Capitals and capabilities: Linking structure and agency to reduce health inequalities

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ABSTRACT

While empirical evidence continues to show that low socio-economic position is associated with less likely chances of being in good health, our understanding of why this is so remains less than clear. In this paper we examine the theoretical foundations for a structure–agency approach to the reduction of social inequalities in health. We use Max Weber’s work on lifestyles to provide the explanation for the dualism between life chances (structure) and choice-based life conduct (agency). For explaining how the unequal distribution of material and non-material resources leads to the reproduction of unequal life chances and limitations of choice in contemporary societies, we apply Pierre Bourdieu’s theory on capital interaction and habitus. We find, however, that Bourdieu’s habitus concept is insufficient with regard to the role of agency for structural change and therefore does not readily provide for a theoretically supported move from sociological explanation to public health action. We therefore suggest Amartya Sen’s capability approach as a useful link between capital interaction theory and action to reduce social inequalities in health. This link allows for the consideration of structural conditions as well as an active role for individuals as agents in reducing these inequalities. We suggest that people’s capabilities to be active for their health be considered as a key concept in public health practice to reduce health inequalities. Examples provided from an ongoing health promotion project in Germany link our theoretical perspective to a practical experience.

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Introduction

Understanding and reducing social inequalities in health have been key issues and a central challenge in public health. Both structural conditions and individual agency have been identified for their roles in influencing these inequalities. Since the spawning of the Ottawa Charter (World Health Organization, 1986), promoting the public’s health by enabling people to increase control over and improve their health is a laudable goal that has become the benchmark for health promotion. The Charter’s proponents deliberately underscored the importance of structure and agency; social structural forces were believed to be creating and sustaining health inequalities and individuals were understood to be able to productively influence social structural conditions affecting their health through their actions (WHO-EURO, 1984). While some agreement has been reached since the writing of the Charter with regard to the importance of the structure–agency processes in the quest towards the reduction of inequalities in health, how exactly to enable people to act in favour of their health remains unresolved in health promotion.

We suggest that a better understanding of the basic dynamics behind the creation of health inequalities through social inequalities might help lead to an answer. More specifically, we examine the conditions and the role of individual and collective agency in the social reproduction and modification of social inequalities in health. It is here that social theory, in particular medical sociological theory, can provide guiding insights. We draw and expand on two related literatures: the structure–agency debate within sociology over the past 30 years (Bourdieu, 1986; Frohlich, Corin, & Potvin, 2001; Giddens, 1984; Hays, 1994; Sewell, 1992) and research concerned with theoretical approaches to health inequalities (Abel, 2007; Cockerham, 2005; Frohlich, Potvin, Chabot, & Corin, 2002; Popay et al., 2003; G.H. Williams, 2003; S.J. Williams, 1995). We do not aim to engage in direct dialogue with the vast social scientific literature on the structure–agency debate, but instead, draw on a few fundamental issues from it in order to move towards an understanding of the mechanisms lying between social and health inequalities, including perspectives applicable for social change.
Structure and agency in the current discourse on health inequalities

The discussion regarding the role of the social structure on shaping human activity has permitted for a strong understanding of its patterns and its potential relevance to health (Frohlich et al., 2002; Popay et al., 2003; Singh-Manoux & Marmot, 2005; Williams, 2003). First, structures are laden with differences in power and thus empower individuals and classes differentially. Second, the term social structure often implies stability (Sewell, 1992), which has led to sophisticated descriptions of how patterns of social life persist over time (Bourdieu’s concept of habitus being a case in point), with less success noted in explanations of how these patterns change over time. Indeed, as Sewell (1992) remarks, many structural accounts of social transformation tend to introduce change only from outside the system. Third, the very essence of social structure has been questioned with disagreement arising with regard to its materiality. While more traditional notions of structure viewed the “material” as the “concrete” aspects of social life (e.g. financial resources, housing), contemporary discussions of the social structure have underlined both the material and non-material (meaning, cultural schemes) aspect of it.

Medical sociology has also dealt in recent years with the structure—agency debate, most directly with regard to the issue of health inequalities (Cockerham, 2005; Frohlich et al., 2002; Popay et al., 2003; Williams, 2003). Today there is a near unanimous recognition that concern with the production and reproduction of health inequalities must take into account both the social structure and individual agency to be given credence. Yet we suggest that this literature, while helpful in moving forward the field by underlining and explicating the importance of both, has left some questions open with regard to how structure and agency are linked in the production, reproduction or reduction of health inequalities. For example, the work of Williams (2003) and Popay et al. (2003), through explorations of lay knowledge or knowledgeable narratives, demonstrates the power of causal narratives in their ability to contextualize risks. Their focus is on the production and reproduction of health inequalities with less attention for the dynamics that might lead to social change. And in more common population level studies on health inequalities, researchers tend to rely on the power of statistically significant associations, without delineating, or even exploring, the conceptual and theoretical relationships between structure and agency.

In the present paper we examine the role of agency in the social production and reproduction of health inequalities and include potential contributions of agency for structural change. We focus most specifically on two recent theoretical concepts we think may offer some novelty to the current debate on the interplay of structure and agency in the production of health inequalities: capital interaction and capabilities. We discuss Pierre Bourdieu’s capital interaction theory in order to explain the importance of structurally-based resources while also considering the function of habitus as a structure-reproducing form of agency. We then extend the discussion to include the concept of structurally transformative agency as a critical component for the reduction of social inequalities. Moving from explanation to an applied perspective, we explore Amartya Sen’s capability approach and draw attention to the range of options for health-relevant agency as a potentially helpful concept for understanding how social inequalities in health might be reduced through public health action. We begin with a discussion of the key concepts from both of these scholars and their contribution to the current discourse on social inequalities in health. Examples from a recent intervention project to reduce health inequalities are included to link our theoretical perspective to a practical experience. First however we briefly re-visit Max Weber’s theory on lifestyle which we use as the basis for our structure—agency perspective.

The structuring of choices

We begin our theoretical foray with some of the basic concepts Max Weber developed in his writing on lifestyles. Weber is particularly important here for two reasons. First, his discussion of “Lebensführung” (life conduct) helps us make the claim that agency and social structure are both critical for understanding how health is unequally produced (Cockerham, Abel, & Lüschen, 1993). Second, and in a related manner, the “Lebensführung” concept helps us move beyond a notion of agency as being equivalent to ‘risk behaviour’, an approach that has been criticized by medical sociologists as being too limited (Shim, 2002; Williams, 1995) and viewed by others to be thwarting the development of health promotion beyond its roots in health education (Abel, 2007; McQueen, 2007).

Max Weber (1978) focussed on life conduct to explain how individuals actively contribute to the social reproduction of status group distinctions through their dress codes, marriage patterns, eating habits, etc. A major contribution of Weber’s work to a critical understanding of lifestyle is his acknowledgement that people’s choices are constrained by the material resources and normative rules of the community or status group they belong to, thereby acknowledging both material and non-material aspects of structure. These resources and rules are all components of what Weber referred to as life chances, the structural part of lifestyle processes (Abel, 1991; Ruetten, 1995). Life chances thus refer to the structurally anchored probabilities of achieving one’s goals (Cockerham et al., 1993; Dahrendorf, 1979).

The notion of “Lebensführung” therefore goes beyond behaviours to focus on people’s active role in responding to demands and opportunities in everyday life. When it comes to behaviours, Weber was concerned with the social processes that link structural constraints and opportunities (life chances) on the one hand, and people’s re-active or pro-active behaviours (life conduct), on the other. This issue has been at the root of the sociological discourse on lifestyles from either a Weberian or Bourdieusian tradition (Cockerham, Ruetten, & Abel, 1997). However, it is Weber’s dualism of structure-based life chances and people’s choice-based life conduct that provides the fundamental ground for thinking in terms of a duality of structure and agency with regard to social inequality.

Capitals and the (re)production of social inequalities

Weber’s view on the dialectic interplay between life choices and life chances laid the ground for later analyses including some of Bourdieu’s work (Bourdieu, 2007). However, Weber’s analysis is insufficient in accounting for social differences in the contemporary patterning of health lifestyles (e.g. Cockerham et al., 1997). Moreover, Weber was concerned with status group formation and his definition of life chances (structurally anchored probabilities) does not clearly address the issue of how much individual freedom is left in the selection of lifestyles. This question is addressed by Bourdieu who argues for a strong link between the possession of different forms of capital, a class specific habitus and the choices individuals have. The significant advancement in Bourdieu’s work for our argument is that it allows us to analyze key components of social inequality directly relevant for agency. We will argue that a closer consideration of the different forms of capital and their interactions opens a gateway into explorations of the role of the individual in the production and reproduction of health inequalities (Abel, 2007).

According to Bourdieu the unequal distribution of structurally-based resources (capitals) can be understood as part of the fundamental system of inequality in a given society; it is both the result and a key mechanism of the social reproduction of power and
privilege. His concept of capital is based on the distinction of three forms: social, economic and cultural capital. These three forms of capital are interrelated and inextricably linked. A major thrust of Bourdieu’s theory is the elaborate account of the interaction between these three forms of capital in everyday life and the ways in which this interaction process contributes to the reproduction of social inequalities and power distribution in society (Bourdieu, 1984; Swartz, 1997). Since this interaction has not yet been given full attention in health research (Abel, 2008), we concentrate here on the interaction between the capitals in their different forms. Prior to this we briefly discuss Bourdieu’s notion of economic, social and cultural capital (for more see Abel, 2007; Bourdieu, 1986; Williams, 1995).

According to Bourdieu (1986), “capital is accumulated labour (in its materialized or its ‘incorporated’, embodied form) [...]. It is a force inscribed in objective or subjective structures, but it is also the principle underlying the immanent regularities of the social world” (p. 241). A critical aspect to Bourdieu’s capital theory is that no single one of the three forms of capital alone can fully explain the reproduction of social inequalities; it takes all three, and importantly, the interaction between the three to permit for social inequalities to endure over time.

Economic capital (or the lack thereof) in the form of money and material assets (income, property, financial stocks), is a decisive factor in social advantage and disadvantage. It is also “at the root of all the other types of capital” (p. 252). Social capital, from a Bourdieusian perspective, is located at the inter-individual level. As such, it refers to material and non-material resources which can be mobilized by virtue of many different kinds of social relationships. Social capital is thus understood as: “... [the] aggregate of the actual or potential resources which are linked to possession of a durable network of mutual acquaintance and recognition – or to membership in a group – which provides each of its members with the backing of the collectively-owned capital” (Bourdieu, 1986, p. 248).

Lastly, cultural capital can be broadly defined as people’s symbolic and informational resources for action (Bourdieu, 1986; Wacquant, 1992). Cultural capital exists in three different forms: incorporated (e.g. skills, knowledge); objectivized (e.g. books, tools, bicycles); and institutionalized (e.g. educational degrees, vocational certificates) (Bourdieu, 1986). It is acquired mostly through social learning, with learning conditions varying across social classes, status groups or milieus (Abel, 2007; Swartz, 1997; Veenstra, 2007; Williams, 1995). A person’s educational level can be understood as an indicator representing cultural capital (for strengths and limitations of that measure see Bourdieu (1986)). Yet, cultural capital refers to more than a person’s formal education or cultural capital. It is acquired mostly through social learning, with learning conditions varying across social classes, status groups or milieus (Abel, 2007; Swartz, 1997; Veenstra, 2007; Williams, 1995). A person’s educational level can be understood as an indicator representing cultural capital (for strengths and limitations of that measure see Bourdieu (1986)). Yet, cultural capital refers to more than a person’s formal education or cultural capital.

The decisive meaning of the three forms of capital and their interaction leads us to acknowledge the active role of individuals who (beyond simply owning or consuming such resources) acquire and use, in some active way, health-relevant capital. The active acquisition and development of such capital is part of individual and collective agency, as is making health-relevant use of them. In other words, in order for cultural, social and economic capital to become health promoting, individuals have to actively use them. For instance, money is ‘spent’ on health-relevant behaviours (such as physical activity classes), support in health matters is ‘sought out’ (such as participating in self-help groups) and knowledge is ‘applied’ by individuals in order for it to function actively to engender health (for instance decisions about what one eats).

**Capital interaction and health inequalities**

There is a high degree of complexity among capitals in their different forms. Three of these relationships (conversion, accumulation and transmission) have been discussed by Bourdieu (1986) and here we add a fourth principle of interaction we call “conditionality.” All four forms of interaction are important for the purposes of our argument.

First, different forms of capital, in their acquisition and use, are dependent and conditional on each other. For instance, cultural capital is essential in the acquisition of social capital; certain values, communication styles and behavioural skills are expected from all those who want to belong to, and participate in, powerful social networks. The (gainful) use of economic capital might depend on the authorizing properties of higher educational degrees and on the knowledge that comes with it.

Second, the different forms of capital can be converted one into another; economic capital, in the form of money, can be invested in order to improve one’s education or cultural capital. Third, capital in these different forms can be accumulated; money can be invested in the stock market, for instance, in order to make more money. Fourth, the different forms of capital can be transmitted; children can inherit financial assets from parents and/or capital can be received through family socialization e.g. when knowledge and social skills are passed on from parents to their children.

Practical examples might serve to illustrate the importance of these four principles of interaction for the (re-)production of social inequalities in health: Conditionality occurs, for example, when knowledge with regard to health and health determinants (cultural capital) becomes a pre-requisite for spending one’s income (economic capital) in a health promoting way. The conditionality relationship also accounts for the fact that some resources may lose their potential health benefits and turn into questionable assets from a health perspective, e.g. when excess income is spent for health compromising behaviours or when social capital is linked to participation in health damaging group behaviours. Spending money on health courses, books or other health education measures means converting parts of one’s economic capital into health knowledge i.e. health-relevant individual or family cultural capital.

Health-relevant knowledge and skills can also be accumulated over time in individuals, families or peer groups through personal and collective investment such as social and cognitive learning, social exchange and support, all often part of individual’s life long socialization. Finally, transmission of health-relevant cultural capital takes place in social networks (e.g. peer groups, work place or school settings) and, most important perhaps, in families, when they provide their children with environments conducive to the acquisition of certain health competencies and health promoting learning experiences (for a discussion and empirical findings of the particular role and function of the family for the transmission of cultural capital see Bourdieu (1984, 1986), DiMaggio (1982), and Georg (2004)).
In the shaping and reproduction of social inequalities these ‘actions’ are related to each other through capital interaction that facilitates class or status-specific habitus and lifestyles. We therefore suggest that inequality goes beyond just the unequal distribution of capital. We argue that there is considerable social inequality also in the chances and ability for people to have the different forms of capital consistently support and complement each other with the end result of their interaction being a health advantage.

It should be emphasized here again that agency requires capital and that the unequal distribution of capital is first and foremost a matter of social structure: cultural capital is unequally distributed through stratified school systems as much as it is through milieus and families; access to social capital is regulated through class barriers as much as it is through language codes; and the unequal distribution of income is the primary marker of privilege or social disadvantage. Our point is that capital interaction needs the active individual and provides for a key role of agency in the conversion of social inequalities into health inequalities.

In Bourdieu’s work the formation of the habitus depends on the availability of the different forms of capital, and in turn, the habitus affects the chances for the acquisition and use of capital. In the reproduction of unequal chances for good health, in particular, the habitus is a useful concept in so far as it explains how particular forms of agency contribute to the re-iteration of class differences in health disadvantages over time. Consequently, current work using Bourdieu’s theory to explain social inequalities in health have stressed the “choice limiting” aspects in the links between structure (unequal distribution of capital) and agency (habitus and strategies) (Cockerham, 2005; Singh-Manoux & Marmot, 2005; Veenstra, 2007). With its focus on reproductive processes, the habitus concept however, does not attempt or mean to explain how structure-based patterns of behaviours are changed, nor does it point to ways in which conditions can be created to alter or increase individual agency for change. When theoretical guidance is sought in applied public health, and particularly in health promotion, for interventions to reduce social inequalities in health, the notion of habitus is not readily applicable; there is insufficient explanation of chances to expand opportunities or even on how agency might lead to structural change.

In fact, because its coherent frame and structure are clearly focussed on a comprehensive explanation of the reproduction of social inequality, it remains a major challenge to apply Bourdieu’s capital and habitus theory when seeking guidance for action on reducing health inequalities. His capital theory has not yet been applied to explanations of how opportunity structures may change over time or how they may be improved by public health interventions to reduce social inequalities in health. However, although his theory stresses class specific habitus and habitus-conforming behaviours and actions, his explanations are not to be misread as “deterministic” as they refer to probabilities more than causal links (Bourdieu, 1977; Bourdieu & Wacquant, 1992; Cockerham, 2005). In fact as Wacquant (1992) has emphasized, there is considerable openness in Bourdieu’s theory to accommodate a theory of change. As Swartz (1997) notes, Bourdieu showed that “the idea that structures reproduce and function as constraints is not incompatible with the idea that actors create structures” (Swartz, 1997, p. 290). Thus, the concept of habitus does clearly focus on the role of agency in the reproduction part of social action and has less to offer for our understanding of the dynamics of actual changes in the range of options to act for one’s own benefit. However, we also find that Bourdieu’s framework, while not fully accounting for explanations of change, provides options to add a theoretical component that might help identify and understand forms of agency for change including those that directly relate to health inequalities (for a more comprehensive discussion of the limits and potentials of Bourdieu’s theory of change see Swartz, 1997).

**From understanding social reproduction of health inequalities to reducing them: the capability approach as a nexus between explanation and public health action?**

Drawing on Weber’s dualism of life chances and choices, we view that despite material and normative constraints people do have some element of choice in their behaviours affecting their health. These choices arise out of the conditions they face and the opportunities they enjoy. In the production and maintenance of health, therefore, there is an important role for individual agency. The question can then be posed: "What theory of agency permits for individual and structural change?"

Following Hays (1994) we understand agency as “human social action involving choices among the alternatives made available by the enabling features of social structure, and made possible by solid grounding in structural constraints” (Hays, 1994, p. 64). For Hays, agency refers to social choices made and operating within the limits of social structures. As explained above, we suggest the dynamics of capital interaction as a key factor linking agency to structure. Applied to social inequalities in health we refer to agency as the socially structured development, acquisition and application of structural and personal resources by individuals in a given context. Agency is at work when individuals use the different forms of capital in the production of health and the improvement of their chances for being healthy (e.g. through certain lifestyle choices). Beyond individual health gains, in their roles as parents, neighbours, teachers etc., individuals (intentionally or not) are directly involved in the social paterning of health. As members of populations and subpopulations, unequally equipped with the different forms of capital, individuals — through their agency role — cannot but contribute to the reproduction, or to the modification, of both social and health inequalities.

The reproduction and modification of structures of inequality has been discussed by Hays (1994) who distinguishes between “structurally reproductive agency” and “structurally transformative agency”. These two differentiate between agency resulting in empirically observable reproduction and that which modifies structural conditions. Bourdieu’s agency concept is close to the first of these agency functions, explaining social reproduction through a link between structure, the unequal distribution and interaction of different forms of capital and class based habitus. As for health and social inequalities, certain health behaviours can acquire the form of “structurally reproductive agency”, e.g. when sedentary lifestyles and unhealthy eating habits (rooted in unequal access to capital and empirically found to be more common in the lower social classes) contribute — through habitus — to a re-iteration of social patterns of health risks and to the reproduction of health disadvantages in lower social classes. In this respect health promotion has been rightly criticized for being vulnerable to practising inequality reinforcing measures, e.g. when not reaching deprived populations or when relying on interventions that are more attractive to, and effective in, certain population groups (Frohlich & Potvin, 2008). In such cases public health action might be contributing to structural health inequalities by promoting health advantages for those already privileged thereby reinforcing class differences in health through structurally reproductive agency.

Based on a solid understanding of the structure—agency processes at work alternative approaches might instead be focused on promoting “structurally transformative agency”. Examples include new community structures that allow for citizen participation and increased autonomy in community health matters. Other examples might include the support of neighbourhood
actions which lead to the construction of safer sidewalks or to better and more equal access to youth leisure time facilities, etc. When searching for theoretical guidance for interventions of this kind the habitus theory shows some considerable limitations as it is more concerned with the social reproduction of inequalities and structurally reproductive agency, and therefore imperfectly equipped to explain those forms of agency that can contribute to structural modifications and social change. Also, generally speaking, epidemiological and health promotion research on health inequalities tends to be lacking or devoid of discussions with regard to the notion of structurally transformative agency. In particular the theoretical links between meaningful explanation and practical public health action are lacking. We therefore propose the consideration of additional concepts that can be used to develop theoretically sound approaches to the reduction of social inequalities in health. We turn therefore, to Amartya Sen’s capability approach as a potentially useful perspective when exploring issues of structurally transformative agency in health matters.

The capability approach

In the last 10 years or so, Sen’s capability theory (CA) has been proposed as being potentially important for our understanding of inequalities in health and for public health action towards reducing social inequalities. This has recently been spearheaded by the WHO Commission on Social Determinants of Health (CSDH, 2008) and the writings of experts like Ruger (Marmot, 2010; Ruger, 2010). The CA puts the emphasis on the empowerment of individuals to be active agents of change in their own terms — both at the individual and collective levels (Ruger, 2004). Central to the CA is the idea of “the public as an active participant in change, rather than as a passive and docile recipient of instructions of dispensed assistance.” (Sen, 1999, p. 281). This perspective on collective activity for change allows us to link the CA to the current sociological discourse on the role of agency and, in particular, to the concept of structurally transformative agency.

The core characteristic of the capability approach is its focus on what people are effectively able to do and be; that is, on their capabilities (Robeyns, 2005). For Sen, only the ends (called “doings” and “beings”) have intrinsic importance. This distinction between means and ends provides the starting point of the capability approach (Robeyns, 2005; Sen, 1985, 1999). Individuals’ effective opportunities to undertake the actions and activities that they want to engage in are what matter. These actions and activities (“doings”) together with the “beings”, or what Sen calls “functionings”, constitute a valuable life. Functionings include, but are not limited to, being healthy, being active as a community member, working, resting, being literate, etc.

The distinction between realizable and realized functionings is crucial to the capabilities approach. “A functioning is an achievement, whereas a capability is the ability to achieve” (Sen, 1987, p. 36). Sen puts much emphasis on the distinction between functionings and capabilities because he believes that well-being should not only include realized functionings, but that the ability to choose from a set of alternative functionings is a freedom sui generis (Sen, 1999). Consequently, and in relation to inequalities in health, evaluations of social and health interventions based on the CA should include, on the structural side, not only the quality and quantity of available resources, or the realized doings and beings on the agency side, but also, the range of capabilities available to people. In other words we must take into account the “capability sets” from which individuals can draw (Sen, 1983). When it comes to evaluating the well-being of individuals or populations, therefore, the capability approach places people’s chances to realize their life goals and plans as its focal point.

In contrast to utilitarian approaches, those that drive much of health promotion work specifically and public health more generally, resources according to Sen are not at the centre of the capability approach; instead, resources are understood as means to ends, namely to realize one’s life goals. With the capability approach, then, the idea of fairness or justice does not apply to the availability of resources alone, but to the range of options for agency — the capabilities. This range of options, and one’s ability to choose and actualize them, creates conditions for health-relevant agency from which, in turn, well-being, happiness and health may result. Moreover, beyond the freedom to be active for one’s own health, capabilities can also be understood as a means for structurally transformative agency, namely when an improved range of capabilities allows for the actual realization of choices which yield consequences on the structural level.

The following example, taken from a recent health promotion project in Germany, BIG (Ruetten, Abu-Omar, Frahsa, & Morgan, 2009; Ruetten, Abu-Omar, Seidenstuecker, & Mayer, 2010), indicates similarly that agency in health promotion can be understood as going beyond social class differences in the uptake of healthier behaviours. In fact, from an empowerment oriented health promotion perspective, one’s capabilities of living a healthy life should include options for structurally transformative agency, i.e., the chance to be active in relation to the structural conditions relevant for health. Conceptually based on the interactive processes between structure and agency, the BIG project demonstrates that these theoretical considerations can guide successful health promotion interventions.

Capitals and capabilities in health promotion practice: the BIG project

BIG is short for “Bewegung als Investment in Gesundheit (BIG) — Movement as an Investment for Health”, and is aimed at promoting health through the promotion of physical activity among women in difficult life situations (www.big-projekt.de). The city-based project addresses women of low socio-economic status known from national statistics to represent the population group most physically inactive with a high prevalence of sedentary lifestyles, and thus high levels of associated conditions such as obesity. Particular about this project is its cooperative planning approach in which the target group, the political level (i.e. mayor and city councillors) and operational level (public health practitioners, sport club representatives etc.) participate on an equal footing from the very beginning of the project. The researchers acted as perceived neutral facilitators and moderators of this academia-driven policy development process (Ruetten & Gelius, 2011). After funding for the research part of the project ended in 2008, the municipality took over responsibility for sustaining the local activities. BIG has been transferred to other municipalities in Germany. Currently, about 800 women weekly take part in BIG activities at ten locations across the country.

The BIG approach was designed to reduce social inequality in health in a low income community characterized by a high proportion of people of lower socio-economic position and ethnic minorities (Ruetten et al., 2010). Its participatory intervention approach focuses on women and their role as social catalysts, defined as empowered individuals acting in (in-) formal networks, mediating social institutions and organizational structures that might function as particularly important assets for the implementation of health promotion actions (Ruetten et al., 2008). Women from different ethnic backgrounds were provided the opportunity to get involved in, and were trained for, cooperative planning from the very early stages of the project. This yielded improvements in their abilities to engage in the development of new
and more adequate health promotion programs (physical activity courses, health courses, women-only pool hours, access to school gyms and fitness studios, etc.). Among the many positive results, the intervention led to the discovery of an unexpected demand for swimming courses by Muslim women. Not only were new swimming courses for women then offered, but the existing administrative rules of the local facilities were adjusted (extra opening hours were added, gender rules changed, culturally appropriate swim-suits/clothing in the pool was permitted). The women also successfully lobbied the city administration to change rules for school facilities and allow them access to a nearby school gym. Of course, such changes faced resistance on the side of the established stake holders, but significant structural changes were achieved through round tables and negotiations in which the women took an active part as social catalysts (Ruetten et al., 2008, 2009).

The interactive processes between structural opportunities and individual agency thus led to an increase in women's range of options for action that included not only their health behaviours (swimming courses becoming available to them according to their social cultural needs), but also their ability to actively socially engage towards improving health promoting conditions in their community. For instance, as a result of the high participation rates in the project, a new position was established within the local city administration in order to promote physical activity among the socially disadvantaged — an example of structurally transformative agency. There were also individual gains for the women by improving their chances for agency beyond health matters. One Muslim woman whose husband took care of her administrative tasks with local authorities in the past, said: “Now I can go myself when I have things to take care of at the city hall” (Röger, Ruetten, Frahsa, & Abu-Omar, 2011, p. 468). Women who were unemployed at the beginning of the project increased their chances of finding a job through the experience of exercising and improving their agency competencies. One was later hired by the city for a newly established position related to the project. The opportunity to establish new contacts through the project's community network was used by another woman to find a new job outside the health sector. A third woman was asked and agreed to run for city council. It should be noted, however, that the women who were most successful in achieving those functionings (e.g. better jobs) were those with the highest cultural capital (educational degrees) from the beginning. Some women, in particular Muslim women with low educational degrees, did however also become opinion leaders in their communities, contributing to and benefitting from the social capital in those groups (Ruetten et al., 2008).

The fact that many of the benefits became apparent only over the course of the intervention underlines the relevance of our theoretical approach. Linking capital to capability sets, rather than deterministic and which do not exclude the option of change can and should include options for individual and collective action through their interaction, into health; 2) different forms of capital and their interaction provide for ranges of options (capabilities) from which individuals can choose in practising health-relevant agency; 3) depending on the capital available some forms of agency may yield improvements in the structural conditions of health enhancing behaviours and beyond.

Discussion and conclusion

In this final section we first briefly summarize our line of argument and how it might lead to new questions in the current discourse in Medical Sociology. We then close our paper with a discussion of the relevance of our theoretical argument for public health and health promotion.

Previous theoretical explanations of social inequality and health have convincingly argued that the (re)-production of health inequalities cannot be explained on the basis of a theoretical or empirical divide between structural and behavioural effects, but instead, will always have to include complex and highly dynamic structure–agency processes. Drawing on theoretical contributions from Weber, Bourdieu and Sen, we suggest that major parts of the transformation of social inequality into health inequality can be understood in terms of capital interactions that shape people's range of options for health-relevant agency. While we draw mostly on Bourdieu's insights about the key role of the different forms of capital, we also observe that his habitus concept is primarily focused on the social reproductive processes between structure and agency. As such, it does not fully meet the need in public health and health promotion research for structurally transformative agency theories. We suggest, therefore, that the notion of capabilities should receive more attention in current debates on structure–agency explanations in health inequalities.

To those who look for theoretical guidance in reducing social inequalities in health, the capability approach can provide a missing link from explanation to action by accounting for individual agency that itself is dependent on structural factors, promoting or constraining agency in any given society and/or context. With regard to structural effects on health, it is the interplay of different forms of capital which needs to be better understood in order to explain the dynamics that lead to the unequal distribution of resources required for health-relevant agency. We further argue that our understanding of the choices in health-relevant agency should not be reduced to healthy behaviours or lifestyles among individuals. Instead, our focus should be on structurally-based choices which can and should include options for individual and collective action on the social conditions of health. These options would ideally allow for initiation and re-enforcement of processes that yield transformations or modifications of the structural conditions relevant for health and health behaviours.

We are aware that Bourdieu’s theory, and in particular his notion of habitus, has been interpreted as a rather closed and deterministic explanation of social inequality (e.g. Archer, 2000) and that such a reading might preclude any attempts to link Bourdieu’s work to perspectives of “change from inside” (Sewell, 1992) or “structurally transformative agency” (Hays, 1994). In response to these interpretations we refer to Bourdieu’s original texts which are not totally deterministic and which do not exclude the option of change through agency (Bourdieu, 1977; Bourdieu & Wacquant, 1992).

We are also aware that Sen’s theory has been viewed to be primarily individualistic (Stewart, 2005). Yet, while his capability approach is focused on individuals’ freedom to achieve their personal goals, it does not exclude the idea that structural constraints and normative powers might structure or even determine the range of these choices. Sen’s original texts do not,
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The capability approach, if solidly rooted in a structure-agency perspective as we have outlined above, could squarely address the basic principles of health promotion. The Ottawa Charter and later adherents to its fundamental ideas seek to ensure, through policy and other health promotion interventions, that the largest number of opportunities are made available to the largest number of people to enable them to make healthy choices for themselves, their families, communities etc. and eventually lead healthier lives. The focus here is on the individual’s ability to choose and use resources which lead to health.

Indeed, unfortunately, the very notion of individual agency is too often dismissed from health promotion literature and research. Individuals targeted by health promotion are too often reduced to their behaviours directly relevant to health risks (e.g. smokers, obese, drinkers) and thus are reduced to risk carriers. These individuals are seen to have become so either because they do not know what is good for them or are in conditions in which they become exposed to risk. The health promotion consequences to date of this objectification of the individual is to either teach people to be healthier or to protect them; both approaches lack respect for individual autonomy and agency, and therefore disable people from realizing their true potential, and often, from becoming healthier. As we have indicated above there are alternatives to such agency limiting approaches.

A more solid grounding of health promotion in social theory might help to avoid such problems. Drawing on Weber we understand health-relevant behaviours as part of purposive human action that includes patterns of perception and decisions to (not) act, as well as the social patterning of preferences. Weber also helps recognize the interplay between individual’s health-relevant choices and structurally anchored life chances (Abel, 1991; Cockerham et al., 1993). Both of these insights from Weber’s work suggest that health promotion theory and practice would be better able to understand the relationship between social and health inequalities: conversion of one form of health-relevant capital into another e.g. income into (health relevant) knowledge; accumulation and transmission of cultural and/or economic capital e.g. within families and conditional effects such as economic and cultural capital conditioning the acquisition of (health promoting) social capital; these processes to be successful in terms of health gains, require the active individual. They also render the different forms of capital key in the structure-agency interplay that leads to the social reproduction of health inequalities. It is in this way, indeed, that we think Bourdieu’s capital interaction theory can be of utmost importance to our understanding of the potential and limits of health-relevant agency through capabilities.

Most individuals do have some choice with respect to the factors influencing their health and those choices are limited according to their socio-economic position, including those choices that relate to or include health behaviours. Next to the constraints of choice argument, normative pressures typical of modern societies are also important to consider. These include not only expectations towards certain healthy behaviours, but also the very basic question of choice-making in modernity. Increasingly individuals have, as Giddens puts it, “no choice but to choose” (Giddens, 1991, p. 81). So, choice has undoubtedly become an important feature in health inequalities (Cockerham, 2005). However, the concept of choice under these modern circumstances requires critical reflection (Donahue & McGuire, 1995; Leichter, 2003; Michailakis & Schirmer, 2010). In the context of capital and health-relevant capabilities we need to take into account that: 1) the range of options for any individual is limited by the amount of different forms of capital available to him or her; 2) the effectiveness of the application of the different forms of capital for health benefits depends on contexts and people’s abilities to “play” their capital most effectively and; 3) the non-material aspects of the social structure shape individual preferences as well as what people find appropriate. The capability approach might be vulnerable, however, to a somewhat uncritical understanding of choice. When Sen writes of people’s abilities and options to choose “what they have reason to choose” (Sen, 1999, p. 148) he is proposing a somewhat simple promotion that emphasizes equal opportunities for making healthy choices as well as people’s control over the determinants of their health (Marmot, Allen, & Goldblatt, 2010; World Health Organization, 1986). However, while Sen stresses the interplay of resource availability and individual agency, he does not deal squarely with which resources, or what elements, should be distributed more equally in order to improve well-being or health. So, while Sen would suggest that the relationship between capabilities and realized functionings (e.g. living a health life) is one of constrained choice, he does not fully explain the nature of these constraints (Stewart, 2005). Recently, some authors have attempted to operationalize what these constraints might look like, suggesting conceptual models involving large numbers of concepts and variables (Ruger, 2010). To date, however, such attempts have been largely a-theoretical and somewhat difficult to imagine in practice.

Because Bourdieu’s theory addresses which resources comprise social inequalities, it is a suitable accompaniment to Sen’s capability theory. The fundamental tenet of Bourdieu’s theory was to describe how the unequal distribution of economic, social and cultural capital functions as a root principle in the distribution of power and privileges. The interaction of the different forms of capital is a key factor that draws our attention not only to the absolute amount of health-relevant resources available to people, but to their chances and abilities to link material and non-material resources towards maximizing their individual or collective benefits. Indeed, we propose here that interactions of the different forms of health-relevant capital determine major parts of the dynamic processes in the (re-)production of health advantages and disadvantages: conversion of one form of health-relevant capital into another e.g. income into (health relevant) knowledge; accumulation and transmission of cultural and/or economic capital e.g. within families and conditional effects such as economic and cultural capital conditioning the acquisition of (health promoting) social capital; these processes to be successful in terms of health gains, require the active individual. They also render the different forms of capital key in the structure-agency interplay that leads to the social reproduction of health inequalities. It is in this way, indeed, that we think Bourdieu’s capital interaction theory can be of utmost importance to our understanding of the potential and limits of health-relevant agency through capabilities.
assumption regarding the ability of individuals to simply resist normative pressures. His capability approach has been criticized accordingly by Stewart who argues that: “[…] society — and indeed particular groups within society — shapes every individual, influencing preferences and consequent choices” (Stewart, 2005, p. 189, italics in original). Indeed, by focussing largely on personal factors, rather than the structured and collective factors that lead to the application of capabilities for health, the social conditions and dynamics get insufficient attention in Sen’s approach.

Here again, Weber and Bourdieu can be most helpful. As indicated above, Weber describes how behaviours are chosen according to status-specific norms and values as well as the resources available to people (Cockerham et al., 1993). And, referring to Bourdieu’s theory on the reproduction of social inequality, the question arises as to what degree even the perception of potential choices is socially structured through class specific habits and cultural capital. This leads us to conclude that while offering an important new focus on health-relevant capabilities Sen’s approach cannot qualify as a “stand alone” application in a highly stratified world of social inequalities. Its application requires a social theory that can account for the social and cultural determinants of health and health-relevant behaviours in order to prevent approaches that might lead to more individual-level interventions in health promotion rather than more structural change. In this sense we propose that primary emphasis should be given to the promotion of the different forms of capital, rather than focus on personal factors, in order to facilitate structural change that improves the range of options for health promoting agency.

As an application oriented theory the capability approach points to ways to improve the probabilities for good health in individuals from lower classes by providing more (healthy) choices for those who did not have them before. For public health action aiming to reduce health inequalities at a structural level (i.e. the probabilities for being in good health associated with a certain social position in a given society) the capability approach needs certain conditions to be met: 1) the range of options needs to improve at a higher rate for the disadvantaged population groups (classes) compared to advantaged population groups; 2) the improved range of options must lead to the realization of more healthy choice options (functionings) and; 3) improved capabilities must yield effects beyond individual agency and personal health gains to improve — through agency — the structural conditions of health. While more theoretical and empirical work will have to follow, we believe that the capability approach can be helpful to move the structure — agency discourse on health inequalities from sound explanations to sound actions on their reduction… including people as active agents.

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