Social Capital, Health, and Francophone Minorities

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ABSTRACT

The goal of this article is to outline the analytical perspectives of the concept of social capital regarding health and health management. Social capital, as defined in terms of social networks and resources, has a positive impact on a number of areas, notably the health, well-being, and social and economic development of communities. It is also a useful tool for implementing social policy, especially for marginal populations, the elderly, social assistance payments, etc. An action strategy based on the support and development of networks is the key to achieving the social development, health, and well-being of populations. The social ties promoted by these networks provide people with social, cognitive, and emotional support. This has a direct impact on their self-esteem and sense of personal achievement. They also facilitate access to social resources, including social advancement opportunities. In this paper, we examine the vitality, determinants of health, and health management of Canada’s minority Francophone communities.

MeSH terms: Social determinants of health; social capital; Francophone minority

The goal of this article is to outline the analytical perspectives of the concept of social capital regarding health and health management. Social capital, as defined in terms of social networks and resources, has a positive impact on a number of areas, notably the health, well-being, and social and economic development of communities. It is also a useful tool for implementing social policy, especially for marginal populations, the elderly, social assistance payments, etc. Population health research has highlighted the importance of certain social determinants of health, the most important of which is an individual’s social position in the community. Those whose health is most vulnerable tend to be the poorest and least educated, since they have the fewest social resources and the least access to them. A community’s ability to build its social capital is a measure of its vitality, its ability to govern, and its compassion toward its most vulnerable members. In this paper, we examine the vitality, determinants of health, and health management of Canada’s minority Francophone community.

There are two important aspects to any discussion of literacy issues. First, living conditions and access to social resources may differentially affect an individual’s health. In our information and knowledge-oriented societies, illiteracy is a major barrier to social integration and inclusion in a growing number of activities. Second, action strategies based on social networks have a positive impact on health and human development. The social ties promoted by these networks provide people with social, cognitive, and emotional support. This has a direct impact on their self-esteem and sense of personal achievement. They also facilitate access to social resources, including employment and social advancement opportunities.

Conceptual framework: Population health

The research approach to population health is concerned with the heterogeneity of states of health and their complex determinants. It focusses on populations by asking the question, “Why are certain communities healthy while others are not?” Its analytical framework includes determinants of health, individual characteristics (demographic, socio-economic, and
demonstrated by Wilkins, who showed an example of this reality has been clearly evident in most causes of death, such as cardiovascular problems, respiratory and gastrointestinal disease, cancer, accidents, and suicide. Those at the low end of the social hierarchy continue to have higher mortality rates and die at an earlier age.

The work hierarchy can also have negative effects on the neuroendocrine, metabolic, and immune systems. In the absence of psychosocial resources, workplace stress tends to be felt more strongly by those at the bottom of the scale. A Canadian example of this reality has been clearly demonstrated by Wilkins, who showed that the life expectancy of someone in a poor neighbourhood, like the Saint-Henri sector in Montreal, is roughly 10 years shorter than that of someone in Westmount, the city’s wealthiest neighbourhood.

The most solid arguments of population health research support the theory that health disparities are a reflection of social disparities. The expression “get under one’s skin” aptly describes the negative physiological effects of certain social determinants and living conditions. Because they lead lives of daily hardship and stress, the lifestyles of those at the bottom of the social hierarchy tend to be more detrimental to health (e.g., smoking, alcoholism, poor diet, risky sexual behaviour, etc.). Their access to resources such as social and health services is also more limited. This knowledge led us to conduct an in-depth analysis of the complex chain of determinants of health, and to integrate social background into the explanatory model. In addition to the combination of individual factors, there continue to be differences between communities. This suggests that environment has a certain impact on the health of individuals and on health disparities within society. This theoretical complexity has given rise to an analytical framework that includes a number of explanations for health disparities. One such explanation, set out by Macintyre, concerns opportunity structures, such as material and infrastructure resources. Another concerns a community’s day-to-day life, including social customs, sociocultural and historical characteristics, degree of integration, social mobility, and norms and values. Relational and cross-sectional concepts like social capital, power relationships, social identity, social position, and sense of control over one’s living conditions are opening up interesting contextual analysis approaches for health.

Social capital as a determinant of health

A number of empirical studies have shown a link between health and social capital, as measured by the strength of social networks. These studies have revealed a close association between social networks and rates of morbidity and mortality. People without social support are two to five times more likely to die, of all causes of death, than those who belong to social networks. In Canada, Lomas has studied the comparative impact of medical and social intervention in preventing deaths related to heart disease. His findings have proven the effectiveness of the social intervention of social networks. More recently, analyses from Cycle 17 of the General Social Survey indicated a link between Canadians’ level of social capital and their health and well-being.

How do we explain this link between social capital and health and well-being? Kawachi has suggested three ways in which social capital can affect health. First, it can influence behaviour by promoting health and disseminating information. Second, it can affect access to health and social services by encouraging communities to mobilize and coordinate their activities to improve the quality and availability of services. Third, social capital influences health by providing people with psychosocial resources and the moral, emotional, and instrumental support to cope with everyday life. The notion of social capital in an approach to population health seems valid enough to merit further study.

These avenues of exploration are highly relevant to our study, though there is still the problem of how to define and measure social capital. We need to determine what it is, how it works, and its effects. Woolcock and Narayan have proposed a synergistic approach. It combines the structure of networks and the resources within them. This approach is attractive because it draws on a number of analytical levels. It takes into account the unique environments that bring networks to life. Lévesque and White have distinguished the functionalist from the network-based approach. The functionalist approach to social capital, developed by Coleman and then Putnam, refers to “features of social organization, such as trust, norms, and networks, that can improve the efficiency of society by facilitating coordinated actions.” The problem with this definition is that it is too heterogeneous. Therefore, determinants, sources, and effects may be confused with one another. The network approach to social capital is based on Bourdieu’s definition: “the actual or potential resources which are linked to the possession of a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.” This approach is part of the theory, later developed by Lin, that social capital is a resource. According to Lin’s theory, “social networks offer individuals and communities access to resources that are available to the people and groups who belong to the networks.” These networks are a place to produce social capital. It can be directly measured without affecting the desired results. Social networks can have a variety of functions. This is why Szreter and Woolcock have identified three forms of social capital: bonding, bridging, and linking. These three forms of social capital produce various effects, ranging from emotional ties to more practical ones. They also have a number of objectives, ranging from everyday social support for individu-
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Awareness leads to an understanding of the legitimacy and stability of one’s minority status. These three factors have a clear impact on the development of language and identity.28,33,34 Above all, this approach encourages people to take control of their own lives. The approach is useful for helping people understand the factors that promote balanced psycholinguistic development. It can also be used in a number of areas of human development, including health promotion.

Health and Francophone minorities: Status report

Canada’s minority Francophone communities comprise roughly one million people. They are scattered throughout the country. The largest populations are in Ontario (509,265) and New Brunswick (239,400). In other provinces and territories, the number of Francophones ranges from 63,000 in Alberta to less than 500 in Nunavut. Francophone and Acadian communities represent 4.4% of the population outside Quebec.35 The characteristics of these communities vary widely depending on their geographic and socio-economic environments. Data have shown that members of Francophone communities are generally older, less educated, and less represented in the workforce. Minority Francophones tend to live in economically disadvantaged regions. This makes it harder to develop and access social resources.

Little is known about the health of Francophones in minority situations, though a number of studies have been conducted to assess health differences between Canada’s various cultural groups. Kopec et al.36 analyzed data from the National Population Health Survey for 1994-1995. They found that 17.8% of Francophones obtained a low mark on the Health Utilities Index compared to 12.7% of English-speaking immigrants. Significant differences were noted among the cultural groups surveyed with regard to pain and emotional and cognitive functioning. This indicates the importance of cultural factors.

The few studies aimed at Ontario Francophones who took part in the National Population Health Survey for 1996-1997 support the theory that health levels vary among Francophones and that certain determinants have a greater impact on their health.37-39 Though these gaps are not major, Ontario Francophones are less likely to say they enjoy excellent health. They are more likely to say that their activities are limited due to chronic health problems. The survey found higher average stress levels among Francophones. It also found that Francophones take more medications. A higher percentage say they do not have access to the services they require. They report that they smoke more and drink alcohol more often, though in smaller quantities, than non-Francophones.

They are more likely to take steps to improve their health. They have fewer social supports but are more involved in their communities. In addition, Ontario Francophones have limited access to health services in their own language.40,41 The Robichaud study42 showed language to be a determining factor in the health of New Brunswick Francophones. In contrast, a more recent study43 showed poverty to be the greatest determinant of health.

Research has also indicated major regional disparities for access to French-language services. Accessibility is three to seven times higher for Anglophones,41 even in regions designated to provide such services under the Official Languages Act. While these disparities account for health differences among minority Francophones, it is the poor who suffer most, regardless of cultural group. Despite universal coverage, users of the health care system who cannot properly communicate, whether due to the language of service or their own inability to read, do not have the same access to or quality of care as other citizens. These communication barriers make it harder to understand information, verbal or written, regarding prevention, prescriptions, or medical follow-ups.

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Although coexistence between Francophone and Anglophone populations was one of the goals of Confederation, Canada’s history has been marked by hostility to the survival of Francophone communities outside Quebec. Like other nation states, Canada has supported policies to assimilate its cultural minorities into the language of the majority.44 Only after the Royal Commission on Bilingualism and Biculturalism and the proclamation of the
Ontario Roundtable on Health, an Ontario Francophone women's health forum, the Consortium National de Formation en Santé (an organization of 10 universities and community colleges that provide French-language training for health care professionals), the Société Santé en Français (a national organization), and the joint commission for research support. The Montfort victory has had a ripple effect in all provinces and territories. These social networks serve as resources for the three impact levels of social capital. They are the exercise of rights, negotiation and provision of services within the institutional and community health care system, and psychosocial support. An action strategy based on the support and development of networks is the key to achieving the social development, health, and well-being of populations.

REFERENCES


