

Beyond the Desk: Concept-Building in Practice

A Bourdieusian, abductive reconstruction of
'health capital' across data, methods,
peer review and student response

Kristian Larsen

Abstract

This article examines the epistemological construction of *health capital* over a twenty-year period of sociological inquiry. Anchored in Bourdieu's relational framework—particularly the concepts of field, habitus, and capital—the study employs abductive reasoning to reconstruct the concept's emergence across diverse empirical and institutional contexts. Methodologically, it draws on document analysis, pedagogical encounters, and reflections on peer review, tracing how theoretical and empirical registers have co-evolved. The results reveal that *health capital* did not develop through linear application of theory, but rather through iterative ruptures, conceptual negotiations, and embodied academic practice. The discussion foregrounds the researcher as both subject and object of inquiry, showing how tacit knowledge, affective investments, and socio-political shifts (e.g. welfare state transformation) have shaped conceptual elaboration. By offering a reflexive account of sociogenesis, this study contributes to discussions on knowledge production, the craft of concept formation, and historical epistemology in sociology. It is relevant to scholars of theory, method, and reflexive practice.

Keywords

Bourdieu, historical epistemology, craft of sociology, health capital, abduction, construction of object, methodology

Why This Paper?

In the social sciences, numerous textbooks and articles provide step-by-step instructions for conducting theoretical empirical studies, often emphasizing structured guides, systematic data collection, and the design of measurable studies (Bryman 2016). A more reflexive

approach to this such control and standardization can be found in Braun and Clarke's (2006) six-phase coding framework for thematic analysis, which outlines analytical phases such as familiarization with data, code generation, and the identification of themes.

While such texts are intended to be useful for students and researchers, my own experience, informed by Bourdieu's *The Craft of Sociology* (1991), suggests that sociological research is far from straightforward. Many scholars in health sociology share this perspective (Allsop and Saks 2019; Cockerham 2017; Collyer 2015; Nettleton 2020). However, there remains a lack of studies that engage in intensive, thoughtful, and in-depth reflection on the multiple inspirations, influences, and constraints that shape the research process.

Much of the available literature focuses on the formal, direct, explicit conditions underlying sociological manuals – what Bourdieu might describe as desk-produced, paper-based instructions that impose a chronological order: beginning with a literature review, followed by theory selection, operationalization, methodological choices, empirical data collection, and proceeding sequentially to coding, analysis, results, discussion, and conclusion.

In this paper, I draw on a case from my colleagues' and my own research on the concept and phenomenon of health capital to analyse and rethink the implicit, indirect, and unobserved factors that shaped our research process. Positivist epistemology removes the researcher from the research, reducing the process to the execution of predefined manuals. In contrast, historical epistemology and social constructivism recognize the researcher as a central instrument in the production of knowledge, requiring that both the research and the researcher be objectified throughout the entire process.

This paper contributes to the theory and history of science, not by engaging in abstract debates on scientific paradigms (e.g., positivism vs. constructivism, qualitative vs. quantitative approaches, or deduction vs. induction), but by offering an empirically grounded reflection that foregrounds complexity and, crucially, the subtle and often hidden factors shaping knowledge production. My aim is to highlight the complexity of sociological research, caution against the oversimplification of manuals, and encourage greater self-reflexivity. I hope that this study, through its objectification – the explication of abstract processes through use of explicit examples - of the research process and the metamorphosis of health capital, will serve as inspiration for both new and experienced researchers.

Introduction: The Evolution of Health Capital

Over the past two decades, I have engaged in research, teaching, and scholarly debate on the sociology of the body and health, particularly in relation to health capital—a concept akin to economic, cultural, and social capital, related to fields or social spaces (Bourdieu 1977, 1986). The basic idea is that some types of body practices can be converted to social advantages. Bourdieu studied as an example how education (cultural capital) could be applied and used as a resource or capital at a job market. Thereby the time, money and energy invested in studying medicine or law can be converted to a job position and economic capital. I expect that investment in the body (physical training, diets, yoga, surgery) in a similar way, can be converted to social advantages at a marriage, housing, or job market. The body performance physical and/or online/virtually gives the 'owner' of the body distinctive advantages compared to those who do not invest.

Initially conceptualised in 2005 as a diffuse welfare state resource, health capital has since undergone significant epistemic transformation. In its contemporary articulation, it now encompasses diverse and contested investment strategies among patients and healthcare professionals, reflecting broader shifts in societal and institutional health practices.

This article examines the evolution of health capital through a reflexive, historical epistemological analysis of my own research production. Drawing on Bourdieu's sociology, I seek to objectify the conditions that have shaped this conceptual transformation, interrogating both explicit factors (empirical frameworks, methodological choices) and more tacit influences (review processes, peer discourse, student engagement). By reconstructing the iterative knowledge-making process, this study demonstrates how theoretical concepts are dynamically co-constructed through academic structures, social interactions, and shifting epistemic contexts.

Abduction and Historical Epistemology

This inquiry aligns with abductive reasoning (Timmermans and Tavory 2012), where theory emerges through iterative engagement with empirical surprises and conceptual refinement. Rather than imposing a fixed theoretical framework, this study traces the contingent and evolving nature of health capital, illustrating how sociological concepts are shaped by empirical encounters, reflexive critique, and shifting theoretical landscapes. The study is also informed by historical epistemology (Bachelard 1968, 2002; Canguilhem 1988, 1991 & Bourdieu 1998a), which emphasises ruptures, transformations, and competing epistemic formations in knowledge production.¹ Much like Canguilhem's exploration of shifting conceptualisations of the body and disease, this work critically examines the social and intellectual forces that have influenced the evolving meaning of health capital. Rather than presenting fixed research findings, this article explores the conditions, limits, and possibilities of constructing sociological knowledge, engaging in a micro-historical epistemological approach (Broadly 1990, 1996) to trace the conceptual trajectory of health capital.

Constructing the Research Object

This study contributes to a sociological understanding of knowledge production, demonstrating that researchers are never external to the objects they study. Following Bourdieu's principle of reflexivity, I critically interrogate my own position within the academic field, recognising how epistemic shifts are shaped by institutional, intellectual, and social forces. In line with Bachelard's assertion that knowledge is the opposite of opinion, this work seeks to move beyond doxa – the taken-for-granted assumptions that underpin spontaneous sociology² – towards a more rigorous, reflexive construction of the research object. By applying this approach, the study underscores how sociological knowledge is not merely discovered but actively constructed through a continuous interplay of theory, methodology, empirical inquiry, and researcher positionality. This challenges linear, step-by-step models of research, advocating instead for a dynamic, recursive process, where empirical findings, theoretical insights, and methodological considerations co-evolve over time.

I hope this study offers a significant contribution to multiple sociological domains,

particularly in theoretical-empirical research, research methodology, and reflexive sociology. It is relevant for scholars, students, and researchers engaged in concept formation, knowledge production, and methodological critique.

Relevance in sociology

This paper engages with historical epistemology (Bachelard 1968, 2002 & Canguilhem 1988, 1991), and abduction (Timmermans and Tavory 2012), showing how knowledge is shaped through theory, methods, and researcher positionality. It challenges linear models of research, instead advocating for an iterative, abductive approach where concepts evolve through empirical surprises, peer critique, and institutional contexts. The following text could be of relevance to:

1. Graduate students and early-career researchers learning about research design and concept development.
2. Methodologists interested in alternative research strategies beyond deductive/inductive reasoning.
3. Interdisciplinary scholars who explore conceptual adaptation across disciplines (e.g., sociology, public health, STS).
4. Researchers interested in reflexive sociology with attention to the researchers' embeddedness within the knowledge production process
5. Researchers interested in autoethnographic and self-reflexive methodologies.
6. Academics engaged in concept-building and critical sociology. I believe this text may be particularly relevant for master's and PhD students when they have to account for and reflect on their work of construction.

Empirical basis and methods of analysis

The empirical material for the study consists of all my research documents accumulated over 20 years, with a computer search for the terms health capital and health/body capital undertaken find all relevant. There are several hundred documents from incomplete and complete Word texts, PowerPoint presentations used for teaching and conferences, PDF files comprising the following categories:

1. Peer-Reviewed Academic Publications. This category includes peer reviewed journal articles that contribute to sociological theory and empirical research: Larsen, Cutchin, and Harsløf (2013); Larsen and Harsløf (2019); Larsen, Hindhede and Henriksen (2020); Larsen, Hindhede, Larsen, Nicolaisen and Henriksen (2020); Harsløf, Larsen and Bamba (2022); Larsen, Røpke and Hindhede (2025).
2. Scholarly Contributions to Edited Volumes. Includes book chapters and edited volumes that engage with theoretical and empirical developments in sociology. Chapters in international and Nordic anthologies and edited collections: Larsen (2009b); Larsen (2010); Jensen et al. (2007); Harsløf, Poulsen and Larsen (2019); Larsen (2021a); Larsen (2018); Larsen and Esmark (2013).
3. Academic and Public Engagement Outputs. This category comprises contributions to

academic and public discourse, including conference presentations, opinion pieces, and research notes. Conference papers, public chronicles, lectures, and research notes: Larsen et al. (2018) [Conference papers]; Larsen (2009a) [Chronicles]; Larsen (2005) [Research notes]; Larsen (2009a) [Chronicles] & plenty of PowerPoint presentations used in lectures and teaching.

4. Empirical and Policy-Oriented Research Reports. comprises reports addressing health inequalities and educational programmes, contributing to applied sociology and policy discussions. Reports on health inequalities and educational programmes: Larsen and Hansen (2014); Larsen and Bystrup (2013); Larsen et al. (2014).

Using criteria relating to differences in definitions of the concept and empirical bases to reconstruct similarities and differences in the way the concept of health capital has been used the search resulted in 21 texts.

The texts were analysed using pragmatic text analysis, focusing particularly on definitions and explanations of the concept of health capital. But also, with attention to the whole context like questions about the type of paper/publication, the empirical data material, use of methods etc. Such definitions and explanations have often been in the form of five to ten lines within a larger body of text, requiring examination, for example, of research questions that were asked, the central empirical material, the methods used, and the literature references cited.

The hidden aspects

Sociological research, indeed, perhaps all research, has its obvious, objective aspects, as can be seen above. However, there are also many hidden, implicit aspects that are difficult to reconstruct. It can be both an advantage and disadvantage being at once the object and subject of this study. With a view to analysing hidden aspects, I have expressly sought to explore the activities, times and places that are linked to the individual articles.

In developing the concept of health capital, various forms of input—beyond what can be seen in a formal text analysis – have influenced my thinking in ways that were not always immediately apparent. For instance, during a lecture at Aalborg University, student discussions on digital health practices made me more aware of how mobile apps are increasingly used to monitor and optimise the body. Their reflections further highlighted how individuals actively engage with technology to track fitness, diet, and wellbeing, reinforcing the idea that health capital, certainly among some of the young students involves a conscious investment in one's body. A student made it very explicit how she invested in her body and the body performance, as an example at a bar, for oral examinations, at job interviews etc. She knew exactly which body performance that was valued and counted in different social positions in social space. This informal input subtly shaped my understanding of the role of self-surveillance in contemporary body (health) practices.

Similarly, at a medical sociology conference, discussions led me to a clearer distinction between health capital and other capital concepts. I learned that the concept was constructed and positively delimited through empirical studies. But also negatively, for example through my attention to how it differs and does not have explanatory power in the same

area as, for example, the concept of cultural health capital (Shim 2010), Healthcare choice (Collyer et al. 2015) or personal capital (Scambler and Newton 2011). Beyond these interactions, expert feedback from colleagues and review processes have also been pivotal in shaping the development of the concept. The book *Health Capital*, published by Samfundslitteratur (Larsen 2021d) presents a collection of the work on the concept, with an autobiographical section and sections on the state, public health, health economics and the body. Below is a description of the changes to the concept.

Health capital as a shared benefit of welfare

In a book about young people, health, and inequality (Jensen et al. 2007), I managed chapters two, four, five and six. The book examined social capital, primarily based on Bourdieu, but also looked at the widely different concepts of social capital defined by Putnam and Coleman (Jensen et al. 2007; Larsen and Morrow 2009). We studied a group of 16-year-olds that was heterogenous by virtue of their parents' mix of different economic and cultural capital, gathering information through qualitative interviews and visiting them at their boarding schools. Health capital ultimately filled the gap when we were unable to explain or interpret using the conventional forms of individual or family related amount and composition of capital (economic, cultural, social). There were huge disparities between the young people in terms of the economic, cultural and social capital they could draw on via their families and networks, but they also shared something, which we described thus:

the youngsters [...] grew up in a Danish setting, which can be seen as having provided them with certain important resources. It could be said that in some countries and regions a certain amount and certain types of capital have accumulated that to a point they are universally available. As described, we can say that these resources have been built up through what we call the state, for example in *basic artefacts* (material and physical products) such as road networks, water supply, sewerage system, hospitals and power supply, but also in institutionalized products like accumulated in health knowledge, e.g. among health professionals (evidence and professional knowledge) and institutionalized as state funding of medical treatment, prevention and care as well as in certificates & authorizations (Jensen et al. 2007, 120).

These reflections, constituting the first contours of health capital, were based on research notes from 2005. The concept had some similarities with health resources and medical care accessible to future generations, as described by Becker (2007), although it was not until many years later that I read about concepts defined by Becker and others that resembled health capital. Furthermore, the point of departure for health capital was much broader compared with the benefits produced by the welfare state in the social, education and health domains. The welfare state grew out of a long historical process spanning a hundred years, with the development of institutions and professions in Denmark (Bonderup 2006; Skydsgaard 2006; Vallgård 2003; Vallgård and Krasnik 1999) and other countries with the intention of reducing morbidity and optimising health (Porter 1995).

This first welfare state perspective of health capital was not oriented towards the body

or investment in the body in terms of health and wellbeing, but rather towards the structural factors that enabled the optimisation of health, wellbeing, and quality of life. Laws and regulations within the social, education and health spheres were built upon enormous investment that was invisible to many. Rights that felt natural were in fact earned or rather fought resources (capital) i.e., products of a long struggle between social groups. These ‘natural health benefits’ were therefore cultural products. Today, with reference to Bourdieu and Wacquant’s theorisation of the dual nature of the state (Bourdieu and Champagne 2014; Bourdieu, Wacquant, and Farage 1994; Wacquant 2009, 2014), I would conceptualise the early formulation of health capital as a resource situated within the left hand of the state—that is, the ensemble of social, health, and educational institutions traditionally tasked with care, redistribution, and the production of social cohesion. This ‘left hand’ has, however, come under increasing pressure and marginalisation in recent decades, as neoliberal governance, austerity, and punitive regulation have strengthened the ‘right hand’ of the state: its repressive apparatus composed of police, military, and coercive bureaucracies. Health capital, in this light, becomes not only a form of embodied resource but also a reflection of the broader structural weakening of the social state and the ascendance of disciplinary forms of governance.

Health capital in materiality, institutions and bodies (of health professionals)

Since writing my PhD dissertation (Larsen 2000) I have been concerned with materiality, undertaking hospital ethnography, where I have seen not only how bodies relate to one another, but how they also relate to physical, built surroundings (Larsen 2005). My attention was drawn to the material dimension of health capital when I began to reflect on the tangible, concrete, physical conditions that influence health outcomes—ranging from access to healthy environments and quality housing to harmful exposures such as damp homes or pollution. These material factors not only contribute to health but can also significantly undermine it, highlighting that health capital is also deeply embedded in lived, physical realities.

Health sociologists clearly show that sewerage systems and clean water have had huge implications for public health (Porter 1995; Skydsgaard 2015). This definitely led to my awareness that hospitals, penicillin, scalpels and scanners also constituted a material contribution that enhanced people’s health. Hospitals were an example of a human-made material product or health technologies that brought together resources, i.e., a form of (health) capital, the key point being that health capital embraced a material dimension. It was emphasised in this next version of the health capital concept, that hospitals could be regarded as being part of shared health capital (Larsen 2009b). In other words, health capital is effective in a material, as it were, physical form, in the same way as schools, nurseries, education institutions, special needs centres, social institutions, and smaller artefacts and health facilities. Hospitals such as Rigshospitalet in Copenhagen or Skejby Hospital in Aarhus were concrete and material structures of brick and glass and not just thoughts or linguistic constructions. These buildings, with their interior and medical technology design constituted universally accessible constructed value. They encompassed knowledge and know-how that had been invested in and developed, from minor technical procedures and routines to

work processes and innovations in health in a broad sense, i.e., regarding medical treatment and care, etc. (Larsen 2009b).

It is difficult for me to reconstruct how the material dimension came in as a supplement and contribution to the work with health capital. This was probably based on my reflections on the material side of health, for example during my travels in remote parts of Asia where sanitation, health technologies or hospitals were absent or rare. With hindsight I was able to arrive at other aspects of health capital by taking inspiration from Bourdieu's concept of cultural capital. Proceeding from Bourdieu's (Bourdieu 1986, 1990; Bourdieu and Wacquant 1992) sociology and cultural capital, you could say that health capital was embedded as mentioned in materiality (in actual buildings, substances such as penicillin and vitamins, in technologies such as measuring devices, scanners and computers); institutionally in texts and theories (science/knowledge of anatomy, physiology, textbooks); and also bodily (in knowledge built up in the health professional's body in the form of knowledge about hygiene, illnesses or, say, use of digital technology).

In this later, changed version, materiality was central, as was the embodied aspect. However, since the analysis was mainly directed at the hospital as one element of a benefit of welfare, the body aspect only comprised knowledge incorporated (embodied) in the health professional.

In summary, the study investigating young people and social inequality (Jensen et al. 2007; Larsen 2005), health capital was about a shared resource such as a welfare state regime that can help to optimise health and minimise illness. In the subsequent version (Larsen 2009b, 2010) the concept was enlarged to include hospitals, vitamins, health technologies, theories about health and disease, and knowledge embedded in the body of the health professional.

Patients must have health or body capital

In the following analyses, capital was more closely related to the patient, user or clients, who used, or potentially wanted to use, the health service. This happened at the same time as sociological health research increasingly focused on the user and client as well as inequality in health. In this connection, I was also concerned with the topic of inequality in general (Larsen 2008; Larsen 2009c) and with an empirical focus on Norway (Larsen and Hansen 2014).

The focus on the user and inequality also had great importance in analyses of the future health service (Larsen et al. 2014). These conditions were probably, more or less, the direct reasons for my increased attention to the patient as an active player in the field. Overtime, the position assigned to the patient in highly specialized hospital institutions has changed. In a study of how the healing institution (the hospital) had become ill (Larsen 2009b; 2010) I describe that patients were objectified through the health professionals' use of standards, fast-track programs and manuals. At the same time, patients also increasingly became individualized subjects, with a larger proportion becoming knowledge seekers, for example through the democratization of knowledge (internet). Each country has several health information websites, for example in England: NHS Choices (nhs.uk), in Australia Healthdirect Australia (healthdirect.gov.au) or in the United States WebMD (webmd.com). These

platforms provide new possibilities for those who have the resources to obtain accessible health information.

With the internet new types of resources were available for some individuals or patients. They, or some of them, occasionally acted as expert patients who entered dialogue with and challenged the health professionals and their knowledge and knowledge monopoly. The patient could be defined as both objects and subjects, but they remained objectified in the institutional fields (Larsen 2010). Looking back, I think it was through studying the historical development of health institutions, professions, and patients that I became interested in the patient's role in relation to the concept of health capital. I remember engaging with 'patientology' – the study of patients' experiences and how they manage illness – especially because I had to teach it. In sum, growing awareness of patients, including how gender and class differences shape their experiences, likely led me to apply the concept of health capital to them.

Detour or support of health body capital

In this context, I described that increasingly more demands were placed on patients during illness, hospitalization and transitions between sectors. The structural changes in the field necessitated that patients should be able to activate a 'health body capital' in order to optimize their own process of becoming healthy (Larsen 2010). That concept was probably described with a focus on the body because I wanted to draw attention to the fact that it was linked to the individual body and this body's habitual dispositions to master illness, suffering, pain, hospitalization and rehabilitation. But the detour of health body capital, which was in a way a detour on the road, became a catalyst for seeing the patient's own bodily capacity (habitus, capital and strategy) in relation to managing the course of illness.

Health body capital supported and built on the previous concept of health capital, which referred to resources that in principle everyone could potentially draw on. In this version of health body capital (Larsen, 2010), the focus was on the unequal resources of the users/patients. The point was that if patients could not demonstrate the necessary capital in and through their bodies, it would be difficult for them to reap the fruits of the conquests of medicine and society in relation to health and illness³.

It was described that the healthcare field (medical practice, health care, hospitals) mediated through doctors and nurses expected patients to be subjects, i.e., self-active and self-driven in relation to hospitalization, disease treatment, prevention and care (Larsen 2010, 46-47).

In the (for me empirically new) context where I worked more with patients and hospital processes, health body capital was an important capital because it could be converted, transformed and exchanged for goods on the market, i.e., the health field. The health body capital, which only concerned the embodied dimension, can in retrospect be said to have similarities with Bourdieu-inspired concepts of cultural health capital (Shim 2010, Dubbin, Chang and Shim 2013), which concerned specific capital that was active in the American health system, with a focus on relationships between doctor and patient in general practice. Shim and colleagues were able to show how patients who were proactive, knowledge-seeking and somewhat instrumental and biomedical in their way of relating to their own body

and health received relatively many services from their doctor compared to those who were more expectant, passive, etc. Cultural health capital (Shim 2010) was in the health system what cultural capital was in the education system. I have since collaborated and supervised with Janet Shim and Leslie Dubbin, who have further developed the concept of cultural health capital (Dubbin, Chang and Shim 2013). But in 2008-2010 my concept of health capital was completely virgin and, in any case, not in any way supported, shaped, inspired, guided, or disturbed by other concepts that could have conceptual-empirical similarities.

I was aware of concepts such as health literacy and health competence, etc., but with health capital I wanted to investigate something different. Health capital has been thought of throughout as an analytical counter-concept in relation to the two concepts. At that time – around 2010 – I had not given lectures internationally on health capital and even less done any literature review as a prerequisite for the concept of health capital. My attention was much more directed towards Bourdieu's concepts of field, capital and habitus, linked to the various empirical areas of study such as youth, inequality, materiality, etc. Furthermore, in collaboration with my colleagues, I had received responses from students, colleagues, and other researchers on the different versions of the concept of health capital and its scientific value, for example in relation to body capital, physical capital, cultural capital, or symbolic capital.

The concept of health body capital probably emerged and became meaningful to me due to two factors. First my growing interest in inequality in health and second a simultaneous ideological change. It was increasingly a requirement that patients should be physically active, non-smokers, eat healthily and otherwise be proactive with their bodies to get maximum benefit from the services that health institutions could provide. Time dictated that you were not just the architect of your own luck. You were also the architect of your own health. This focus on inequality was likely also influenced by my strong interest at the time in the broader transformation of the Nordic welfare states, its institutions, and professions, driven by neoliberal reforms and the emergence of New Public Management (NPM). These changes included the outsourcing of services to private health actors, occurring alongside my engagement with Bourdieu's work (Bourdieu, Wacquant and Farage, 1994) and Wacquant's (2009) analyses of state transformation. In this context, I also explored Bourdieu's politically and sociologically motivated critique of neoliberalism, particularly his indignation at its effects on society (Bourdieu, 1998b).

Patients should cultivate and tone their physical body

Health capital and health body capital was generally perceived as being capital that counted as a resource in relation to the healthcare field. Individuals were 'encouraged' or motivated to invest in their own body and health status, for example by being aware of correct dietary habits and accompanying studies and course activities for following authorised diets and nutritional advice.

Individuals were also supposed to look after their bodies by engaging in physical activity, i.e. spending time in gyms and joining in activities such as spinning, body toning, fitness classes, running or possibly even extreme sport. This version (Larsen 2010) involved a wholly conventional medical approach supplied with technologies to measure the body

using biomedical indicators such as pulse rate, blood pressure, body mass index and serum cholesterol to gauge quality of life. Activities associated with health capital also included shopping and use of the correct equipment: running shoes, sweat bands and creams. The last-mentioned items possibly harked back to health capital as capital based on positions in the social space or other fields.

However, at that time there was still only the notion of a resource that could be thought of as having value in a specific health field, i.e., capital that could be converted to benefits directly in this field, such as better treatment and care or the offer of more medical examinations, support and help. This concept shared many similarities with Cultural health Capital (Shim 2010) It was not until later that the concept of health capital was described as and developed into capital that was also more globally convertible.

Health capital as a general theory

The concept has since been used as a tool in a general analysis of how the state as a meta-field and a number of fields and institutions are changing. In Larsen (2021d), I have referred to this as our being ‘liberated by or from the state’ in a double movement. The structure of bodily labour has been changed by a number of transformations, not least of which is the state, e.g., the dominance of the right-hand state (Bourdieu and Champagne, 2014, Bourdieu, Wacquant and Farage 1994; Wacquant 2009) and the emergence of a neoliberal market. The body has been liberated from the protection and security of the state, but at the same time also freed to take care of itself. This liberation does not necessarily indicate that the state has made a strong withdrawal, where it was previously active and supportive.

We are dealing here with new forms of governance, in which the state retreats and delegates responsibility to the market. The individual is, so to speak, further ‘liberated’ and left to navigate life autonomously. Yet crucially, this autonomy is accompanied by intensified regulation—an obligation to optimise one’s own health and bodily well-being (Larsen 2021d, 102). The state reappears not as an external authority, but as an internalised compass or GPS, directing individuals towards the ‘right’ way of living while simultaneously producing feelings of guilt and shame. The notion of this ‘inner compass’ is clearly informed by Foucauldian thought and, more specifically, by my encounters with the work of Nikolas Rose. I first met Rose when I organised a lecture with him at the Danish University of Education in 2006 through the association HEXIS, of which I was – and still am – chair. His presentation, titled Changing Ideas of Normality and Abnormality, left a strong impression. Even in concepts that are fundamentally shaped by a Bourdieusian framework, we find traces – or indeed direct inspiration – from other theoretical traditions. In this case, the influence of both Foucault and Rose is unmistakable.

Thus, changed conditions of opportunity have been constituted for and increased pressure on the individual in relation to optimizing oneself in a societal context. The societal change (Larsen 2021b) underlies the emergence of the fitness, yoga and marathon movements (Larsen, Cutchin and Harsløf 2013). My colleagues and I have since used the concept in relation to rehabilitation processes (Guldager et al. 2018; Harsløf, Poulsen and Larsen 2019). That is, a capital that was still directed towards and had market value linked to the health field.

In summary, the important idea in the next phase of health capital was the development of the concept into a more general theory or assumption that some forms of work with the body could have market value in positions in social space and other fields. My assumption was that, for example, bodybuilding, fitness and yoga could have a certain capital value in very disparate fields. In an interview study that we conducted, a fitness centre manager recounted, by way of example, that he had once employed a woman at the reception desk. He had given her a warning, but when she failed to lose weight, he felt compelled to dismiss her: “We can’t have her representing our centre to the outside world.” (Larsen and Harsløf 2019). The earlier version of health capital accounted for ‘what works’ in the sense ‘is valued and seen as capital’ among patients in the healthcare field (in a health field). Now health capital – i.e., the bodily dimension – was expanded to a general theory about different types of investment in the body and the different receptions in positions in the social space or social fields. We have studied this among Danish health professionals (Larsen and Harsløf 2019; Larsen, Hindhede and Henriksen 2020; Larsen et al. 2022).

Social differentiation and five forms of investment

Further refinement of the concept involved social differentiation (class, sex, geography). Social groups invest differently in the body (habitus) and marketing of these endeavours is different (positions and positionings in social spaces or fields). Furthermore, it became relevant for investment to be differentiated and divided into five types. Previously, in collaboration with a colleague (Larsen and Hansen 2014), I described how it was possible to differentiate between investment in, for example the external and internal body and in the visible and the invisible. These ideas helped me try to approach the body and work on the body in new ways. In recent years I have taken part in marathons and cross-country skiing events (90-km Vasa race) and have considered them objectively for the most part afterwards and wondered why I spent so much energy and time on something that causes pain for several days. One could also similarly approach phenomena such as plastic surgery or strict diets. In doing so, I have tried to see the other person’s point of view (Bourdieu 1986, 1999). As a young man, I was often critical – and somewhat amused – by the idea of jogging and running – especially without a football! However, my own later experiences with mountain biking, road cycling, and marathon running – activities that I earlier found absurd – may have helped me develop a greater ability to ‘put myself in another person’s place’ and act as a midwife for stories from individuals differently positioned in the social space. In the Understanding chapter of *Distinction*, Bourdieu (1986) compares the sociologist to a midwife, illustrating how sociologists do not impose their own ideas, but instead help individuals articulate their own social conditions, experiences, and struggles by bringing to light what is already there. Just as a midwife assists in childbirth, I believe these personal experiences have made me a better sociologist, enabling me to help uncover knowledge that already exists within individuals and groups, making their social realities, struggles, and perspectives more visible.

It is not quite clear how precisely the five forms of investment were developed. I remember ideas about how to make interventions in, on and via the body. The idea was fairly simple: you can put something into it (food), inject something into it (medicine), cut it

(surgery), and activate it physically (physical exercise) or mentally (yoga). The five types of investment were constructed as follows: the surgical body (operation/piercing), the chemical body (medication/micro dosing), the nutrition body (diets), the physical body (physical training) and the mental body (e.g., literature or yoga). The five types of investment are rough categories which, like the rest of this construction endeavour, are a complex interaction between seeking and explorative (inductive) and abstract and broad-based (deductive) processes – in deductive reasoning (Timmermans and Tavory 2012).

Travels abroad and differentiated perceptions of the body's value

The Bourdieusian conceptual world has played a central role throughout the 20 years under study, acting as a doctrine, a set of inherent premises that were indisputable. It is possible that the concepts of investment, market (field), economy, value, conversion and costs became particularly apparent in 2008–2009, i.e., at the same time as the global financial crisis, when similar concepts were circulating in the media. I am not sure, but it may have indirectly provided inspiration for further integrating the concepts into health capital. It became particularly clear to me from my travels abroad, that bodies are cultivated extremely differently to conform to with exceedingly disparate markets. It has not been alien or strange to me to approach endeavours to develop extremely large breasts or muscles with the same objectivity – in sociological terms – with which I approached my own equally absurd efforts to run a marathon.

Dominant and dominated health capital

Another nuance exists in the fact that some health capital can be said to be dominant while other health capital can be described as dominated health capital. It has always been the case, albeit not explicitly, that social groups cultivate the body differently and that there are different and also contradictory perceptions of what a beautiful, proper, normal or healthy body looks like. In my own life, I have experienced myself having contradictory views about body cultivation, going from a period in my youth when we made fun of the fitness craze to my own participation in marathon races (Larsen 2021d). But the actual division into dominant and dominated health capital is inspired by a text about what counts in a school context (dominant cultural capital) and what counts in a ghetto context (dominated cultural capital). Thus, it made sense to construct health capital not just as something quantitative (accumulating to varying degrees), but also as making distinctions (dominant versus dominated).

When it comes to the mental body as part of health capital, it is fair to say investment takes a long time and requires stamina, although it can also be assumed that the capital, which could be likened to bonds, is long-lasting and has relatively general applicability with many positions in diverse fields and in the social space. This is not empirically illuminated but is inspired by Bourdieu's work looking at how school and education capital has a certain general applicability and that it takes a long time to develop. One example is that it requires generations to learn the correct cultural code for ways of walking, standing, speaking and eating (Bourdieu 1986; Bourdieu and Passeron 1977). On the other hand, investment in the medical body could be said to be a direct, immediate investment, the

effects of which are also reaped quickly, as seen, for example, when in some cultural field's diverse medicines, drugs and chemicals are taken to be at one's peak and others are taken to relax (Larsen, Hindhede and Henriksen 2020). When considering the approach to the body, a distinction could be made between long-term investments, like with bonds, and more short-term, risky investments, like with shares, although the latter would include the possibility of a fast yield from the investment (Larsen 2021d).

Forms of investment, market value and fields undergoing change

During my reflections on investment and marked of endeavours regarding the body, I have personally experienced for over 50 years how no stigma used to be attached to having a large body in Denmark in the 1960s (Larsen 2021c). Once associated with power and gravitas—particularly in the case of the male body—the large, smoking, stoic physique formerly idealised by the upper classes has largely lost its symbolic capital in the 2020s. Certain body types – physiognomies⁴ – are persistently devalued across many positions in social fields and the social space. Overweight, smoking, and phlegmatic bodies are now frequently perceived as low-status and are disadvantaged in labour, marriage, housing, and health insurance markets; in some instances, individuals may even be excluded from employment due to a high body mass index. Processes of social inclusion and exclusion based on bodily form are also mediated through state institutions, with the Danish Health Authority and health professionals playing a notable role in these dynamics (Larsen 2021d; Larsen & Brinkkjær 2009). Among Danish health professionals, particular emphasis is placed on the cultivation of the physical – and especially the nutritional – body (Larsen, Hindhede & Henriksen 2020). Instances of weight-based job dismissal have been documented, and Høyer (2019, 42) notes that some American insurance companies now require clients to wear fitness trackers and share personal health data in order to access coverage.

However, the social positions in the respective social spaces or fields change. Something that is valued for one position can change rather fast in the case of some forms of investment. For example, we are seeing that some types of body tattoos, use of piercing, but also plastic surgery to optimise the body's appearance and aesthetic are becoming more widespread in a relatively short period of time and finding new markets. When studying body sociology and health sociology, one must be aware of both the analytical tools, e.g. the concept of health capital - but also the object moves! In the 20-year period I am referring to, significant changes have occurred in who gets tattoos, as well as in the new distinctions that emerge—for instance, in their placement on the body and the identity of the tattoo artist.

Process of construction

Over two decades, the concept of health capital has evolved from analysing welfare state resources to encompassing bodily investments as a form of social distinction. Our research has examined health capital among European workers, healthcare professionals, and patients, showing how practices like diet and exercise vary by class and are shaped by post-industrial occupational structures. A recent mixed-methods study of Danish hospital patients prompted further theoretical and methodological refinements, including new

categories such as ‘mental body investment.’ Across contexts, health capital highlights emerging inequalities and competing body ideals, underscoring its relevance as both a conceptual and empirical tool.

Inter-related factors in the construction process

Thus, the concept has evolved over time. While it is not entirely possible to map out the full development of research as a craft, I will attempt to summarise some of the key factors and components that have actively shaped the construction process. The case of health capital serves merely as an example – a case that can be reflected upon and potentially applied to other types of studies. I believe that preconscious, hidden, or overlooked factors and components are particularly important to consider in sociological research.

Empirical data. The description above shows that research questions and empirical fields in particular have played a central role in how health capital has been constructed. To start with, Bourdieu’s central concepts of capital came into play in the exploration of health inequity among young people (Jensen et al. 2007); however, we were not able to analyse some of the empirical material using the concepts of economic, cultural and social capital. Health capital became a potential answer to the question of what shared resources young people could draw on, and today, I would call this concept the institutionalisation of health capital. The concept was gradually refined and narrowed down in later analyses, mainly because the empirical fields relating to health inequity, young people and the elderly, the healthy and the sick, and materiality constituted different objects of study.

It is evident that the empirical dimension – its impact and focus area – holds a special position in the dialogue between theory and empirical research. Ideally, there should be a degree of alignment between theory and empirical reality. However, even if the empirical field is constantly shifting – a moving target, as seen in the changing patterns of tattoo placement on the body, the most crucial calibration between theory and empirical research occurs precisely when empirical conditions change. For instance, when interviewing young and adult individuals, it may be relevant to conceptualise body investments in terms of ‘optimising’ appearance, functionality, and societal recognition (health capital). However, demographic factors may shape the empirical data collected. For example, it may be argued that older individuals typically do not seek to optimise their bodies. Instead, they may aim to ‘maximise maintenance’ or ‘minimise physical decline’. Such ‘empirical’ factors – here exemplified by age – significantly influence research design. Similarly, other empirical factors – such as whether a body is ‘sick’ or ‘healthy’ or socially privileged or disadvantaged – play a crucial role. Empirical reality can challenge or even reject a theoretical concept if that concept fails to adapt, meaning if it is not sufficiently sensitive to empirical data.

Studies of the literature. I have read and re-read parts of Bourdieu et al.’s (1986) studies dealing with class, body, sex, identity and distinction with the intention of identifying possible classed and gendered differences in a French context dating back 50 years that could be related to the contemporary Danish situation. It was also relevant to explore how these factors

had been examined using a similar approach in Danish (Prieur and Rosenlund 2010) and Nordic studies (Hjellbrekke et al. 2007; Hultqvist and Palme 2009). None of these studies has an equivalent conceptual approach but they provided inspiration for guides and questionnaires. Järvinen, Ellersgaard and Larsen (2014), gave huge inspiration providing their questionnaire from a Danish study on alcohol consumption in a major Danish company. These questions inspired our work with the questionnaire used in a study of health capital among Danish health professionals. In general, studies of literature have played a key role in theoretical and empirical endeavours in health capital.

Methodology. Methodological techniques such as statistical analyses of Norwegian preferences regarding nutrition (Larsen and Hansen 2014) have greatly increased awareness of classed and gendered differences in taste preferences. This has also led to the nutrition body becoming one of the five bodies under health capital. Use of multiple correspondence analysis (MCA) as an illustrative way of presenting all the information obtained via the health questionnaire study provided important insight into distinctions between ‘culture’ and ‘nature’, between the ‘instrumental’ body and the ‘natural’ body (Larsen et al. 2022), which corresponded to class and age. Furthermore, the technique of multiple correspondence analysis (MCA) helped to uncover how the mental body category was ambiguous and vague regarding cultural capital. The advantage of correspondence analysis was to link and relate various data sources such as information about income, education, post codes, practices, preferences and aversions among the informants in the study. MCA is descriptive and explorative and the new studies about different patient groups are interesting as we can interrelate and show distinct patterns of investment in health capital revealing opposed patient groups involving, for example, active vs passive investment related to young vs older, highly vs low educated etc. (Larsen, Røpke and Hindhede 2025).

In summary, methods are a crucial dimension of sociological research. In the previous section, I introduced MCA as a method and technology, but inspired by the concepts of ‘mixed methods’ and ‘triangulation of methods’, I wish to emphasise the importance of methodological approaches in the process of knowledge construction.

Different methods allow us to perceive varying angles and perspectives. We can observe practices (ethnographic observation), listen to informants (interviews), question participants (surveys), analyse documents (ranging from personal diaries to legal records), or reconstruct other forms of evidence, such as human remains or cultural legacies, within both contemporary and historical contexts. The choice of method establishes a central framework for what can be constructed as knowledge within a given research area.

The researcher researched. From a purely methodological point of view, the researcher/object relationship as a basis for the construction endeavour has been extremely interesting. As a researcher, I - me - am the most important research tool. A tool, i.e., a habitus with a perception matrix that, as object and subject, is included in a wide range of social fields beyond the academic field that constitutes the specific work. My interest and attention to social conditions and transformations of the state, institutions, professions, and identities motivates a universal and omnipresent attention to bodies, health, capital, etc. I cannot, so

to speak, abandon or fail to be aware of bodies and the diverse ways in which they are handled. My curiosity has also led me to seek out knowledge about bodies professionally, but also in everyday life. Like asking family, friends, acquaintances, and strangers about their body conditions, e.g., about physical training and diet/nutrition but also about piercing and tattooing, etc.

I have also mentioned how I have used myself more explicitly as a method (Larsen 2021b) by reflecting on the (sociological) absurdity of taking part in a marathon or a 90 km cross-country skiing race. I was able to use this critical insight to understand how other social groups do similarly extreme things to their bodies, such as other types of extreme sports, plastic surgery, piercings and tattoos.

Studying body practices forces the researcher to be open to different and opposite body practices. Bourdieu (1999) makes the point that researchers occupy a position and must be able to adopt the informant's point of view (position) to be able to understand that person's view (positioning). I have a feeling that I from my early upbringing 'learned' to understand that we do not choose our parents and early upbringing. This has been helpful when trying to understand heterodox body practices. For example, interviewing someone for more than two hours about their motivation and incentives for covering virtually their entire body with tattoos was interesting. I read about the growth in popularity of tattoos and observed how designs and tattoo placements have developed, which means I was well-informed for the interview (Bourdieu and Wacquant 1992). It became clear during the interview, however, that tattoos and body decorations can very much lead to exclusion, for example from employment in some sections of the health service but were a plus point in other social positions, such as in some sections of the dating and relationships market.

I grew up in a lower-middle-class family, and my parents' upbringing in the countryside under relatively poor conditions, alongside many siblings, has provided me with profound insights. I experience a form of double habitus or dual socialisation—one that allows me to understand, from within, the experiences of relatively low-privileged individuals, such as those in my family and social circles. At the same time, I also participate in, navigate, and connect with relatively privileged positions within the academic field and the broader social space in my capacity as a professor. This dual socialisation likely underpins my heightened sensitivity, sense of unresolved tension, and critical perspective on inequality, social injustice, and related issues. My own class trajectory—that is, the dispositions (habitus) shaped through movements across social fields and social space—has been highly influential in shaping my research interests, my theoretical choices, and my overall sociological approach.

Academic exchange and conferences. International academic conferences have been an important source of input leading to a more nuanced approach to health capital that encompasses factors such as changes over the years in the way the body is cultivated and, not least, variations between and within individual countries, social classes, the sexes, and various age groups. For example, I met researchers at a conference who discussed the fact that despite the pain and hazards of undergoing surgery, the correction of the body was nonetheless felt to be essential for social recognition (Rahbari et al. 2018).

Another example of direct academic inspiration was a meeting with Karen Willis, who introduced us in lectures at a health sociology conference in York, England to, e.g. health-choice capital. Through my contact with Willis, I also came into contact with Fran Collyer (Collyer ed. 2015, Collyer 2018) and Sasha Scambler (Scambler and Newton 2011) and learned about concepts they developed with similarities to health capital. My understanding of health capital was enhanced through areas of overlap with their concept of health-relevant cultural capital (Abel 2008), healthcare capital (Collyer et al. 2015), cultural health capital (Shim 2010), healthcare navigation (capital) (Willis et al. 2016) and personal capital related to illness (Scambler and Newton 2011). The overlap was in the inspiration from Bourdieu, with habitus, capital and field playing an active role in the field of health, but the difference lay in the fact that the latest version of health capital (Larsen et al. 2022) related to a more general phenomenon concerning differentiated investment in the body and its reception in the case of different positions in the social space and fields. I was more concerned with the tension between capital and field than by the respective types of capital. The other concepts strictly related to the field of health and types of capital as well as strategies in this context. Studies of the literature also served to make the distinction from concepts such as health literacy and self-efficacy clearer (Bandura & Wessels, 1997), and this is described in Larsen (2021d). My concept of health capital was not only honed and narrowed down through confrontation with others' concepts of capital relating to the field of health, for example in the sense that I discovered and described what positively characterised it, but it was also sharpened through the differences and divergences within the concept in relation to cultural health capital (Shim 2010).

I have often had, say, students providing insight on how they tone, measure and monitor their bodies using various apps. They are far more up to date than I am, and I have learned a great deal from them about cosmetic surgery, tattoos, fitness, micro dosing and apps. This input also pushed me to review my work and further elaborate the aspects of health capital that concern technology and monitoring. The phenomenon of investing in the physical body, say through running, cycling and fitness, should, to understand it properly, be coupled with knowledge about self-tracking. In this context, it became relevant to involve Lupton's (2016) work when considering health capital.

Talking with colleagues, students, and researchers has taught me, I guess, more than any textbooks or articles. Conferences opened my eyes to new takes on health and the body, while students kept surprising me with what's happening on the ground – apps, tattoos, microdosing. Their insights made me rethink parts of my own work. It's in those everyday exchanges that the concept of health capital really came to life.

Media and conversations. Media and everyday conversations have played a crucial role in shaping my reflections on health capital. The ongoing public debate around the body, identity, and normality – especially in relation to trends like microdosing, self-monitoring, and body activism – has helped refine the conceptual contours of health capital. Platforms such as naafa.org and fedfront.dk, along with broader body-positive movements, exemplify how normative ideals are both reinforced and challenged. These engagements have led me to explore how bodily normativity is negotiated, resisted, or redefined across different social

positions.

Browsing the internet reveals a vast ecosystem of resources – ranging from therapeutic support to educational content – targeted at individuals struggling with physical wellbeing, stress, or a sense of imbalance. At the same time, other forms of activism engage with bodily cultivation, self-tracking technologies, or even smokers' rights (e.g. dary.dk), further underscoring the diversity of body-related discourses.

My learning process has also been enriched by informal conversations with friends, students, and acquaintances. Their personal experiences with fitness apps, body modification, or wellness routines often introduce perspectives that challenge or expand my academic lens. These moments of spontaneous exchange – whether about television programmes, hashtags, or lifestyle practices – have offered concrete, grounded insights into how people navigate and invest in their bodies.

In addition, being interviewed by journalists – across national television, radio, and print media – has offered another layer of reflexivity. Media professionals often bring to the table emergent cultural questions: Why are LED masks gaining popularity? Why do young men shave their legs? What drives the middle class towards cosmetic procedures? These inquiries compel me to engage empirically and theoretically with phenomena that might not have originally been on my research agenda. In this way, media discourse becomes a form of epistemic dialogue – an unexpected interlocutor that helps shape sociological inquiry. Rather than simply transmitting knowledge, I find myself also receiving and reworking it in light of public discourse.

Peer review. Written responses from peer-review processes where colleagues have read and responded to articles or chapters. Previous versions of health capital have been in review processes in journals, which have provided important contributions with regard to Foucault-inspired studies of biopolitics or governmentality in connection with, say, physical training and diets (Elliott, 2016). Similarly, Rose's (2009) analyses of the medical field such as networks and concepts of the pre-patient and the individual as their own health economist. These latter concepts have been interesting in terms of what possibly also spurs people on to train for a triathlon despite pain, soreness and injury. Literature suggestions from peer reviewers have especially drawn my attention to others' use of Bourdieu (1977) and his practice theory, e.g., in connection with physical training, transport and ethnicity (Nettleton and Green 2014) or in relation to the field of health and the body (Shilling, 2016, 1991), in connection with physical capital. Choice and circumstances are a topic in research on lifestyle, and I have been inspired by what I have read about lifestyle versus choice and circumstances (Cockerham 2005).

Peer reviews have made me aware of others' concepts of health capital, e.g., within health economics (Grossman 1972), as a component of human capital (Becker 2007) and as a resource that concerns healthcare (Mushkin 1962). In particular, Skeggs (2011) has challenged my use of Bourdieu regarding the question of whether and how much people are oriented towards social mobility or self-interest. Analysis of changes such as neoliberal reforms of the transnational field indicates that sociality and values today are formed in ways other than what she calls the bourgeoisie model (Skeggs 2011, 509). Not all social

groups are in a position to be future- and self-oriented. Some working-class values, for example can sometimes be directed at the present and others rather than themselves.

Summary and discussion of construction work

As I mentioned in the beginning, educational books about theory and empirical data emphasise review of literature, choice of theory, reflections about the empirical data, operationalisation of concepts or items must be developed. There is a strong correspondence and close alignment between the way in which the IMRAD structure (Introduction, Methods, Results, and Discussion) organises the structure of academic articles and the way the sociological research process is conventionally outlined. Step by step. Everything in order. A logical progression, that is also privileging the ‘scientific’ model of research.

However, drawing on insights from historical epistemology and Bourdieu’s sociology – and, not least, the reflections found in *The Craft of Sociology* – this linear, controlled, and ostensibly simplified model is fundamentally challenged. Research is neither neat nor straightforward; it is inherently messy and presents challenges both externally, in terms of questioning dominant social conventions, and internally, as a reflexive and epistemic struggle. Sociological inquiry is complex and demands ongoing critical reflection rather than mere procedural execution. It necessitates moments of rupture – pausing, rethinking, and working across different conceptual and empirical dimensions – while perhaps still ‘following a manual’.

Bourdieu had trouble with queries about definitions of his concepts, which led to a schoolmaster- and manual-like description and use of terms such as capital, habitus and field. He criticised his book *The Craft of Sociology*, the first edition of which was in French and appeared in 1968. Twenty years after the book was first published, he talked about this in an interview with Beate Kreis, in which he criticised his work for being programmatic and containing requirements rather than practical examples (Bourdieu, Chamboredon and Passeron 1991, 255). His point was that you can read books about epistemological break, object construction and applied rationalism, but that the craft should be learned mostly through practice and good examples. Similarly, another point was that the sociological concepts – health capital in my case – should be sufficiently improved to capture structural patterns but at the same time should be open and flexible so that they can be used for diverse types of empirical material and various research questions. In this reconstruction of health capital, I have the same experience of the need to be ‘armed’ in the sense theoretical aware in relation to the empirical data and concepts have to be open and flexible, just like the reflexive process of the researcher.

Conclusion – the amalgam of inspirations

The reconstruction of *health capital* over the past two decades is not merely a story of gradual refinement. It is a story of how concepts are nourished by a rich amalgam of inspirations – some clearly visible, others opaque and only partially reconstructable. At its core, *health capital* was rooted in Bourdieu’s conceptual framework, especially his theorisation of capital, habitus, and field. Yet this was only the starting point. The journey of this concept has been defined by its openness to unexpected influences: empirical surprises,

theoretical tensions, and situated experiences.

Empirical engagements played a central role in shaping the evolution of the concept, prompting reconsiderations, reinterpretations, and, at times, significant redirections. These were not simply applications of a pre-formed idea, but occasions where the empirical materially reshaped the concept itself. Equally important were methodological decisions and constraints, which often acted as productive limitations, guiding the framing and scope of inquiry.

But beyond these formal elements, other inspirations were decisive. Conversations with colleagues, feedback from reviewers, teaching encounters, bodily experiences, and larger societal shifts (such as the financial crisis of 2007–2008) all fed into the intellectual process. These diverse influences often operated beneath the threshold of explicit academic articulation, yet they shaped what questions were asked, which patterns were noticed, and how theoretical tools were deployed.

This mix of explicit and tacit knowledge – of visible and invisible labour – is what I mean by the amalgam. The concept of health capital, far from being monolithic, has proven bendable and responsive, able to absorb diverse insights while still retaining a coherent structure. It has evolved not through linear accumulation, but through iterative ruptures and reintegrations – a movement reminiscent of Timmermans and Tavory’s abductive model, where theoretical and empirical registers are held in constant tension.

If this retrospective offers anything, it is not a final definition but a reflection on the very process of conceptual construction. As Bachelard reminds us, concepts are always provisional hypotheses, temporarily stabilised for analytical use. And as Bourdieu insists, scientific knowledge production is also self-production; the sociologist is both subject and object of the inquiry.

In tracing the genealogy of health capital, I hope to foreground this dual movement – of theoretical rooting and inductive transformation – and, above all, to emphasise the varied inspirations that make conceptual labour not only possible, but meaningful.

Kristian Larsen, Head of research Center of health Research (UCSF) and Professor University of Copenhagen, Public Health, Copenhagen Denmark. Professor 2 OsloMet University, Oslo Norway. Email Kristian.larsen@regionh.dk

Notes

- ¹ I have presented basic ideas in the historical epistemology and related to sociology and pedagogy (Larsen 2008) and in relation to my Ph.D. (Hansen & Larsen. 2015).
- ² ‘Spontaneous sociology’ refers to the unreflected, everyday ways people – including sociologists – make sense of society using common sense, ideology, or personal experience rather than scientific reasoning (Bourdieu 1990).
- ³ 15 years later, we study a heterogeneous sample of patients’ health capital with Multiple Correspondence Analysis (MCA) on 503 patients and 38 individual interviews (Larsen, Røpke & Hindhede. 2025).
- ⁴ I attempt to objectify and analyse bodily forms through the concept of physiognomy,

understood here not in its traditional essentialist sense, but rather as a sociologically informed reading of how bodies are perceived, interpreted, and valued within specific cultural and institutional contexts.

References

- Abel, T. (2008). Cultural capital and social inequality in health. *Journal of Epidemiology & Community Health*, 62(7), e13. <https://doi.org/10.1136/jech.2007.066159>
- Allsop, J., & Saks, M. (Eds.). (2019). *Researching health: Qualitative, quantitative and mixed methods* (3rd ed.). SAGE Publications Ltd.
- Bandura, A., & Wessels, S. (1997). *Self-efficacy*. Cambridge University Press.
- Bachelard, G. (1968). *The philosophy of no: A philosophy of the new scientific mind*. Orion Press.
- Bachelard, G. (2002). *The formation of the scientific mind: A contribution to a psychoanalysis of objective knowledge*. Clinamen.
- Becker, G. S. (2007). Health as human capital: Synthesis and extensions. *Oxford Economic Papers*, 59(3), 379–410. <https://doi.org/10.1093/oeq/gpm020>
- Bonderup, G. (2006). *Det medicinske politi: Sundhedspolitikken i Danmark 1750–1860* [The medical police: Health policy in Denmark 1750–1860]. Aarhus Universitetsforlag.
- Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge University Press.
- Bourdieu, P. (1986). *Distinction: A social critique of the judgement of taste*. Routledge & Kegan Paul.
- Bourdieu, P. (1990). *In other words: Essays towards a reflexive sociology*. Polity Press.
- Bourdieu, P., Chamboredon, J.-C., & Passeron, J.-C. (1991). *The craft of sociology: Epistemological preliminaries*. Walter de Gruyter.
- Bourdieu, P. (1998a). Georges Canguilhem: An obituary notice. *Economy and Society*, 27(2–3), 190–192. <https://doi.org/10.1080/03085149800000012>
- Bourdieu, P. (1998b). *Acts of resistance*. New Press.
- Bourdieu, P. (1999). *The weight of the world: Social suffering in contemporary society*. Stanford University Press.
- Bourdieu, P., & Champagne, P. (2014). *On the state: Lectures at the Collège de France, 1989–1992*. Polity Press.
- Bourdieu, P., Wacquant, L. J. D., & Farage, S. (1994). Rethinking the state: Genesis and structure of the bureaucratic field. *Sociological Theory*, 12(1), 1–18. <https://doi.org/10.2307/202032>
- Bourdieu, P., & Passeron, J.-C. (1977). *Reproduction in education, society and culture*. SAGE Publications.
- Bourdieu, P., & Wacquant, L. J. D. (1992). *An invitation to reflexive sociology*. Polity Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>

- Broady, D. (1990). *Sociologi och epistemologi: Om Pierre Bourdieus författerskap och den historiska epistemologi* [Sociology and epistemology: On the authorship of Pierre Bourdieu and historical epistemology] (2nd corr. ed.). HLS.
- Broady, D. (1996). The epistemological tradition in French sociology. In J. Gripsrud (Ed.), *Rhetoric and epistemology: Papers from a seminar at the Maison des sciences de l'homme in Paris, September 1996* (pp. 97–119). University of Bergen, Department of Media Studies.
- Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.
- Canguilhem, G. (1988). *Ideology and rationality in the history of the life sciences*. MIT Press.
- Canguilhem, G. (1991). *The normal and the pathological* (1st American ed.). Zone Books.
- Cockerham, W. C. (2005). Health lifestyle theory and the convergence of agency and structure. *Journal of Health and Social Behavior*, 46(1), 51–67.
<https://doi.org/10.1177/002214650504600105>
- Cockerham, W. (2017). *Medical sociology* (14th ed.). Routledge.
- Collyer, F. (Ed.). (2015). *The Palgrave handbook of social theory in health, illness, and medicine*. Palgrave Macmillan.
- Collyer, F. M., Willis, K. F., Franklin, M., Harley, K., & Short, S. D. (2015). Healthcare choice: Bourdieu's capital, habitus and field. *Current Sociology*, 63(5), 685–699.
<https://doi.org/10.1177/0011392115590082>
- Collyer, F. (2018). Envisaging the healthcare sector as a field: Moving from Talcott Parsons to Pierre Bourdieu. *Social Theory & Health*, 16, 111–126.
<https://doi.org/10.1057/s41285-017-0048-6>
- Grossman, M. (1972). On the concept of health capital and the demand for health. *Journal of Political Economy*, 80(2), 223–255. <https://doi.org/10.1086/259880>
- Dubbin, L. A., Chang, J. S., & Shim, J. K. (2013). Cultural health capital and the interactional dynamics of patient-centered care. *Social Science & Medicine*, 93, 113–120.
<https://doi.org/10.1016/j.socscimed.2013.06.014>
- Guldager, R., Poulsen, I., Egerod, I., Mathiesen, L. L., & Larsen, K. (2018). Rehabilitation capital: A new form of capital to understand rehabilitation in a Nordic welfare state. *Health Sociology Review*, 27(2), 199–213.
<https://doi.org/10.1080/14461242.2018.1481223>
- Hansen, C. S., & Larsen, K. (2015). Teori-metode-empiri-teknik: sammenvævede konstruktioner! [Theory–method–empirical evidence–techniques: Interwoven constructions!]. In J. E. Møller, S. S. E. Bengtsen, & K. Munk (Eds.), *Metodefetichisme: kvalitativ metode på afveje?* [Method as a fetish: Qualitative methods gone astray?] (pp. 123–143). Aarhus Universitetsforlag.
- Harsløf, I., Larsen, K., & Bambra, C. (2022). When health is wealth: Occupationally differentiated patterns of health capital in post-industrial Europe. *Social Theory & Health*, 21(3), 388–408. <https://doi.org/10.1057/s41285-022-00187-3>
- Harsløf, I., Poulsen, I., & Larsen, K. (Eds.). (2019). *New dynamics of disability and rehabilitation: Interdisciplinary perspectives*. Palgrave Macmillan.

- Hjellbrekke, J., Le Roux, B., Korsnes, O., Lebaron, F., Rosenlund, L., & Rouanet, H. (2007). The Norwegian field of power ANNO 2000. *European Societies*, 9(2), 245–273. <https://doi.org/10.1080/14616690601002749>
- Hultqvist, E., & Palme, M. (2009). Stå vid rodret eller tappa bort sig: en sociologisk studie av rekryteringen till lärarutbildningen och dess följder [Stand at the helm or lose the way: A sociological study of recruitment to teacher training and its consequences]. *Praktiske Grunde – Nordisk tidsskrift for kultur og samfunnsvitenskap*, 3(4), 77–94.
- Høyer, K. (2019). *Hvem skal bruge sundhedsdata – og til hvad?* [Who needs health data – and for what?] Information.
- Jensen, B., Larsen, K., Koudahl, P., & Andsager, G. (2007). *Ulighed i børn og unges sundhed: set i lyset af social kapital* [Child and adolescent health inequalities: From the perspective of social capital]. Danmarks Pædagogiske Universitetsforlag.
- Järvinen, M., Ellersgaard, C. H., & Larsen, A. G. (2014). Drinking to the limit: Alcohol, social status and health governance. *Drugs: Education, Prevention and Policy*, 21(4), 283–298. <https://doi.org/10.3109/09687637.2014.899991>
- Larsen, K., & Brinkkjær, U. (2009). Om videnskabsteoriens rolle som værktøj i produktion af viden [The role of scientific theory as a tool in the production of knowledge]. In C. Aabro & S. G. Olesen (Eds.), *Individ, institution og samfund: antologi for faget* [Individuals, institutions and society: Anthology of the subject]. Billesøe & Baltzer.
- Larsen, K., & Bystrup, M. R. (2013). Marginale: udsatte, men ikke kun socialt: om konstruktionen “socialt udsatte” anvendt i politik, administration og videnskab [Marginal: Not just socially vulnerable: The construction ‘socially vulnerable’ as used in politics, administration and science]. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, 7(1–2), 53–71.
- Larsen, K., & Esmark, K. (2013). Velfærdsstat, sundhed og kroppe under forandring: norske og danske studier [Welfare state, health and the changing body: Norwegian and Danish studies]. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, 7(1–2), 5–13.
- Larsen, K., & Hansen, G. I. (2014). Social ulighed i sundhed – mere vilkår end valg: indsigter og forklaring på norske forhold: underlagsrapport til Sosial ulikhet i helse: en norsk kunnskapsoversikt [Social inequality in health – more circumstance than choice: Insights into and explanation of the situation in Norway: Background report on social inequality in health: A Norwegian review]. In E. Dahl, H. Bergsli, & K. A. van der Wel (Eds.), *Nasjonal kunnskapsinnsamling om sosial ulikhet og helse* [National data on social inequality and health]. Høgskolen i Oslo og Akershus.
- Larsen, K., Hansen, P. E., Højbjerg, K., & Dige, M. B. (2014). *Kompleks fremtid og reflek-sive sundhedsprofessionelle: om videreudvikling og forbedring af sundhedsuddannelserne: afrapportering af Sundhedskartellets uddannelsesprojekt* [Complex future and the reflexive health professional: Developing and improving healthcare education programmes: Report on the Danish Health Confederation’s education project]. Implement Consulting Group.
- Larsen, K., & Harsløf, I. (2019). Promoting health as a form of capital: The transformation of the Danish healthcare field as experienced by private healthcare professionals. In F.

- Collyer & K. Willis (Eds.), *Navigating private and public healthcare: Experiences of patients, doctors and policy-makers* (pp. 123–143). Palgrave Macmillan.
- Larsen, K., Harsløf, I., Højbjerg, K., & Hindhede, A. L. (2018). Health capital: An empirical study of Danish healthcare professionals' bodily investments. In *Book of Abstracts: XIX ISA World Congress of Sociology, Toronto, Canada, July 15–21, 2018: Power, Violence and Justice: Reflections, Responses and Responsibilities*. International Sociological Association.
- Larsen, K., Hindhede, A., & Henriksen, F. M. (2020). Sundhedskapital blandt danske sundhedsprofessionelle: en kvantitativ og kvalitativ undersøgelse af kropsofattelser og distinktion blandt forskere, klinikere og studerende i Danmark [Health capital among Danish health professionals: A quantitative and qualitative study of body image and distinction among researchers, clinicians and students in Denmark]. *Praktiske Grunde – Nordisk Tidsskrift for Kultur- og Samfundsvidenskab*, 14(1–2), 43–74. [http://praktiskegrunde.dk/2020/praktiskegrunde\(2020-1+2e\)larsen-hindhede-henriksen.pdf](http://praktiskegrunde.dk/2020/praktiskegrunde(2020-1+2e)larsen-hindhede-henriksen.pdf)
- Larsen, K., Larsen, M. H., Nicolaisen, M. H., & Henriksen, F. M. (2022). Bodies need yoga? No plastic surgery! Naturalistic versus instrumental bodies among professions in the Danish healthcare field. *Social Theory & Health*, 20(1), 1–20. <https://doi.org/10.1057/s41285-020-00151-z>
- Larsen, K., Røpke, I., & Hindhede, A. (2025). Mapping health capital: A multiple correspondence analysis (MCA) of navigating illness and social stratification among patients in Danish healthcare. *In review*.
- Larsen, K. (2000). *Praktikuddannelse, kendte og miskendte sider: et observationsstudie af praktikuddannelse inden for sygeplejerskeuddannelsen: ph.d.-afhandling* [Known and misunderstood aspects of practical training: An observational study of practical training in nurse training: PhD thesis]. UCSF, Universitetshospitalernes Center for Sygepleje- og omsorgsforskning.
- Larsen, K. (2005). Hospitalsarkitektur og social arkitektur: om klasser af rum, klasser af mennesker og klasser af tanker [Hospital architecture and social architecture: Categories of space, people and thought]. In K. Larsen (Ed.), *Arkitektur, krop og læring* [Architecture, the body and learning]. Hans Reitzel.
- Larsen, K. (2007). Videnskab mellem kontinuitet og brud: hvad siger historisk epistemologi og kan pædagogik og sociologi lære af den? [Science between continuity and change: What historical epistemology tells us and whether pedagogy and sociology can learn from it]. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, (2), 5–19.
- Larsen, K. (2008). Myter og sandheder om sundhed, ulighed og privatisering [Myths and truths about health, inequality and privatization]. *Information*, August 29. <https://www.information.dk/debat/2008/08/myter-sandheder-sundhed-ulighed-privatisering>
- Larsen, K. (2009a). Det betaler sig at investere i egen sundhed [Investing in your health pays off]. *Information*, April 1. <https://www.information.dk/debat/2009/03/betaler-investere-egen-sundhed>

- Larsen, K. (2009b). Hospitalet mellem stabilitet og forandring: sociologiske og historiske perspektiver [The hospital between stability and change: Sociological and historical perspectives]. In M. Holen & B. Winther (Eds.), *Akut, kritisk og kompleks sygepleje: samfunds- og humanvidenskabelige perspektiver* [Acute, critical and complex nursing: sociological and human scientific perspectives] [Academic Press].
- Larsen, K. (2010). Det behandlende hus er blevet sygt: Sociologiske og historiske perspektiver på patientforløb [The house of care has become sick: Sociological and historical perspectives on patient pathways]. In H. Timm (Ed.), *Sammenhængende forløb i sundhedsvæsenet – i social- og sundhedssektoren* [Joined-up processes in the health system – in the social and health sector]. Videnscenter for Sammenhængende Forløb.
- Larsen, K. (2018). Pierre Bourdieu. In P. T. Andersen & H. U. Timm (Eds.), *Sundhedssociologi: En grundbog* [The basics of health sociology] (2nd ed.). Hans Reitzel.
- Larsen, K. (2021a). Rekonstruktion af sundhedskapital: Formelle og informelle kilder og veje i et konstruktionsarbejde over 15 år [Reconstructing health capital: Formal and informal sources and pathways in 15 years of construction work]. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, 15(1), 93–114. [http://praktiskegrunde.dk/2021/praktiskegrunde\(2021-1j\)larsen.pdf](http://praktiskegrunde.dk/2021/praktiskegrunde(2021-1j)larsen.pdf)
- Larsen, K. (2021b). Folkesundhed, politik og sundhedsøkonomi [Public health, politics and health economics]. In *Sundhedskapital: Investeringer i kroppen* [Health capital: Bodily investment] (pp. 45–67). Samfundslitteratur.
- Larsen, K. (2021c). Selvbibliografi og introduktion [Autobiography and introduction]. In *Sundhedskapital: Investeringer i kroppen* [Health capital: Bodily investment] (pp. 9–20). Samfundslitteratur.
- Larsen, K. (2021d). *Sundhedskapital: Investeringer i kroppen* [Health capital: Bodily investment]. Samfundslitteratur.
- Larsen, K., Cutchin, M. P., & Harsløf, I. (2013). Health capital: New health risks and personal investments in the body in the context of changing Nordic welfare states. In I. Harsløf & R. Ulmestig (Eds.), *Changing social risks and social policy responses in the Nordic welfare states* (pp. 151–172). Palgrave Macmillan. https://doi.org/10.1057/9781137267191_8
- Larsen, K., & Morrow, V. (2009). Social position and young people's health: A Bourdieu'ian critique of dominant conceptualisations of social capital. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, 3(3), 7–30. [http://praktiskegrunde.dk/2009/praktiskegrunde\(2009-3d\)larsen-morrow.pdf](http://praktiskegrunde.dk/2009/praktiskegrunde(2009-3d)larsen-morrow.pdf)
- Lupton, D. (2016). *The quantified self*. Polity Press.
- Mushkin, S. J. (1962). Health as an investment. *Journal of Political Economy*, 70(5), 129–157.
- Nettleton, S., & Green, J. M. (2014). Thinking about changing mobility practices: How a social practice approach can help. *Sociology of Health & Illness*, 36(2), 239–251. <https://doi.org/10.1111/1467-9566.12101>
- Nettleton, S. (2020). *The sociology of health and illness* (4th ed.). Polity Press.
- Porter, R. (1995). *Disease, medicine and society in England, 1550–1860*. Cambridge University Press.

- Prieur, A., & Rosenlund, L. (2010). Danske distinksjoner [Danish distinctions]. In K. Dahlgren & J. Ljunggren (Eds.), *Klassebilder: Ulikhet og sosial mobilitet i Norge* [Class pictures: Inequality and social mobility in Norway] (pp. 241–268). Universitetsforlaget.
- Rose, N. (2009). *Livets politik: Biomedicin, magt og subjektivitet i det 21. århundrede* [The politics of life: Biomedicine, power and subjectivity in the 21st century]. Dansk Psykologisk Forlag.
- Scambler, S., & Newton, P. (2011). Capital transactions, disruptions and the emergence of personal capital in a lifeworld under attack. *Social Theory & Health*, 9(2), 130–146. <https://doi.org/10.1057/sth.2011.1>
- Shilling, C. (1991). Educating the body: Physical capital and the production of social inequalities. *Sociology*, 25(4), 653–672.
- Shilling, C. (2016). *The body: A very short introduction* (Vol. 454). Oxford University Press.
- Shim, J. K. (2010). Cultural health capital: A theoretical approach to understanding health care interactions and the dynamics of unequal treatment. *Journal of Health and Social Behavior*, 51(1), 1–15. <https://doi.org/10.1177/0022146509361185>
- Skeggs, B. (2011). Imagining personhood differently: Person value and autonomist working-class value practices. *The Sociological Review*, 59(3), 496–513. <https://doi.org/10.1111/j.1467-954X.2011.02018.x>
- Skydsgaard, M. A. (2015). Toilettet: Vandforsyning og kloakering [The toilet: Water supply and sewerage]. In H. Kragh & K. H. Nielsen (Eds.), *50 opfindelser: Højdepunkter i teknologien* [50 inventions: Highlights of technology] (pp. 120–125). Aarhus Universitetsforlag.
- Skydsgaard, M. A. (2006). *Ole Bang og en brydningstid i dansk medicin* [Ole Bang and a breakthrough in Danish medicine]. Aarhus Universitetsforlag.
- Sodemann, M. (2019, December 26). Debat: Professor: Sundhedsvæsenet drukner i middelklassens små problemer [Debate: Professor: The healthcare system is drowning in the minor problems of the middle class]. *Altinget*. <https://www.altinget.dk/artikel/189907-professor-sundhedsvaesenet-drukner-i-middelklassens-smaa-problemer>
- Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, 30(3), 167–186. <https://doi.org/10.1177/0735275112457914>
- Vallgård, S., & Krasnik, A. (Eds.). (1999). *Sundhedstjeneste og sundhedspolitik: En introduktion* [Healthcare and health policy: An introduction] (2nd ed.). Munksgaard.
- Vallgård, S. (2003). *Folkesundhed som politik: Danmark og Sverige fra 1930 til i dag* [Public health as politics: Denmark and Sweden from 1930 to the present]. Aarhus Universitetsforlag.
- Wacquant, L. J. D. (2009). *Punishing the poor: The neoliberal government of social insecurity*. Duke University Press.
- Wacquant, L. (2014). Foucault, Bourdieu og straffestaten i den neoliberale æra [Foucault, Bourdieu and the penal state in the neoliberal era]. *Praktiske Grunde – Nordisk tidsskrift for kultur- og samfundsvidenskab*, 8(1–2), 103–110.

- Wacquant, L. J. D., & Bourdieu, P. (1992). *An invitation to reflexive sociology* (Vol. 106). Polity Press.
- Willis, K., Collyer, F., Lewis, S., Gabe, J., Flaherty, I., & Calnan, M. (2016). Knowledge matters: Producing and using knowledge to navigate healthcare systems. *Health Sociology Review*, 25(2), 202–216.