



Chapter 11: Social Capital and Aboriginal and Torres Strait Islander Health— Problems and Possibilities

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Introduction

The concept of social capital has gained widespread currency within public health. Social isolation has long been understood to be detrimental to health, hence it is not surprising that there should be interest in the value of social connections for health. Explorations of the role of social capital in creating healthy communities now encompasses an international literature concerned with redressing health inequality within both rich and poor countries. Numerous definitions abound concerning social capital, however, at its core, social capital refers to the ability of people to secure benefits by virtue of membership in social networks or other social structures (Portes 1998).

Social capital research encompasses a wide spectrum of topics within the broad field of social and economic inequality. Health inequality is now an important part of this field. Studies largely within the area of social epidemiology have described significant associations between levels of social capital and levels of health status. Despite burgeoning enthusiasm for the concept, how to operationalise it in health policy and programs is by no means clear. Firstly, there is scepticism about whether there is really anything new about social capital. Secondly, social capital remains conceptually immature, hence open to vagueness and ambiguity. Thirdly, measuring social capital is fraught with many methodological difficulties. Fourthly, and perhaps most importantly for this paper, social capital is to a large extent a cultural construct, and, as such, may possess quite different meanings in different cultural contexts. For Aboriginal and Torres Strait Islander communities, already too familiar with ethnocentric research, the concern about constructing 'another' non-Indigenous representation of their issues is very real.

To date, there has been little research effort using the social capital concept within Aboriginal and Torres Strait Islander health. Therefore, this review seeks to describe *potential* application of the concept rather than a summative account of social capital within Indigenous Australia. The purpose of the review is to discuss problems and possibilities in operationalising the social capital concept within Aboriginal and Torres Strait Islander health. The review has been

compiled from published data with a focus on social capital, health and Aboriginality. A range of sources were searched including:

- electronic library databases
- Australian Government websites
- Australian university and research centres
- international websites concerned with social capital research
- Google search using key words.

Approximately 400 references were located and they form the basis of this review.

Theorising social capital

Definitions: what are we talking about?

Lyda Judson Hanifan (1920), quoted in Feldman and Assaf (1999:2), is credited with the first use of the term describing social capital as

those tangible assets [that] count for most in the daily lives of people: namely goodwill, fellowship, sympathy, and social intercourse among the individuals and families who make up the social unit.

Mignone (2003) collected seventeen definitions of social capital in order to track the trajectory of ideas behind social capital, but there are many more versions available. Portes and Sensenbrenner (1993) have described different types of social capital definitions corresponding to four different theoretical trajectories from (1) Marx and Engels, (2) Simmel, (3) Durkheim and Parsons, and (4) Weber. This is not the place to describe in detail these different trajectories, however it is important to acknowledge the diversity of definitions available and the consequent lack of conceptual consistency. Putnam's definition of social capital is arguably the most quoted in contemporary literature and defines social capital as:

features of social organisation, such as networks, norms and social trust that facilitate coordination and cooperation for mutual benefit (1995:35–36).

Often social capital is referred to as the 'glue' that keeps communities together. The simplicity of this is appealing, but there is also, as Schuller *et al.* (2000) argue, an 'over- versatility' of the concept that has allowed it to be applied to almost any social situation and to mask potentially important differences in its use. Baum (1997), for example, has noted diverging understandings of the role of the state in the creation of civil society and social capital. The libertarian slant promotes the idea of social capital as 'beyond' the capabilities of government, while the communitarians would acknowledge the importance of an 'activist state'.

Woolcock (1998) has argued it is important to distinguish between what social capital is and what it does. This is a particularly important distinction in relation to Aboriginal and Torres Strait Islander health. Here we must ask what kinds of social capital are actually valuable to Indigenous people? A starting point for answering this question might be to first acknowledge the different levels of social interaction studied within the social capital literature. Macinko and Starfield (2001) have argued that there are four levels of social space in which social capital is used: a macro level (countries, regions); a meso level (neighbourhoods); a micro level (social networks); and an individual psychological level (attitudes such as trust). All of these levels have relevance to the social formations of Aboriginal and Torres Strait Islander Australia.

Putzel (1997) has argued that there is a profound theoretical confusion in the social capital arena created by 'failing to distinguish between the mechanics of trust (the operation of networks, norms etc.) and the political content and ideas transmitted through such networks and embodied in such norms'. As Ostrom (1997) has noted, cartels and organised crime groups can display substantial social capital. This 'dark' side of social capital is often obscured by the concern to idealise the value of social connections. Putnam (1995), in particular, has idealised the American family as well as community association membership. The idea that families can be oppressive social instruments, or that many of the associations in the USA with declining memberships may hold deeply conservative and exclusionary roles, is ignored by Putnam (Putzel 1997).

The big picture: is there a role for social capital in theorising Aboriginal and Torres Strait Islander health inequality?

The enormity of Indigenous health inequality in Australia implores us all to consider its nature and potential solutions. While there can be no dispute that a history of colonisation, dispossession and discrimination have formed the conditions from which poor health has resulted, there remains a vacuum in our understanding of how we place ideas about poor health causation within a theoretical framework. In particular, the struggle to reconcile social accounts of poor health with the dominant biomedical emphasis on individual agency has unfortunately attracted little interest.

Brady (1999) has argued the need for a 'syncretic approach' that integrates both structural and socio-cultural levels of explanation. The social capital literature generally acknowledges the need to address structural issues, but nevertheless downplays class relations and focuses predominantly on social policy remedies around facilitating social cohesion rather than economic and political change (Germov 2002:89). Muntaner *et al.* (2002) have argued that the social capital literature around health has a tendency to 'blame the victim' by suggesting that the source of health problems of deprived groups is their lack of social networks and initiative. The role of social capital in helping to theorise Aboriginal and Torres Strait Islander health inequality has yet to be articulated, although Hunter has observed that: 'Social Capital theory is articulated at a level abstract enough to encompass the experiences of many Indigenous Australians', but adds more critically that 'unless more attention is paid to modelling exactly how these social exchanges add (or subtract) economic value to individuals or groups, then the term social capital is little more than a metaphor' (2000:38).

A logical starting point for considering the uptake of social capital within Indigenous Australia would be to consider the broader theorising of ethnicity within social capital research. However, Carlson and Chamberlain (2003) argue that, at present, the exploration of ethnicity within social capital research remains both conceptually and methodologically immature. For example, in the study by Kawachi *et al.* (1997) that analysed racial difference between black and white Americans, it was found that social mistrust highly correlated with being black, low income and low education. However, these studies also found that the health outcome for black Americans explained by social mistrust was significantly less than for white Americans. The theoretical implications of

these findings remain unexplored (Carlson & Chamberlain 2003). Some useful work on the relevance of social capital to the health and wellbeing of First Nation communities has emerged in Canada, shedding light on the nature of social capital in an Indigenous context (see Mignone 2003; Matthews 2003; Matthews *et al.* 2005).

We should not be surprised to find mistrust of institutions among Aboriginal and Torres Strait Islander Australians, but whether this constitutes an 'independent' source of health inequality or whether such mistrust is the result of many deeper injustices needs careful thought. These theoretical issues are not only related to questions of academic rigour, but also connect to very real political issues that are the consequence of our understanding of Aboriginal and Torres Strait Islander health inequality. There is already an alarming number of descriptions of Aboriginal and Torres Strait Islander communities in terms of dysfunction and disease (Brough 2001). Before another potential descriptor of dysfunction is constructed, it is crucial that the validity of the description be thoroughly examined. For example, at a very basic level, there seems to be an assumption within some of the social capital literature that if low social capital produces poorer health, then communities with poor health, logically, must have low social capital. If this were the case, then we could assume right now, without any empirical research, that Aboriginal and Torres Strait Islander communities must have low levels of social capital, since poor health status is not in question. Perhaps, instead, we need to reverse the hegemonic logic of measuring how 'well-connected' Aboriginal and Torres Strait Islander people are to non-Indigenous Australia, and instead ask how well connected is non-Indigenous Australia to Aboriginal and Torres Strait Islander Australia?

Active citizenship: by whose standard?

A common idea within social capital literature (particularly the line of inquiry evolving from Putnam (1993, 1995) is concerned with the extent to which individuals display civic habits conducive to healthy communities. This line of thinking fits particularly well with 'third way' social policy thinking of mutual obligation and other anti-welfare-dependency strategies. This kind of social policy logic has gained significant ground in Australia and has received additional momentum in terms of Aboriginal and Torres Strait Islander social policy through the analysis of the Aboriginal social commentator Noel Pearson. Pearson (2001) has argued that the passive welfare system is ultimately to blame for many of the social and health problems facing Aboriginal

and Torres Strait Islander communities. Like many working under the banner of the 'third way'—social capital, social entrepreneurship, and community building—Pearson argues the importance of active citizenship in finding solutions to long-standing social problems.

Civic participation may well be a useful idea to encourage, but the problem remains as to whose standards this should be measured by. It is unlikely Pearson's imagination of Aboriginal civic responsibility is the same as conservative liberal imaginations. Hunter (2004) notes this too, arguing that disadvantaged people may find resonance in social capital, but are nevertheless still likely to be talking about very different experiences to their political leaders.

A major stumbling block in theorising 'healthy' citizenship for Aboriginal and Torres Strait Islander Australians must be an acknowledgment that citizenship itself has been an excluding and socially divisive political ideal within Australian colonial and post-colonial history. Turner's commentary on the problematic nature of citizenship for Indigenous people is relevant here:

In particular, in the modern period, if citizenship has emerged primarily within the nation-state, then citizenship simultaneously excludes and subordinates various Aboriginal groups within so-called white-settler societies (especially Australia, Canada, New Zealand and the United States). These aboriginal groups are faced with the choice of either separate development within their own 'state' or some form of assimilation into existing patterns of citizenship (1993:14).

For Aboriginal and Torres Strait Islander people who have struggled against assimilationist policies and programs, often in order to create healthier outcomes for their communities, the idea of measuring 'civic participation' against a benchmark set by 'mainstream' Australia would not only be theoretically and methodologically flawed, but, more importantly, politically and historically insulting. Moreover, does being an active member of the Aboriginal and Torres Strait Islander community confer the same possibility of benefit as being an active member of other communities?

Part of the difficulty in taking a universalist view of social capital is that it does not acknowledge the possibility

that social capital clusters around particular social spaces, some of which may sit in opposition to each other. As Portes has argued, sometimes group solidarity is cemented by a common experience of adversity and opposition to mainstream society:

In these instances, individual success stories undermine group cohesion because the latter is precisely grounded on the alleged impossibility of such occurrences. The result is downward levelling norms that operate to keep members of a downtrodden group in place and force the more ambitious to escape from it (1998:14).

Measuring social capital

Social epidemiology

There is a growing body of public health research considering the interconnection between social issues, economic indicators and wellbeing for both neighbourhoods and individuals. Cross-disciplinary studies investigating social capital have emerged recently which provide new perspectives from urban planning, community development and psychology to enrich the health debate (Grootaert & van Bastelaer 2002; Mohan & Mohan 2002; Gilson 2003; Jackson 2003; Robison & Flora 2003).

Some population studies by Baum and others link social dimensions with health outcomes providing practical suggestions for structural health interventions or policies (Tijhuis *et al.* 1995; Baum 1999a, b, c; Baum *et al.* 1999; Wallis & Dollery 2001). Focused studies, such as for children, injecting drug users or mental health, offer suggestions for public policy (Lovell 2002; Jutras 2003; Stewart 2004). Programs such as that by Glass *et al.* (2004) develop population health through social approaches, such as intergenerational programs. These studies are welcome, as human services research and policy more commonly focuses on deficits or matters needing improvement than on strengths and wellbeing. Social issues and wellbeing indicators, while recognised as linked and important, have been less well researched than biomedical factors and ill health, and likewise are less well resourced in health services (Gorski 2000).

Social capital generally shows weaker associations with population health indicators than economic inequality. While social capital has been embraced as a model to help explain connections between the social environment and health,

some suggest the notion of class remains a more valid measure to explain differences in health status (Muntaner *et al.* 2002; Kennelly *et al.* 2003; McCulloch 2003). Muntaner and colleagues (2002) suggest a closer relationship between health outcomes and poverty rather than social capital, where strong welfare states are associated with lower rates of both infant deaths and injury mortality for workers.

The nature and context of relationships is poorly developed in current research with a presumption that middle-class Western values and systems apply in other situations. There seems to be no 'one size fits all' for social indicators, and research results are often contradictory (Hyden 2001; Lindstrom & Ostergren 2001; Lynch *et al.* 2001; Moss 2002; Edmondson 2003). Social background seems to have different effects on health outcomes. For instance, people living in poor neighbourhoods who knew few neighbours displayed lower levels of anxiety and depression than others living in more affluent places (Caughy *et al.* 2003). McMichael and Manderson (2004) suggest that while social capital is a useful concept for understanding some aspects of adaptation to a new environment for Somali women resettled in Australia, the institutions of social capital are politically and culturally loaded. The impact of social connectedness may depend both on class and socio-economic background, or social norms may have various impacts depending on customary behaviours. Siggers and Walter (2004) suggest a dynamic relationship between Indigenous status and the socio-economic, cultural and political arrangements of a society, and that this underlies the differences in health outcomes for Indigenous people.

Challenges in measurement

The nature of the association between social connectedness and health is poorly understood (Berkman & Glass 2000; Kawachi & Berkman 2000; Veenstra 2000; Cattell 2001; Cullen & Whiteford 2001; Scanlon 2004). One important reason for this is the difficulty in measuring social connectedness. Epidemiology, as the traditional quantitative discipline of public health, must come to grips with this measurement, especially in the crucial area of Indigenous health and wellbeing. More generally, Leeder and Dominello have thrown down the gauntlet:

There is no claim that epidemiology has been successful in illuminating fully the association between socio-economic status and health, but then who has? So, are we seriously to believe that a concept such as social

capital—defined differently by many people who use it, burdened with middle class fantasies and nostalgia for the picket fence and mum at home cooking the evening meal—will see us out of that fix?

For social capital to find a place at the social policy table, it must be given some stability and... be subject to quality epidemiological research, not too dissimilar to that which has underpinned epidemiology's immense success in public health over the decades (1999:428).

Morrow suggests we conceptualise social capital

not so much as a measurable 'thing', rather as a set of processes and practices that are integral to the acquisition of other forms of 'capital' such as human capital and cultural capital (i.e. qualifications, skills, group memberships etc.) (1999:744).

Shortt (2004) has briefly reviewed the lack of international consensus around the measurement of social capital, including attempts to design a generic social capital assessment tool. Baum and Ziersch (2003) observe that most studies measuring social capital have done so quantitatively, often using measures such as per capita membership in voluntary groups and levels of inter-personal trust, but that there have been fewer in-depth qualitative studies that may be fruitful in the way they examine the contexts in which social capital operates and its multi-dimensional nature.

Hughes and Stone (2001) consider social capital measurement to be an emerging field, and identify four key principles to help avoid past pitfalls in measuring social capital in empirical research (Portes 1998; Stone 2001; Stone & Hughes 2001). These are that: (1) social capital measurement and 'practice' needs to be theoretically informed; (2) social capital should be understood as a resource to collective action; (3) empirical work must recognise that social capital is a multi-dimensional concept; and (4) a recognition that social capital will vary by network type and social scale.

Social capital research requires multi-level analysis. Should we measure it at the group level if we agree that social capital is a collective characteristic? Kawachi and Berkman (2000) consider there are two possible approaches, one using aggregate variables (aggregating individual level data), and the other using integral variables (direct observation at the group level). We must be mindful of the well-known 'ecological fallacy' that associations at the group level (e.g.

family, community, town, city, country) could differ from the corresponding associations at the individual level within groups of the same population (Robinson 1950). Firebaugh (1978) has shown that under certain conditions aggregate level data can provide unbiased estimates of individual level relationships. Ecological studies are the only studies that can measure group effects, however, they have several methodological problems that may limit causal inference, especially biologic inference (Morgenstern 1998). Van Deth (2003) has discussed various pitfalls around the measurement of social capital, including the use of aggregate measures for collective phenomena.

Social capital theory can provide an explanation for local contexts, although Shortt (2004) observes that social capital tends to ignore context. A validation of social capital indicators in different settings is, therefore, required (Van Deth 2003; Hunter 2004). While there is no single test to establish the causality of an observed association between an exposure and an outcome, we can use various guides to assist in determining whether an association is causal (Bradford Hill 1965; Susser 1991; Lucas & McMichael 2005).

Hughes and Stone (2001) describe a study in which existing survey data from a random sample of 1500 Australian households (with at least one person aged eighteen years or older)¹ were used to develop and test three approaches to measuring social capital, using statistical techniques such as cluster and factor analysis—a network-based approach, an overall measure approach and a typology-based approach.

Measures of informal social capital used included 'trust in family', 'reciprocity within family', 'trust in friends' and 'reciprocity among friends'. Measures of generalised social capital used included 'trust in people around here (local area)', 'reciprocity among people around here (local area)', 'trust in people in general', and 'number of group memberships (individual item, actual number)'. The authors concluded that while the three approaches to measurement had statistical validity and reliability, further research was required to determine their validity and usefulness. Although the measurement approaches used in this study may not apply to Aboriginal and Torres Strait Islander Australians, they are worth exploring further.

The Australian Bureau of Statistics (ABS) has recently published an information paper with a broad conceptual framework for statistics on social capital and a set of possible indicators for measuring aspects of social capital (ABS 2004). Four main elements of social capital are identified: network qualities, network structure, network transactions and network types. Further, sub-elements within each of the four main elements have sets of possible indicators. For example, within the main element of network qualities, indicators of trust and trustworthiness are listed as: generalised trust; informal trust; institutional trust; generalised trustworthiness; feelings of safety using public transport; feelings of safety walking in the street; and feelings of safety at home after dark. An indicator of generalised trust is listed as 'the proportion of people who feel that most people can be trusted', and data items are 'most people can be trusted' and 'cannot be too careful dealing with people'. There is no discussion in this ABS information paper about the applicability to Aboriginal and Torres Strait Islander Australians of the social capital conceptual framework, elements or indicators. This framework will need to be looked at critically, taking into account the complex issues of kinship, before applying these empirical measures of social capital to Aboriginal and Torres Strait Islander people.

Onyx and Bullen (2000) measured social capital in five communities in New South Wales—Deniliquin, Greenacre, Narellan, Ultimo and Pyrmont, and West Wyalong—which included rural, outer metropolitan and inner city communities. The final non-random sample consisted of 1211 people, aged between eighteen and sixty-five, interviewed face-to-face. Using factor analysis and the thirty-six best social capital items, they concluded that eight elements appeared to define social capital: participation in the local community; pro-activity in a social context; feelings of trust and safety; neighbourhood connections; family and friends connections; tolerance of diversity; value of life; and work connections. In their 2004 USA study, O'Brien *et al.* (2004) used a random telephone survey adaptation of the Onyx and Bullen (2000) non-random, face-to-face interview questionnaire, and concluded, using exploratory factor analysis, that the Australian-based instrument deserves further attention as a practical tool for health researchers interested in measuring social capital. Again, careful work would be required to determine if this non-Indigenous based questionnaire instrument is relevant, valid and reliable for measuring social capital in Aboriginal

¹ Hughes, J. & Stone, W. 2002, Families, *Social Capital and Citizenship Project Fieldwork Report*, Australian Institute of Family Studies. Available at <http://www.aifs.org.au>.

and Torres Strait Islander communities and populations. The development and testing stages prior to operationalisation of large- surveys will be crucial.

It is worth noting that Matthews *et al.* (2005) are examining aspects of social capital in First Nation coastal communities in British Columbia. The study has generated successful methods for collecting data on social networks inside Indigenous communities. Measures for individual and institutional trust have been trialled as well as indicators of community commitment and attachment. This Canadian work presents potential openings for researchers in Australian Aboriginal and Torres Strait Islander health to consider.

Complicating these issues of measurement, both those specific to Aboriginal and Torres Strait Islander Australia and to broader epidemiological rigour, is the current atmosphere of apprehension towards research and researchers in Aboriginal and Torres Strait Islander communities and neighbourhoods, which has seen a strong move towards action research rather than purely descriptive or analytical studies. Indeed, one of the unexpected benefits of an explicit focus on social capital among researchers involved in Aboriginal and Torres Strait Islander health, could be the encouragement of a concern for how the research process itself either builds or erodes social capital.

Social capital in public health practice

The burgeoning literature defining, applying and referring to social capital demonstrates the term's increasing usage by both theorists and practitioners alike. While debates about the clarity and rigour of social capital research abound, there has nevertheless been a heavy investment in the concept by practitioners and policy-makers. References to social capital now cross a range of geographical locations and populations. What was initially a concept applied in the USA or Europe has become a global phenomenon applied in regions and countries that differ socially, culturally and economically. They can range from a Los Angeles neighbourhood (Arefi 2003) or the state of California (Twiss *et al.* 2003) to the Ivory Coast (Aye *et al.* 2002), Jamaica (Honig 1998), Russia (Rose 2000) or Australia (Baum 2000). Social capital has been used in programs in rural areas particularly in those areas either developing or declining (Bossert 1998; Narayan & Pritchett 1999; Williams 2003). There is also an emerging urban social capital literature in Australia (Baum 1997, 1999a,b, 2000;

Baum *et al.* 1999; Leeder & Dominello 1999) and elsewhere such as in the USA (Putnam 1995; Aday 1997; Cohen 1998; Bartelt & Brown 2000; Hutchinson 2004).

Social capital research now spans an enormous mosaic of populations including age groups (Sun 1998; High *et al.* 1999; Bazemore 2001), work groups (Butler 1999; Marger 2001), linguistic groups (Hyypä & Maki 2001; Silverman 2001), religious groups (Candland 2000), those 'at risk' (Aday 1997; Knowlton 2003), those with low socio-economic status (Runyan & Wanda 1998; Grootaert 2001; Drukker *et al.* 2003), migrants (Liang 1994; Campbell & McLean 2002) young people (Sun 1998; Earls & Carlson 2001; Campbell & MacPhail 2002, Douglas 2005), women (Gittel & Ortega-Bustamante 2000), and sex workers (Campbell & Mzaidume 2001).

Social capital and community work

There is an expectation that 'societies with a rich web of relationships and widespread participation in community organisations will flourish at many levels including the economic' (White 2002). Hence, it is not surprising to find the social capital concept being operationalised in areas such as community development, capacity building, social development and community building. The connection between social processes, economic outcomes, health and wellbeing—both for individuals and at a whole neighbourhood level—have been highlighted in many studies (Baum 1999a, b, c; Veenstra 2000; Denner *et al.* 2001; Lindstrom & Ostergren 2001; Lynch *et al.* 2001; Subramanian *et al.* 2001; Kennelly *et al.* 2003; Wen *et al.* 2003; Altschuler *et al.* 2004). Many writers acknowledge the link between neighbourhood social processes, individual empowerment and improved health and wellbeing (Campbell & Jovchelovitch 2000; Semenza 2003; Twiss *et al.* 2003; Guareschi & Jovchelovitch 2004), although it is agreed evaluating the connections is problematic (Billings 2000).

At a neighbourhood level, social capital was reported as basic infrastructure for community development (Flora 1998) and, more specifically, community building in the inner city (Cohen 1998). A public health study in Adelaide established links between urban civic infrastructures and opportunities for people to connect (Baum & Palmer 2002). Roseland (2000) explored the connections between social and natural capital in an environmental framework, and the implementation of participative governance for achieving sustainable development in communities. Temkin and

Rohe (1998) propose a theoretical model linking social capital to neighbourhood stability, while other studies suggest that social capital contributes to increases in neighbourhood prosperity (Arefi 2003) and quality of life in poor neighbourhoods, particularly in public housing (Lang & Hornburg 1998).

Altschuler *et al.* (2004) examined the impact of environment on health and the effect of bridging and bonding capital in an urban neighbourhood with varying socio-economic status (SES). Bonding capital refers to links with close-knit peer and family groups, while bridging capital refers to connections outside of these immediate social networks. They found that while bonding capital may be more uniform across neighbourhoods of varying SES, bridging capital (and consequently improved health outcomes) tends to be found in greater amounts in higher SES areas (Altschuler *et al.* 2004).

Among the literature espousing the positive implications of social capital, there are few examples of its negative effects that are often referred to in theoretical papers. While Ostrom (1997), for instance, suggests some organised crime groups display characteristics of social capital, many more authors refer to it in the context of crime prevention (Carson 2004; Hughes 2004; Lee & Herborn 2003).

Social capital and public health

Several projects have set out to test the hypothesis that increasing social connections could show improvements in health. Litwin found that physically active people had better social connections (Litwin 2003). Cattell discovered that different kinds of social networks had an impact on individual health along with perceptions of neighbourhood and poverty and social exclusion (Cattell 2001). Building local connections between older adults and children is believed to have health benefits for both (Glass *et al.* 2004). Likewise, building relationships between women to improve play opportunities for children was believed to improve outcomes both for overall social functioning and for health (Jutras 2003). A community building project in the USA involved local residents constructing public art in a major civic intersection (Semenza 2003). A similar process was used in California to

establish community gardens, which showed public health benefit while strengthening community building skills (Twiss *et al.* 2003). A study in the Netherlands found that the higher the degree of social control in a neighbourhood, the better the children's mental health (Drukker *et al.* 2003).

Holtgrave and Crosby (2004) found a highly predictive relationship between social capital and tuberculosis. McCulloch (2003) conducted an analysis of social disorganisation in Britain and found connections between individual health outcomes and neighbourhood structural characteristics such as population density, concentration of affluence and residential instability. The effect of social capital has been explored in several studies focusing on HIV and STDs. Holtgrave and Crosby (2003) demonstrated clear links between social capital, economic inequality and STDs and suggest the need for structural interventions designed to increase social capital in communities. Clearly, finding an association between social capital and a variety of health outcomes has not proven difficult. However, some authors have been concerned that deeper social divides may be more fundamental to health inequality. A study of peer education of sex workers in a deprived community in South Africa found it difficult to translate the theory of social participation into improved health outcomes because of the dominant structural conditions of poverty (Campbell & Mzaidume 2001). A French study considered social capital and access to reproductive technology, and concluded that social class is more influential on behaviour than social capital (Tain 2003).

Social capital and culture

The role of the culture concept within social capital has not been deeply explored, although a large body of research now describes international social capital in a large range of cultural contexts. There remains the question of whether social capital is relevant only to Western, neo-liberal societies (Szreter 1999; Edmondson 2003), or if it has application in Indigenous communities (Gasteyer & Flora 2000).

A study of the Roma population in Hungary considered the relationships with ethnic minorities in terms of institutional social network resources. It concluded that there was a higher institutional capacity where the Roma population demonstrated high levels of social cohesion, where social networks had norms of trust and cooperation, and where there were effective links with external organisations (Schafft & Brown 2000).

Several studies have considered links between social capital and economic outcomes for ethnic groups (Fox & Gershman 2000). The possible nexus between social capital, cultural background and health status has been examined in a variety of locations, particularly in Europe and North America. A study in Finland found differences in the onset of disability and in self-reported health between Swedish- and Finnish-speaking residents in the same locality. The authors suggest these differences can be explained by social capital (Hyypä & Mäki 2001). A British study explored the impact of ethnic identity for African–Caribbean people on organisational participation and health outcomes, and concluded that institutional racism meant participation was unlikely (Campbell & Mclean 2002). A study in Chicago found higher social capital associated with better health outcomes for whites, although the association was not as strong for African Americans (Lochner *et al.* 2003). While these kinds of studies make links between ethnicity and social capital, there is still a lack of conceptual clarity concerning the ways in which social capital is itself a cultural product.

What we already know about social capital in Aboriginal and Torres Strait Islander Australia

Social capital has yet to attract a concerted interest within the study of Aboriginal and Torres Strait Islander Australia. To date, interest has largely been restricted to the study of economic development and education. Predominantly through the works of the Centre for Aboriginal Economic Policy Research (CAEPR) researchers, a series of findings have emerged that point both to potential and problems in the use of social capital as an analytical device in understanding economic and to educational inequality.²

Martin (1995) has argued the importance of connecting socio-cultural understandings of Aboriginal and Torres Strait Islander 'economic' values and practices in order to understand the nexus of culturally constructed ideas about exchanges of food, goods and cash. In this kind of analysis, Aboriginal and Torres Strait Islander Australians face a choice between participation within the dominant social spaces or within the socio-cultural spaces of their own communities. Similarly, Schwab's discussion of Aboriginal and Torres Strait Islander participation in higher education took up this point:

Clearly, for many Indigenous people, participation in higher education is an attempt to acquire cultural capital that is convertible to economic capital in the dominant economy, but it is worth considering to what degree that same cultural capital is convertible in the Indigenous community (1996:12–13).

Here, Schwab (1996) found that Aboriginal and Torres Strait Islander people often weigh up the costs and benefits of education in terms of their own particular social and cultural circumstances. The 'cost' of education, for some Aboriginal and Torres Strait Islander people, can be a loss of connection to their own community and can bring with it substantial new responsibilities to their extended families and communities.

This theme resonates with the tensions Aboriginal and Torres Strait Islander people can face in 'choosing' between bonding and bridging capital. A qualitative study of social capital within an urban Aboriginal and Torres Strait Islander community (Shannon *et al.* 2003) found that people can face this 'choice' in a more generic sense, often having to decide which aspect of their identity they feel they should or can emphasise in a particular circumstance. Stories of not feeling trusted by non-Indigenous people and institutions were common, leading many Aboriginal and Torres Strait Islander people into situations of having to 'manage' the presence of their identity on a day-to-day basis. A recent survey of social capital and health in a rural town with a significant Aboriginal population (23 per cent) also found that Aboriginal people were more likely to think about their identity than their non-Indigenous counterparts (Gilles *et al.* 2004). Indeed, one-third of Aboriginal and Torres Strait Islander respondents had in the previous four weeks felt negative physical or emotional symptoms as a result of how they were treated because of their identity. Under such circumstances it is not surprisingly that Gilles *et al.* (2004) also found lower levels of civic participation among Aboriginal and Torres Strait Islander participants than non-Indigenous participants.

Civic participation may, of course, hold different meanings within an Aboriginal and Torres Strait Islander context. For example, Shannon *et al.* (2003) found that many Aboriginal and Torres Strait Islander people did not consider work they did for the community as 'voluntary'. Rather, they described such community work as 'just what you do', with some seeing it in terms of their identity—their shared responsibility. This is supported quantitatively in the National Aboriginal and

² See Rowse, T. 2002, *Indigenous Futures: Choice and Development for Aboriginal and Islander*, University of New South Wales Press, Sydney, for a useful overview of this work.

Torres Strait Islander Survey findings concerning voluntary work, in which Aboriginal and Torres Strait Islander people were found to be more likely to volunteer than their non-Indigenous counterparts (Smith & Roach 1996).

What is clear from these few studies of Aboriginal and Torres Strait Islander social capital is that it is difficult to separate an understanding of social capital from an understanding of lived identity. The diversity of Aboriginal and Torres Strait Islander people's cultural practices and social contexts around Australia is well known. Social organisation and kinship are complex subjects that must be taken into account when measuring social capital in relation to the health outcomes of Aboriginal and Torres Strait Islander people. We must be mindful that much of the literature about social capital has a Western, colonial focus, and there is an important need to develop and test reliable and valid measures of social capital for Aboriginal and Torres Strait Islander Australians.

Implications for the development of an Aboriginal and Torres Strait Islander social capital research agenda

The way forward in social capital research in Aboriginal and Torres Strait Islander health is by no means clear-cut. The theoretical, methodological and political challenges (and even dangers) of social capital research have been openly canvassed within this review. Based on these concerns, it would not be appropriate to conclude that social capital offers a panacea to the development of a more 'social' perspective within the study of Aboriginal and Torres Strait Islander health inequality. However, neither would it be wise to conclude that social capital does not have something valuable to offer.

The poor health of Aboriginal and Torres Strait Islander people has long been argued to be the result of social forces, yet there is little research on how exactly these social forces affect health. Social capital is neither inherently 'good' nor 'bad' for health status. Hence, we need to imagine the possibilities of a research agenda that points towards an understanding of the production of health and wellbeing, and not simply 'another' way to

describe poor health status. In their review of social capital in health promotion, Hawe and Shiell (2000:880) argue that the growing importance of place within health promotion involves

the recognition that people's experience of themselves as persons with meaning, dignity, power to act on their own behalf and care respectfully for others, happens in a social context and properties of that context can either encourage human interaction, connection, growth and respect or conversely, foster alienation and despair.

It will be important to describe a variety of macro, meso, micro and individual contexts, from which a variety of perspectives can be produced about social capital in Aboriginal and Torres Strait Islander communities.

At the very least, social capital provides an alternative to the dominant biomedical, risk-factor approach that has failed to contribute substantially to an improvement in Aboriginal and Torres Strait Islander health status. An understanding of social capital in an Aboriginal and Torres Strait Islander context might not only contribute to a better understanding of traditional risk factors, but also offer the possibility of exploring the direct relationship between the social environment and health. Perhaps the single largest contribution that social capital research might make to the Aboriginal and Torres Strait Islander health field is to provide a space in which the dynamics involved in the social determinants of health can be critically examined. It is in the debate about the usefulness of these dynamics in explaining Aboriginal and Torres Strait Islander health that progress might be made. Acknowledgment of the Aboriginal and Torres Strait Islander voice in the description of Aboriginal and Torres Strait Islander circumstances will be important in this debate. This voice will be needed to ensure that the research addresses the value and meaning of social capital from an Aboriginal and Torres Strait Islander perspective. The research questions here are not just about describing what kinds of social capital presently exist in Aboriginal and Torres Strait Islander Australia, but, more importantly, what kinds of social capital do Aboriginal and Torres Strait Islander people desire? The current trend in social policy towards building social capital in marginalised communities seems often simply to assume a match between policy and community agendas. The ultimate test of the social capital concept will be whether it resonates with Aboriginal and Torres Strait Islander voice and experience.

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