Social Integration, Social Capital and Access to Health

Paul Dourgnon, Senior research fellow, (IRDES) – mailto: dourgnon@irdes.fr

Michel Grignon (McMaster University , Ontario) – mailto: grignon@mcmaster.ca

Florence Jusot, Senior research fellow (University Paris-Dauphine, Legos and IRDES) – mailto: jusot@irdes.fr

Caroline Berchet, (IRDES)

Abstract

Objective

The purpose of this paper is to investigate the link between country of origin and religion and access to care, as it is mediated via social capital.

Background

French and international literature and previous research show the followings:

1. There is a clear link between social capital and health, even though any causal relationship is hardly proven. The link between Social Capital and Health services consumption has been rarely investigated, except by Laporte et. Al. (Laporte, Nauenberg, Shen, 2007) who that Social Capital had a significant impact on GP services utilization.

2. On average, immigrants have less access to social capital resources through social or linguistic isolation or access specific community social capital with differential returns (Kao, Lindsay, 2007)

3. Religion and country of origin (where parents were born) seems to play an important role in access to social capital among immigrant communities and visible minorities notably as a source of shared values.

4. There is a link between immigration status and health (Jusot, Silva, Dourgnon, Sermet, 2007), but it is complex and multi-directional: country of origin socioeconomic and sanitary situation effect; migration selection effect (the healthy immigrant effect means that on average immigrants are in better health when they arrive in the country) ,socioeconomic situation and isolation in the arrival country effect. These can confound the impact of living in a foreign environment with lower access to social capital.

5. Ethnological approaches show heterogeneity across religious groups in the same country in utilization of health services in France (Faizang, 2001).

As a result, we will investigate the simultaneous impact of origin, religion, and social capital on utilization of health care services.

Data and methods

- **Data**

The analysis will be based on a unique dataset, the 2006 wave of the Survey on Health, Health Care and Insurance run in France. It is a general population survey linked to administrative files from the main national sickness funds, comprised of exhaustive information on reimbursed health services consumption within the year.

Our analysis will use the following data :

- Social Capital measured by membership in informal organizations;
- Religion (religious affiliation, frequency of religious attendance);
- National origin and migration status: the data allow to distinguish new immigrants and "second generation immigrants" meaning those born in France from migrant parents, and their countries of origin.
- Health: Self Assessed Health, Lifestyle (alcohol, cigarette);
- Health Care Consumption: inpatient and outpatient care (primary care, secondary care, preventive care);
- Educational attainment;
- Standard socio-demographic factors (occupation, income, age and gender).

- **Analytic strategy**

We will estimate simultaneously :

- how Social capital is determined by Origin and migration status, Religious affiliation, the type of neighbourhood, education, income, work status
- and How Health Care Consumption is affected by Social Capital, Health Status, Insurance Status, Education, Income.

A simultaneous estimation strategy (two-stage least squares or probit) will allow taking into account the direct effect of origin and religion on utilization and its indirect effect (the portion that is mediated by social capital). We will address the following question: what is the share of social capital (and interactions between migrant or minority populations with the broader society) in heterogeneity of health care utilization across immigration or minority status