Home is where the governing is: social capital and regional health governance

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Abstract

The relationship between the civic nature of a community and effective political governance by regional health boards in Canada is explored. A model is proposed that identifies components of social capital such as trust, commitment and identity, associationalism, civic participation and collaborative problem-solving. These concepts are then theoretically linked to effective governance, in particular to reflection of health needs, policy implementation, population health, fiscal responsibility and administrative efficiency. The generalizability of this model is discussed, as are current research directions and policy implications for governments. The conclusion is that governments might want to incorporate a dual perspective encompassing both the political institutions and the community structure.

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1. Introduction

In Canada nine provincial governments have created devolved regional health boards responsible for making many health-related decisions in their regions (Hurley et al., 1994; Lomas, 1997; Lomas et al., 1997). These governments likely hope that the new boards will be effective, i.e. able to tailor the delivery of health care to the needs of particular regions, implement innovative policy, ensure an efficient delivery of services and, thus, create a cost-contained health-care system serving a healthier population. The move to devolution in Canada has been fast and widespread, with the majority of provinces instituting the new structures during the past six years. What is unknown is whether some boards are (or will be) more effective than others and, if so, why? What characteristics of governing bodies and their regions might make some boards more effective than others?
Researchers have focused on several issues in an attempt to explain effective governance. One focus has been the organizational design of the political body (e.g. March and Olsen, 1989). With this focus the debate centres on the functions and responsibilities of particular geographic bodies (should regional or should local governments be responsible for decisions?), whether two-tier systems are better than single-tier ones and whether and to what extent existing community structures (e.g. hospital boards) should be incorporated into or excluded from the new structures. Another focus is the representativeness versus the expertise of the members of the political body who are making the decisions (e.g. Pitkin, 1967). Should we include providers or exclude them and do we want an appointed governing body, an elected one or some combination? Other analysts claim that because decision-making depends in part upon the available information, the quality and nature of this information is especially pertinent for good governance (e.g. Weiss, 1983; Hurley et al., 1995).

This paper offers the additional perspective suggested by work (Putnam et al., 1993a) linking the civic nature of a community to effective governance in Italy, a community-focused perspective. Rather than placing the effectiveness of governance entirely on the shoulders of available information, those making decisions or on the political structure, Putnam suggests that ‘social capital’ in the community being governed is an, if not the most, important influence on governance. Others have used the terms ‘civiness’ or ‘cultural capital’, referring to concepts similar to social capital (such as Bourdieu, 1984; Coleman, 1988; Portes and Sensenbrenner, 1993). But what exactly is social capital? Does it really exist in some instrumental form? Can it be defined and isolated? Might it be increased by government and community interventions?

This paper, therefore, outlines the relationship between social capital and effective governance in the health care sector and is based on the empirical work done by Putnam and theoretical work done by sociologists such as Giddens. Our model of social capital describes the constructs of trust, commitment and identity, associational and civic activity and collaborative problem-solving skills and opportunities. This model is theoretically linked to effective governance constructs such as health needs reflection, policy implementation, population health improvement, fiscal responsibility and administrative efficiency. The paper also outlines some of the actual measures we are using in an empirical investigation of the links between our social capital constructs and the effectiveness of some specific governance authorities in health care. If the theory we put forward here, that social capital is a crucial element in local effective governance, turns out to be supported by the data we are now collecting, then a significant shift will be needed in what governments and others choose to focus on when designing local governance. This is compelling because it entails moving attention from the political institutions of health care to the poorly-understood interactional and participatory qualities of the community.

2. Putnam and social capital

Putnam et al. (1993a) have related aspects of community relations to political governance. Following de Tocqueville, Putnam defines a ‘civic’ community to be one that is marked by active participation in public affairs and where the pursuit of the public good supersedes the pursuit of private and individual ends. The citizens in this community are not necessarily altruists, but pursue ‘self-interests properly understood’, i.e. in the context of broader public needs. The civic community is bound by horizontal relations of reciprocity and cooperation rather than vertical ones of authority and dependency. Tolerance and especially trust (interpersonal and mutual) are virtues that help to surmount opportunism. This community tends to form many civil associations, a dense network of secondary associations that serve to instil cooperation and solidarity in citizens, which then contributes to effective social collaboration and adds to the store of social capital (Putnam et al., 1993a, pp. 86–91).
To measure effective governance in twenty Italian regions over a period of more than twenty years Putnam explored three dimensions: (1) policy processes, (2) policy pronouncements and (3) policy implementation. For the first he looked at cabinet stability, budget promptness and information services. For the second he tested reform legislation and legislative innovation. For the third he investigated regional uptake of centrally-offered opportunities for day care centres, family clinics, industrial policy instruments, agricultural spending capacity, local health unit expenditures, housing and urban development, as well as evaluating bureaucratic responsiveness.

The other side of the equation, social capital, was measured in each region by combining the following four indicators into an index: the vibrancy of associational life (looking at membership in sports clubs, cultural and scientific activities, music and theatrical activities, technical or economic activities, health and social services and leisure time activities); newspaper readership (the percentage of households in which at least one member read a daily newspaper); referendum turnout and electoral candidate preference voting.

The social capital index correlated extremely well with the measures of effective regional governance, performing better, in Putnam’s opinion, as an explanation of effective governance than socio-economic modernity or social and political strife. Based on this and an extensive historical analysis in each region, Putnam concluded that social capital is not easily generated but once it exists in large amounts in a community it remains for long periods of time, serving as a resource for community endeavours. When he traced levels of social capital back to the Middle Ages, he found that regions scoring high in social capital today corresponded to those high in social capital through history. The implications of these intriguing findings have been extended to the US in more recent work by him (Putnam, 1993b, 1995). In this work, however, he is less pessimistic about the prospects for generating social capital without a 600 year history!

As a brief caveat we mention that Putnam’s conclusions have not been entirely well-received by all critics. For example, Goldberg (1996) questions the methodological and statistical methods used by Putnam, Sabetti (1996) questions the path dependency model and historical interpretations used and Levi (1996) questions the extent of concept clarity (especially with respect to trust) and the links between social capital and governance. On the other hand, one recent study has shown that a Putnam-based measure of social capital does better than income inequality at explaining overall mortality variations across the fifty states of the US (Kawachi et al., 1997). Putnam’s results, therefore, are interesting enough to warrant further conceptual explication.

3. Understanding social capital

Putnam’s macro-level indicators of a community’s social capital, newspaper readership, referendum turnout, preference voting and associational memberships, do little to tell us why associationalism or any of the indicators contribute to effective governance. In this section we explore what might be some of the underlying mechanisms that link social capital to effective governance. To do this we will introduce several macro-level processes (relating to community- and aggregate-level behaviours) along with several social-psychological processes (relating to the individual and his/her immediate social environment). Clearly there is an interconnectedness between these levels of analysis, the individual affects his/her social environment and is in turn affected by that environment. At the community/aggregate level we label three important concepts that link with effective governance: civic participation, opportunities to experience (and abilities to exploit) collaborative problem-solving and associationalism. At the individual level we isolate two contributing concepts: trust and commitment.

3.1. Community level

First, are many citizens participating in civic affairs? Do they have knowledge about the im-
importance of legislation proposed by governing bodies (knowledge gained through interaction with other members of the community)? Is the public realm where policy implementation takes place one in which they feel comfortable acting and have acted before (circulating a petition or campaigning in a local municipal election)? Putnam’s voting and newspaper readership statistics are examples of such civic participation. In our own research we are using the proportion of eligible citizens who voted in recent regional health authority, provincial and federal elections, the proportion of households who subscribe to a local newspaper and the proportion of individuals who have belonged to a neighbourhood improvement association, donated blood, volunteered regularly in the past year or written a letter to the editor of a local newspaper to proxy this construct.

Second, do individuals and groups have the opportunity and ability to collaboratively solve common problems, to work together with others and with other groups to achieve common goals (such as organizing the local churches or social action groups to offer a hot breakfast program in schools)? In a survey to randomly selected citizens we are asking them to identify problems in their community, whether there have been opportunities available to confront the problems, whether they availed themselves of the opportunity and whether they have ever organized a group to deal with a community problem as our measure of this construct.

Third, what is the associational life of the community like? Are people involved in the public sphere, playing baseball, taking aerobics classes, interacting and networking with many other members in the community? Are the networks highly hierarchical or are lines of authority horizontal and diffuse? Do the associations cross ethnic, religious, class and other boundaries? We are collecting data from public libraries about clubs and associations in communities and in the survey to randomly selected citizens we ask for a list of groups in which the respondents participate. We also ask them to describe the activities and character (ethnically homogenous, etc.) of the groups and how much time they spend in different ‘networks’ (friends, family members, workmates, neighbours, etc.).

3.2. Individual level

First, associationalism, civic participation and collaborative behaviour are built on trust (for further analyses of the role of trust in present society, see Gambetta, 1988; Giddens, 1990; Kasperror et al., 1992; Fukuyama, 1995; Misztal, 1996). The Oxford English Dictionary defines trust as “confidence in or reliance on some quality or attribute of a person or thing, or the truth of a statement”. For Giddens (1990, p. 27) trust is involved in a fundamental way with modern institutions and in the lives of present-day individuals: “Trust, in short, is a form of ‘faith’ in which the confidence vested in probable outcomes expresses a commitment to something rather than just a cognitive understanding”. It presupposes awareness of circumstances of risk (Giddens, 1990, p. 31) and operates within and between all people in every social situation.

Giddens (1990, p. 102, Table) claims that the pre-modern environments of trust were (1) kinship relations (stabilizing social ties across time-space), (2) the local community (providing a familiar milieu), (3) religious cosmologies (providing an interpretation of human life and of nature) and (4) tradition (as a means of connecting the present and the future). These environments, while still important today, are being slowly replaced by modern environments of trust, such as (1) personal relationships of friendship or sexual intimacy (stabilizing social ties), (2) abstract systems (to stabilize relations across time-space) and (3) future-oriented, counter-factual thought (to connect past and present). We are interested in determining what forms of trust are most prevalent in Canadian society and how these different forms of trust contribute to (or take away from) the formation of social capital. We speculate that the trust environments of community of place and personal relationships are important contributors to associational and civic participation activities and collaborative problem-solving in the community sphere.
We plan to measure trust with survey questions to citizens that address the environments of trust cited above, such as: “if you needed assistance in a personal matter, how likely would you be to turn to a family member, physician, neighbour, member of your ethnic (or religious) group, work colleague, etc.”?, “do you enjoy talking to strangers in your community?”?, “do you trust the federal government to make good decisions?” and “do you think experts and other professionals can help solve problems in your community?”.

Trust in institutions is also integral for civic participation. The act of voting presupposes at least some belief in the importance and relevance of the election process and the system of governance that sponsors the vote. Participating in a political event presupposes some trust in the political structure of the community. Individual trust is integral for solving problems collaboratively. Taylor and Singleton (1993) identified three phases that a community undergoes when solving a collective action problem. The parties must (1) identify the possibilities for cooperation (which are generally numerous), (2) agree on one scheme of cooperation through bargaining and (3) once agreement has been reached, monitor the others to ensure that everyone is doing their part. Because each of these phases entails transaction costs (search costs, bargaining costs and enforcement costs respectively, according to Taylor and Singleton), communities high in trust will be better able to overcome the costs (or, more accurately, the costs to be overcome will be lower). Bargaining and the enforcement of responsibility (and thus collaborative problem-solving) are, therefore, easier in a community where individuals are willing to invest their trust in a wider and more comprehensive range of the disparate groups that comprise ‘the community’.

Second, developing common community-level goals and participating in civic issues often requires a perspective beyond an entirely egoistic one. It requires a commitment to take the common good into consideration. That is, a community with individuals looking out for more than their own personal interests are more likely strongly committed to their community and participate more readily in civic affairs.

This commitment to the common good, to the community itself (also involving a sense of belonging or a sense of place), stems from an important social-psychological process, an identification with the community that occupies a significant position within an individual’s hierarchy of identities. As members of a social world humans have identities and roles corresponding to the specific relationships and social communities to which they belong (McCall and Simmons, 1966; Burke and Tully, 1977; Stryker, 1980). Thus an individual may classify herself as female, Catholic, a committed member of her nuclear family and a long-time resident of her community. These make her who she is. Another individual may feel strongly Canadian but not tied to any single community. The strong identification of the first with her regional or local community results in a stronger commitment to that community’s good.

Commitment is closely interconnected with trust. In fact, Giddens (1991) claims that commitment is a form of trust and that commitment to an outcome lies at the heart of trust. “Commitment […] will involve conviction as to what is right and proper as well as their converse: what is worth striving for, fighting for, what is to be avoided, abhorred, considered cheap and sinful, and so on” (Strauss, 1959, pp. 39–40). Commitment serves as motivation for activity contributing to the common (in this case regional) good, whereas trust is necessary when engaging in activity (thereby acting on the motivation). Thus individuals sharing common goals will be more likely to overcome conflict in the interests of reaching some solution to a community problem. They will be more likely to participate in those civic activities that involve themselves with the collective life of the community. Associational activity can also serve to increase an individual’s commitment to the larger community, if the people one associates with represent a broad spectrum of the community’s disparate groups.

In our work we are assessing identification at the individual level by asking citizens to rank the
importance to them of personal identities (such as being Canadian, a member of my ethnic group, a member of my religious/spiritual group, resident of my neighbourhood, etc.). Questions asking how important the welfare of different groups are to respondents (groups such as family, community, region, province, country, etc.) assess commitment.

These two social-psychological processes of trust and commitment underlie the more behavioural-level processes and attributes of associationalism, civic participation and collaborative problem-solving. Increased levels of trust facilitate collaboration and participation. The identities that people hold dear manifest in commitment, whether that commitment be to the self, the family, one's ethnic group or, in this case, to the region. Thus, communities that value the common good, foster trusting relationships between individuals and where people are committed to the community itself can better facilitate associationalism, civic participation and collaborative action and thereby build social capital that becomes available as a resource for governance purposes. This theory would predict that communities with formal organizations emphasizing these ideals and informal ones facilitating these ideals contribute to a community's social capital.

3.3. Caveats

We caution against interpreting this chain of causation too unidirectionally. Individuals trusting one another will collaborate more easily, but formerly untrusting individuals might develop a trusting attitude themselves after entering into high social capital environments. Participation in networks and organizations will also increase commitment. There are interconnecting relationships between all these processes; society shapes the individual and the individual shapes society (Berger and Luckmann, 1966). Thus, for example, when we try to discover what types and levels of trust exist in some communities, we want to look both at individuals (who manifest the trust) and at the social contexts and institutions where this trust was developed and learned, such as in schools, churches, families and kinship networks (Matthews, 1983).

We also recognize that the description of social capital we offer is a highly consensual one. Class divisions may stand in the way of collaboration, as may power, ethnic, religious and occupational differences that often serve to divide communities into distinct groups with their own agendas and political goals. The version of social capital we present would appear to flourish with homogeneity, a scenario seldom found in a country such as Canada. The relationships (and lack thereof) between such groupings will be extremely important for the development and expression of social capital.

These divisions likely interfere with the expression of social capital at a regional level. If the associational networks only operate and exist within classes, for example, then the entire community is likely unable to mobilize for problem-solving. But we think that class divisions can be overcome by some communities. We speculate that some communities have stronger shared identities and common lines and directions in which associating occurs, such as a shared concern for a public education system in a community without private education venues. Other communities may have developed entirely separate worlds (cultural, social, political and economic) where the lines of shared interests joining strata are few. The concern about exclusionary forms of association is expressed well by the Australian social policy analyst, Cox (1995, p. 33 and 62, respectively):

Communities which reduce social capital share certain characteristics. They turn inwards, form cliques, resist change and exclude those who criticise. The structures of such groups are usually top-down, though the power may be informally held. Too often, allocation of rewards is based on patronage... We need communities but not ones which exclude.

There are many examples of closed groups whose survival depends on the maintenance of
power structures and who lack the capacity therefore to deal with change... Most closed groups use distrust to maintain control and so reduce social capital.

The attitude and character of the divided groups will, therefore, influence the creation (or repression) of social capital. Exclusionary groups are formed to fight with other groups or interests and, equipped with formally designated powers or informally maintained informational and status advantages, can dominate or overpower opponents more mindful of inclusionary processes. Inclusionary groups, however, grow outwards to incorporate progressively more members of the community and serve to dilute or delegitimize excessive concentrations of exclusionary power. Our model presumes that social capital operates through the many pathways described above to overcome impediments to effective decision-making such as exclusionary groups or power imbalances across groups in a community. This is, however, a presumption. The specific nature of the groups in a community and their degree and type of exclusionary criteria or power imbalance may well determine at what levels and if social capital is operant, accessible for community needs, and contributing to effective governance of the health care sector.

4. Social capital and effective regional health board governance in Canada

If the effectiveness of regional health boards is measured according to the objectives that provinces have for them, then they will: (1) accurately reflect the needs and preferences of the citizens (i.e. represent the community), (2) innovate and be successful policy implementors, (3) improve the overall health of the population, (4) live within a constrained budget (i.e. demonstrate fiscal responsibility) and (5) reduce duplication of services via integration and coordination (i.e. demonstrate administrative efficiency). Thus, if social capital is to improve the effectiveness of regional health board governance in Canada we should be able to demonstrate at least theoretical reasons why it will improve performance on each of these dimensions. There are other facets of health care system ‘culture’ and practice that will influence these dimensions, such as the talent and experience of the bureaucrats in the system, the attitude of health care providers toward higher-level decision-makers, the quality of available information, etc., but the health system culture operates within the broader social capital milieu. Social capital influences these factors, but also independently influences the objectives we delineated above. Thus we attempt in the following to draw theoretical links between a community’s social capital and the end product, effective regional health governance.

4.1. Social capital and reflection of health needs

In order to reflect health needs in their regions, board members require not only technical data on health needs but also information on perceptions of health needs. As Pitkin (1967, p. 211) has stated,

The more [a board representative] sees interests (or welfare of whatever) as objective, as determinable by people other than those whose interest it is, the more possible it becomes for a representative to further the interest of constituents without consulting their wishes... But if such a view is pushed too far we leave the realm of representation altogether, and end up with an expert deciding technical questions and taking care of the ignorant masses as a parent takes care of a child.

Social capital works to supplement the experts’ objective information with constituents’ wishes, thus making the board member a representative of rather than a parent to the community. The horizontal networking implicit in associationalism distributes community members’ perceptions of their important needs. Needs and desires are shared, circulated and given visibility, with two implications. First, people are more
aware of each other’s needs, which they can balance against their own to develop a more shared community perspective on health needs. Second, persons can therefore form alliances with like-minded others that can lead to more coherent representation of these particular needs, expressed through civic participation avenues.

Civic participation works to bring needs information to the governing body’s, as well as to the general community’s attention, through avenues such as lobbying, petitioning, publishing newspaper articles and disseminating information. As well as confronting populace needs from civic/political fronts, members of regional governance boards, who themselves are part of their community’s social world, can through their own associational activity come into contact with a wider and deeper sense of people’s health needs. Social capital, through civic participation avenues and board members’ own associational habits, may insert needs information into the public domain and place it before board members prior to, during and after other deliberations.

4.2. Social capital and policy implementation

Once policies have been formulated and services devised to meet actual and perceived needs, social capital helps make these services effective and broadens the range of potential services that can be utilized to meet these needs. Voluntary groups can be depended upon to provide some services. Trust-filled communities will more readily permit strangers to bring meals-on-wheels to other strangers’ homes, who will more likely open the door (and in any event, fewer of the people in the community will be strangers). Traditional service providers can relinquish some tasks or share them with the community.

Persons and community groups who perceive needs will be better able to collaborate with one another to propose and implement solutions and services to meet these needs. At its most basic level, service implementation and provision is collaborative problem-solving: a collaboration between community groups, voluntary organizations, individuals and regional governments. The identification of solutions to meet community difficulties and needs is not only in the hands of the regional board, collaboration within the community and between it and the regional authority can bring about innovations that the regional legislators alone are not capable of producing.

4.3. Social capital and the health of the population

Improving the health of the population is presumably the health care system’s (and therefore the regional health board’s) ultimate goal. The governing body allocates monies and resources to various services and segments of the health care system to improve and maintain the population’s health. Social capital may also work to improve people’s health apart from the health care system. Many researchers have demonstrated links between social support and health. House et al. (1988) summarize a number of these studies to suggest that “social relationships have a predictive, arguably causal, association with health in their own right”. Working in Ontario, Hirdes and Forbes (1992) found a strong correlation between a social relationships index (comprised of marital status, number of children, family contact and participation in voluntary associations) and mortality. Orth-Gomer and Johnson (1987) found a correlation between a social network interaction index (comprised of items such as parent, sibling, child, friend, co-worker, and neighbour contacts) and mortality, with confounding effects produced only by age. Also, as cited earlier, Kawachi and colleagues have shown that American states high on social capital have both lower mortality rates and less income inequality than those low on social capital (Kawachi et al., 1997).

Social capital gives people frequent, albeit possibly casual, interaction through association. The relationships and support systems created through membership in clubs and formal and informal organizations can influence people’s health directly. This introduces an additional layer to our argument. Our model claims that regional governments can not only fulfill their task more effectively with a community rich in social capital but also that social capital’s impact on
individual’s health will make their task easier. Thus the process and outcomes of governance are affected positively by social capital.

This illustrates the potential circularity of the social capital concept. Social capital, like monetary capital, builds on itself. You need money to make more money and you need trust to create more trust. In causal terminology social capital can serve as both independent and dependent variables. We envision this capital to be a causal variable that affects the process of health governance directly and its goals indirectly. In the other direction, an effective government can contribute to and increase a community’s store of social capital, by enlisting community participation and providing opportunities for network affiliations in people’s lives. The causal direction to focus on will depend on context and goals. Regional governments will want to identify social capital resources that can be used for governance purposes. Provincial governments might also identify where social capital is low and allocate resources accordingly to increase it, if this is possible, thereby improving regional health governance (among other outcomes).

4.4. Social capital and fiscal responsibility

A regional health board can be said to demonstrate fiscal responsibility when it operates and achieves its goals within a constrained budget, passes this budget on time and allows the community to know the choices that have been made. Making difficult choices among alternatives and funding some programs but not others requires some resolution of conflict among the special interest groups in the community who have a stake in the budget allocation exercise. Social capital will help to resolve these in the community, through increased lines of communication among the interest groups and a better understanding of one another. Fewer irreconcilable differences among interest groups will also contribute to a more timely presentation of the budget.

Community members who trust one another may be willing to forego benefits in this round of allocations if they believe (trust) redress may occur in future allocations. Similarly, community members with commitment to the region may be more willing to let this override their (or their group’s) short-term interest. Conversely, however, social capital may enable citizens to band together to provide a more unified and effective front when campaigning against such things as hospital closure.

4.5. Social capital and administrative efficiency

In health care in Canada many service organizations have developed with circumscribed missions and ideologies, some of whom provide overlapping services. A big challenge for regional health boards is the identification of these duplicated services and the provision of integrative links among them. For example, a community may have three unconnected organizations delivering care for troubled street children who might be better served by an integrated system.

When different administrations and structures are working at cross-purposes we can speak of non-integrated sub-cultures. When a community has a rich store of social capital, it shares an influential common culture (a common commitment) bridging the mini-cultures. Sharing a common community-wide culture facilitates communication and cooperation, hence allowing better integration and coordination of services. The different administrations can find recourse in the shared culture to achieve common goals in concert rather than in isolation, and the networks of interaction in the community may facilitate such concerted action.

5. Generalizability

Putnam’s strong correlations between ‘social capital’ and effective governance were found in an ethnically and religiously homogeneous society. He found continuity in civic behaviour in the Italian regions that extended back beyond the Middle Ages. Canada has an aboriginal population with a long history in Canada, but the majority of the population is composed of European and Asian ‘newcomers’ with a history in Canada.
stretching back less than two hundred years. If social capital does rely on entrenched history it implies that there is little that a ‘new’ country such as Canada can do to actively encourage its development. Putnam is, however, more hopeful about the prospects for overcoming the historical imperative in his more recent writings (Putnam, 1993b, 1995). Nevertheless it is still by no means clear how long it would take for the positive governance and health impacts of changes in social capital to manifest. Even if levels of social capital can be changed over the short-term, the impact of this change on health may take far longer.

There are attributes of Canada’s multicultural society that would seem to make a conceptualization of social capital difficult. Our concepts are sufficiently general in nature, however, to apply to almost any setting: the multicultural nature of Canada will be an issue when attempting to determine the contextual nature and manifestation of the concepts, but trust and commitment are elemental enough to provide the foundations for all civic societies.

Putnam evaluated governing bodies that differ substantially from the regional health bodies in Canada. The regional governments in Italy are responsible for almost all aspects of political life, including health, social services, agriculture and education. Is there reason to believe that social capital affects the governing quality of comprehensive governments but not specific ones? There are important parallels between the two government forms that suggest the difference may not be very important. Both governments have an entire region under their jurisdiction, making decisions and enacting legislation that affect nearly all members of the region. If a comprehensive government depended upon trust, commitment, public participation and subsequent collective problem-solving skills in the governed community to govern well, then a government making decisions for only a portion of the governing envelope (those decisions related to health) would depend upon the same processes. Reflecting community needs, implementing innovative policy, and demonstrating fiscal responsibility and efficiency are relevant for all substantive governing areas. In fact, social capital’s direct influence on the population’s health, independent of the health care system, may mean that it’s impact on health care governing bodies is stronger than on other governing bodies, and operates through subtler pathways.

6. Current research

Although regionalization has been a part of health care in Quebec since 1971, Canada’s other provinces (all but Ontario) have instituted regional health boards only recently. There have, therefore, been few systematic attempts to evaluate how well the boards are doing and link their performance with social capital. In Saskatchewan, Canada, G.V. is conducting an evaluation of the boards that will be correlated with social capital elements within the health districts. Some of the measures being used in this study have been outlined above to illustrate our section on the constructs underpinning social capital. The project will measure board effectiveness with a survey of board members, an analysis of board minutes and the provincial auditor’s investigation into the financial status and needs assessment process of the boards. Social capital will be measured using a survey of randomly selected members of the public and a collection of associational and civic participation indicators. In Prince Edward Island, J.L. is investigating regional governance and, as part of this, the demise of displaced ex-hospital board members. This study explores the link between regionalization and social capital by attempting to discover if valuable resources for collaborative problem-solving, i.e. hospital and other health care boards, have been lost in the move toward regional governance which may, therefore, contribute to ‘disempowering’ the regions (Lomas, 1997; Lomas and Rachlis, 1996).

A number of groups around the world are struggling with how to measure social capital and whether it can be done in a way that is generalizable and comparable across cultures and/or jurisdictions. A multi-country project called “The Decline of Social Capital: Political Culture as a Condition of Democracy”, headed by Putnam,
has enlisted cooperation from the UK, Australia, Japan, the USA, Spain, France, Sweden and Germany. The measurement of social capital welcomes further investigation into regional composition along class, status and other lines and how these have an impact upon a region’s ability to recognize problems, mobilize forces and overcome conflicts to solve these problems.

7. Policy implications

Underlying our analysis is a presumption about the instrumental nature of social capital; given adequate resources directed at the appropriate targets a society can ‘purchase’ social capital and its consequent benefits. If this presumption turns out to be true then a provincial government in Canada (or elsewhere for that matter) anxious to improve governance of health-care might therefore want to have a dual perspective encompassing both political organization and community structure. The government might want to act as a catalyst for social capital, to provide support for programs that entice community members into interaction with one another, lower barriers among interest groups and ethnic communities and that allow individuals to learn about civic issues, learn to trust one another more readily and to develop the skills and commitment toward solving community problems in a collective manner. Putnam found that Italians in such vibrant regions were participating in many extra-curricular organizations, such as sport clubs and musical societies. Such non-denominational and non-ethnic activities foster important attitudes and skills in community members, contributing to a community’s store of social capital.

Particular examples of this approach that are relevant to the Canadian scene are government subsidy of sports institutions like Little League baseball and squash ladders, apartment architecture (perhaps encouraged by tax incentives) that creates free space for neighbour interaction, and legislation facilitating community economic development initiatives. Clearly this community perspective shows that close ties among social services, housing, environment, education and health are important. One Canadian province, Prince Edward Island, has decided to combine nearly all human services under one devolved governing structure (Lomas and Rachlis, 1996). This combination may encourage interventions on community structure such as skills exchanges for seniors, programs for high school volunteers to visit disabled ‘shut-ins’, community daycare services, cooperative housing developments and so on. To the extent that these are not only facilitating and coordinating service delivery, but are also doing so in a way that encourages trust and community commitment among individuals and strengthens community opportunities for associationalism, civic participation and collaborative problem-solving, then effective governance as well as improved health and well-being are the potential outcomes of such social capital inducing measures.

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References


Gerry Veenstra is a postdoctoral fellow at the University of British Columbia in the Centre for Health Services and Policy Research and the Institute of Health Promotion Research at the University of British Columbia. With Jonathan Lomas he has researched devolution in health care through one project that assessed different community perspectives of health care decision-making responsibility and another that assessed regional health board members’ perspectives of their role. His ongoing research explores further the nature of social capital and its relationship with health.

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