Social Capital and Health: Implications for Health in Rural Australia

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INTRODUCTION

This paper examines the contribution of social capital to the health of rural Australians. It will consider the importance of social capital to health promotion and public health practice and ask a series of questions about the role of government in supporting or not supporting social capital. My argument is that a crucial aspect of the creation of healthy communities lies in achieving a balance between economic and social factors in public policy. It is also argued that equity underpins socially cohesive communities. The paper is illustrated by reference to data from two studies colleagues and I at the Department of Public Health and South Australian Community Health Research Unit (SACHRU) are conducting. One is on health development and social capital in Adelaide and the other on community groups and health promotion in the Hills Mallee Southern region of South Australia.

The study of health development and social capital being conducted at Flinders provides some images of rural life. As part of the study we conducted 40 detailed interviews with respondents who were identified as either low or high participators. From these interviews some glimpses of peoples’ perceptions of rural communities were gained. They presented a somewhat mixed picture. In the first instance I would like to concentrate on the positive view presented – other perspectives will come later. Some respondents saw country communities in ideal terms. Typical comments were:

To me an ideal community is one of these little country communities where people all know each other and help each other and do things for each other. That's what I would class as a community.

The image of a rural community high in civic pride and social capital was often articulated in opposition to the perceived social decay of urban areas, where unemployment and crime was purportedly rife, to the detriment of meaningful social relations built on altruism and trust. Whether respondents had relocated from the country to the city, or vice versa, there was a strong sense of the country as affording some sort of charmed life (whether real or imagined) that the city couldn’t offer. Those respondents who were born in the country but had moved to Adelaide for work or other reasons tended to share a deep nostalgia for the community that they’d left behind.

1. These data were collected by Catherine Palmer and Megan Warin and analysed by Catherine Palmer.
For people who were born and bred in the country, the connectedness of social life was an important aspect of rural living, being perhaps the single most defining feature of their experiences of community in the country.

A young woman who had moved to Adelaide from the Yorke Peninsular to pursue a nursing career noted:

[Community is] a lot stronger in the country I think, because everyone sort of knows everyone and it seems every time I get a patient through from the country, I know them. Everywhere you go and start talking with someone in the country, they can eventually work out who you are. Like, “Oh, you’re so-and-so’s daughter” or “so-and-so’s granddaughter”. No matter what generation you’re talking to, they sort of can work out who you are. I mean in the last week I’ve had it three times happen to me – “Oh, you’re [John Smith’s] sister”.

Perceptions of rural communities as being close knit, friendly, helpful, civic minded were also endorsed by city folk who had spent time in the country through work or through family reasons. For people who were born and bred in the country, the connectedness of social life was an important aspect of rural living, being perhaps the single most defining feature of their experiences of community in the country. So these perceptions present a somewhat romantic and idealised view of life in the country. Material I present latter will suggest this is only one aspect of the picture.

Before going any further in this exploration of social capital I would like to examine the meaning of social capital. The term has entered the discourse of public policy with a bang in the dying years of this century. It is a complex term full of ideological and moral implications. Consequently it is crucial to be clear on what we understand by it before exploring its implications for health in rural communities.

SOCIAL CAPITAL EXAMINED

There are growing theoretical debates about the concept of social capital. One commentator has gone so far as to say: “The current literature on social capital is very confusing, lacking both terminological precision and theoretical rigour” (Lenci, 1997, 24). The concept has a long history certainly to the 1920s when the US sociologist Jan Jacobson used it (Woolcock, 1998, p. 192). Literature on the topic generally concurs that social capital concerns the following: social and civic trust, thick and thin or embedded and autonomous networks and the encouragement of co-ordination and co-operation for mutual benefit. Beyond this definition three areas of debate are appearing in the literature and on email discussion lists. These concern the extent to which social capital is beneficial, its relationship with socio-economic circumstances and the ways governments can support and foster social capital.

Social capital is not necessarily beneficial - for instance thick networks may be good for those embedded in them but exclusionary to others (Woolcock, 1998). Table 1 shows a tentative list of ‘healthy’ and ‘unhealthy’ characteristics of social capital.
Table 1: Unhealthy and Healthy Forms of Social Capital

<table>
<thead>
<tr>
<th>Healthy Social capital</th>
<th>Unhealthy Social capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust</td>
<td>Distrust of strangers/difference</td>
</tr>
<tr>
<td>Co-operation</td>
<td>‘Them’ and ‘Us’</td>
</tr>
<tr>
<td>Understanding</td>
<td>Tight knit but excluding</td>
</tr>
<tr>
<td>Empathy</td>
<td>Fear of the unknown</td>
</tr>
<tr>
<td>Alliance across difference</td>
<td>Dislike change and new ideas</td>
</tr>
<tr>
<td>Questioning and open to new ideas</td>
<td>Racism</td>
</tr>
</tbody>
</table>

Certainly in the past Australian rural areas have provided examples of unhealthy social capital. While white Anglo-Saxon communities may be internally cohesive they may also be exclusionary of the local indigenous people and not welcoming of people from a non-English speaking background. This has never been more powerfully shown than by the past treatment of Indigenous Australians. In the 1950s (an era to which many non-indigenous Australians look back to as one of comfort, high employment, affluence and safety) if you were indigenous you stood a good chance of having your child removed from your family and stood very little chance of employment, education or understanding. The levels of social capital for you were not high. The trust being generated for you in civil institutions and wider community beyond your family or skin group was very, very slight.

A more contemporary view of exclusion in a rural community came from a detailed interview with a respondent in our Adelaide Health Development and Social Capital study.

Now I’ve lived for about seven years up in Rivertown. When I married this Filipino girl they really started putting rubbish on me. I had a nervous breakdown. I had to get transferred out of Rivertown because of it. Now there’s only about say twelve people in Rivertown think they own the town and if you don’t fall into line with them, they’ll put rubbish on you all the time. What kind of things were they saying?

Oh, just things that... You know, they were saying that she was black and all this sort of thing, like you know. They’re very prejudiced - race, whatever you like to call them. But because I wouldn’t fall into line with them, they always had it in for me. And even the house that I was renting up there, because I married a Filipino, the bloke said, “I want you out of the house now”. So I got kicked out of the house ...

Elizabeth Reid (1997) has noted that ‘good’ social capital should enable the “creation of alliance across difference”. In this view social capital is about more than a sense of community and extends to the degree to which a community accepts outsiders. Hughes et al (1999) compared the levels of trust (as measured in a self-completion mailed questionnaire) in rural and urban areas. They found that:

- trust in ‘locals’ was higher in rural than urban areas (except for large rural areas);
- local trust and familiarity with neighbours were directly related and both were higher in rural areas;
- trust in ‘most Australians’ was highest in urban areas;
- people in rural communities were more wary of strangers.
Hughes et al (1999) suggested that ‘local’ trust was likely to be increased in rural communities because people are more likely to know others, face-to-face contact is frequent, there is a relative closed and small number of people and there are few strangers. They also noted that rural areas are less diverse and accept strangers less.

Social capital should not be seen as a panacea for socio-economic hardship. Networks, trust and co-operation are not substitutes for housing, jobs, incomes and education even though they might play a role in helping people gain access to these things.

Table 2 Socio-economic wellbeing by Metropolitan, Rural and Remote Areas

<table>
<thead>
<tr>
<th>SEIFA Index</th>
<th>Metropolitan</th>
<th>Rural</th>
<th>Remote</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Capital Cities</td>
<td>Other Large Centres</td>
<td>Small Centres</td>
</tr>
<tr>
<td>Disadvantage</td>
<td>1,018</td>
<td>986</td>
<td>981</td>
</tr>
<tr>
<td>Economic Resources</td>
<td>1,041</td>
<td>996</td>
<td>970</td>
</tr>
<tr>
<td>Education and Occupation</td>
<td>1,032</td>
<td>977</td>
<td>979</td>
</tr>
</tbody>
</table>


The Socio-Economic Indexes for Areas (SEIFA) are a set of summary indicators on socio-economic wellbeing on a geographic basis. Details are provided in reference above. Note that the higher score for socio-economic disadvantage indicate more advantaged populations.

The general trend in socio-economic wellbeing is that disadvantage increases as population density decreases. For indigenous people levels of socio-economic well being are particularly poor. Few people would believe having a close-knit community would be sufficient to make up for the economic factors currently affecting rural communities. The higher suicide rates in country areas may, in part, reflect responses to the economic pressures rural areas are feeling.

Social capital is not a substitute for investment in communities by governments (whether they are local, regional or national)

Rather its importance poses the policy questions of how can governments support, enhance and extend ‘good’ social capital? What success stories can be documented of governments supporting community groups and other civil society associations in a way that contributes to health promotion? How can governments form effective partnerships with Non Government Organisations (NGOs) and through them with grass root organisations? What role does economic policy play in shaping the strength of communities – how much should
governments intervene? Should Governments provide incentives for companies to establish themselves in rural areas? Or should major investment decisions be left to the market?

The relationship of social capital to markets, governments, civil society and primary health care is illustrated in Figure 1. This demonstrates the interrelationships between these different aspects of society and is based on the view that strong institutions both national and international are fundamental to underpinning a healthy society. Each sector is important in creating the whole structure.

*Figure 1: Model of the Inter-relationships between Government, Civil Society and the Economy*

SOCIAL CAPITAL AND PUBLIC HEALTH

There appear to be three reasons why social capital is important for public health in rural areas:

- the links to patterns of inequity;
- the redress and counter-balance it offers to economic rationalism; and
- its legitimisation of the direction of much health promotion work in the past decade.

Determinant of health and contributor to patterns of inequity

Rural Australia has significantly poorer health status than Australia as a whole. Male and female total death rates for those living in ‘capital cities’ were 6 per cent lower than for those living in ‘large rural centres’ and 20 per cent lower than for those living in ‘remote centres’ (AIHW, 1998). Injury death rates are particularly high for rural and remote areas. Motor vehicle deaths and unintentional injury both follow a similar pattern, with areas of the remote centre, north and north west having Standardised Mortality Rates (SMRs) 3 to 6 times higher than the eastern seaboard and metropolitan centres. Men living in remote, non-major settlements have 4.26 times the death rate for unintentional injury of males living in capital cities. Indigenous peoples’ health status is significantly and persistently worst than that of non-Indigenous Australians.

For our purposes today the question of WHY these inequities exist and persist is crucial. Three main areas of explanation are evident in the literature:

Material Deprivation

We know that people are likely to be healthier if they have a satisfying job, have warm, secure and safe housing, have enough to eat and drink, have good sanitation and water supply, appropriate and safe transport and adequate income. Social capital will not be a substitute for these factors. The increasingly difficult economic time farmers are having is well recognised. A recent report from the Bureau of Agricultural and Resource Economics (People in Farming) found that the average income of broadacre and diary farm families was around $27,300 in 1994-5 compared with an average Australian Bureau of Statistics (ABS) household income of $38,700 in 93/94.

Social Support and Health

There is a growing and large literature which indicates that people who have positive social support recover better from illness and are even less likely to die (summary of the literature on social support and health is available in Rosenfeld, 1997)

A study of social ties and nine-year mortality from Alameda County, California is typical of the patterns noted. It reports the results of a nine-year longitudinal study. For both men and women having social connections was associated with a lower mortality rate (Berkman and Syme, 1979).
There is, perhaps, some contradictory evidence from rural Australia in regard to social support. On the one hand, the evidence already presented indicates that rural areas are perceived as supportive. But remote and rural locations have dramatically elevated rates of suicide and accidental injury and death. The ten statistical sub-divisions with the highest standardised mortality rate for suicide for all persons (average 206.6) are all in remote and rural areas. Notably these also have some of the highest proportions of Aboriginal people in their populations. Of the ten sub-divisions with the lowest SMR for suicide (average 58), 8 were within a major city or town and all were within 200 kilometers of one (National Injury Surveillance Unit, 1995). The suicide rate for men in these remote locations is 1.5 times that for the capital cities, although the suicide rate for women is actually slightly lower in remote areas (Australian Institute of Health, 1996, p.82). Homicide rates in rural and remote areas are also high. The particularly high rate in remote areas is explained by the higher death rates from interpersonal violence in indigenous communities (Australian Institute of Health and Welfare (AIHW), 1998, p. 28).

Patterns of Inequity and Hierarchy within Populations

There has been some interesting research on the pattern of inequities in populations in recent years. This evidence will be described briefly as a basis for speculation about what such patterns might mean for rural Australia.

1. A study looking at the link between average life expectancy of countries and the distribution of wealth (Wilkinson, 1996) found a link between life expectancy and distribution of income. The US has one of the highest living standards in the world. Gross Domestic Product (GDP) per capita was $24,680 in 1993 but it has a lower life expectancy (76.1 years in 1993) than less affluent but more egalitarian countries such as the Netherlands (GDP $17,340; life expectancy 77.5 years) Israel (GDP $15,130; life expectancy 76.6) Spain $13,660; life expectancy 77.7 years. Sweden and Japan with the smallest income differences between rich and poor tend to enjoy highest life expectancy. Wilkinson’s conclusions are that the quality of social relations is a crucial determinant of a country’s human welfare and quality of life and that social relations affected the extent of equity within a society.

2. Further evidence comes from the US on the links between income distribution, health and social factors. Kennedy and Kawachi et al (1996) found that income distribution in the USA (measured by the Robin Hood index) was linked to variations in mortality2. They then became interested in whether ‘social capital’ or the extent to which people feel a sense of trust and involvement in their communities, might be responsible for the observed differences in health and mortality.

In their next study (Kawachi and Kennedy, 1997) they found that as income inequity increases the level of social mistrust increases and this in turn is associated with increased mortality rates. A similar significant inverse relationship was observed in the study between participation in civic groups and mortality. We do not have these kinds of data for rural and remote areas. But we

2. Income inequality was measured using the Robin Hood Index (measure of income inequality) which equals the proportion of aggregate incomes that would have to be re-distributed from household with disproportionate earning to those earning less, if incomes were to be level. So the higher the Robin Hood Index the higher the gap.
do know that there are significant gaps in income distribution between indigenous people and non-Indigenous Australians and between rural and country areas more generally.

Figure 2: Links between income distribution, social capital and health

The exact causes of the links are not fully understood but the pattern that is emerging appears to be something like that shown in Figure 2. It is interesting to speculate about the extent to which this international research may have pointers for differences noted in rural areas. Is lack of a control a key issue? For Indigenous people who had control of their land and culture largely taken away from them it clearly is. Is there a more general issue for rural communities in that a sense of powerlessness and loss of control is evolving in response to globalisation? Changes related to globalisation have resulted in impacts such as close of local facilities (banks) and the passing of control to large Transnational Corporations. Agribusiness means that there is less and less control for an ordinary farmer (Vanclay and Lawrence, 1995) and the farming sector is increasingly dominated by multi-national companies. The stresses of this situation are relatively unexplored. Further exploration of these macro factors and their impact on health is important.

INCOME AND WEALTH AND ROLE OF GOVERNMENT

The data described above requires us to reframe public health problems. So often we conceive of problems as being the fault of those who suffer from them. This victim-blaming tendency is very powerful in the individualism of western societies. So this means that often Indigenous people are blamed for their poor health status relative to the rest of Australian society and poor people are blamed for the fact that they smoke, and are more likely to be overweight. Yet when we dig deeper and consider the underlying causes of ill health a different picture emerges. Peoples’ private problems often have complex and deep public roots.

My reading of the evidence leads me to conclude that an important public health problem is the way in which we distribute income and wealth both in Australia and locally. This is very much an invisible and hidden public health issue. It is
also a problem that is becoming more worrying. Let’s look at some of the evidence to support this contention. UNICEF/WHO recently reminded us that the world’s 358 billionaires have a combined net worth of $760 billion – equal to the total assets of the poorest 45 per cent of the world’s population.

Senior executives of transnational corporations are also receiving higher and higher salary packages. In 1992 the average pay of Chief Executive Officers (CEOs) of the one thousand largest companies surveyed by the US *Business Week* was US$3.8 million - up 42 per cent from the previous year and the difference between their salaries and that of average workers had increased from forty times in 1960 to 157 times in 1992 (Korten, 1995, p. 108). The situation would be much the same with Australian salaries.

Aarons (1996) argues that inequalities have grown rapidly in Australia in the past decade. He maintains that government taxation reforms have contributed to this by systematically favouring richer people. Comparing 1994/95 with 1982/3, he notes that the super rich (incomes of $500,000 a year) are 2.6 times better off whereas those on low incomes (less than $25,000 per year) are 3 per cent worst off. He also notes that the richest Australians have grown much richer in the period 1983-1996, far outstripping inflation.

### Table 3: Business Review Weekly Richest Australians: 1983 & 1996

<table>
<thead>
<tr>
<th>TOP 10 IN 1983</th>
<th>WORTH</th>
<th>TOP 10 IN 1996</th>
<th>WORTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Murdoch Family</td>
<td>$250m</td>
<td>Kerry Packer</td>
<td>$3,300m</td>
</tr>
<tr>
<td>Fairfax Family</td>
<td>$175m</td>
<td>Richard Pratt</td>
<td>$1,500m</td>
</tr>
<tr>
<td>Smorgon Family</td>
<td>$150m</td>
<td>Frank Lowy</td>
<td>$1,200m</td>
</tr>
<tr>
<td>J&amp;R Ingham</td>
<td>$150m</td>
<td>Smorgon Family</td>
<td>$1,000m</td>
</tr>
<tr>
<td>Kerry Packer</td>
<td>$100m</td>
<td>David Haines</td>
<td>$900m</td>
</tr>
<tr>
<td>Robert Holmes a’Court</td>
<td>$100m</td>
<td>Harry Triguboff</td>
<td>$750m</td>
</tr>
<tr>
<td>John Kahlbetzer</td>
<td>$100m</td>
<td>Myer Family</td>
<td>$710m</td>
</tr>
<tr>
<td>Richard Pratt</td>
<td>$70m</td>
<td>J&amp;T Fairfax</td>
<td>$650m</td>
</tr>
<tr>
<td>John Robert</td>
<td>$70m</td>
<td>Elisabeth Murdoch</td>
<td>$600m</td>
</tr>
<tr>
<td>David Hains</td>
<td>$60m</td>
<td>John Gandel</td>
<td>$560m</td>
</tr>
</tbody>
</table>

(Source: Aarons, 1996, p. 6)

The faces behind the wealth are those of the corporate world. Transnational corporations (TNCs) control 70 per cent of world trade and 80 per cent of all land growing crops. Yet these TNCs employ only three per cent of the world’s paid labour.

While it seems politically impossible to imagine a world in which these stark and obscene inequities are reduced there is no technical reason why they could not be. Starting discussions and raising questions may help to erode the complacency with which we live with and accommodate this wealth. At the moment questioning it hardly peeps through into public discourse. The media, and mainstream politicians fear to tread on that ground. Most commentators would agree that equity and fairness can not simply be left to the market.
Distributions of income and wealth are not pre-ordained. They can be very much affected by government policy. I think we need a discussion in Australia about how we would like our wealth and income to be distributed and what type of social wage we want. This will raise questions such as whether governments should support communities even though they are declining economically. It also raises issues about the responsibility of corporations such as banks to their community. Should large banks be able to report significant profits but then take closure decisions, which contributes to the decline of rural communities? What responsibility do large mining or agribusiness companies which profit from their activities in rural and remote Australia to plough some of that profit back into the local community? The interaction between economic and social issues might seem very removed from health issues but I believe that, in fact, they are THE fundamental issues for rural areas.

REDRESS AND COUNTER-BALANCE TO ECONOMIC RATIONALISM

Economic rationalism has been the dominant plank of the platforms of Australian political parties in the 1980s and 1990s. The mantras of low debt, cutting public expenditure, seeing the private sector as necessarily more efficient and effective than the public and running our economy to gain the grace and favour of international institutions such as the International Monetary Fund (IMF), World Bank and credit rating agencies such as Standard and Poors.

But we have seen in the past years a growing public unease and distrust in these mantras. There also seems to be a cynicism with politicians which comes, in part at least, from their focus on economic rationalism. The continual call for change and restructuring that comes with economic rationalism is often seen as chaotic. These trends may contribute to declining levels of civic trust.

In March 1999 the Human Rights and Equal Opportunity Commission (HREOC, 1999) published “Bush Talks” which surveys the destruction of rural infrastructure which has occurred in recent years. (Human Rights Commissioner) noted in his introduction to the report

> In almost every aspect of our work, the HREOC has noticed that people in rural and remote Australian generally come off second best. Distance, isolation, lower incomes and minority status all exacerbate the experience of discrimination, harassment and lack of services and participation.

For much of rural and remote Australia the past decades have been one of declining population with a consequent threat to the viability of these communities. A typical picture is this one from Hopetoun:

> Hopetoun’s population fell by 19 per cent between 1976 and 1991. It now has just 703 people. This downturn is the result of a drastic decline in the income of the district’s farmers. When the cereal- and sheep- farmers don’t have money to spend it’s not long before the small businesses begin to struggle. Hopetoun has lost many of the services which made it the hub of the Shire of Karkaroo. Gone are the former State Rivers and Water Supply Office, the solicitor, the Westpac Bank, the court house, Elders office, the Massey Ferguson dealership and the weekly visits from the dentist. The doctor lives in the town only during the week. If you
Smith (1998) conducted a study of the impact of the Victorian State Government’s economic rationalist policies on East Gippsland. She described the battery of changes that were affecting the region: school closures, local government amalgamations, restructuring and privatisation of State government agencies, withdrawal of services, tightening up of eligibility criteria, centralised telephone numbers away from the region. Her conclusions suggested people felt powerless and cynical as a result of the changes. While she also documented some positive examples of community action to try and stop change of increase support for people the overall picture she presents is a depressing one and suggests recent government policies had had an adverse effect on the health of the East Gippsland community.

At the moment economic consideration dominate most others in public policy making. The bush has suffered as a result of these policies because provision of services to rural and remote communities is seen as too expensive and uneconomic. Yet as one of the Perth respondents to HREOC (1999) noted:

This country 40-50 years ago was building physical and social infrastructure with far less rural population and far less GDP and government funding. Yet now we are being told the nation can’t afford it.

LEGITIMISING THE DIRECTION OF MUCH HEALTH PROMOTION WORK IN THE PAST DECADE, ESPECIALLY THAT RELATED TO EMPOWERMENT

Finally, I think social capital is important to public health and health promotion work because it reflects the direction in which these enterprises were going prior to the concentration on social capital in public policy debates.

Health promotion in the past decade has recognised that behavioural change strategies have severe limitations as a means of promoting health. They are only successful for people who have other factors in their life going well. So if you have a good job, happy social and family life, good housing, sufficient income then you might be able to change your behaviour in line with exhortations to ‘eat less fat’, ‘quit smoking’, ‘drink alcohol responsibly’. The experience of US behaviour change programs such as Mr. Fit and many of the heart health programs was that despite the expenditure of millions of dollars very little behaviour change was achieved (Syme, 1996). Behaviour change strategies are most successful when they reflect a community desire for the program and have some structural support (for example tobacco legislation, ‘no hat no play’ policies in schools).
Instead the new generation of health promotion, typified by the Ottawa Charter for Health Promotion (WHO, 1986), is stressing the importance of empowerment, linking people together, encouraging community action for health and tackling structural factors that affect health. Social capital is an important concept because it both legitimises the means of much of this health promotion action (i.e. bringing people together) and sees the very act of providing spaces in which people can interact, socialise and plan action as health promoting in and of itself. Some of this health promotion action can act to increase the levels of trust and understanding between groups.

An example of this type of work comes from the links between the Whyalla Aboriginal community and the Community Health Centre. A lot of trust has developed between the Centre and the Aboriginal community.

Through the Aboriginal Health Workers discussions were held with the community to find out their needs and issues in relation to service provision. As a result a community based clinic has been established at Buttlingara (it is nearly operational). From Buttlingara the Aboriginal Health Workers advise the Community Health Centre (CHC) staff on what services the community needs/wants and the CHC workers then go out to this location, instead of Aboriginal people having to travel to the CHC. There appears to be a lot of trust surrounding these partnerships. They are a good example of how services can work together to make the best use of human and financial resources, in a way that fosters the community’s capacity to manage their own health. Such partnerships also enable service providers to feel and know they are working more effectively to meet the needs of the community.

The Leisure Activities Program, Barrossa Valley is a program to which a broad range of groups contribute under the auspices of the local council. The program is designed to:

- consider the needs of individuals and the community in relation to leisure/socialisation;
- assess what is available to meet these needs; and
- determine ways of linking people into these broad range of activities rather than directing them to activities that they would perhaps normally go to and where they would meet only people in similar situations as themselves, such as day care or mental health support groups.

Local workers report that this program is an example of strong links between agencies and with the community which fosters peoples’ ability to take care of each other in a supportive and trusting environment.

The World Health Organisation (1994) has promoted the idea of Health Development Structures (HDSs). These were identified as community groups and organisations, which formed an invisible resource for health promotion, and one which was hardly tapped into by formal health services. They include a

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3. The following examples were provided by Angela May of the South Australia Rural Health Training Unit
4. For more information contact Lee Martinez at Whyalla CHC -86488930
myriad of groups: sporting, religious, arts and culture, ethnic focussed, youth, older people, people with disabilities and professional associations. The ways in which they may assist health promotion and primary health care are as follows:

- their activities may in and of themselves be health promoting (e.g. sporting clubs);
- they bring people together and contribute to social capital building (Country Women’s Association, service clubs such as the Lions and Probus and group of quilters who meet weekly (usually 15 people) to make quilts for hospitals. They listed their key aims as “community friendship, social interaction and group therapy – sanity saver”;
- they may support health services function (Red Cross volunteers, rural chronic illness peer support groups for young people with chronic illness);
- they may advocate and lobby on issues that will improve health (e.g. Local Consumer Advisory group who advocate on behalf of people with mental illness or a Friends of the Coroong group and a local progress association which saw its health role as representing the community to health services.); and
- they may be a means to implement the participation goal of primary health care. An example from the HMS study is that of a local community broadcasting association, which includes in its aims “it provides access…to satisfying voluntary participation in the work of the station”.

A partnership between the Department of Public Health (DPH), SCAHRU and the Hills Mallee Southern region has shown that these groups are a real strength in the country. But all is not rosy. Some groups have problems obtaining volunteers and a representative from a group for people with disability commented “People cannot seem to commit themselves to helping two and a half hours per fortnight. Volunteers are like hen’s teeth in our town”. An environmental group complained that they had problems attracting new and younger members to their group. Despite this we already have evidence that many HDSs are functioning to promote health in rural South Australia. Rural people are more likely to volunteer than people in capital cities (Lyons) are.

CONCLUSION

Social capital emerges as a concept, which is central to the health of rural Australia. It is not a notion that exists apart from the other elements of society. In our increasingly globalised world maintaining social capital will depend on strong support from government to control unhealthy aspects of the market and to promote and support structures which are good for health. Government policy decisions that promote health are likely to reflect a balance between economic, social and environmental factors. These elements are far from being independent and, in fact reflect considerable interdependence as I have tried to demonstrate in Figure 1. A healthy rural Australia in the future will rest on the need to balance the different aspects of society displayed in this Figure. Each element is important to building healthy communities. The HREOC’s report

5. These examples were compiled by Rosie King, Project Officer, Hills Mallee Southern Health Development Structures study being conducted jointly by SACHRU, Department of Public Health at Flinders University and the Hills Mallee Southern Regional Health Service
claims the bush comes off second best in Australia. If Australia wants to be a
country high in resources of social capital then the trust of the residents of our
rural areas must be restored by supporting and strengthening the economic and
social aspects of life in the bush. Then a healthy future for all Australians is far
more likely.

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