak about linking social capital (see Chapter 2, Figs. 2.1 and 2.2). Decentralization is assumed to potentially help local actors and citizens in building up social capital. However, such desirable positive development in the field of social capital has not been observed in, for example, Sweden or Finland where the decentralization of governmental agencies has been on the political agenda for years.

Government programs for promoting community social capital should be formulated so that they develop participatory structures and view participants as producers (Warner 2000). Public spaces are important for citizens to gather together, as discussed in Chapter 5. To invest in public spaces, such as libraries, would be a good policy from government in terms of creating horizontal social capital. The role of other governmental institutions or facilities may not always be favorable for creating social capital. Social surveys worldwide have repeatedly shown that distrust in government authorities is not a particularly rare phenomenon among citizens. Schools,

social and medical services, the police and military are not democratically governed organizations, and they are increasingly distinguished from local horizontal community processes maintained by autonomous citizens.

Third-sector organizations are more horizontal social networks, but even they include vertical structures that discourage grass-root social activities. Unlike the government structures and third-sector organizations, it is the various non-governmental, voluntary and non-profit institutions and community organizations that are the most fertile ground for investments and actions for the aim of constructing social capital.

Building Community Social Capital

Some of the most interesting studies on the role of community in the formation of social capital have been done in developing countries, and even in pre-industrial societies (Krishna 2003, 2007, Godoy et al. 2007, Paek et al. 2008). In 2004, three hypotheses were tested within a diverse group of 61 villages, originally selected in 1997 in Rajasthan, India (Krishna 2003, 2007). The first hypothesis defined social capital as a product of government institutions. The second set of assumptions emphasized the role of a community group's internal characteristics for its ability to generate social capital. The third hypothesis assumed that external interventions are necessary for communities to build up social capital. However, when assessed in terms of government organization membership, political organization membership, or faith in government institutions, the external interventions had no significant impact on the generation of social capital. In contrast, grass-root activities and internal efforts, especially setting higher values on self-initiated organization memberships, internal rules and new leaders helped raise the value of social capital from the original level in 1997 to the higher level observed in 2004.

Self-initiated rules and new leaders who helped villagers overcome the collective dilemma were effective in building social capital in the studied Indian villages. Neither the authorities nor other outsiders seemed to support the process of generating social capital. Instead, internal community leaders were important for creating social capital. The competent leaders of community social capital are called "actors" by Krishna (2003). In the Indian villages, it is also interesting that fair rules have causal priority – formulating clear and broadly accepted rules (in 1997) resulted in building more social capital in a later period (in 2004), and not *vice versa*. Another interesting finding drawn from Krishna's data is the observation that external agencies may not, after all, be crucial for raising community social capital – that was not the case, at least, in the studied Indian villages.

A study in Uganda investigated the contextual effects of social capital on family planning behavior. Perhaps contrary to expectations, the effect of social capital on the family planning behavior was in a negative direction. The result was explained by the gender-related norms in family planning, meaning that, in a traditional society like Uganda, male-dominated patriarchal values are the most important and must be

maintained by all members within the society (Paek et al. 2008). Building up social capital can result in a powerful resistance against the dominant values and culture of a society. The finding provided empirical evidence on the proposed "dark side" of social capital (Portes 1998, Putnam 2000), as discussed in Chapter 2.

Even if social capital as such is a universal phenomenon, its forms and manifestations, however, are clearly shaped by culture, place, and history. This was shown in an interesting study conducted in a pre-industrial society, a native Amazonian community in Bolivia. Using the cultural anthropological approach, the study aimed to explore which incentives drive private investments in social capital. The strong group-level associations with social capital seemed to stem from equally strong kinship ties that blurred the line between the group and the individual in the pre-industrial society. The village-level amount of social capital was positively and significantly associated with the individual measures of generosity (gift giving, labor help, communal work), which represented private investments in social capital (Godoy et al. 2007). The authors state, however, that their results from a pre-industrial society are not applicable to industrial Western societies. The strength of the cultural anthropological setting derives from the ethnographic understanding of individual motivations that have been built over centuries. Such innermost motives may have become obscured by the modernized human mind in industrialized societies.

As to the building of social capital, urban contexts distinguish from rural views (e.g., Nogueira 2009). In Australia, qualitative in-depth interviews were conducted among residents in the western suburbs of Adelaide to study the complexity of social capital and health relations (Baum and Palmer 2002). The qualitative data revealed a strong link between local opportunity structures – public spaces and psychosocial environment – and social interactions and ties. Environmental design and layout can influence social interactions, and thereby social capital (Cattell 2001, Baum and Palmer 2002).

The discussion about healthy places as promoters of social capital seems to be far-fetched and far from the scope of this book but it is not so, for many reasons. First, the sense of place is not only important for environmental psychology, but it also has a clear traction in the field of social capital and public health. The sense of place, sense of belonging, and pride in place can be regarded as public health constructs because they are at the top of social capital ranking among urban people (Cattell 2001, Baum and Palmer 2002, Frumkin 2003, Nogueira 2009). Second, certain public places such as public libraries have been shown to have beneficial effects on population health, as discussed in Chapter 5. Third, public places have been constructed in many cities in line with the social capital approach. In Scandinavian countries, in particular, many municipalities and cities have built special community centers for leisure activities, or, if such buildings have not been specially built for leisure activity purposes, closed-down schools or similar premises have been restructured to meet local leisure demands.

Streets and parks are genuinely public spaces. Architects like the British Richard Rogers emphasize that modern city design, urban planning, and architecture should nourish community social capital. The planning of the innermost and newest

suburb Hammarby Sjöstad (approx. 30,000 residents) in Stockholm, Sweden is a good example of socio-cultural urban design. Its streets, parks, and squares are designed according to the principles and theories of communitarian social capital, i.e., with a focus on local shops and cafes, parks with community facilitations, attractive places to walk, and even waterways for boats. Homes are opening directly to a public place where the local residents can independently of their age, gender, and social status meet other locals, spend leisure time, and engage in social dealings. Because Hammarby Sjöstad is a very new suburb, it has not yet been possible to analyze the impact of urban social capital on population health and well-being in this new community, but many previous reports assure that well-designed urban environment is beneficial to public and population health.

Empowerment by Social Capital

Empowerment is a concept that is frequently used in health promotion and developmental planning. It is defined as the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes. As a collective characteristic of groups, social capital increases citizens' empowerment, and through this empowerment, influences public and population health. In addition to the individualistic biomedical and economic view of health, the picture is complemented with a collective idea of social capital. Health workers and politicians, however, do not easily take in this shift in the world view. In a multinational study on social capital and health equity in urban context, ten key elements were identified as important elements in building social capital for health policy and planning (Pridmore et al. 2007). The authors present a checklist of ten actions – ranging from stakeholder analysis to mobilizing resources – needed for building social capital as part of a social development and justice process. The ten actions in the checklist are aimed for government authorities, local politicians, and health planners, providing them with a useful practical guide for policy development and practice. Although this contribution to the empowerment discussion is interesting and may open new avenues for empirical studies, it does not exactly state or advise how ordinary people or community groups can promote social capital for better health and well-being.

In its traditional form of civic engagement, neighborliness and social trust, social capital is argued to be on the decline in the U.S. society (Putnam 2000). The elderly, in particular, need social capital for healthy aging. A report on the role of senior housing, for example, has recommended investment in communities "aging in place" (Cannuscio et al. 2003). In Northern Europe, senior residences have already for a longer time coexisted with schools, businesses, parks, libraries, and shops in city or community centers and neighborhoods. Senior housing has been designed to fulfill the requirements of neighborliness, and thereby, to allow social contacts and activities. Whether the European-style senior dwelling has actually succeeded in contributing to healthy aging, has not yet been empirically proved.

In Baltimore, a broad-based, multilevel and intergenerational social model of health promotion, entitled the Experience Corps program, was designed to operate at both individual and community levels by engaging older adults and local schools in interaction. By establishing productive roles for older adults in public elementary schools, the program aims to boost the social capital available through the mobilization of a critical mass of older adults (Glass et al. 2004). Theoretically, the program is based on the idea of generativity presented by Erik H. Erikson, meaning the transfer of knowledge and wisdom to younger generations in order to take care of the "others". In the Experience Corps program, generativity involves the individual level whereas social capital approach involves the community level at the school. The design of the Experience Corps program and a causal model of the impact of Experience Corps on the health of older adults were reported by Thomas Glass and coworkers (2004). Having elderly volunteers in the classroom for at least 15 h a week improved both reading or academic performance and classroom behavior. Short-term evidence of elevated social capital was reported, although the pilot trial did not show if the program improved health among the volunteering older adults (Rebok et al. 2004).

The era of digital communication via the Internet has facilitated new social communication networks and social media. Many older people use the Internet for not only surfing and seeking data, but also for keeping up satisfying contacts with geographically dispersed family members, other relatives, and friends. Internet-based social networks can also enhance leisure activities, provide opportunities for voluntary work, as well as improve access to information and services. In Australia, older people were interviewed about their Internet use. Of the 154 Internet users who completed an electronic survey for the study, 30 participated in an in-depth interview. The data confirmed the assumption that the use of Internet enhances the ability of the older people to access the economic, social, and political institutions and services of their community. Hence, the use of Internet is a good tool for generating and maintaining social capital in old age (Russell et al. 2008).

In this Australian study, the participants were people with good stocks of locality-based social capital and without health-related limitations for access to local networks (Russell et al. 2008). The unpublished results from our recent comparison in Finland between a Swedish-speaking community and an age and gender-matched Finnish-speaking community showed significant differences in the Internet use. The Swedish-speakers used the Internet for boosting their hobbies and associational activities, whereas the Finnish-speakers used the Internet mainly for work-related matters. Furthermore, the Swedish-speakers used it to actually become acquainted with new people in real life, whereas the Finnish-speakers preferred using it incognito, but, nevertheless, found new friends via the Internet. The former seem to value relations between real human beings, whereas the latter are satisfied with virtual connections. All these findings support our previous results that have repeatedly proven that the Swedish-speaking community in Finland is exceptionally rich in stock of social capital. It is very probable that the type of Internet use among the Swedish-speakers is a consequence of their rich social capital – and not only a promoter of social capital.

The general idea of social capital as the key concept covering weak network ties, norms, and reciprocal trust has moved into health and community care. The feasibility of social capital approach within health and community care systems has been proposed in two reports (Eilers et al. 2007, Scott and Hofmeyer 2007). While the former report describes the guidelines for creating a retirement community that promotes social capital among older people (Eilers et al. 2007), the latter report discusses the key concepts of a network approach in primary healthcare (Scott and Hofmeyer 2007). However, both two reports conclude that the critical use and analysis of the application of social capital approach within healthcare systems remain limited. Hence, social capital approach at its present stage seems to be more a heuristic idea than a theoretical framework to adopt for further empirical studies, as has also been concluded in the most recent systematic review on social capital and health care access (Pitkin Derose and Varda 2009).

The Role of Arts and Cultural Engagement

According to Bourdieu (1979, 1980, 1986), building and maintaining networks requires investments, which can yield a return. Cultural capital endows building networks and ultimately social capital. In fact, cultural capital and social capital are intertwined, as has been shown previously in Chapter 5. On the other hand, there is much evidence in the social capital literature that engagement in the fine arts and attendance at cultural events strengthen both bonding and bridging social capital. It has become a common assumption that chorus singing would have a beneficial impact on building social capital, but as far as I know, there is actually no empirical evidence proving this assumption true. Regardless of this, choral activity – independently of voice – is a beautiful candidate for a proxy of social capital. In Finland, we found that singing in a choir was independently associated with self-rated good health among Swedish-speaking women (Hyyppä and Mäki 2001b).

The role the arts play in social inclusion and in building social capital was discussed in a literature review published in Australia (Barraket 2005). For the purposes of the review, the "participation in arts" covered the visual, performing and literary forms of art, ranging from the "high" arts to creative activities. Literature reports showed that arts initiatives had positive effects on social cohesion and network building – arts and cultural activities bring together people from diverse backgrounds. Arts initiatives are particularly effective in building networks amongst diverse groups, and thereby, contribute to the creation of bridging social capital.

Participation in the arts can be divided in passive attendance and active creative expression. Also, the term of community arts has been used to cover community-based passive and active activities. Community arts cannot be practiced without availability of public places: music halls, theaters, public libraries, studios or workshops. Public spaces are buildings and premises where people can assemble and meet without any special restrictions, usually independently of age, gender and

social status. Public places are important venues facilitating a large variety of activities that improve social and cultural interactions – and therefore, they have marked population health implications.

Ethical Issues

Recent years have seen the rise of new bioethical considerations regarding epidemiology and social determinants of health. The new bioethics has expanded its horizons from the moral issues that relate to the distribution and delivery of health and medical care, and started to consider the ethical issues of social determinants of population health. Philosophy of epidemiology is among the issues of interest (Venkatapuram and Marmot 2009). Epidemiologists have found that, beyond the availability of health and medical care, there are other factors that determine public health disparities. Most bioethical considerations have been focused on the socioeconomic determinants of population health as driving health disparities in societies. Health behavior, education, absolute and relative income distribution, environment, and health beliefs belong to the category of socioeconomic determinants of population health, but similarly, the availability of social capital may also be an important factor, which should be reflected from the bioethical point-of-view.

Relationships between social capital and population health are gendered. Depending on their gender, individuals have varying access to social capital. Similarly, the communitarian view of social capital proposes that individuals are not self-determined but nested in networks consisting of other individuals (bonding social capital), communities and groups (bridging social capital), and institutions (linking social capital). The meaning of the "we" embedded in the theory and practice of social capital will challenge the new bioethics to consider moral issues, causation, rights, autonomy, paternalism, and justice in the social network perspective. Many of these challenges have been handled in the preceding chapters, although the word "bioethics" has not been expressed. Questions such as "Can the state limit individual liberty to volunteerism and civil activities?", "Can a community create self-protective systems?", "Can the government limit by law a community's own style to improve population health?", "Who will decide on public spaces?", or "Can politicians decide to close down public libraries?" inevitably lead to bioethical reasoning in the field of social capital and population epidemiology (see Venkatapuram and Marmot 2009).

Ethical problems may not be actual when social capital is seen and handled as a cultural phenomenon that emerges from the background culture of a given society or community. Similarly, ethical issues may not be so burning, if the building of social capital is only structural, as it is when public spaces are designed for people to create social bonds and bridges.