

Discussion on Berchet and Jusot, Contribution of social capital to health inequalities between immigrants and native health in France, IRDES

Workshop, June 2010.

The 2010 IRDES Workshop on Applied Health Economics and Policy Evaluation  
24-25 June 2010 – Paris – France  
[www.irdes.fr/Workshop2010](http://www.irdes.fr/Workshop2010)

Page 1: the healthy immigrant effect does not suggest that people born overseas are in better health, but that, among those born overseas, those who can afford to migrate are healthier.  
Empirical evidence on the healthy immigrant effect in Canada: strong at arrival but fades away with time in the country.

### **Major questions:**

My main question is one of method: if the goal is really to assess the importance of differences in the stock of social capital across immigration (migrants having less social capital than native born French), as argued on page 2, there is no need to run a Oaxaca decomposition. What is needed is a straightforward equation of health status as the dependent variable and immigration status and social capital as the two main independent variables. If introducing social capital reduces the effect of immigration on health then we would know that some of the difference between migrants and native born is due to differences in social capital. You could then run a series of simulations, similar to the Fairlie methodology used in this paper, based on the estimated coefficients to answer the following questions: if immigrants had the level of social capital of non-migrants what effect would that have on the health-gap between the two populations?

My sense is that the Oaxaca decomposition allows you to do something different (and possibly more interesting): to use the differences in coefficients of social capital on health within each population (migrants, native born) to understand better the causal mechanism between social capital and health. That the question addressed in the study is about the causal link between social capital and health more than anything else shows in the fact that your literature review starts and (almost) ends with the concept of social capital and how it can enhance economic growth, and is not concerned at all with population health and its determinants.

What we need to do in the discussion is think about plausible explanations/interpretations for these differences in intensity across migration status. How can we explain that social capital influences health more for the French than for the immigrants, and that the difference in intensity explains 60% of the health gap?

One comment here: my recollection from the literature on social capital and health is that, on top of all the causal mechanisms cited in the introduction (between social capital and health), a direct effect was hypothesized, namely that trusting your community was stress-reducing and good for one's health. The indirect mechanisms cited in the introduction cannot really be tested based on a Oaxaca decomposition and would rather require a 2-step system of equations (social capital as a determinant of access to health care services or information or preferences for health, then access, information and preferences as determinants of health). So, could it be that non-French individuals do not expect much from their community or French society and are not affected as a result by not participating? Could you use your findings to support the idea that the psychological effect of participation is key to the causal mechanism between social capital and health? I appreciate of course that you don't argue you have anything causal here, mostly correlations. But these correlations could suggest causal mechanisms. The question comes down to the choice of indicators for social capital (participation and loneliness) in the study.

### **Minor questions:**

Data: questions on social capital are answered by key-informants only. Does this mean that the study sample is restricted to key-informants? If so, do you have any idea of the selection process and how it could influence your findings (e.g., if, in a household of immigrants, the key-informant is the one who speaks fluent French and feels integrated in the French society, your sub-sample of immigrants might not be representative of the immigrant population in France).

Three populations are distinguished relative to migration status: native-born of French ancestry (82%), born in France but of foreign-born parents (at least one?, 10%) and immigrants (born abroad, 8%). In the remaining of the study, the last two categories are lumped together as immigrants, however one would be interested in knowing more about the differences across these two sub-categories (1<sup>st</sup> generation immigrants born abroad are certainly subject to an information and access issue stronger than the 2<sup>nd</sup> generation immigrants, who might suffer from a psychological effect of being rejected more often than the 1<sup>st</sup> generation immigrants). This could work as a proxy for the missing variable length of stay in the host country.

Health status: self-assessed health in two categories (very good and good, 72%, versus fair, poor, and very bad, 28%). Immigrants are 33% to report in the poor broad category. The paper mentions some reporting bias linked to culture and, therefore, possibly to immigration status. Any sensitivity analysis on the construction of the binary variable?

Social capital is measured as: participation to an association (self-reported, binary), and experience of loneliness (same). No cognitive social capital (level of trust).

Immigrants have less social capital, are less healthy, and social capital correlates positively with health.

Findings:

Introducing social capital reduces the effect of migration from -0.06 to -0.04 (introducing socio-economic variables in a model with age, sex, and immigration only reduces the effect of migration from -0.09 to -0.06). The unexplained effect remains at -0.04 though.

Separate estimations: social capital has stronger effect on health among French compared to immigrants.

Oaxaca: Unexplained (intensity plus interaction) represents 60% of the health-gap across migration status.

Fairlie: within Explained (characteristics), social capital is the most important factor (56%) before income (38%) and occupation (14%) -- how come the sum is more than 100%?