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**Researching Irish Health Inequalities in England:
A Case Study of
First and Second Generation Irish Men and
Women in Coventry**

by

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A thesis submitted in fulfillment of the requirements for the
degree of
Doctor of Philosophy in Sociology

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Declaration

This thesis is presented in accordance with the regulations for the degree of Doctor of Philosophy. It has been composed by myself and has not been submitted in any previous application for any degree. It contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma. The work in this thesis has been undertaken by me except where otherwise stated (see the “Collaborative Community Based Participatory Approach” section in chapter 4, p. 82).

Abstract

Background. Despite consistent evidence that the Irish people living in Britain face a significant health disadvantage, when compared to white British people on a range of health indicators, the reasons and underlying generative mechanisms, need further uncovering.

Design and Objectives. This research uses a mixed strategy design compatible with a critical realist perspective. The extensive/quantitative research component aims to evaluate the demi-regularity that Irish people in England have poorer health than the British general population. It engages in a secondary analysis of data from the Census 2001 Individual Licensed SARs, using self-reported Irish ethnicity and self-reported general health. The intensive/qualitative research component explores the generative mechanisms shaping Irish health experiences and inequalities in England, and Coventry in particular, including the contribution of, and interaction between, generative mechanisms of structural and identity/cultural aspects of ethnicity. It carries out an in-depth primary analysis of thirty-two semi-structured interview accounts from two generations of Irish men and women in Coventry, using a framework analytical approach. This is elaborated within a model of ethnicity as structure and identity developed in accordance with a critical realist and socio-historical perspective. The research is realized through a collaborative community-based participatory approach.

Results and Conclusions. The extensive findings provide further evidence for an Irish health disadvantage in England, with some differences by country of birth, and provide clues to generative mechanisms for the demi-regularity found. The intensive findings concur with the extensive analysis and show that generative mechanisms from structural and identity dimensions of ethnicity 1) contribute to the health inequalities and/or experiences of first and second generation Irish people in England, 2) interact in complex ways, 3) are impacted by the socio-political context, i.e., British colonialism and a world capitalist economy, and 4) are shaped by interweaving forces of structure and agency.

Chapter 1: Introduction

Rationale for Research Topic

Like many other doctoral students, I was asked several times, during the course of my PhD, what is the topic of my research. My reply, that I am researching the health situation of the Irish people in England and in Coventry, has almost always elicited an element of surprise, “The Irish? Really? But why? And why Coventry?”

Several years ago, before I began my doctoral research, I would have had a similar response. Driven by an interest in health inequalities and issues of social justice more generally, in particular as they relate to ethnic minority groups, I had read quite a bit about the health disparities faced by the Black Caribbean, Pakistani, Bangladeshi, Indian and Chinese populations in the UK. To my embarrassment, however, I was oblivious to the health inequalities faced by the Irish population in the UK and had not really thought of the Irish as a major ethnic minority group in the UK, although they make up an estimated 4% of the population¹ (Hickman & Walter, 1997; FIS, 2007a).

This is why, when I came across an article on Irish health inequalities in the UK in my search for an ethnicity and health-related PhD topic, I was both surprised and keen to learn more. It would not be long before I found consistent evidence that the first and second generation Irish population not only faced considerable health disadvantages in the UK on a range of health indicators, including mortality rates (e.g. Marmot et al., 1984; Raftery et al., 1990; Harding & Balarajan, 1996; Harding & Balarajan, 2001), limiting long-term illness rates (Owen, 1995; Kelleher & Hillier,

¹ 1.3% of the population of England was recorded as being white Irish in the Census 2001. However, this proportion is likely to be an underrepresentation of the actual Irish community in England (FIS, 2007a).

1996, FIS 2007a) and mental illness rates, including for alcohol-related disorders and depression, common mental disorders, suicide and attempted suicide (e.g. Cochrane & Bal, 1989; Raleigh & Balarajan, 1992; Bracken et al., 1998; Nazroo, 1997b; Weich et al., 2004; Harding & Balarajan, 1996; Leavey, 1999), but also that they were the largest immigrant group in England and Wales (Census 2001, as cited in Leavey et al., 2007). This raised important questions in my mind, why had I never previously read or heard about Irish health issues despite considerable evidence of an Irish health disadvantage in the UK? Could their “invisibility” have something to do with their being “white” skinned and the dominant paradigm for understanding racism in Britain being constructed on the basis of a black-white dichotomy, as suggested by Hickman and Walter (1997, p. 7)? Could their “whiteness” also be partly to blame for their failure to press for recognition of their community’s problems in the way that other groups have? Most importantly, why were they in poor health to begin with and why does their poor health persist across generations? All this convinced me that the causes of health inequalities affecting Irish people in the UK should be the topic of my research.

Coventry was chosen as case study because it contains a large first, second and third generation Irish community (Hickman & Walter, 1997). Indeed, in the late 1950s and 1960s, one of the largest waves of Irish migrants came to the UK in search of employment, particularly to the West Midlands: “the large scale immigration of the 1950s focused particularly on cities in the English Midlands, especially Birmingham, as well as Coventry” (Hickman & Walter, 1997, p. 29). In the 2001 Census, 10,401 individuals living in Coventry (3.5% of the population) stated an Irish ethnicity, making the Irish the second largest self-ascribed ethnic minority group in Coventry

after the Indian ethnic group (FIS, 2007b). The actual Coventry Irish population has been estimated to be as high as 10.4% (FIS, 2007b).

Main Research Aim and Methods

Despite consistent statistical evidence of Irish poor health in England, the reasons behind it, or underlying “generative mechanisms” (Bhaskar, 1978), are only partly understood. The aim of this research is to deepen the understanding of Irish health inequalities in England and Coventry by means of a mixed strategy design compatible with a critical realist perspective, which combines extensive and intensive research methods, with a collaborative community-based participatory approach. The research provides additional evidence of Irish health inequalities in England, via the analysis of a fairly recent national dataset, the Census 2001 Individual Licensed Sample of Anonymised Records (SARs) (ONS [a]), and puts central emphasis on exploring the possible reasons for Irish health inequalities in England, through semi-structured interviews with two generations of Irish men and women in Coventry, researched in collaboration with the Coventry Irish Society (CIS). Subjective, or self-reported, general health is the main focus of the research.

Theoretical Perspective and Research Strategy

The research fits within the wider debate of health inequalities research which explores the relative impact of socioeconomic disadvantage and other ethnicity related influences on health. Nazroo and others (Nazroo, 1998; Karlsen & Nazroo, 2002a; Smaje, 1996, Williams et al. 1994) argue that, while socio-economic disadvantage or structural factors make a substantial contribution to ethnic inequalities in health, there remains an essential “cultural” component to ethnicity that can also make an

important contribution to health²; structural and cultural dimensions of ethnicity interact in complex ways (Karlsen & Nazroo, 2002a). Hence, they argue for the need to conceptualize ethnicity and its influence on health as incorporating interacting elements of both structure and identity/culture.

They view the structural component of ethnicity as being imposed on ethnic minority groups and as having largely negative effects on health. In contrast, the identity or cultural component of ethnicity is seen as the product of both internal and external processes and has having both negative and positive effects on health. The appreciation of positive “resilience” factors (Bartley, 2006) associated with “Irish culture”, which ethnic minority groups can draw on to cope with structural (or other) adversity, permits a departure from a focus on negative “cultural” factors and gives policy makers additional resources to draw on to help redress Irish health inequalities.

Other important structural factors, in particular migration and the wider socio-historical context, are also seen as important influences on the health of ethnic minority groups (Williams, 2002; Nazroo, 2003); the wider socio-historical context is viewed as the root cause of ethnic health inequalities (Nazroo, 1998).

The research strategy seeks to implement this approach of conceptualizing ethnicity and its influence on health in terms of interacting elements of structure and identity since it is a powerful way of bringing together two sides of the health inequalities debate in unified and holistic ways. The research critically assesses and develops the above arguments within a critical realist, socio-historical and holistic perspective and builds the core of the intensive research conceptual framework around them. The full conceptual model, and its development within a critical realist

² The third potential cause highlighted by Nazroo (1998) for ethnic health inequalities is genetic differences. However, genetic influences were considered to be beyond the scope of the current study; there is also evidence that genetic factors are unlikely to be a key explanation for Irish health inequalities (see literature review).

and socio-historical perspective, is described in the conceptual framework section in chapter two.

The resultant more cohesive framework forms the foundation of the intensive research and is used for the first time as a means of testing out the influences on Irish health inequalities in England and in Coventry. It is applied to first and second generation Irish people's "biographical" accounts and informs the methodological approach and guides the interpretation of the findings.

More specifically, the intensive research investigates the contribution of influences linked to ethnicity as structure, i.e. structural aspects of being Irish (i.e., migration, socioeconomic position, discrimination experiences, and experience of the NHS), and to ethnicity as identity, i.e., identity and cultural related aspects of ethnicity (i.e., sense of belonging, beliefs, lifestyle, support structures, and religion) to Irish health inequalities and experiences. Consistent with a critical realist perspective, it explores the interactions between the two dimensions of ethnicity and the extent to which structural influences and associated mechanisms underlie identity/cultural influences and mechanisms and the latter mitigate or exacerbate the impact of structural influences/mechanisms. The research also investigates the interactions between influences and mechanisms within each dimension.

Moreover, the research explores the interplay between structure, here defined as encompassing "the features of society which constitute a context for constraint or enablement" (Ratcliffe, 2004, p.7), and agency, or "meaningful social action [or decision-making] of an individual" (2004, p. 7) within Irish people's "lived" structural and identity/cultural experiences.

The critical realist research links structural and identity influences at the level of society with people's appreciation of how they play out in their or other people's daily

lives and affect health. It thus attaches significance to people's daily realities, including their experiences, beliefs, and perceptions, and their discursive knowledge of influences on health while, recognising the limitations of qualitative accounts for uncovering generative mechanisms, it extends the analysis beyond people's accounts.

In relation to this, to integrate the broader socio-historical structural context and explore the root causes of Irish health inequalities, the research takes into account the influence of British colonialism and a world capitalist economy on Irish people's life and health experiences.

The research employs a collaborative community-based participatory approach, which, through allowing an "insider" perspective of the Irish through the knowledge of community representatives, and supporting the agency of the Irish community by integrating knowledge generation with community and social change efforts that address the concerns of the community, is consistent with a critical realist standpoint.

The extensive research provides additional, up-to-date, evidence on the socio-economic and health status of first and second generation Irish people in England. It is consistent with a critical realist perspective since, recognising the limited explanatory power of statistical analyses, it confines the analysis to investigating the correlative trends and thereby to providing clues to generative mechanisms. Moreover, the analysis is compatible with the model of ethnicity as structure and identity since it is based on a more sensitive indicator of Irish ethnicity (which is seen to reflect both structural and identity aspects of ethnicity) employed by the Census 2001.

Research Questions

The main research questions are:

1. What are the trends in socioeconomic status and ethnic health inequalities across the first two postwar generations of Irish people in England, in terms of the persistence of an Irish ‘health disadvantage’?
2. Using Coventry as a case study, to what extent are the health inequalities and experiences of the first two post-1945 generations of Irish men and women in England influenced by their structural position (ethnicity as structure), identity and cultural aspects of being Irish (ethnicity as identity), the interaction between these two dimensions, and agency?

Outline of Chapters and Structure of Thesis

In order to pursue this research agenda, Chapter two first provides a general overview of the literature on socio-economic and ethnic inequalities in health in the UK, focusing on the debate of ethnicity as structure and ethnicity as identity and the contribution of each in explaining ethnic health inequalities. It then concludes with the conceptual framework adopted by this research, which builds on the above literature and applies a critical realist and socio-historical perspective.

Chapter three reviews the Irish health inequalities literature within the construct of the conceptual framework developed in the previous chapter to bring out what is known of possible influences on Irish health. This section first presents evidence for the existence of Irish health inequalities in the UK. Secondly, it demonstrates the relevance of the wider socio-historical, economic and political structural context for Irish health inequalities. Thirdly, it reviews the literature on the structural position of the first two post-war 1945 generations of Irish people in England, which focuses on the experience of migration, socioeconomic position and discrimination experiences, and then the literature on identity and cultural related aspects of being Irish in England, which focuses on Irish processes of identity formation, health behaviours

and support structures. It also begins to assess the contribution of both aspects of Irish ethnicity to Irish health inequalities and experiences.

Chapter four describes the methods used to investigate Irish health inequalities and experiences in England and Coventry, including the use of a mixed strategy design incorporating intensive and extensive research approaches and its compatibility with a critical realist perspective. It also elaborates on the use of a community-based participatory approach.

Chapter five investigates Irish health inequalities in England using an extensive approach. Its principal aims are first to provide up-to-date evidence on Irish health trends at the England level using a nationally representative dataset, including descriptive statistics on the health, socio-demographic and economic characteristics of the Irish population as a whole and divided by country of birth (Irish Republic-born, Northern Irish-born and Second generation Irish), compared to the white British population. Secondly, it seeks to determine whether there is an “Irish health disadvantage” independent of socio-economic factors for the Irish population as a whole and the three Irish country of birth subgroups. Thirdly, it explores whether there is an Irish ethnic identity effect which operates on health. Conscious of the “positivist” nature of the second and third component of the above analysis and of its limitations within a critical realist frame of reference, the research engages in a critical realist critique of the conclusions drawn and reinterprets the main findings in a way that is consistent with a critical realist perspective.

The intensive qualitative research findings presented in Chapters six and seven form the centerpiece of the thesis. These two chapters explore the possible reasons or generative mechanisms for Irish health inequalities through the analysis of the interview accounts of two generations of Irish men and women in Coventry.

Following the logic of the ethnicity as structure and identity conceptual model, the findings have been divided into two long chapters. Chapter six explores the relative contribution of ethnicity as structure, i.e., of the structural position of the Irish in England to Irish health experiences and inequalities. It is divided in five sections encompassing the socio-historical and political context of migration, the migration experience, socioeconomic position, discrimination experiences, and experience of the NHS. Chapter seven explores the contribution of ethnicity as identity, i.e., of identity and cultural related aspects of being Irish and it also divided in five sections, namely Irish processes of identity formation, beliefs, lifestyles, religious practices and support structures.

Although the previous two chapters are presented separately, there are many interactions between structural and identity components of ethnicity. Therefore, the overall conclusions for these chapters are presented in chapter eight. This final chapter also presents the findings of the thesis as a whole and briefly considers the policy implications of the findings.

Research Contributions

In summary, the current research aspires to make the following important contributions to the field of ethnic health inequalities, in the context of the Irish population in England:

- Provide additional, and fairly recent, evidence on Irish health trends at the England level
- Provide further insight into the reasons for Irish health inequalities, examining how Irish biographical experiences connect to generative mechanisms arising from both structural and identity-related aspects of Irish ethnicity, and considering both negative and positive factors.

- Investigate the interaction between the structure and identity components of Irish ethnicity, the significance of the socio-political context, and the interplay between structure and agency within each dimension, incorporating Irish people’s beliefs and perceptions, and their discursive knowledge of influences on health, to develop the “ethnicity as structure and identity” model within the framework of a critical realist and socio-historical perspective.
- Leverage a community based collaborative approach to gain “insider cultural knowledge” of the Irish community, access sometimes “hard to reach” Irish respondents for in-depth interviews (see footnote p. 89), and then “give back” information which may help the Irish population redress the health inequalities that they face.

Chapter 2: The Ethnic Health Inequalities Debate and Conceptual Framework

Introduction

The existence of ethnic inequalities in health, in terms of both mortality and morbidity, has been repeatedly documented in both the US and the UK (Nazroo, 2003). Studies conducted in the UK include studies of immigrant mortality data (e.g., Harding & Maxwell, 1997; Marmot, Adelstein, & Bulusu, 1984), of national survey data including the 1999 and 2004 Health Surveys for England (HSE) (Erens, Primatesta & Prior, 2001; Sproston & Mindell, 2006), and the Fourth National Survey of Ethnic Minorities (FNS) carried out in 1993 and 1994 (e.g., Nazroo, 1997a; Nazroo, 1997b; Nazroo, 2001), as well as smaller scale regional studies (Fenton, Hughes & Hine, 1995).

This chapter focuses on an important debate in health inequalities research which centers on the relative contribution of socioeconomic disadvantage and other ethnicity related influences (e.g. culture and identity) to ethnic health inequalities. While some authors argue that socioeconomic disadvantage is predominantly responsible for ethnic inequalities in health (Navarro, 1990, as cited in Davey Smith et al., 2000a), others (Karlsen & Nazroo, 2002a; Nazroo, 1998; Smaje, 1996) argue that ethnicity cannot be “simply emptied into class disadvantage” (Smaje, 1996, p.153) since there remains an essential “cultural” component to ethnicity that can also make a major contribution to health.

The chapter presents both sides of the debate, and discusses the contributions of the structural and identity/culture components of ethnicity to ethnic health inequalities. It also considers the role of other important aspects of ethnicity as

structure, namely, migration and the socio-historical context. It concludes by presenting the conceptual framework adopted by this research, which builds on the above literature and applies a critical realist perspective.

Ethnicity as “Structure”

Some researchers argue that ethnic inequalities in health are predominantly a result of “structure” or socio-economic inequalities (Navarro, 1990, as cited in Davey Smith et al., 2000a). Indeed, several studies have documented the existence of socio-economic gradients in mortality and morbidity, and in other health outcomes, for different ethnic groups in the UK and US (e.g., Erens et al., 2001; Fenton et al., 1995; Karlsen & Nazroo, 2002b; Lillie-Blanton & Laveist, 1996; Nazroo, 1997a; Nazroo, 1997b; Nazroo, 1998; Nazroo, 2001; Nazroo, 2003; Williams, 2002). Others have emphasized the negative impact on health of experiences of discrimination and harassment (e.g., Harrell, Sadiki & Taliaferro, 2003; Karlsen & Nazroo, 2002b; Krieger & Sidney, 1996; Williams, Neighbors & Jackson, 2003), which they regard as an integral part of the socioeconomic disadvantage experienced by ethnic minorities.

There is thus a growing body of evidence from both the United States and the United Kingdom indicating that the socio-economic inequalities faced by ethnic groups contribute strongly to health inequalities (Nazroo, 2003). However, most of the aforementioned studies (e.g., Erens et al., 2001; Fenton et al., 1995; Harding & Maxwell, 1997; Nazroo, 2001) also reveal enduring health differentials between ethnic groups, even after adjusting for socio-economic factors. Proponents of the socioeconomic explanation for health inequalities attribute these enduring health differentials to methodological limitations, including the lack of data on socioeconomic risks across the lifecourse, and an inadequate conceptualization and measurement of ethnicity and socio-economic position in health studies, which fails to

take into account the subjective nature of ethnicity, the heterogeneity of ethnic groups and class groupings, and the entirety of the structural context of ethnicity, such as living in a racist society and the geographical concentration of ethnic groups in particular economically disadvantaged locations (Karlsen & Nazroo, 2002b; Nazroo, 1998; Nazroo, 2001; Nazroo, 2003). Unfortunately, they argue, this residual effect is often mistakenly taken as evidence that there is something inherent in ethnicity, such as culture or biology, which impacts health. Hence, they are concerned with developing better ethnic and socio-economic indicators.

According to Nazroo, ethnicity as structure refers to the socio-economic position of the ethnic group and experiences of racism, or more specifically, to a “sense of discrimination and relative disadvantage” (1998, p. 723). Put differently, it refers to a process “by which ethnic collectivities enjoy differential access to a variety of social resources” (Smaje, 1996, p.140). The two following sections will therefore look at the contribution of poor socioeconomic status and experiences of discrimination to ethnic health inequalities.

Contribution of Poor Socioeconomic Status to Ethnic Health Inequalities

The existence of social class inequalities in health in the UK is now widely recognized, owing principally to three crucial reports, the Black Report, the Health Divide, and the Acheson Report (Townsend & Davidson, 1982; Townsend, Davidson, & Whitehead, 1992; Acheson, 1998; Gordon, Shaw, Dorling, & Davey Smith, 1999). These reports demonstrated the existence of social class differences in health and provided some explanations for their existence. Since then, more studies on the existence and determinants of socioeconomic inequalities in health have been published, notably the Social Determinants of Health report (Wilkinson & Marmot, 2003).

Various explanations for the negative impact of poor socioeconomic status on health have been offered. The materialist explanation maintains that poor socioeconomic status leads to poor health via material deprivation or absolute poverty, i.e. via the direct effects of poorer material circumstances (Townsend & Davidson, 1982; Townsend et al., 1992), low income levels which limit access to resources, and poor living, housing and working conditions that carry a health risk in themselves.

This explanation was accepted until health inequalities were found to stretch right up the social scale, with a fine level of social differentiation in health risks (Blane et al., 1997, as cited in Bartley, Blane & Davey Smith, 1998). In other words, health inequalities did not only exist between the materially deprived and everybody else, but also, for instance, between lower ranking and high ranking staff among middle-class office workers (Wilkinson & Marmot, 2003), and between home-owners with two cars and home-owners with one car (Goldblatt, 1990, as cited in Bartley et al., 1998). This finding led Wilkinson and others (1997, 2000) to seek to modify materialist explanations for health inequalities by arguing that income inequality or relative deprivation matter for health, via psychosocial pathways, i.e., through “the experience of low social status or subordination itself” and via poor social affiliations (as cited in Scambler, 2002, p. 96; Wilkinson, 1996). In short, they primarily emphasized a psychosocial explanation for health inequalities. Support for Wilkinson’s hypothesis was provided by Kawachi et al. (1997) who found an association between income inequality and reduced social cohesion and between decreased group membership and social trust and increased mortality from all causes and from coronary heart disease, in the United States.

In line with Wilkinson's argument that there are psychosocial costs of living in unequal societies, Elstad (1998) emphasizes the health-damaging potential of psychosocial stress, and its direct and indirect effects on health, via health-related behaviours. Moreover, he postulates that in societies which have more equal income distributions, more material and emotional support will be given to those who are experiencing life events. In other words, "perhaps what inequality does is condition the experience of these critical moments over the life course" (Bartley et al., 1998, p. 566).

In contrast, the neo-materialists continue to stress the importance of structural explanations for health inequalities and argue that "there has been an overwhelming tendency to focus on the possible social/psycho-biological mechanisms through which social factors may be tied to health rather than on examination of the basic social causes of inequality and health" (Coburn, 2000, p. 136, as cited in Scambler, 2002, p. 97). Coburn takes a critical realist stance, examining the wider underlying structural mechanisms, and argues that structural causes of income inequality include the rise of neo-liberalism and the decline of the welfare state, themselves tied to globalization and to the changing class structures of advanced capitalist societies (2000). He contends, "rather than income inequality producing lowered social cohesion/trust leading to lowered health status, neo-liberalism [...] produces both high income inequality and lowered social cohesion...and presumably, either lowered health status or a health status which is not as high as it might otherwise have been" (Coburn, 2000, as cited in Scambler, 2002, p. 97).

The importance of socioeconomic position during the life course and of the contribution of early or childhood material circumstances to health in later life has been documented in numerous studies (Berney, Blane, Davey Smith & Holland, 2000;

Dike van de Mheen, Streaks, & Mackenbach, 1998). Class relations and early material circumstances systematically affect the flow of biological, psychological and cultural capital (Scambler, 2002); low-income families are more likely to suffer from poor nutrition; poor nutrition during pregnancy and childhood affect adult biological health, via poor fetal development and impaired growth (Barker, 1998). According to Elstad (1998), a “sense of coherence” (Antonovsky, 1987), which has important consequences for resistance to stress and physical risk factors, develops through life and is influenced by placement in the social structure and the availability of resources. Plesis (2000) and Smith (2000) argue that class-related (early) impediments to the flows of cultural capital that are typically generated through processes of primary socialization and which later encompass formal educational opportunities and attainment, can have long-term ramifications for employment, income levels and, therefore, health (as cited in Scambler, 2002, p.105).

Berney et al. (2000) found that people who were in the most disadvantaged circumstances in retirement were more likely to be in poor health and to have had the highest levels of hazard exposure (e.g., residential damp, physically arduous labour, inadequate nutrition) during their entire lives, a combination of events which was socially structured. The overarching conclusion was that,

‘Social class’ at any given point is but a very partial indicator of a whole sequence, a ‘probabilistic cascade’ of events which need to be seen in combination if the effects of the social environment on health are to be understood. (Bartley et al., 1998, p. 573).

Evidence for the above statement was provided by a study conducted by Davey Smith et al. (1997) which found men who were located in manual social classes at the three stages of life (father’s job, their first job and job at time of screening), as opposed to at one or two stages of life, to have increased age adjusted relative death rates from all causes and from cardiovascular disease.

Moreover, socioeconomic status may affect health through psychosocial aspects of work, such as job satisfaction, work atmosphere, levels of demand and control at work (Marmot et al., 1997), work-related and financial stress, and through unemployment (Wilkinson & Marmot, 2003). Stress makes people feel anxious and unable to cope, and triggers the “fight or flight” response which diverts energy from many important physiological processes. If the stress is prolonged, it will affect the cardiovascular and immune systems, making people more vulnerable to a wide range of diseases (Wilkinson & Marmot, 2003).

Even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death (Wilkinson & Marmot, 2003). Unemployment can affect health via its financial consequences (especially debt) (2003), and via the loss of the many psychological benefits of work including self-esteem, physical and mental activity, social status, interpersonal contact and “traction” – a reason to go on through the day and from one day to the next (Bartley, Ferrie & Montgomery, 1999). Moreover, unemployment is in itself a stressful and disturbing life event, which may affect health as a result perhaps of chronically increased levels of anxiety, and there is evidence that health begins to be affected at the time when people begin to anticipate unemployment (Bartley et al., 1999).

Finally, poor socioeconomic status may affect health via differential access to, and use of, health services for different social classes (Mackenback, Stronks & Kunst, 1989). Although UK NHS services are free for all at the point of delivery, class-related factors include physical barriers to accessing the GP, the difficulty in obtaining GP appointments, the socially-biased character of the GP diagnosis, the quality of doctor-patient communication, and referral rates (Davey Smith et al., 2000b).

Contribution of Racial Discrimination and Disadvantage to Ethnic Health Inequalities

Two types of ethnic/racial discrimination can be distinguished, interpersonal and institutional, or direct and indirect (Ratcliffe, 2004). Each has direct and indirect effects on health. Interpersonal discrimination refers to “discriminatory interactions between individuals, which usually can be directly perceived” (Karlsen & Nazroo, 2002b, p. 624). The experience of such discrimination is widespread among ethnic minority people in the US and the UK (Chahal & Julienne, 1999; Modood, 1997; Nazroo, 2003; Virdee, 1995; Virdee, 1997) and may affect health directly through pathways of stress – both acute and chronic (Karlsen, 2007) – and via an individual embodiment of social risks, through the effect such risks have on the biology or the psychology of the body (Krieger, 2000).

Many studies have used the measurement of systolic blood pressure (SBP), which is known to be causally related to higher incidence of cardiovascular disease, as an objective indicator of the stress induced by racial discrimination. For example, Krieger and Sidney (1996) found that SBP was significantly elevated among African American working class men and women, and professional women, reporting substantial compared to moderate discrimination. Interestingly, SBP was also higher in working class men and women reporting no compared to moderate discrimination, suggesting that the association between racial discrimination and SBP was contingent on coping style and social class, with “a disjuncture between words and somatic evidence” for the working class who may be in denial of discriminatory treatment (Krieger, 2000, p. 59).

In addition to being associated with raised blood pressure, interpersonal discrimination has been linked to increased psychological distress, depression, anxiety

and poor self-reported health (Karlsen & Nazroo, 2002b; Williams et al., 2003; Krieger & Sidney, 1996; Krieger, 2000). Negative emotional states such as anxiety and depression can impact physical health by adversely impacting biological processes (e.g. immune defenses), or leading to high risk behaviours (Cohen et al., 1995, as cited in Williams et al., 2003).

In contrast, institutional discrimination refers to “discriminatory policies or practices embedded in organizational structures; therefore it tends to be more invisible than interpersonal discrimination” (Karlsen & Nazroo, 2002b, p. 625). From a critical realist viewpoint, it is a “deep” generative mechanism of health inequalities. This type of discrimination may affect health indirectly through its role in structuring the social and economic disadvantage faced by ethnic minority groups (Nazroo, 2003) and leading to differences in opportunities (e.g. education or employment), living conditions and access to health services (Karlsen, 2007). Institutional racism “promotes the identification of ethnic minority groups, their reification as biologically and culturally different, and their consequent social and economic exclusion.” (Miles, 1989, as cited in Karlsen & Nazroo, 2002b, p. 630). It has its roots in socio-political, economic, and historical factors (see discussion on p. 29).

Experience, or perceptions, of discrimination may shape ethnic identity or the way ethnic minority people view themselves by leading them to internalize this pejorative external definition (Jenkins, 1994), with negative health consequences. It may also cause ethnic minority people to feel excluded and disadvantaged compared to others, which can also have a negative impact on health (Wilkinson, 1996).

Using data from the UK FNS, Karlsen and Nazroo (2002b) showed that both the experience of interpersonal racism and the perception of institutional racism (whether British employers racially discriminate) were independently related to a range of

negative health consequences, including self-assessed poor health, respiratory illness and psychosis and depression, independently of the effect of socioeconomic disadvantage, measured by household occupational class. The three dimensions of socio-economic inequality, economic disadvantage, a sense of institutional racism or of being a member of a devalued group and the personal insult and stress of being a victim of racial harassment (interpersonal racism), were also shown to operate simultaneously (Nazroo, 2003).

Finally, the impact of discrimination on health is contingent on many factors including responses of the victims to racism, e.g. whether or not they perceive the ethnic discrimination as discrimination, the use of coping techniques, and the internalization of the blame for the incident (James et al., 1987; Karlsen & Nazroo, 2002b; Karlsen, 2007; Krieger & Sidney, 1996).

Ruggiero and Taylor (1995) suggest that individuals may deny external influences such as discrimination to maintain an internal sense of control over their experiences. While this coping strategy may be protective of health, limiting the negative effect of discriminatory experiences under some circumstances, it is also linked to hypertension (Krieger & Sidney, 1996; James et al., 1987). In contrast, people who explicitly recognize the racist nature of their experiences appear to retain higher levels of self-esteem and efficacy (Krieger, 2000).

The impact of discrimination on health may also be contingent upon the history of the minority group, and the extent of integration of the victim within an area (Chakraborty & McKenzie, 2002). People who live in a climate of fear or insecurity may constrain their lives to avoid vulnerable situations, a response which may lead to stress (Virdee, 1995; Virdee, 1997).

Ethnicity as “Identity”

On the other side of the ethnic inequalities in health debate, some researchers point out that while wider social inequalities are the underlying root cause of ethnic health inequalities, and socioeconomic position in the broader sense of the term is very important, identity/cultural influences also play a significant role (Nazroo, 1998).

The identity component of ethnicity is defined as “real collectivities, common and distinctive forms of thinking and behaviour, of language, custom, religion and so on; not just modes of oppression but modes of being” (Modood, 1996, as cited in Nazroo, 1998, p.723) or “self-identification with cultural traditions that both provide strength and meaning, and boundaries (perhaps fluid) between groups” (Nazroo, 1998, p. 712).

This conception of ethnicity as identity renders a “contextualized culture” visible whereby ethnic group members identify with cultural traditions that may be both “harmful” and “beneficial” to health (Nazroo, 1998, p.724). Thus, in contrast to ethnicity as structure which is associated with discrimination and disadvantage (1998), is seen as a mode of oppression and as being externally imposed or ascribed (Jenkins, 1996, as cited in Nazroo, 1998), ethnicity as identity is viewed more positively, as also providing resources for health, and as being largely internally shaped or self-ascribed (Jenkins, 1996, as cited in Nazroo, 1998) In this way, ethnicity can be separated from the outsider’s negative definition (Nazroo, 1998).

Ethnicity as identity can provide resources, which can help ethnic communities cope with adversity and thus promote their resiliency (Bartley, 2006). Ethnic identity can provide a political resource...

Ethnic identity, like gender and sexuality, has become politicised [...] It is a politics of projecting identities in order to challenge existing power relations; of seeking not just toleration for ethnic difference but also public acknowledgement, resources and representation. (Modood, 1997, p. 290)

...and a social resource i.e., enhanced social support via membership in an ethnic community, thus reducing the potential adverse impact of alienation on health.

Halpern (1993) found that ethnic group clustering was associated with reduced psychiatric admission rates via (a) a reduction in the exposure to direct prejudice, and (b) the social support and buffering that a relatively homogeneous local network can provide.

Indeed, the protective effect of social networks and support on health has been widely documented (Wilkinson & Marmot, 2003; Seeman, 1996 and Oakley, 1992, as cited in Popay, Williams, Thomas, & Gatrell, 1998; Richmond, Ross & Egeland, 2007; Kaplan et al., 1988; Berkman & Syme, 1979). Proposed mechanisms include increased perceptions of control over the environment, and an assurance of self-worth, the encouragement of healthier behaviours, and a “buffering” effect with supportive others providing practical or emotional resources which help moderate the impact of acute and chronic stressors on health (Stansfeld, 1999).

Ethnicity may also be an important source of cultural-social or ethnic capital and be partly responsible for the upward educational mobility of the “second generation” through migrant parents getting their children to internalize high educational ambitions and enforcing appropriate behaviour, with the help of significant relatives and other community members³ (Modood, 2004, p. 87; Zhou, 2005).

Espousal of customs generally leads to improved social support (Kelleher, 1996), socio-communal engagement and psychological well-being (Halpern & Nazroo, 2000) (as cited in Karlsen & Nazroo, 2002a). However, in some circumstances, it may also lead to negative discrimination and isolation, which may be detrimental to health

³ Conclusion based on British South Asian and Chinese populations.

(Karlsen & Nazroo, 2002a). Moreover, some customs related to lifestyle, in particular drinking and smoking, can be harmful in their own right.

Finally, ethnicity as identity may provide a religious resource, which may also be protective of health. Hannay (1980) found the increase in religious allegiance (i.e., participation in a religious service or activity) among minority groups, including Roman Catholics of Irish extraction to act as a stabilizing factor, particularly for those who were distant from their cultural base, and to be associated with better mental, social and physical health. Devout and mature commitment to Judeo-Christian beliefs in the form of activities such as church attendance has been linked to greater well-being, life satisfaction, personal adjustment, lower levels of depression and anxiety (Koenig, 1992), and even decreased mortality (Powell et al., 2003).

Involvement in the religious community may protect health through providing social networks of similar age and interest, a supportive environment to buffer stressful life events (Larson et al., 1992, as cited in Sproston & Bui, 2002), an atmosphere of acceptance, hope, and forgiveness, a source of practical assistance and a common world view (Koenig, 1992). According to Ellison et al. (2001), routine affirmations of faith may allow meaning to be ascribed to life's events and emotional catharsis may be derived from certain worship styles (as cited in Abbotts et al., 2004a).

Prayer and Bible reading, and intrinsic religiosity (personal religious belief and commitment), have also been positively associated with greater well-being (see Koenig, 1992). Prayer was ranked seventh in effectiveness among 25 coping behaviours mediating between life events and depression by patients (Parker & Brown, 1982, as cited in Koenig, 1992). Religious belief was shown to be an

extremely important coping mechanism for certain ethnic groups, through providing inner strength/peace (Sproston & Bhui, 2002).

However, religion may also have detrimental effects on health, by creating anxiety and fear due to beliefs in punishment (e.g. hell) “for our evil ways” and fostering low self-esteem through generating feelings of inadequacy and guilt (Schumaker, 1992, p.3). There may also be adverse effects on lifestyle; tolerance of alcohol consumption among Catholics is higher than among Protestants, although lower than among non-religious people (Walls, 2005, as cited in Tilki, 2006; Mullen, Williams & Hunt, 1996).

Studies on minority members have demonstrated strong ethnic identities to relate positively to psychological well being, including self-esteem, purpose in life, optimism, happiness, and lower levels of depression and anxiety (see Abbu-Rayya, 2006). A strong ethnic identification may mitigate the negative effects of discrimination on well-being by preventing the internalization of negative stereotypes (see Abbu-Rayya, 2006). Conversely, people with weak ethnic identities may come to internalize these stereotypes. This may partly explain the association between lower levels of ethnic identification and higher rates of suicidal episodes, delinquency, and substance abuse (see Abbu-Rayya, 2006).

The process of identity formation itself deserves some discussion in this context. While this is a largely internal process, a sense of ethnic identity is not entirely self-constructed in that defining *who* is and *what* it is to be a member of a particular social group is heavily influenced by the wider society (Karlsen & Nazroo, 2002a). According to Jenkins (1994), ethnic identity is the “practical product of the ongoing interaction of processes of internal and external definition” (p. 219). An ethnic group internalizes the terms in which another group defines it and assimilates that

categorization or “racialisation” in whole or in part into his identity (1994). When these “external definitions” are pejorative, it may negatively impact the health of the ethnic group through affecting their self-image.

According to Modood et al. (1997), “ethnicity, including the development of group features such as religion, is ‘interactive’ – shaped partly by its original heritage and partly by racism and the political and economic relations between groups in Britain” (as cited in Modood, Berthoud & Nazroo, 2002, p.420). Moreover, membership in an ethnic group is both an individual subjective view and is subject to conferment by at least some members of that group (Modood et al., 2002).

Similarly, lifestyle choices or health-related behaviours, and beliefs or attitudes towards seeking medical care, are not solely a consequence of agency, and identity/cultural factors such as cultural perceptions about health symptoms or acceptable lifestyle practices, but are made within social constraints (Karlsen & Nazroo, 2002a), including financial considerations and the type and quality of services provided by the social structure one lives in. Moreover, the notion of ethnicity cannot be considered fixed, secure or coherent because it is only one element of identity and a range of identities (e.g. gender and class) come into play in different contexts (Halls, 1992, as cited in Nazroo, 1998). Moreover, it is transformed in relation to external audiences (Ahmad, 1993, as cited in Karlsen & Nazroo, 2002a).

In order to incorporate the element of ethnicity as identity, in addition to that of structure, in ethnic health research, some authors highlight the importance of using more sensitive strategies for collecting information on ethnicity, such as allowing individuals to define their ethnicity in their own terms, rather than externally imposed classifications (Aspinall, 1995, as cited in Nazroo, 1998). However, in a rare study of the relation between ethnic identity and health, Karlsen and Nazroo (2002a) did not

demonstrate an effect on health of five dimensions of ethnicity as identity that emerged from a factor analysis of data from Caribbean, Pakistani/Bangladeshi, and Indian/African Asian populations in the FNS. A possible explanation advanced by the authors for this negative finding was that the relationship between ethnicity as identity and health may be contingent on context (2002a). In particular, a “strong” ethnic identity may be protective of health for ethnic minority people living in an area with a large number of people from a similar background but may be detrimental to health for those living elsewhere (Halpern & Nazroo, 2000; Neeleman & Wessely, 1999, as cited in Karlsen & Nazroo, 2000). This explanation will be discussed further in the following section.

This section on ethnicity as structure and identity is best concluded by drawing on Scambler’s critical realist typology of generative mechanisms for relations of class and ethnicity (2002, p. 107) which argues that, with respect to ethnic inequalities in health, the generative mechanism of ethnic relations may be as much “derivative” of class relations as “categorical” in its own right. In other words, while the causal relevance of ethnicity to ethnic inequalities in health is in part a function of the causal power of class or socioeconomic position (cf. ethnicity as structure), ethnicity in its own right also bears a strong causal responsibility for these inequalities (cf. ethnicity as identity) (Scambler, 2002).

Geography, Migration and the Socio-political Context

This section further elaborates the debates about structure and identity by examining other important explanations for ethnic health inequalities, including geographic location, processes of migration and acculturation, and the socio-historical context (Nazroo, 2003; Williams, 2002). The interconnectedness of these factors with socioeconomic position and identity formation needs to be recognized.

Geographical location or ecological effects may be of particular relevance for researching ethnic health inequalities since ethnic minority people have been shown to be disproportionately concentrated in economically disadvantaged locations, when compared to the white majority (Nazroo, 1998; Nazroo, 2001; Nazroo, 2003). Moreover, it was found in both the USA and the UK that when ethnic minority groups form a smaller proportion of the population in an area, they are more likely to suffer from mental illness (Laveist, 1996 and Boydell et al., 2001, as cited in Chakraborty & McKenzie, 2002). These processes may reflect complex interactions between exposure to discrimination, social support and socioeconomic factors (2002). Other ethnic minority studies have noted the negative impact on health of having a “strong” ethnic identity but not being surrounded by many people from the same ethnic background (Halpern & Nazroo, 2000; Neeleman & Wessely, 1999).

There are three broad approaches to migration, namely, classical (or rational) economic, (neo-) Marxian, and subjectivist (Ratcliffe, 2004, chapter 4). The classical economic model or push-pull theory argues that the rational economic actor will migrate where labour is needed, pulled in by the promise of relatively well-paid work, while unemployment and low wages are push factors. Other push factors may be of a political or religious nature (2004). The (neo-) Marxian models attach greater significance to the historical and politico-economic context and argue that colonialism and its legacy explain contemporary disparities between the economies of the metropolitan “core” and those of the colonial (or postcolonial) periphery (Ratcliffe, 2004, p.46). Workers in the latter societies constitute a “reserve army of labour” for the core economy, which then subjects them to exploitative labour market conditions (2004, p. 46). More sophisticated accounts (e.g. Miles, 1982) accord a greater role to race and ethnicity (Ratcliffe, 2004). Subjectivist explanations argue that, given the

same external stimulus, not all individuals will behave in the same way; they thus place greater emphasis on listening to the reasons individual people give to explain why they left their native country (2004).

Migration may affect health through several pathways. Firstly, entry into a migrant group will be related to both health and human capital, potentially leading to a healthy migrant effect (Nazroo, 2003) whereby the more healthy individuals are selected into the groups that migrate, an effect that diminishes with subsequent generations (Marmot et al., 1984; Nazroo, 1997a). Secondly, the childhood experiences in the country of origin of first generation migrants may lead to differences in health across generations via long-term adverse health outcomes or pathways that lead to an accumulation of social and health disadvantage (Nazroo, 2003). Thirdly, the experience of migration in itself, and the process of acculturation, can be health-damaging since it will occur alongside social and economic upheavals (Bhugra & Jones, 2001; Nazroo, 2003; Williams, 2002). Both processes are accompanied by stressors and resources, but the ways in which they combine to affect the health of immigrants is still not well understood (Williams, 2002).

Bhugra and Jones (2001) identify a set of factors in migration and psychological distress and suggest that phases of migration (pre-migration, migration and post-migration), interlinked with significant life events and chronic ongoing difficulties, as well as personal factors (e.g., age, gender, reason for migration, self-concept, self-esteem, cultural identity) and relational factors (e.g., social support, ethnic density, racism, unemployment) must be considered separately and continually. Therefore, several authors stress the importance of adopting a lifecourse perspective and of considering the cumulative accumulation of disadvantage during a lifetime when researching ethnic inequalities in health since migrants will have been through a

number of life-course transitions and may have suffered from significant deprivation during their childhood (Davey Smith et al. 1997, as cited in Nazroo, 2001; Nazroo, 2003).

Finally, it is argued that it is of paramount importance to frame the study of ethnic inequalities in socioeconomic position and in health within a wider political, economic and social historical context (Ahmad & Bradby, 2007; Fenton, 1999; Miles, 1982; Nazroo, 2003; Williams, 2002). The “making” of ethnic minority groups, the patterns of migration, and the socioeconomic disadvantage faced by ethnic minority migrants was, and continues to be, structured by national, international, and historical factors (Nazroo, 2003), including colonialism and the political economy.

Indeed, one of the main origins of racism appears to be “common-sense definitions of otherness implicit in the ideologies surrounding slavery and colonialism” (Lawrence, 1982, as cited in Ratcliffe, 2004, p. 19)., For colonialism to “work” in an economic sense, colonists had to make the natives inferior others and lock them into subordinate social positions (Memmi, 1974, as cited in Ratcliffe, 2004, p. 21). The migration of colonial citizens to the metropolis led to the “importation of colonial ideology and a development of a distinctive form of inferiorisation driven by political economy” (Ratcliffe, 2004, p.19).

According to Miles (1982),

The process of racial categorization or racialisation is simultaneously the historical consequence and the site of subsequent struggles between classes and of the formation and reproduction of class fractions. The ideology of racism and the practice of racial discrimination are central components of this process of racialisation which has determinate effects on ideological, political and economic relations [...] this process of racialisation (which occurs at the level of ideological relations) has effects on, but is also structured by, economic relations. (p. 184-185).

The relevance of the political and economic historical context to the health of ethnic migrants will be treated in more depth in the section on “British Colonialism

and the World Political Economy” in the following chapter on Irish health inequalities.

Conceptual and Theoretical Framework

In order to research Irish health inequalities and experiences, it is important to first develop a cohesive conceptual framework to guide the methodological approach and the interpretation of the results. The research builds upon the concept of ethnicity as structure and identity described above by integrating it with a socio-historical and critical realist perspective, which recognizes the complexity of the social world.

The core of the conceptual framework is built around five important elements of the concept of structure and identity described by Nazroo and others (see previous section). Firstly, both structural (i.e. socioeconomic disadvantage and discrimination) and identity/cultural influences contribute to ethnic inequalities in health.

Secondly, wider structural factors or social inequalities are important root causes of ethnic inequalities in health and therefore need to be examined. They underlie more immediate structural aspects of ethnicity as well as cultural aspects of ethnicity, “much of what passes as tradition is in fact little more than the end product of earlier struggles: in many cases value systems imposed by imperialist and colonialist powers” (Ratcliffe, 2004, p. 34). They operate through pathways such as individual risk factors or resources, which can be seen as surface causes.

Thirdly, there is an interaction between structural and identity influences. For instance, the development of a community with a strong ethnic identity, which may result from the concentration of ethnic minority groups in disadvantaged neighborhoods, may be protective of health through enhancing ethnic minority people’s levels of social support and reducing their sense of alienation (Nazroo,

1998). In addition, structural aspects of ethnicity such as the experience of racism are seen as structuring an individual's own identity (Karlsen & Nazroo, 2002a).

Fourthly, structural aspects of ethnicity and its influence on health have negative effects on health while identity/cultural aspects can have both negative and positive effects on health, in the form of risks and resources respectively. Risks and resources include an "unhealthy" lifestyle and high levels of community support, respectively. Thus, the resiliency of ethnic minority groups or capacity to draw on some of their resources to cope with adversity (Bartley, 2006) is recognized.

Fifthly, structural aspects of ethnicity and its influence on health are imposed or ascribed, while identity/cultural aspects, such as ethnic identity and lifestyle, are the product of internal and also external processes, such as discrimination and socio-economic position, i.e., of both agency and structure.

The research strategy concurs with the first three arguments. While it largely agrees with the fourth and fifth arguments, it also somewhat departs from them, since it argues that structural influences, can also have positive effects on health, in the case for example of ethnic minority groups who are socioeconomically advantaged. Thus, the research views both structure and identity aspects of ethnicity as having potentially positive and negative effects on health. Moreover, ethnicity as structure is not entirely imposed but can be influenced by agency; ethnic minority groups have been shown to demonstrate upwards intergenerational social mobility (Modood et al., 1997). This later point is discussed further below in the frame of a critical realist approach.

Other important structural influences, in particular migration and experience of the National Health Service, are also seen as important influences on the health of ethnic minority groups and are therefore included within the conceptual framework as

elements of ethnicity as structure. The resulting concept of ethnicity as structure and identity forms the core of the research framework.

The research elected to integrate the above concept of ethnicity as structure and identity within a critical realist and socio-historical approach in order to pull together all the elements within a more comprehensive framework.

The concept described above is already compatible in many ways with a critical realist and socio-historical perspective for the following reasons. Firstly, it provides a framework to explore the causes for ethnic inequalities in health, consistent with a critical realist approach which distinguishes between three levels of reality - what is experienced, what actually happens and what is real - and seeks to uncover the real by identifying the “structures” and mechanisms which generate tendencies in the behaviour of phenomena (Porter, 1993). In this sentence, the research uses the word “structure” in the broad sense of the term to refer to different types of influence, including identity influences, in addition to structural (e.g. socio-economic) influences in the usual sense of the term.

Secondly, the concept gives due weight to structural mechanisms. This is compatible with a critical realist perspective which seeks to uncover structural mechanisms and permits a departure from an exclusive focus on cultural, behavioural or lifestyle factors which adversely affect health, and may lead to victim-blaming.

Thirdly, the concept recognises the interaction between identity and structural influences; it views structural mechanisms as underlying identity/cultural influences, and identity/cultural influences as mitigating or exacerbating the effect of structural influences; this is consistent with a critical realist perspective which views generative mechanisms as operating in a complex interaction with other mechanisms (Danermark et al., 2002).

Fourthly, consistent with a critical realist perspective, the concept recognizes the interplay between structure and agency within the identity component of ethnicity and its influence on health (Danermark et al., 2002).

Finally, the concept is placed within the wider socio-historical context. This is compatible with both a socio-historical perspective, which recognises the importance of framing the study of ethnic inequalities in socioeconomic position and in health within a wider political, economic and social historical context (Ahmad & Bradby, 2007; Fenton, 1999; Miles, 1982; Nazroo, 2003; Williams, 2002), and a critical realist perspective, which looks at deep generative mechanisms. The research argues that the socio-economic, political and historical context, including colonialism and capitalism, has affected, and continues to affect, both structural and identity aspects of identity, with implications for health.

On the other hand, the concept of ethnicity as structure and identity can be further developed through the application of a critical realist approach in the following ways. Firstly, a critical realist approach recognises the interplay or bilateral interaction between, and qualitatively different characteristics of, structure and agency; it views structures as laying down conditions for people's lives, while agency provides the effective causes for what happens in society (only human beings can act) (Danermark et al., 2002), and seeks to reflect the "complex dialectical relationship between [...] agency and a myriad of structures/forces of regulation" (Ratcliffe, 2004, p.34). Consequently, it leads the researcher to look at the interplay between structure and agency, not only within the identity dimension of ethnicity but also within the structural dimension. Indeed, ethnic minority groups have been shown to display agency and challenge the status quo through demonstrating upwards social mobility and mobilizing against discrimination.

Secondly, a critical realist approach emphasizes the importance of viewing generative mechanisms as operating in a complex interaction with others, as indicated above. This means that in addition to recognizing the bilateral interaction between identity/cultural and structural components of ethnicity, it is important to investigate the interactions between generative mechanisms within both dimensions.

Finally, a critical realist perspective, whilst recognizing the existence of an objective and independent reality, argues that “people’s experience of and knowledge about that reality has a separate existence – it is subjectively and intersubjectively generated” (Bhaskar, as cited in Pilgrim, 2000, p.19); people assign socially mediated meanings to phenomena, to their life and health experiences, and to “good” and “poor” health (Pilgrim & Bentall, 1999), and can change the social reality (Danermark et al., 2002). These social meanings may influence the effects of generative mechanisms from both dimensions of ethnicity. While this means that people’s descriptions, knowledge and experiences of the social reality need to be investigated, their socially constructed nature means that they are fallible or more or less truth-like (2002). Moreover, people’s experiences of the social reality only reveal so much owing to a discrepancy between what is experienced at the level of the individual, what actually happens at the level of society, and what is real (2002). Consequently, the critical realist researcher needs to go beyond respondents’ accounts to uncover the real (Pilgrim, 2000).

These arguments can offer an interesting approach to researching ethnic inequalities in health, which links structural and identity influences at the level of society to biographical accounts, investigating how these influences “play out” in people’s daily lives, while also going beyond what respondents say to uncover the actual and the real.

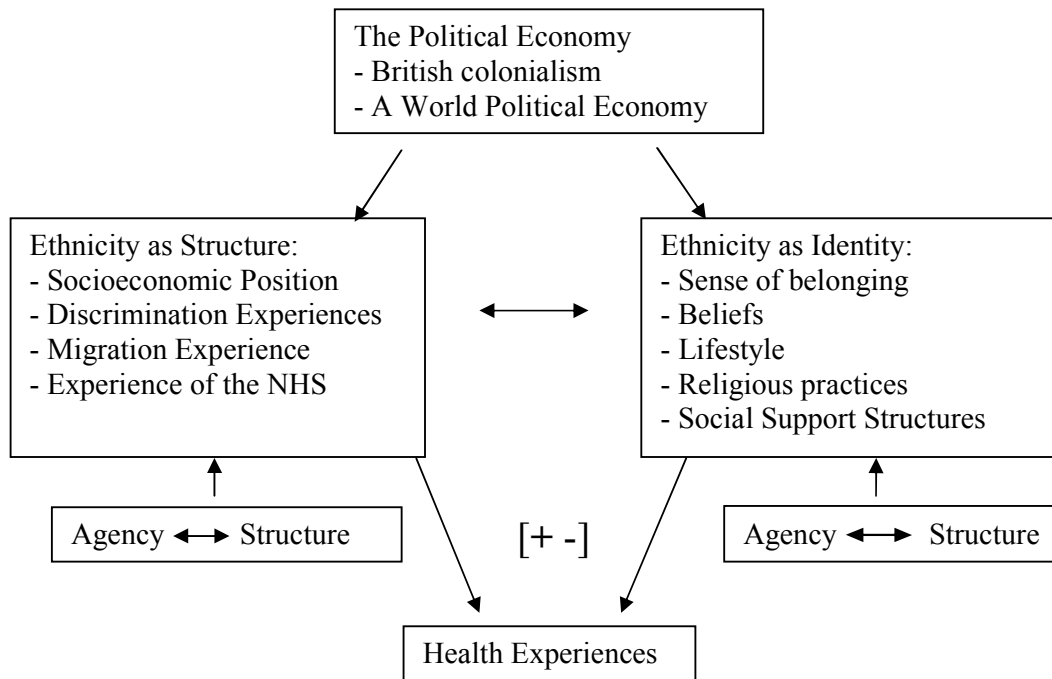
In conclusion, ethnicity as structure, or structural influences, are seen as encompassing the generative mechanisms of socioeconomic position (including childhood poverty, occupation, absolute and relative deprivation, unemployment, work, education), discrimination, as well as migration and experience of the NHS. Ethnicity as structure also incorporates the deeper structural generative mechanisms of British colonialism and the world political economy, which are seen to impact aspects of both dimensions of ethnicity (structure and identity). Ethnicity as identity, or identity/cultural influences, are viewed as encompassing the generative mechanisms of ethnic identity or sense of belonging, culture (including beliefs and lifestyle), religion and social support structures. Both ethnicity as structure and ethnicity as identity are seen as having potentially positive and negative effects on health, although the former is seen as having generally more negative effects and the latter more positive ones.

Mechanisms from ethnicity as structure and identity are seen as interacting forces and the extent to which structural influences and mechanisms underlie identity/cultural influences, and identity/cultural influences and mechanisms mitigate or exacerbate the effect of structural influences and mechanisms, needs to be investigated. Moreover, the interplay between structure and agency within structural and identity components of ethnicity is recognized. Finally, both the importance of investigating people's experiences, beliefs and actions, the meaning they attach to events and actions, and discursive knowledge of influences on health, and of going beyond qualitative accounts, is recognized.

The end product is an inclusive, holistic, dynamic, socio-historical, and critical realist framework, which will be used to test out the influences on Irish health inequalities in England and in Coventry and answer the second research question (see

figure 2.1 below). This model is the investigative tool which provides the foundation of the intensive research. The extensive research also takes into account the structural and identity dimensions of ethnicity and is compatible with a critical realist approach (see methodology chapter).

Figure 2. 1: Conceptual Model - Contribution of Structural and Identity-Related Dimensions of Ethnicity to Irish Health Inequalities and/or Experiences



Conclusion

This chapter has presented both sides of the ethnic inequalities in health debate. It first presented the arguments of authors who largely attribute ethnic inequalities in health to the disadvantageous socio-economic position (in the broad sense of the term) of ethnic minority groups, and then those of Nazroo and others who believe ethnic inequalities in health are the product of both structural and identity/cultural influences. The existing literature reveals that both structural, and identity/cultural, components of ethnicity affect the health of ethnic minority groups, through several

pathways; identity/cultural influences impact health in both positive and negative ways, and are the product of both internal and external (structural) processes; other structural influences, including migration and the socio-historical context, also significantly contribute to ethnic inequalities in health. The chapter concluded with the conceptual framework adopted by this research, which takes the unified model of structure and identity endorsed by Nazroo and others, and the above literature, as its starting point and then builds upon it by integrating it with a critical realist and socio-historical perspective.

The following chapter reviews the Irish health inequalities literature within the construct of this conceptual framework to bring out what is known of possible influences on Irish health and begin to provide answers to the research questions.

Chapter 3: The Irish Health Inequalities Literature

Introduction

Despite consistent statistical evidence of Irish poor health in England, the reasons behind it, or underlying generative mechanisms, are only partly understood. This chapter reviews the Irish health inequalities literature within the construct of the conceptual framework developed in the previous chapter to bring out what is known of possible influences on Irish health.

The chapter first summarises the literature on Irish health inequalities in the UK. Secondly, it demonstrates the relevance of the wider socio-historical, economic and political structural context for Irish health inequalities. Thirdly, it reviews the literature on the structural position of the Irish in England, which focuses on the experience of migration, socioeconomic position and discrimination experiences, and, on the other hand, the literature on identity and cultural related aspects of being Irish in England, which focuses on Irish processes of identity formation, health behaviours and support structures. The chapter also begins to document some of the known interactions between the two aspects of ethnicity and to assess the contribution of both aspects of Irish ethnicity to Irish health inequalities and experiences.

Irish Health Inequalities: the Evidence

In comparison with the South Asian and Black Caribbean or African populations, the Irish have been largely neglected or “invisible” in ethnic health inequalities research in the UK (Bracken & O’Sullivan, 2001). This neglect occurs despite the fact that they are the largest immigrant group in England and Wales (Census 2001, as cited in Leavey et al., 2007) and face a significant health disadvantage (Hickman &

Walter, 1997; Abbotts et al., 1997), which has been shown to persist across first and subsequent generations.

Using Census data, many studies have highlighted the excess overall age-adjusted mortality of first and second generation Irish people in Britain, when compared to all residents of England and Wales (Marmot et al., 1984; Raftery, Jones & Rosato, 1990; Harding & Balarajan, 1996; Harding, 1998⁴; Harding & Maxwell, 1997⁵; Wild & McKeigue, 1997). In the above studies⁶, the observed excess mortality could not be fully accounted for by the indicator of social class, or even by the more powerful indicator of social class, housing tenure and car access, in Harding and Balarajan's study (1996)⁷. Furthermore, although the socio-economic disadvantage⁸ of the first generation Irish living in England and Wales does not appear to persist in second and third generations, a recent study⁹ (Harding & Balarajan, 2001) found the age-adjusted hazard ratios for all cause mortality for the years 1971-97 to increase with each successive Irish generation¹⁰.

Many of these studies documented the major causes of the excess mortality of the first and second generation Irish. Marmot et al. (1984) highlighted the particularly high Standardized Mortality Ratios (SMRs) for the Irish-born for tuberculosis, diseases of the respiratory and digestive systems, for certain cancers, and for external causes of injuries and poisonings. This finding was later confirmed by Harding and Maxwell (1997), who also found significantly higher mortality rates for Irish-born

⁴ all four studies (and Harding and Balarajan, 2001) used population at risk enumerated at the 1971 Census, calculated SMRs for the years 1970-1978, 1971-81, 1971-1989, 1971-1992 respectively, and operationalised Irish ethnicity using Irish country of birth or Irish parentage.

⁵ used population at risk enumerated in the 1991 Census and calculated SMRs for the years 1991-1993, used Irish country of birth

⁶ except for Wild and McKeigue (1997) who failed to control for socioeconomic position

⁷ this is a positivist critique

⁸ measured by housing tenure and car access

⁹ used Irish country of birth or Irish parentage as proxies for Irish ethnicity

¹⁰ the excess mortality of the first generation Irish from the Republic was explained by socio-economic indicators but not that of the first generation Irish from Northern Ireland nor that of the second and third generation Irish.

men from ischaemic heart disease, cerebrovascular disease and lung cancer. Haworth et al. (1999) showed a statistically significant two-fold excess of mortality from cirrhosis of the liver among Irish-born men and women resident in England and Wales, when compared to the national average.

Importantly, Wild and McKeigue (1997) found Irish migrant men and women to have higher SMRs for all causes and for ischaemic heart disease than did the comparable groups resident in Ireland, indicating that this is not simply a “genetic” effect. In a study of second generation Irish, Harding and Balarajan (1996) found a pattern of higher mortality from most major causes of death, except for cerebrovascular diseases for men, and injuries and poisonings for women. They observed significantly higher mortality from all cancers and lung cancer for men of working ages and for women aged 60 and over. The latter also had a significant excess of deaths from respiratory diseases. Harding (1998) also observed a high incidence of cancer in the second generation Irish (Scanlon et al., 2006).

Using data from the Health Survey for England (HSE) 2004, Mindell and Zaninotto (2006) found Irish men¹¹ to have the second highest risk ratio¹² for stroke, about twice that of the general population (1.98). Their prevalence (and risk ratio) of CVD, IHD and IHD or stroke was significantly higher in the lowest income category than in the highest income category.

Other studies have highlighted the high rates of limiting long-term illness or disability of the Irish-born in Britain (Owen, 1995; Kelleher & Hillier, 1996¹³) and of the “white Irish” people of working age, men in particular (FIS, 2007a). Poor self-reported general health was also found for “white Irish” men and women of working

¹¹ People were included as being of Irish origin in the HSE 2004 if they were born in Ireland, or their father or mother was born there.

¹² Risk ratios compare the prevalence or mean for a given minority ethnic group with the prevalence or mean in the general population, after adjusting for age in each group.

¹³ Neither studies adjusted for socioeconomic factors

age (FIS, 2007a)¹⁴. In contrast, the HSE 2004 did not find significantly higher rates of poor self-reported general health or longstanding illness for Irish men and women, defined by country of birth or parentage, in England as a whole (Natarajan, 2006). However, this analysis was not adjusted for socioeconomic factors, which were presented by equivalised household income tertiles in separate tables.

In particular, the Irish seem to have elevated mental illness rates. Cochrane and Bal (1989) found the Irish-born (especially the Republic born) to be grossly overrepresented as users of psychiatric services with particularly high hospital admission figures for alcohol-related disorders and depression, findings which were supported by Walls (1996) in his study of Irish people in Haringey. The study found Irish women to have the highest admission rates and overall rates for depression and alcohol abuse while Irish men had high relative rates of schizophrenia (1996). Based on a sample survey of patients in 25 practices in England and Wales, McCormick et al. (1990) also found very high rates of consultations for illnesses classified as mental disorders for the Irish (as cited in Kelleher & Hillier, 1996). Using data from the EMPIRIC study, Weich et al. (2004) confirmed that middle-aged Irish men had significantly higher rates of common mental disorders (CMD) than their White counterparts, a trend which persisted after controlling for socioeconomic factors.

The Irish living in Britain seem to be particularly prone to depression and self-harming behaviours. In a community-based study, Nazroo (1997b) found that Irish men were more likely than white British men to consider that life was not worth living. Moreover, the Irish-born in Britain have been consistently shown to have high rates of suicide and attempted suicide, higher perhaps than the indigenous population and any other ethnic group (Burke, 1976 and Balarajan, 1996, as cited in Leavey,

¹⁴ The FIS study used the self-reported Irish ethnicity measure available for the first time in the Census 2001, but only reports descriptive statistics by age and sex.

1999; Raleigh & Balarajan, 1992; Bracken et al., 1998; Merril & Owens, 1988, as cited in Leavey, 1999; De Ponte, 2005; Neeleman et al., 1997). Two studies (Burke, 1976 and Merril & Owens, 1988, as cited in Leavey, 1999) found the rates for attempted suicide and self-poisoning of the Irish-born in England to be higher than those for the Irish-born in Ireland. Merril and Owens (1988) also found the Irish to be significantly more often diagnosed as alcoholic, when compared to the English group (as cited in Leavey, 1999). Finally, Harding and Balarajan (1996) found a mortality excess due to suicide of 25% among the second generation Irish people in the UK.

Finally, a series of studies conducted in the West of Scotland by the MRC Medical Sociology Unit¹⁵ provides further insight into Irish health inequalities. Abbotts et al. (1997) found that respondents with a Catholic parent, or born Catholic, were significantly more likely than “non Catholics” to suffer from poor general and physical health, psychological distress, impairment and disabilities, and poor physical development. Interestingly, the Irish health disadvantage could not be fully accounted for by the disadvantageous socio-economic position of the Irish (Abbotts, Williams & Ford, 2001), their health-related behaviours (Abbotts et al., 1999a) or established medical, physiological, behavioural and socio-economic risk factors (Abbotts, Williams & Davey-Smith, 1999b). The extent to which these findings can be generalized to the Irish situation in England is currently unknown.

Explaining Irish health inequalities

Both the literature on Irish ethnicity as structure, i.e., the socioeconomic position of the Irish in England and their experiences of discrimination, social isolation and migration, and that of Irish ethnicity as identity, dealing mostly with issues of identity

¹⁵ for the years 1990-1, 1988-95, 1990-1 and 1970-3 in order of listing. All used Catholic background as a proxy for Irish descent and most used data from the West of Scotland Twenty-07 Study

formation and social support, will be reviewed. Health behaviours, in particular alcohol consumption and medical help seeking, will be considered. I will begin this review by framing these issues within the historical, political and economic context of British colonial rule and of a world political economy.

British Colonialism and the World Political Economy

This section argues that British colonial rule in Ireland and the wider political economy are ultimately responsible for Irish health inequalities; a basic understanding of these processes is thus necessary.

British colonialism and capitalism had a devastating effect on the structural position of the Irish in England, and thus on Irish health, via a complex sequence of events. This was initiated by the negative impact of colonialism on the Irish economy, “as with other colonized countries the productive economy of Ireland was systematically underdeveloped by British imperialisation” (Crotty, 1986, as cited in Tilki, 1994, p. 909), “for most of the population, colonial rule meant utter penury [...] they subsisted on potatoes whilst other crops which they produced were exported” (Clarke, 1998, p. 555). From the Irish perspective, there was no choice but to migrate, “the “push” factors derived from the country’s undeveloped agricultural status relative to rapid industrialisation and capitalisation in other [...] countries (Hazelkorn, 1990, p.7).

The Great Potato Famine of 1845-47 accelerated that trend (Miles, 1982). In the twentieth century, the measures adopted by the Irish Free State were not very successful in improving the situation. They had little impact on employment in Ireland and on emigration, which remained high (Hazelkorn, 1990). In the 1930s, the Economic War with Britain and the international depression had a negative impact on

economic growth and increased the dependence of Ireland on international markets (1990),

The inter-relationships of the British and Irish economies – Marx had called Ireland, England's agricultural sector – transformed emigration into an almost natural part of the “general, secular process of rural-urban drift”. (Glynn, 1981, as cited in Hazelkorn, 1990, pp. 7-8).

After World War II, the Irish migrated to the UK to find work because the Irish economy could not offer them a means of subsistence, while the British economy was booming and work opportunities were plentiful. In fact, the need to rebuild British cities, the demands of an expanding manufacturing economy, and the development of the welfare state meant that labour was needed on a scale that could not be provided locally (Ahmad & Bradby, 2007). World-systems theory provides a framework for this phenomenon within a capitalist world economy with Ireland being at the periphery due to its poor economic status, providing needed labour to the wealthy core of England (Hazelkorn, 1990).

The jobs the post-war Irish immigrants secured were mostly unskilled and badly paid in part because many came from rural settings and had skills not transferable in urban settings (Tilki, 1994). Many of the men worked in the building industry where they worked hard in all weather and were often paid cash-in-hand (O’Meachair, 1990, as cited in Tilki, 1994). Both men and women were employed in factories (1994), particularly in the automobile industry which developed in Midlands’ towns like Coventry after the war. A substantial number of Irish women worked in the domestic sector, in private houses, hospitals and hostels (O’Meachair, 1990, as cited in Tilki, 1994), and as carers or nursing orderlies (Tilki, 1994). Some came to England to take advantage of the free nursing training program and stayed to work (1994).

The economic expansion meant that in spite of discrimination, Irish migrants could secure initial employment and move jobs easily (Ahmad & Bradby, 2007).

However, the Irish were always among the first to be laid off when times got hard and although many were hard and efficient workers, they were bypassed for promotion and better job opportunities (Tilki, 1994).

The racialisation of the Irish by the British and the resultant discrimination experiences can also be seen as a result of British colonialism of Ireland, including the need to justify and rationalize the colonial exploitation of the Irish (Miles, 1982) and the economic role of Irish migrants, and strengthen the formation of British national identity (Hickman, 1995). Moreover, it is significant that some second generation Irish people in Ireland and Britain are discriminated against by the Irish-born and called “plastic paddies”, a means of denying them an Irish identity (Hickman et al., 2005). Again, this discrimination can be viewed as a consequence of British colonialism and the resultant inability of the Irish-born to bring together elements of Britishness and Irishness, which are viewed as conflicting. In addition, it can be argued that persistent British imperialism in the form of ownership of Northern Ireland has led to the IRA events, which exacerbated anti-Irish discrimination.

British colonialism can be seen to have impacted the identity of the Irish. According to Kelleher and Hillier (1996), the psychological fragmentation resulting from the inability to build “an ‘authentic’ sense of self which accepts or accommodates ethnic or religious aspects of identity” can be found among Irish people living in Britain owing to an ex-colonial relationship and sustained political violence between the two countries (as cited in Leavey et al., 2007, p. 241). The way in which the socio-historical context has influenced processes of identity formation for Irish migrants in Britain has been theorized by Fanon.

Fanon’s central argument is that during the process of colonialization, the colonized and his cultural life are devalued and the native is incited to give up his

cultural identity and become like the colonizer. As a result, the colonized finds himself with a non-solvable internal conflict since sustaining his native identity and culture means accepting his inferiority and a life of hostility and oppression while total identification with the colonizer is impossible to achieve. The end product is a fragmented identity leading to a poor mental state (Greenslade, 1992). This internal conflict is aggravated upon migration since the colonized is deprived of the context of resistance that his homeland provided him with and is obliged to accept the negative image the colonizers have of him. In addition, he is reminded of his fragile identity every time he speaks (1992).

British colonialism has also influenced processes of identity formation of the second generation Irish. According to Hickman et al. (2005),

Second generation Irish people are positioned as having to defend charges of inauthenticity both from those pressuring them to be English and from those denying their Irish identifications. Ireland rejects these “hybrids” as not Irish, as in fact English, and England cannot countenance any dilution of whiteness or weakening of the hegemonic domain and thus also insists on their Englishness. (p.177).

Reactions from both parties can be construed as rooted in British colonialism. It ensues that the establishment of a positive, coherent and authentic sense of ethnic identity for the Irish community in Britain should not be taken for granted, with the implication that being a member of a particular ethnic group does not necessarily entail self-identification with cultural traditions that provide strength and meaning.

One potentially positive factor resulting from the socio-historical context of the migration of the Irish to Britain is that the demands of local economies led to the formation of ethnic communities or enclaves. For instance, many Irish people migrated to Coventry after the war because there were plenty of work opportunities in the motor and construction industries. The establishment of these enclaves has allowed the development of community networks and resources, together with

religious institutions, permitting reaffirmation of a positive self-identity, and resources for its maintenance (Ahmad & Bradby, 2007).

Hence, a case can be made that British colonialism and the world political economy have affected both components of Irish ethnicity, i.e., structure, by affecting the migration and discrimination experiences and the socioeconomic position of the Irish, and identity, by creating internal identity conflicts and a fragmented identity for the Irish. It is important to recognize, however, that the above arguments are applicable to the post-feudal era. As related by English (2007), the Irish fairly regularly raped and pillaged the populations of Wales and England during the fourth and fifth centuries, “Irish attacks on Britain, Irish migrations to Wales, England and Scotland, and Irish settlements on the larger island all complicate the often-assumed pattern of timeless English bullying” (p. 29). This places the culturally inherited narrative of Irish victimhood within a longer historical perspective.

Irish Ethnicity as Structure

The Migration Experience, Acculturation and Alcohol Consumption

The plausibility of the Irish being subject to an inverse selection effect whereby a higher proportion of less healthy, poorer individuals migrate due to the geographical proximity of Ireland and England was undermined by evidence of high rates of morbidity and mortality among second generation Irish people (Raftery et al., 1990 and Harding & Balarajan, 1996, as cited in Leavey, 1999). There is evidence, however, to suggest that the relative closeness of Britain and Ireland and the ease of migration that it permits is in itself a risk factor in the mental illness of Irish migrants to Britain. Studies from Scandinavian countries offer support for this (Mortensen et al., 1997 and Ferrado-Noli, 1997, as cited in Leavey, 1999). Mortenson et al (1997),

for instance, found higher rates of mental illness in immigrants from bordering countries for whom immigration is easy and informal.

Most migrants from Ireland were young, single people having left school (Garvey, 1985), fatalistically resigned to migrate in periods of high unemployment in Ireland (Carlsen & Nilsen, 1995, as cited in Leavey, 1999). According to Leavey, Sembhi & Livingston (2004), “migration was considered by many as a pragmatic, customary and inevitable response to economic distress and personal stagnation.” (p. 774).

Moreover, “life in impoverished rural Ireland [...] offered little preparation beyond deep-seated cultural anxieties about secular, permissive England.” (p. 241). Finally, unlike other migrant groups, the Irish tended to view the initial migration to Britain as a temporary necessity or adventure rather than a permanent laying down of roots (Leavey, 1999; Leavey et al., 2004).

The geographical proximity of Ireland and England, the need to migrate for economic reasons and the view of the initial migration to Britain as temporary often led to a poorly planned migration, which Ryan, Leavey, Golden, Blizard & King (2006), in a community-based, case-control study of Irish migrants living in London found to be associated with subsequent depression. Indeed, the odds ratio for depressive illness increased by a factor of 20% for each additional negative answer to eight questions on preparation for migration: whether respondents had 1) discussed their migration with family members in Ireland, 2) obtained family agreement with their decision, 3) pre-arranged employment in England, 4) considered their length of stay, 5) a network of friends and family available upon arrival, 6) pre-arranged accommodation, 7) prepared to any extent for their migration and 8) a principal reason for leaving Ireland (Ryan et al., 2006, p. 561). After adjusting for experiences prior to migration, such as childhood trauma and depression, the odds ratio for

depression associated with poorly planned migration remained significant for men but not for women (2006).

Additional gender differences in the motivation to migrate were noted by Leavey et al. (2004). Although, for both Irish men and women participants in the study, poverty in Ireland was a push factor to migrate, for women it was also a chance to escape the diminished probability of marriage which was essential for a fulfilling social existence in Ireland. For men, however, migration was a means of surviving and bettering oneself through work (Leavey et al., 2004). These gender differences, they argued, influenced attitudes towards settlement, identity and belonging.

The importance of post-migration experiences was stressed by Ryan et al. (2006), who found positive post-migration experiences, such as adequate social support and employment, to protect somewhat against depression, particularly among men. Leavey et al. (2004) noted generally more positive post-migration experiences for Irish women than for men. Irish women often worked in occupations which were tied to accommodation, e.g., hotels, hospitals or domestic service (Ryan, 1990, as cited in Leavey et al., 2004) and had been arranged by recruiting agencies which obliged its clients to work in a particular job until the agency fees were paid. They could therefore more easily form social networks and become part of a settled Irish community with its associated organizations, usually formed around the Catholic Church (Leavey et al., 2004). This could have a protective effect on their health (Ryan et al., 2006) by helping maintain a positive sense of identity and self-esteem, and develop coping strategies and health awareness (Walsh & McGrath, 2000).

Irish men, on the other hand, often worked in the construction industry and did not have pre-arranged employment or accommodation. Construction jobs were usually temporary and demanded constant relocation, which did not permit stability in

accommodation or social or personal relationships (Leavey et al., 2004). The most accessible social existence was found within public houses (2004), which Irish migrants saw as a safe cultural environment where they could get news from home and enjoy camaraderie, “craic” (fun) and music. The public house helped Irish migrants counter social isolation, protect or reinforce their sense of Irish identity and maintain social (and thus employment) contacts (Leavey et al., 2007; Tilki, 2006).

This reliance on pub life as “provider of surrogate family and an Irish cultural milieu established a pattern of heavy drinking which continued into middle and old age.” (Leavey et al., 2007, p. 242). Indeed, for older Irish migrants, particularly single men, pub life appears to provide much of their social existence (Leavey et al., 2004), but is only a transient and artificial substitute for close social support (Leavey, 1999). According to the Irish migrants in Leavey et al.’s study (2007), reliance on alcohol developed as a method of coping with psychological and emotional pain, dismal accommodation and/or chronic illness and poor socioeconomic position more generally; “hurtful” experiences of anti-Irish racism and discrimination featured strongly in the narratives.

Evidence of heavy drinking and excessive rates of alcohol-related diseases among the Irish in England and Wales, when compared to the British general population, has been provided by numerous studies (Becker, Hills & Erens, 2006; Balarajan & Yuen, 1986, as cited in Abbotts et al., 1999a; Commander, Odell, Sashidharan & Surtees, 1999; Greenslade, Pearson & Madden, 1995; Harrison & Carr-Hill, 1992; Harrison, Carr-Hill & Sutton, 1993; Harrison, Sutton & Gardiner, 1997, as cited in Tilki, 2006). While some studies have shown the patterns of drinking of the Irish in Britain to be similar to those in Ireland (Walsh, 1987, O’Connor, 1978, O’Connor & Daly, 1985) (as cited in Mullen, Williams & Hunt, 1996), McCambridge, Conlon, Keaney,

Wanigaratne, & Strang (2004) found the mean weekly alcohol consumption of the Irish in London to be approximately 50% greater than those in Dublin, with more high-risk drinking. There is also evidence from Harrison and Carr-Hill's (1992) survey of Irish migrants that alcohol consumption increases following migration to Britain.

Several authors therefore attribute these high rates of heavy drinking to the combination of structural vulnerability factors related to migration (e.g., homesickness, social isolation, insecure housing, and racism), and Irish cultural attitudes towards drinking habits, where heavy alcohol consumption is treated with apparent extremes of tolerance (Greenslade et al., 1995, Leavey et al., 2004; Tilki, 2006) and linked to a culture of masculinity, whereby drinking heavily while remaining in control is a sign of manhood (Greenslade et al., 1995; Peace, 1992, as cited in Tilki, 2006). Walls (2005) locates this tolerance of high alcohol consumption in Catholicism, a key aspect of Irish identity (as cited in Tilki, 2006).

The recorded personal histories of Irish migrants in a number of qualitative studies (Walls, 1996; Williams & Mac an Ghaill, 1998; Gray, 1998) are consistent in their portrayal of people as “dislocated and stranded, continually postponing the return to Ireland while psychologically and materially unable to prepare a comfortable existence in Britain.” (as cited in Leavey, 1999, p. 170). Looking at older Irish migrants, Leavey et al. (2004) found that, despite an acceptance of having a family and other roots in England, the study participants generally had an ambivalent sense of belonging, which they explained by historical national grievance, a need for cultural familiarity and by poor acceptance and hostility from the host community. For almost all the participants, it was felt important to have a connection of some sort with Ireland, usually through holidays or family visits, although many were not able

to do so. The idea of returning to Ireland to live there constituted an implausible hope for some and a hopeless prospect, strongly rejected, for the rest.

Although Irish women may be more connected than the men to the Irish community in Britain and more likely to have a family, they still have higher rates of heavy drinking when compared to their British counterparts (Becker et al., 2006; Harrison & Carr-Hill, 1992; Greenslade et al., 1995). It is likely that they share the men's feelings of being dislocated from Ireland and not belonging in Britain, and also tend to be materially disadvantaged.

The patterns of heavy drinking observed among second generation Irish men, when compared to the British-born of British-born parents (Becker et al., 2006; Greenslade et al., 1995; Harrison et al., 1993) may also be explained by difficulties in acculturation. Although these problems may not take a structural form in that the second generation Irish do not appear to be socioeconomically disadvantaged (see next section), there are issues of identity formation, which will be discussed below.

The Irish in Britain also have high smoking rates in comparison to the general population (Abbotts, Harding & Cruickshank, 2004b; Wardle, 2006; Balarajan & Yuen, 1986 & Pearson et al., 1991, as cited in Abbotts et al., 1999a), which increases the risk of pulmonary and cardiac disease. The reasons for this behavior are not so well documented, but may well be similarly related to migration and acculturation factors.

In summary, migration may affect the health of Irish migrants through a complex sequence of events. Pre-migration factors, including a forced and poorly planned migration with no intention of settling down in Britain permanently, the stress of the migration itself, and post-migration factors, including socioeconomic disadvantage, racism, social isolation or an ambivalent sense of belonging in England, combined

with the attractiveness of the public house, cumulatively affect the health of the Irish migrant, especially the men.

Socioeconomic Status, Experiences of Discrimination and Social Isolation

Williams observed that although Irish born women have lower standardized mortality rates in the UK than in Ireland, first and second generation Irish men have higher mortality rates in the UK than in Ireland and mortality rates worsen for Irish born daughters of Irish born parents. He concluded that Irish health inequalities stem, not from hereditary, health selection and migration stress explanations but rather, from a disadvantageous minority environment (1992).

A recent study conducted by the Federation of Irish Societies used Census 2001 data (2007a) to examine the socioeconomic position of the “white Irish”¹⁶ in England. The analyses reveal lower levels of housing tenure¹⁷ and worse amenities for the “white Irish” in England when compared to the white British general population with lower levels of home ownership, a relatively high proportion living in rented accommodation (both social and private), in medical and care establishment¹⁸,

¹⁶ The “white Irish” are individuals who reported a “white Irish” ethnicity on Census 2001 forms. This category was offered for the first time in 2001. While it should ideally encompass all first, second and third generation Irish people in England who identify as Irish, there are reasons to believe that second and third generation Irish people are under-represented within this category because self-declared ethnicity is a complicated issue (see footnote #2 in methodology chapter). Of those people in England who described themselves in the Census as white Irish, 74.9% were first generation Irish, i.e., born on the Island of Ireland (65.9% in the Republic of Ireland and 9.0% in Northern Ireland), 23.3% were second generation Irish, i.e., born in the UK (excluding Northern Ireland) and 1.6% were born outside Europe.

¹⁷ Barlow and Duncan (1988) identify particular problems with the use of the concept of “housing tenure” to reflect variations in material well-being. They argue that while it seems logical to assume that there is a substantive link between income and housing tenure in that it is necessary to reach certain levels of income and credit eligibility to purchase a dwelling in Western capitalist societies, the concept of housing tenure is frequently misused and taken to mean a lot more than the relations of occupancy and ownership that it actually describes; it is taken to reflect a wider range of conditions of material well-being including housing attributes such as housing quality, social status and financing mechanisms which, the authors argue, it cannot be assumed to describe. Moreover, researchers have often failed to recognize the historical and geographical specificity of the concept in relation to its ability to describe material well-being.

¹⁸ This includes nursing homes, residential care homes, prison and psychiatric homes. Higher proportions in nursing and residential homes could be due to a higher proportion of the “white Irish” being older in comparison with the British general population.

without central heating (particularly in the West Midlands), in overcrowded accommodation and without a car (FIS, 2007a). The analyses also show a relatively low level of economic activity amongst the white Irish aged 25 to 74, with a higher proportion not working because of permanent sickness or disability. A relatively high proportion of the 16 to 24 age group was in full-time education. In contrast, the unemployment figures of the Irish and British groups were very similar (FIS, 2007a).

Moreover, the analyses suggest a dual socioeconomic position for the “white Irish” in England with, on the one hand, a relatively high proportion of men and women working in the professional and managerial occupations and of people holding high level qualifications and, on the other, a very high proportion of men working in construction and of women working in health and social care, i.e., in occupations which can have significant effects on a population’s health, well-being and (current and future) financial well-being, a relatively high proportion in elementary work and routine posts (NS-SEC) (mid-way position in comparison with the British and minority ethnic populations of England) and a high proportion of people with low level qualifications (FIS, 2007a).

Important differences, however, were noted by age and country of birth for the “white Irish” in England, with the younger sections of the white Irish population and the “white Irish” born in Northern Ireland and in England (second generation Irish) displaying a more advantageous socioeconomic profile than the white British general population with respect to education and occupation respectively and the Republic-Irish born being most disadvantaged with respect to the above indicators and industry (over-representation in construction and health and social care) (FIS, 2007a).

The FIS (2007a) study is consistent with other studies who also found the Republic-Irish born, in particular the bulge of the 1950s migrants, to be strongly

clustered in the areas of personal service and nursing (women) and in the industrial, general labouring and the construction industry (men) (Hickman & Walter, 1997) and the first generation Irish, mainly from the Republic of Ireland, to be socio-economically disadvantaged, not unlike other ethnic minority groups, with respect to several socioeconomic indicators, including higher rates of unemployment, worse housing tenure, housing and working conditions, lower car ownership, higher than average proportion with no recorded qualification, disproportionate concentration in non-skilled manual classes and overrepresentation among the homeless population (Greenslade et al., 1991; Hickman & Walter, 1997; Harding & Maxwell, 1997; Tilki, 1994; Owen, 1995; Department of employment, 1993, as cited in Kelleher & Hiller, 1996; Harrison & Carr-Hill, 1992; Haringey Council, 1990, as cited in Tilki, 1994; Cara Irish Housing Association, 1994, as cited in Diaz, 2000).

The older Irish were shown to have a particularly precarious socioeconomic position, with 68% of Irish retirees in Haringey existing on state pension alone and 87% reporting their income as inadequate (Haringey Council, 1990, as cited in Tilki, 1994). Tilki (1994) commented this was a result of persistent low socioeconomic status, intermittent employment history and sporadic pension contributions during the life course. As corollary of these factors combined with changing places of work is social isolation for this population who were unable to form social networks and get married. Thus, the percentage of single Irish older men is twice the national average (Pearson et al., 1991, as cited in Tilki, 1994). Single Irish women, like nurses and hostel workers, who have spent their lives in tied accommodation, are also often isolated in poor living conditions (Murphy, 1993, as cited in Tilki, 1994).

The young Irish-born and the Northern Irish-born, on the other hand, were found to be highly represented in professional and managerial categories and to be better off

than the British average (Hickman & Walter, 1997; Owen, 1995). Gender differences were also noted with Irish-born women found to have higher qualifications than Irish-born men, except at younger ages (1997).

The FIS (2007a) finding of an advantageous socioeconomic position for the second generation Irish in the UK, compared to both the native British and the first generation Irish-born, is consistent with other studies which documented an advantageous socioeconomic position for the Irish with respect to housing tenure, educational attainment, employment and social mobility (Hickman, Morgan & Walter, 2001). Interestingly, this advantage was limited to second generation Irish men with Republic-born parents, while those with Northern-Irish born parents were “firmly entrenched in the working class.” (Hornsby-Smith & Dale, 1988, as cited in Hickman et al., 2001, p.34). Second generation Irish women, on the other hand, were found to be doing particularly well socioeconomically, regardless of parents’ country of birth, when compared to the English control group and first generation Irish women (Hornsby-Smith & Dale, 1988 and NESC report, 1991, as cited in Hickman et al., 2001). Higher rates of upward mobility for the second generation Irish when compared to the general white British population were also found by Heath and McMahon (2005).

It is significant, however, that despite evidence of second generation Irish people reaching a profile closer or even possibly better to that of the indigenous “white” population, recent research findings in Birmingham indicated an ongoing pattern of low achievement for groups of second- and third-generation Irish young men, indicating that socioeconomic disadvantage may continue (Williams, Dunne & Mac an Ghail, 1996, as cited in Walter, 1999).

A study conducted by Harding and Balarajan (2001) found the first generation Irish to be most disadvantaged in terms of housing tenure and car access and the third generation Irish (respondents with at least one Irish-born grandparent) least disadvantaged, highlighting the lessening of socio-economic disadvantage between generations of Irish people living in England and Wales. In their study, the excess mortality of the first generation was fully accounted for by socioeconomic position, measured by the above two variables, but the excess mortality of the second and third generation could not be accounted for by these factors.

There is evidence that the Irish were and still are victims of racial discrimination and violence in Britain (Lennon et al., 1988, as cited in Hickman & Walter, 1997; Reynolds, 1993 in Doolin, 1994; O'Flynn et al., 1993, as cited in Pender & Lavery, 1997) and face discrimination in employment, in access and provision of health and housing services in the UK (Hickman & Walter, 1997; Tilki, 1994; Diaz, 2000). According to Pender and Lavery (1997), the continued over concentration of Irish-born workers, particularly from the Republic of Ireland, in poorly paid and hazardous occupations, despite a recent influx of a highly educated young professional Irish labour force, is "most worrying and indicative of the extent to which a number of Irish people in Britain are denied the basis of citizenship, namely equality of status and opportunity." (p. 92).

Anti-Irish discrimination was widespread in England in the 1970's during the "Troubles" in Northern Ireland and the IRA events, which led to the adoption of the Prevention of Terrorism Act, founded on racial differences. This act had damaging effects on the Irish community (Hillyard, 1993, as cited in Hickman & Walter, 1997). The widespread tolerance of derogatory Irish jokes in Britain can also be construed as racist (Hickman, 1995).

According to Tilki (1994), the legacy of Irish stereotypes and a victim-blaming approach, which can be traced back in history to colonialism and led to a neglect of the wider social issues of discrimination and deprivation, still affects older Irish people today. Indeed, negative stereotypes portrayed the Irish as inferior, “stupid, dirty and given to drunkenness” (Curtis, 1984; Curtis, 1990, as cited in Tilki, 1994, p. 910). They were also seen as “hot-headed, volatile, rowdy and aggressive” and any demonstration of “high spirits, drunkenness or brawling” substantiated suspicions of “antisocial behaviour” and reinforced stereotypes (Swift & Gilley, 1989, as cited in Tilki, 1994, p. 910). These images pervaded British consciousness and led to the Irish being blamed for their poor life chances and ill-health (1994). Unfortunately, there are grounds to believe that these stereotypes continue to inform British attitudes towards the Irish (Hickman, 1995). According to Walter (1999), anti-Irish discrimination continues in less overt forms.

According to the NESC report (1991), however, “the possession of British qualifications and the loss of perceptible Irish characteristics leaves the second-generation Irish less open to occupational discrimination” than the migrant generation (p.204, as cited in Hickman et al., 2001).

Hence, while socioeconomic disadvantage appears to be a very promising explanation for the health inequalities faced by the first generation Irish population in the UK, it may not be so for the second generation Irish. Alternative explanations must therefore be sought for the Irish health inequalities which persist through second and third generations.

Irish Ethnicity as Identity

Identity, Social support and Health Behaviours

Some authors suggest that, for the Irish in Britain, “a lack of social cohesion and integration meshed with the inability to establish an authentic identity is likely to be the encompassing explanation for high rates of suicide and attempted suicide in this group.” (Leavey, 1999, p. 170). Irish migrants and their children are “obliged to suppress an ‘Irish’ identity which in Britain has been negatively valued and represented” (Leavey et al., 2007, p. 241), and forced to accept the inferior image the colonizers have of them (Greenslade, 1992) (see discussion on Fanon above, p.45).

Clarke (1998) suggests that Irish migrants have responded to the British devaluation of the Irish identity and resultant inferiority complex by forming enclaves in certain parts of the UK. In other words, they have maintained their Irishness by keeping Englishness out. Talking about Irish people’s apparent unwillingness to contribute to British culture and society, Lee (in O’Mahony, 1988, as cited in Clarke, 1998) said:

Part of that reluctance arises from an inferiority complex which makes us claim stridently an absolute distinctiveness and fails to acknowledge the contribution of the Irish because it would link Irish distinctiveness to other traditions, particularly of course the British tradition. (p.559).

Thus the Irish may prefer not to integrate within British society to avoid these feelings of inferiority, prompted by encounters with the British community and perpetuated across generations of Irish people via English history books (Hickman, 1990, as cited in Clarke, 1998). The fact they share a common skin colour deepens notions of inferiority based upon intellectual inadequacy or other self-perceived character traits: “more than skin deep, so to speak.” (Clarke, 1998, p. 559).

The Irish migrants’ strong desire to hold on to their Irish identity may, paradoxically, be a response to a sense of identity loss, created in part by the demise

of the Gaelic language. Richard Kearney (in O'Mahony, 1988, as cited in Clarke, 1998) said:

It seems to me that our obsession with identity, our obsession with Irishness, may have something to do with the fact that the people feel that the language is lost: they regret it, they are nostalgic about it, but they feel it is lost. (p.559).

On the other hand, the Irish strongly resist the possibility of a British identity, seeing one national identity as incompatible with another, owing to British colonialism and a historical grievance with the British state (Leavey, 1999, as cited in Leavey, 1999; Modood, 2003).

Belonging to Irish groups or enclaves may offer some degree of protection against mental distress (Brent Irish Mental Health Group, 1986, as cited in Clarke, 1998) and help in the maintenance of a more positive Irish identity. According to Ahmad and Bradby (2007),

Concentration [of migrants and minorities in certain areas] has allowed the development of community networks, economic activity, community resources, reaffirmation of positive self-identity and resources for its maintenance [...] Such concentration potentially acts as a buffer against prejudice and racism, provides role models, accords status to individuals for skills or knowledge not acknowledged outside the community, offers social and moral support, and provides resources for the recreation of community. (p. 800).

Evidence that embeddedness in the Irish community may help in the maintenance of a more positive Irish identity and offer protection against mental distress was given by Leavey et al. (2007) who found that issues of identity did not appear to affect the development of depressive illness among a sample of Irish migrants who had largely maintained an Irish cultural identity in Britain, which they considered to be essential to their sense of self, and remained strongly embedded in London's Irish community.

Malone (2001), in her study of first generation Irish immigrants in the Queen's Park/Kensal Rise area of London, found evidence for a salutogenic effect on health of belonging to a "densely knit" and "bounded" community (p. 197), which contains

numerous personal relationships and considerable social capital¹⁹, in the form of shared values and helping networks formed over time, as well as financial security through home ownership. This “community saved” appeared to enhance the health of its members by strengthening their “sense of coherence” and enabling them to successfully maintain their own “health” in the face of life’s stressors and disruptions, which affect the health experience of other Irish groups in Britain. Respondents perceived the “community saved” to positively protect their physical, social and emotional health, and mortality figures for older people in the area were shown to be lower than might be expected in comparison with both national and other local data (London Borough of Brent Public Health Report, 1995, as cited in Malone, 2001).

In addition to the social support and resources it provides, it is conceivable that membership in the Irish community in Britain may be protective of health by allowing the Irish migrant to form a positive and “authentic” sense of identity associated with the area in which they now live rather than with their country of origin. They can thus simultaneously resist a British identity and avoid the notions of inferiority associated with the Irish identity coupled with Ireland. Indeed, although many Irish migrants in Malone (2001) study were anxious to keep in touch with their homeland, none expressed a desire to return “home” to Ireland.

According to Fanon, however, “the migrant can “bury him or herself” in the migrant community only to a certain extent” (Greenslade, 1992, p. 214). He/she will have to deal with the majority population in the workplace, in education, or in the shops, where the cultural or racial inferiority presupposed in the colonial relationship will become manifest. The migrant therefore can only resist the worse effects of the

¹⁹ Malone’s use of the term social capital in this context refers to what many authors would describe as “bonding” social capital, that is, “inward-looking networks bringing together similar kinds of people”, as opposed to “bridging” social capital, that is, “outward-looking networks and connections among different kinds of people” (Putnam, 2000, pp. 22-24).

historical relationship between the two cultures and will have to opt for the identity that the Other, the English, has created for him. He/she will thus internalise the “pathological projections of the colonist’s assumptions and fears and [...] risk further alienation from his/her own experience.” (1992, p. 215).

The evidence suggests that issues of identity are also pertinent to the second generation Irish in Britain, although they take a slightly different form. According to Hickman (1995), second generation Irish people in England face cultural pressures to become English and to reject Irishness. While some give in to these pressures, others resist the process of incorporation and find the means to assert their own Irish identities, not necessarily reflecting those of their parents. For instance, of the second generation Irish pupils in Catholic schools (in London in the mid-1980s) whom Hickman (1990) interviewed, 81% gave their identity as “Irish” or “of Irish descent”, thus rejecting assimilationist strategies (Hickman, 1995).

While none of the second generation Irish pupils, aged 14 to 18, which Ullah (1985) interviewed in Catholic schools in London and Birmingham in the early 1980s, claimed to be completely Irish, only a relatively small proportion rejected their Irishness and claimed to be completely English. Instead, respondents adopted a range of identities, with 21.9% claiming to be completely English or mainly English, and 19.7% claiming to be mainly Irish, with the majority (56.3%) saying they were half English, half Irish. In a more recent study, McCarvill (2002) also found the second generation Irish people he interviewed in Birmingham to select an array of labels to signal their personal identity.

While all three studies suggest that a sizeable section of the second generation Irish continue to form an identity which includes an Irish dimension and thus have rejected pure assimilationist strategies, the identities they adopted often reflect the

ambivalence contained in their everyday lives; for instance, “subject to racist jeers in the playground yet living in a society which denies that anti-Irish sentiments are racist” or living in a family where Irish heritage is taken for granted but going to a Catholic school which does not recognise the Irish background of most of its pupils (Hickman, 1995, p. 18).

Ullah (1985) found that the vast majority of second generation Irish participants who adopted an Irish identity were proud of their Irish origins and hence successful in rejecting assimilationist strategies. These individuals tended to be involved in the Irish community and its many social and cultural activities and to have had an Irish upbringing where they enjoyed close family ties and a sense of togetherness, important for the development of a collective and positive sense of identity. In contrast, most of those who adopted an English identity were not proud of their Irish identity, suggesting that they had failed to reject the dominant negative stereotype of the Irish (Ullah, 1985).

According to Tajfel’s theory of social identity, for the second generation Irish who “subjectively identified with the relevant ingroup” and rejected the dominant group’s negative image, a new and positively valued identity could be established by comparing the minority group favorably with the dominant group on a range of characteristics or re-evaluating existing negative characteristics (Tajfel & Turner, 1979, as cited in Ullah, 1985, p. 315). Ullah (1985)’s findings are consistent with Tajfel’s theory; in addition to replacing the negative stereotype of the “thick paddy” with the positively valued image of the Irish as friendly people with a natural capacity for enjoying themselves, respondents who had identified themselves as Irish had also developed their own negative stereotype of the English as boring and reserved (1985). On the other hand, those who accepted the negative image of their group could try to

“avoid the associated unpleasant psychological implications which this has by attempting to ‘pass’ to the dominant group” (Ullah 1985, p. 315).

Finally, Ullah (1985) found limited support for Greenslade’s (1992) contention that the children of immigrants are often prone to the condition of marginality: that of being caught between two cultural worlds, unable to feel a complete member of either. Only about a third of the sample reported being puzzled about their identity, i.e., English or Irish. This confusion was related to several features of the position they occupied “as the second generation of a negatively portrayed minority” (Ullah, 1985, p. 317), i.e., experience of anti-Irish prejudice, trips to Ireland where they faced similar identity issues than in England (being called English in Ireland and Irish in England), feeling Irish in situations in which this identity was more salient and English in situations where that identity was most salient, or an ambivalent attitude towards the “Troubles”.

In a study of the processes of identity formation among second generation Irish people living in Britain, Hickman et al. (2005) noted the difficulties faced by the second generation Irish in asserting a hybrid identity in England:

The points of identification articulated by these second generation Irish people were principally framed by the discourses of two hegemonic domains: England and Ireland. One domain (England) is incorporating, denying the difference of “Irishness”; the other domain (Ireland) is differentiating, denying of commonalities with people of Irish descent. There was substantial and consistent evidence that the second generation Irish are positioned as having to defend charges of inauthenticity both from those pressuring them to be English and from those denying their Irish identifications. (p.177).

One way in which the second generation Irish are denigrated and rejected as not Irish by the Irish-born is through the use of the term “Plastic Paddy”. The implication of the term is that “if you were not born in Ireland your claim to Irishness lacks authenticity and can safely be ridiculed” (Hickman et al., 2005, p. 176). This naming process ensures that second generation Irish people’s English accent and birthplace are definite proof of their Englishness and make them a group apart. To be accepted

as Irish, some second generation Irish may come to adopt an Irish accent (Hickman et al., 2005).

Hickman et al. (2005) go on to argue that, rather than viewing the second generation Irish as being “caught between two cultures” (p. 177), as Greenslade (1992) did, they should be seen as being at the intersection of two hegemonic domains; Ireland is represented by their upbringing, family life and their imaginings, England by education, employment, locality and citizenship. This has material and psychological consequences for this generation. Indeed,

The desire of the majority was for recognition of this hybridity rather than for the key to a successful trajectory along either assimilatory path. Many participants wished there was a way of articulating allegiances to more than one domain, conjoined as their “second generationness” and contingent upon their locational specificity (Hickman et al., 2005, p. 178).

Some of the participants who strongly identified with Ireland but felt false putting down Irish, and did not identify as British or English but felt false not putting down English reconciled their identity-related feelings in the absence of a half and half category by identifying as “being local” or Coventry Irish (Hickman et al., 2005).

In addition to affecting health as a result of psychological stress and anxiety, some authors argue that issues of identity may affect the health of the Irish in Britain via the adoption of a low profile and through medical help seeking patterns and health-behaviours. The Irish perception of themselves as second class citizens and a shared sense of collective insecurity about identity may be partly responsible for their adoption of a position which favoured “keeping your head down, your mouth shut and going about your business without rocking the boat” and their unwillingness to make demands on the health care system, and increase the likelihood that their problems eventually emerge as psychological ones, or at least be diagnosed as such (Connor, 1987, as cited in Pender & Lavery, 1997, p. 81; Kelleher & Hillier, 1996).

According to Stivers (1978), descendants of Irish migrants who remain politically identified with Ireland may commemorate aspects of home culture selectively, and emphasize drinking and smoking rituals, as a means of asserting their ethnic identity and heritage (as cited in Mullen et al., 1996). On the other hand, Walsh and McGrath (2000) found Irish migrants who felt positive about their Irish identity to be more likely to report engaging in healthier behaviour and adopting more beneficial coping strategies when faced with day-to-day stresses and problems. However, individuals who reported their ethnic origin as a core part of their ethnic identity but had fewer than desired opportunities for expressing their ethnic identity were more likely to engage in less beneficial coping and health behaviour.

To conclude this section, issues of identity formation, which appear to be tied to British colonialism, anti-Irish stereotypes and prejudices, and the use of the term “plastic paddy” by the Irish born in England, seem to be pertinent to both the first and second generation Irish population in Britain and appear to contribute to Irish health inequalities in England, both directly and indirectly, via their effect on medical help seeking patterns and health behaviours. However, belonging to an Irish community could help in the maintenance of a more positive Irish identity and be protective of health.

Cultural Beliefs/Attitudes of the Irish and Medical-Help Seeking Behaviours

Many authors link the medical-help seeking behaviour of the Irish to Irish cultural beliefs and attitudes about health. Kelleher and Hillier (1996) suggest that the Irish reluctance to consult a doctor when ill (Gillam et al., 1989, as cited in Tilki, 1994; McCormick et al., 1990, as cited in Kelleher & Hillier, 1996; Scanlon et al., 2006), their tendency to see their personal health largely as a matter of external control rather than something within their control (McCluskey, 1989, as cited in Kelleher &

Hillier, 1996) and to put up with pain and discomfort and play down symptoms (Zola, 1966, as cited in Tilki, 1994; Tilki, 2003, as cited in Tilki, 2006; McCluskey, 1989, as cited in Kelleher & Hillier, 1996) could be seen as the result of the accepting attitudes developed within Irish culture in which religion plays a significant part.

McCormick et al. (1990) also propose that their finding that Irish immigrants visit their GP less than average for England and Wales (although they visit more often for what are classified as serious illnesses) may indicate something relating to Irish cultural beliefs about health (as cited in Kelleher & Hiller, 1996). Finally, Scanlon et al. (2006) found Irish health-seeking behaviours to be influenced by historical, cultural, social and economic circumstances, both in the UK and in the past in Ireland.

Clearly, less frequent visits to the doctor could theoretically lead to worse health through poorer preventive care and delayed diagnosis of serious disease. However, there is no direct evidence of such a link for the Irish.

Conclusion

This chapter has reviewed the Irish health inequalities literature within the construct of the conceptual framework developed in the previous chapter. It first documented the health disadvantage faced by the Irish population in England, which persists across the generations, and then looked at how structural and identity aspects of ethnicity contribute to Irish health inequalities and experiences. Many structural and identity/cultural factors, including British colonialism and the wider political economy, experiences of migration and discrimination, socioeconomic position, Irish processes of identity formation, health behaviours and support structures, were shown to constitute important possible influences on Irish health inequalities. The chapter also documented important interactions between and within structural and identity influences.

While the literature provides insight into several possible influences on Irish health, it can only partially answer the research questions. The following chapter will describe the methods used to investigate Irish health inequalities and experiences in England and Coventry, including the use of a mixed strategy design incorporating intensive and extensive research approaches.

Chapter 4: Methodology

Introduction

While the existing literature provides some insights into the possible influences and generative mechanisms of Irish health inequalities, it only partially answers the following questions:

1. What are the trends in socioeconomic status and ethnic health inequalities across the first two postwar generations of Irish people in England, in terms of the persistence of an Irish ‘health disadvantage’?
2. Using Coventry as a case study, to what extent are the health inequalities and experiences of the first two post-1945 generations of Irish men and women in England influenced by their structural position (ethnicity as structure), identity and cultural aspects of being Irish (ethnicity as identity), the interaction between these two dimensions, and agency?

This chapter outlines the methodology used in the research to answer these questions and fill in some of the existing gaps. It describes the mixed strategy design employed in this research, which incorporates extensive and intensive approaches (see below for definition of concepts), and its compatibility with a critical realist perspective. The extensive component provides answers to the first research question and generates clues for the second. Using Coventry as a case study, the intensive component provides in-depth answers to the second research question. The chapter also describes the collaborative approach adopted by the research, and explains how it is also compatible with a critical realist perspective.

A mixed-Strategy Design: Critical Methodological Pluralism

To answer the above research questions, the research uses a critical methodological pluralism model, that is, a mixed-model design, which incorporates complementary extensive and intensive approaches, set within the metatheoretical context of critical realism (Danermark, Jakobsen, & Karlsson, 2002).

Critical realism distinguishes between three domains of reality, the empirical (what is experienced or observed = individual level), the actual (what actually happens = society level) and the real (where the “structures” and generative mechanisms which produce the empirically observable events are found). Bhaskar defined generative mechanisms as “nothing other than a way of acting of a thing” (1978, p.51).

Critical realism thus departs from positivism or “flat empiricism” which equates “the real with the empirical, that is, with what we can experience, as if the world just happened to correspond to the range of our senses and to be identical to what we experience” (Sayer, 2000, p. 11). It further departs from positivism in three major ways. First, it seeks to uncover the real or the generative mechanisms, which are not immediately observable (Danermark et al., 2002). Secondly, it views generative mechanisms as operating in a complex interaction with others in an open social system; they either cooperate with or work against each other and can be active, dormant, or active but not manifest (2002). Thirdly, critical realism recognizes the existence of an objective and independent reality, but views the social reality as socially defined and produced. Thus, people’s descriptions, knowledge and experience of the social reality need to be investigated in context, while at the same time their changeable and conceptually mediated character means that they are fallible or more or less truth-like (Danermark et al., 2002). Moreover, people’s experiences of

the social reality only reveal so much about the reality owing to a discrepancy between what is experienced, what actually happens and what is real (2002). Consequently, the critical realist researcher needs to go beyond respondents' accounts to uncover the real (Pilgrim, 2000).

A critical realist perspective argues that both extensive and intensive approaches can be used in accordance with the above principles, to inform, in different ways, the search for generative mechanisms (Danermark et al., 2002).

The extensive approach can be applied by adopting Lawson's (1997) working model of the contrastive explanation and confining its role to investigating "how extensive certain phenomena and patterns are in a population" (Sayer, 2000, p. 20). While the extensive approach can provide clues to generative mechanisms, only the intensive approach can really begin to uncover causal explanations or "what makes things happen in specific cases" (Sayer, 2000, p. 20).

According to Lawson, although mechanisms work in a dynamic and open social world and thus may not always appear empirically in their "pure" form, counteractive mechanisms may be involved, and the mechanism may be inactive, "over restricted regions of time-space certain mechanisms may come to dominate others and/or shine through" and they give rise to "rough and ready generalities or partial generalities, holding to such a degree that prima facie an explanation is called for" (Lawson, 1997, p. 204, as cited in Danermark et al., 2002). Another name for these partial regularities is "demi-regularities" (2002, p. 204).

The critical realist's task is thus to first identify these demi-regularities or empirical patterns through the extensive approach, that is, by studying a larger population as a taxonomic group and through the statistical analysis of quantitative data (Danermark et al., 2002). By contrasting systematic differences between two

groups in a given society, one can provide clues to generate mechanisms: Lawson (1997) calls this the contrastive explanation (2002).

Secondly, because the social reality is complex, for the reasons outlined above, the critical realist needs to use the intensive approach in order to begin to uncover the “real” and explore the influences and mechanism(s) which could account for the demi-regularity or phenomenon in question. He/she can then investigate “how a mechanism works in a concrete situation [...] [by] tracing the causal power and describing the interaction between powers that produce a social phenomenon” (Danermark et al., 2002, p. 166). This is done by studying a small number of cases or agents as a causal group and in context, through the collection and analysis of qualitative data (2002).

However, owing to the socially and conceptually mediated, and thus fallible nature of knowledge and the discrepancy between what is experienced, what actually happens and what is real, the critical realist recognizes the need to go beyond respondents’ accounts to uncover the “real” and use social scientific tools to discriminate among theories regarding their ability to inform us about the social reality (Danermark et al., 2002).

With respect to this thesis, the extensive aspect of the research consists in deriving background evidence for the demi-regularity that Irish people in England have poorer health than the general white British population, from the statistical analysis of data from the Census 2001 Individual Licensed SARs quantitative dataset (ONS [a]). It also consists in identifying differences in socio-demographic and economic characteristics between the Irish population as a whole, its country of birth subgroups, and the white British population in England in order to provide clues to generative mechanisms, through the use of descriptive statistics. In keeping with the theoretical

conceptualization of ethnicity as both structure and identity, the extensive research uses the Census 2001 more sensitive indicator of ethnicity (which is seen to reflect both structural and identity aspects of ethnicity) to statistically investigate the trends.

At the beginning of my work on this thesis, a positivist or empiricist approach (see p. 70) was taken which, in addition to deriving purely descriptive statistics, utilized logistic regression analyses to determine the explanatory contribution of demographic, socio-economic and ethnicity factors to the health of different Irish sub-populations. Subsequently, recognising the limitations of statistical analysis for making causal inferences, the results of these analyses were re-interpreted in the context of a critical realist approach or critical methodological pluralism model to more clearly illustrate the demi-regularity that the Irish population in England have poorer health than the British general population and provide clues to underlying generative mechanisms.

Nevertheless, the centerpiece of the research is the intensive component which engages in a primary analysis of semi-structured interviews and employs a collaborative approach to understand the possible reasons for Irish health inequalities, or more specifically, to provide insight into the interacting influences and mechanisms which produce the above empirical manifestation or demi-regularity or, alternatively, prevent its manifestation.

In order to test out the influences on Irish health inequalities in England, the intensive research applies the critical realist and socio-historical model of ethnicity as structure and identity, as described in chapter two, to thirty-two semi-structured “biographical” accounts of first and second generation Irish men and women in Coventry. A biographical approach was taken for the interviews since it permits a study of the life of an individual in its historical context (Mills, 2000).

In accordance with this model, the research links influences at the level of society with people's appreciation of how they play out in their or other people's daily lives and affect health, to provide insight into the relative contribution of structural and identity/cultural related aspects of ethnicity to Irish health experiences and inequalities. It explores people's daily realities, experiences, actions and beliefs, and the meaning they attach to these, as well as their discursive knowledge of influences on health, in context, while, in keeping with a critical realist perspective (see above), it critically assesses, and goes beyond, what respondents say in order to uncover the "real", incorporating knowledge derived from the literature of the pathways or processes by which identity and structural aspects of ethnicity affect health.

Both the mechanisms contributing to, and those alleviating, Irish health inequalities are explored, drawing on the concept of resiliency (Bartley, 2006). The research also explores the interactions between, and within, structural and identity/cultural influences and associated generative mechanisms, and the interplay between structure and agency within Irish people's "lived" structural and identity/cultural experiences.

In addition, the research considers the influence of British colonialism and a world capitalist economy on Irish health experiences, since it views these influences as the possible root causes of Irish health inequalities, and explores respondents' discursive knowledge of the pathways linking Irish life and health experiences to these wider structural forces. In keeping with a critical realist perspective, the limited and fallible nature of this knowledge is recognised.

The Extensive Approach

The research used the Census 2001 Individual Licensed SARs (Sample of Anonymised Records) (ONS [a]), a large nationally representative dataset, to first

provide recent evidence on Irish health trends at the England level, including descriptive statistics on the health, socio-demographic and economic characteristics of the Irish population as a whole and divided by country of birth (Irish Republic-born, Northern Irish-born and Second generation Irish), compared to the white British population, second, determine whether there is an “Irish health disadvantage” independent of socio-economic factors for the Irish population as a whole and Irish country of birth groups (see above), and third, explore whether there is evidence of an “independent” Irish ethnic identity effect which operates on health.

Conscious of the “positivist” nature of the second and third components of the above analysis, the research reinterpreted the main findings in accordance with a critical realist perspective (see below).

Sample and Procedure

The Census 2001 Individual Licensed SARs consists of around 3 per cent of person records extracted from Census 2001 data for individuals, relating to some 1.84 million people. For each person, it contains, amongst other things, information on main demographic, health and socio-economic variables (ONS [b]). Only the population living in England is considered in the present study.

The Census 2001 Individual Licensed SARs was chosen by the present study because it has a large Irish sample size, thus increasing the reliability and generalisability of the findings, includes a general white British comparison group, and comprises information on the independent and dependent variables of interest to this study. Only data for adult respondents, aged 16 and above in the Census 2001 Individual Licensed SARs, was considered. In this study, the Irish sample size was 17,523 in the Census 2001 Individual Licensed SAR (“white Irish”).

Measures

The Census 2001 SARs provides information on the main socio-demographic and economic variables of interest to this study (age, gender, marital status, social class²⁰, educational qualifications, and housing tenure). In addition, it provides a measure of industry type and a household housing indicator (i.e., household is overcrowded, lacks a bath/shower, WC or heating). The measure of economic activity provided in the SARs was excluded from the analysis because an error occurred in its computation (see tables 5.1. and 5.2 in chapter 5 for description of variables).

The SARs offers a relatively sensitive self-reported indicator for ethnicity, which is based on responses to a Census 2001 question asking respondents to select their ethnicity; response categories include “white Irish” and “white British”. Although self-reported ethnicity constitutes an improvement over country of birth, it lacks in validity because of its inherent complexity²¹. The “white Irish and “white British” categories were used to compute the “white Irish” variable (see Box 4.1). Only the “white Irish” born in Northern Ireland, the Republic of Ireland or the UK (excluding Northern Ireland) and the “white British” born in the UK (excluding Northern Ireland²²) were considered in the present study. In addition, the SARs provide a “country of birth” variable. Both variables enabled the computation of another variable, “First and second generation Irish”, which comprises four categories: first

²⁰ The indicator of social class has been criticized for lacking in validity owing to the heterogeneity of class groupings and the tendency for ethnic minority people to occupy a worse socioeconomic position within each class group (Nazroo, 2003). In order to more validly measure socioeconomic position, various socioeconomic indicators were used, in addition to that of social class. Even so, the study was unable to measure the entirety of the structural context (e.g. discrimination experiences).

²¹ People may feel that their ethnicity is Irish and yet not declare that on their Census form for various reasons, e.g. they take ethnicity to mean nationality or country of birth or, having parents from different ethnicities, find the lack of a combined option (Irish and British) difficult to contend with (Walter, 2002, as cited in FIS, 2007a). This is likely to lead to an under-representation of second and third generation Irish.

²² Including “white British” Northern Irish born individuals did not significantly alter the results

generation Irish Republic, first generation Northern Irish, second generation Irish²³, and 4) white British (reference category) (see Box 4.1 for definitions). Finally, an additional variable was computed to compare those individuals who were born in Northern Ireland and classed themselves as “white Irish” to those who were born in Northern Ireland but did not class themselves as “white Irish” (see Box 4.1).

The dataset provides information on the main dependent variables of interest, i.e., self-reported general health and self-reported limiting long-term illness; subjective self-reported health has been shown to coincide relatively well with objective health measures (Blaxter, 1987; Bennett et al., 1995) (as cited in ONS, 2000). Self-reported general health was a binary variable coded as either “not good” or “fair or good” (reference category). Limiting long-term illness was coded as either presence or absence (reference category) of a limiting long-term illness.

Box 4.1: Categorisation of Irish Variables from SARs

White Irish: dummy variable indicating people who ticked the “white Irish” box on the ethnicity question, “What is your ethnic group?” Reference category: “white British”

First and second generation Irish: variable with four categories:

- 1) *First generation Irish Republic:* state having an Irish ethnicity and were born in the Republic of Ireland,
- 2) *First generation Northern Irish:* state having an Irish ethnicity and were born in Northern Ireland
- 3) *Second generation Irish:* state having an Irish ethnicity and were born in the UK (excluding Northern Ireland)
- 4) *White British Reference category:* state having a British ethnicity and were born in the UK (excluding Northern Ireland)

Northern Irish ethnicity: dummy variable indicating people who were born in Northern Ireland and described themselves as “white Irish”. Reference category: people born in Northern Ireland who described themselves as “white British”

²³ This category was labeled “second generation” Irish for convenience. In practice, some Irish of third or subsequent generations could be included in this population. However, this is expected to be a minority since self-identification with being of Irish ethnicity decreases with subsequent generations. Moreover, most third generation Irish would have been younger than 16 in 2001 when the survey was conducted.

Analytical plan

Statistical Analysis

The study first derived descriptive statistics to compare and contrast the socio-demographic, economic and health profile of the “white” Irish, and then of its subcategories, the first generation Irish Republic, first generation Northern Irish and second generation Irish, to that of the “white British” general population (see tables 5.1, 5.2 and 5.3 in chapter 5 for details).

It then conducted a series of binary logistic regression analyses, using SPSS, to investigate:

- 1) The existence of a “health disadvantage” for the Irish living in England which persists after controlling for the basic health-affecting variables (age, gender, marital status and socio-economic factors). This analysis used the “white Irish” self-reported ethnicity variable. Assuming the “ethnicity” variable at least partially reflects respondents’ self-identification with the Irish culture and community, this analysis explores the effect of both structural and identity components of Irish ethnicity on health.

- 2) Which country of birth groups (first generation Irish Republic, first generation Northern Irish, second generation Irish) suffer from this “health disadvantage”, if such an effect is found for the “white Irish”, again before and after controlling for the independent variables described above. With the previous assumption in mind, this analysis explores the effect of both structural and identity components of Irish ethnicity on health.

- 3) The existence of an Irish ethnic identity effect on the health measures for the Northern Irish born. This analysis determined the effect of being born in Northern Ireland and stating having a “white Irish” ethnicity, as opposed to being born in

Northern Ireland and stating having a “white British” ethnicity, on the health measures, again before and after adjusting for key independent variables. The same analysis could not be carried out for the Republic Irish born since the vast majority (90%) stated having a “white Irish” ethnicity, nor for the second generation Irish since the SARs do not provide information on Irish parentage (in this study, the second generation Irish were identified by considering those individuals who stated having a “white Irish” ethnicity and were born in the UK).

“Critical Realist” Analysis

Conscious of the “positivist” nature of much of the above analysis and the limitations of statistical analysis for making causal inferences, the research reinterpreted the above research findings within the frame of a critical realist approach to more clearly illustrate the demi-regularity that the Irish population in England have poorer health than the British general population and provide clues to its underlying generative mechanisms. This involved drawing out the contrasting demi-regularities in socio-demographic and economic status between the Irish and British populations which emerged from the preceding analyses based on Census 2001 SARs data. Expression of Irish identity was also considered in the critical realist interpretation of the findings.

The Intensive Approach

The main aim of the intensive approach was to explore the possible reasons for Irish health inequalities or experiences in England. More specifically, it was to explore the relative importance of, and interaction between, influences and associated generative mechanisms of ethnicity as structure and identity to Irish health inequalities or experiences in England. This included an exploration of the relevance

of the wider socio-political context. Moreover, the research sought to investigate the interplay between structure and agency within structural and identity aspects of ethnicity. In order to achieve these main objectives, the research employed a collaborative approach and conducted “biographical” semi-structured interviews with a sample of two generations of Irish men and women living in Coventry. These were subsequently analysed using a framework approach. The interviews aimed to understand Irish people’s appreciation of how structural and identity influences at the level of society play out in their or other people’s daily lives and affect health, and to explore their capacity for agency. Thus, interviewees’ experiences, actions, beliefs, perceptions and discursive knowledge of pathways linking British colonialism and a world capitalist economy to Irish life and health experiences, and of factors affecting health, were explored. However, in keeping with a critical realist perspective, the limitations of qualitative accounts for uncovering the “real” were recognized.

The Case Study Research Method: Coventry as a Case Study

The case study research method was chosen because it is compatible with a critical realist perspective since it enables a good understanding of a complex issue through emphasizing detailed contextual analysis of a limited number of events or conditions and their relationships (Soy, 1997).

Coventry was chosen as case study because it contains a large first, second and third generation Irish community (Hickman & Walter, 1997). Indeed, in the 2001 Census, 10,401 individuals living in Coventry (3.5% of the population) stated an Irish ethnicity²⁴, making the Irish the second largest self-ascribed ethnic minority group in

²⁴ This proportion of 3.5% is much higher than the proportions found in either the West Midlands region (1.4%) or England (1.3%). Nonetheless, it is likely to be an under-representation of the Irish population in Coventry. Self-declared ethnicity is a complicated issue – the Irish population could be as high as 10.4% of the population (FIS, 2007b).

Coventry, after the Indian ethnic group (FIS, 2007b). Coventry has a large Irish population because “the large scale immigration of the 1950s focused particularly on cities in the English Midlands, especially Birmingham, as well as Coventry” (Hickman & Walter, 1997, p. 29); then, Coventry had one of the most dynamic local economies in the country, owing to its motor and other engineering industries (Dolan, 2003). The first generation Irish population considered in the present study belongs to this wave of people and the second generation Irish population represents the children of this wave of people.

Figures derived from Census 2001 data for England (FIS, 2007a) and Coventry (FIS, 2007b) suggest that the Irish population in Coventry is demographically quite similar to that of England as a whole (see table 4.1). The main differences can be largely attributed to the wave of young adult migrants who arrived in Coventry in the 1950’s, 60’s and 70’s, which is reflected in slightly higher proportions of the Coventry Irish population who are elderly, economically inactive, who own a home (but not a car) and are in poor health. It is also interesting to note that the Coventry Irish have lower proportions in the managerial and professional fields and higher proportions in the elementary occupations.

Table 4. 1: Comparison of Coventry Population Characteristics with those of England as a Whole

Population Characteristic	Coventry	England as a Whole
First Generation Irish (Total)	78.5%	74.9%
- From Republic of Ireland	70.7%	65.9%
- From Northern Ireland	7.8%	9.0%
Second Generation Irish	20.8%	23.3%
Proportion ≥ 65 years	33%	25%
Economically active (Total)	51%	60%
- Managerial		
- Men	11%	19.6%
- Women	9.6%	13.2%
- Professional		
- Men	9%	15%
- Women	9.6%	13%
- Skilled Trades		
- Men	24.9%	17.3%
- Women	1.5%	2%
- Elementary occupations		
- Men	18%	12.3%
- Women	20.4%	11.3%
Economic indicators:		
- Car Ownership	51%	60%
- Home Ownership	71%	63%
- Overcrowded households	10%	11.2%
- Have Central Heating	11.4%	8.3%
Limiting long-term Illness		
- Men (16-49)	15.5%	11%
- Women (16-49)	1%	1%
Poor General Health		
- Men	33%	29%
- Women	29%	25%

Ref: FIS (2007a) and FIS (2007b)

A Collaborative Community Based Participatory Approach

The current research adopted a “collaborative” approach (Cornwall & Jewkes, 1995) or, more specifically, a community-based participatory approach (Israel et al., 2003). That is, while it is acknowledged to be an independent piece of research for thesis purposes, it is conducted in partnership with a Steering Group overseen by the

Coventry Irish Society (CIS), which consists of the student and supervisor, leading members of the CIS, and local health professionals. The CIS provides a range of services for the Irish community in Coventry, including a free information and outreach service on welfare and benefits issues, a free counselling service and befriending scheme, social events and outings. It also undertakes research.

A collaborative approach is consistent with a critical realist standpoint since it allows an “insider” perspective of the Irish through the knowledge of community representatives, and supports agency of the Irish community by integrating knowledge generation with community and social change efforts that address the concerns of the community. However, it is important to acknowledge that community members may not always recognise the wider generative mechanisms of Irish health inequalities.

A Partnership with the Coventry Irish Society

The partnership with the CIS was initiated via contact with a second generation Irish CIS outreach worker at a local conference in Coventry about Irish health. The partnership then grew quite “organically” and was mostly comprised of Irish-born people or people of Irish descent. It included the former Lord Mayor of Coventry (first generation Irish from the Republic of Ireland and a CIS member), the CIS project manager and a second CIS health outreach worker (both second generation Irish), local health professionals working for the Coventry NHS PCT/ Health Promotion Unit (two first generation Irish women from the Republic of Ireland and Northern Ireland respectively, and a British man), a nurse (a British woman), my supervisor and myself (British and British/French respectively). The final Steering Group thus benefited from a broad representation of different fields of expertise and

from a high level of motivation since all the members were keen to be part of the research project, and met on a regular basis²⁵.

A Community-based Participatory Approach

The research adopted a community-based participatory approach (CBPR), defined as,

A partnership approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute 'unique strengths and shared responsibilities' to enhance understanding of a given phenomenon and the social and cultural dynamics of the community, and integrate the knowledge gained with action to improve the health and well-being of community members (Israel et al., 2003, p. 54).

An important benefit of using a CBPR approach is the notion of an exchange whereby the community can help the researcher meet their own doctoral needs and the researcher can help the community address community concerns and provide an empirical grounding for their case for special treatment, here, to raise the profile of Irish people and their health needs and justify claims for Irish culturally sensitive services. In this way, the researcher works *with* the researched, rather than *on or for* them (O'Leary, 2004, p. 144); the research is produced collaboratively, in accountability to disadvantaged or oppressed groups, in ways that facilitated empowerment. The Irish community is directly involved in the research project, via community representatives, and gains a sense of ownership of the research instead of being used by outsiders for academic purposes. It thus becomes an insider to the research taking place.

In accordance with a CBPR approach, the present research worked with existing communities of identity²⁶, here, the Irish community living in Coventry, and

²⁵ The first Steering Group meeting was on the 26th of April, 2006. The Steering Group met about eight times over the subsequent two year period. In the final year of the partnership, only professionals from the CIS, the ex-mayor, my supervisor and I were involved in the project. The meetings then mostly dealt with the organization of a local conference on Irish health inequalities in Coventry where the collaborative research findings would be presented, and the writing up of a local report

²⁶ Here, a community of identity is defined as "a group of people with existing relationships who share a common interest", which can consist in living in the same geographic area or sharing a similar ethnic or cultural background (Sullivan et al., 2003, p.115) and interact with one another (2003).

attempted to strengthen a sense of community through collective engagement (Israel et al., 1994 in Israel et al., 2003). Because communities of identity may benefit from the skills and resources available from individuals outside of the immediate community of identity, CBPR partnerships may include representatives from community-based organizations and/or the community at large, or even academics (Israel et al., 2003). In this research, CIS members of staff, by virtue of being Irish, outreach workers, and having considerable interaction with the Irish community in Coventry, can be viewed as excellent representatives of their community, due to their understanding of the true needs and concerns of their communities. Evidence of outreach workers being seen as good representatives of their communities was given by Sullivan et al. (2003). The CIS members and Irish NHS representatives, by virtue of strongly affiliating with their Irish heritage and having the interests of the Irish at heart, can also be seen as good representatives of the Irish community. Finally, the two British NHS workers, my supervisor and I are probably best viewed as community “outsiders” sharing skills and resources with the Irish community and having the interests of the Irish community at heart.

Moreover, in line with a CBPR approach, the current research recognizes, and built on, the many strengths and resources within the “community of identity”, here the Irish community, to address their communal health outcomes, including skills and assets of individuals (McKnight, 1994), networks of relationships (Israel & Schurman, 1990) and mediating structures within the community (e.g. Churches, CIS) where community members come together (Berger & Neuhaus, 1977) (as cited in Israel et al., 2003). The research views the Irish community as potentially resilient,

that is, as able to cope and bounce back from adversity by drawing on community resources (e.g. social relationships and ties to the community) (Bartley, 2006).

In accordance with a CBPR approach, community members collaborated on issues and concerns that were of direct relevance to them, here, the issue of Irish health inequalities (Israel et al., 2003). Moreover, they participated and shared influence in most stages of the research²⁷ (Israel et al., 2003). While the exact research question and qualitative research strategy were devised by me prior to the partnership meetings, as part of my doctoral research, they were then amended and agreed upon by the partnership. This was partly to enhance the research generally and to ensure that community concerns were addressed. It was also decided that the results of the quantitative analyses, conducted as part of the doctoral research, would be shared and integrated into the collaborative research. The sampling frame and topic guide were discussed collectively, and were informed by community representatives' local theories i.e., understandings commonly held about the community and broader social context (Elden and Levin, 1991 in Israel et al., 2003) – see data collection section below. There was thus, in accordance with a CBPR approach, a reciprocal transfer of knowledge, skills and capacity among partnership members, and the knowledge and expertise of community members was valued in the research (2003).

Data transcription and analysis was carried out by me, the researcher, on community partners' request. However, in response to an overall show of interest, all

²⁷ Ideally, community members should participate in all phases of the research process although it rarely occurs in practice due to time demands and the technical aspects of some processes such as transcription and the analysis of interview transcripts. Choices need to be made on how to best draw on the diverse capabilities and interests that exist (Israel et al., 2003). Different levels of involvement may be appropriate for different partners, while also recognizing that this may be an area where community partners are interested in enhancing their skills (2003).

steering group members were trained to conduct interviews (see Data Collection section below), and each member conducted at least one interview.

Efforts were made during steering group meetings to feed back the results to community partners in understandable and respectful ways where “ownership of knowledge [was] acknowledged” (Bishop, 1994, p. 186, as cited in Israel et al., 2003); community partners made valuable comments on some of the findings, which were taken on board in the interpretation of the data. In keeping with a CBPR approach, there was an acknowledgment of the power inequalities between researchers and community participants and of their impact on community members’ participation and therefore a commitment to create an empowering and respectful information and decision sharing process among members of the partnership (Israel et al., 2003).

Main collaborative research findings were more widely disseminated via a presentation to a large gathering of local and national stakeholders at a local conference organised by the CIS and Rehab UK²⁸ in Coventry in May, 2008; the PowerPoint presentation had been first submitted to the CIS for approval. Thus, community partners were involved in the wider dissemination process (publications, conferences) (Israel et al., 2003). For the purpose of this conference, research findings, which showed trends and the complex influences upon Irish health inequalities across the first two post-war generations of men and women in England and Coventry, were translated into policy and service implications for the Irish community, so as to inform action. Indeed, the main aim of the conference was to raise the profile of the Irish community and their health needs within the Irish community itself, and local health agencies, and justify claims for Irish culturally-sensitive services. Thus the research followed the CBPR principles of generating

²⁸ Organization working for the elderly Irish community

knowledge related to health and well-being and integrating it with community and social change efforts that address the concerns of the community (Israel et al., 2003). The conference was successful; about one hundred people attended, including many representatives from local health agencies and ten research participants, who attended the conference free of charge.

Despite a commitment to helping the CIS obtain an empirical basis for action, the aim of the doctoral student for thesis purposes was to keep findings and conclusions as free from bias as possible by recognizing and developing strategies for counteracting identified subjectivities (discussed below) (O’Leary, 2004, chapter 5).

While the research was relatively successful in fulfilling CBPR principles, it cannot claim to be fully implementing these strategies. Firstly, the identification of the research questions and plans, and the analysis and interpretation of the data, lay mostly within the hands of the doctoral student/outsider, and not the disadvantaged group. Secondly, the principles of a long-term commitment to the partnership, that extends beyond a single research process, and systems development and maintenance through an iterative and cyclical process, including the establishment of mechanisms for sustainability, was not fulfilled (Israel et al., 2003).

Advantages and Disadvantages of a “Collaborative” Approach

From the CIS point of view, the advantages of using a “collaborative” approach are the following:

- The doctoral student researched Irish health issues on a full-time basis and, with the support of her supervisor, could generate research evidence of an academic standard to provide an empirical basis for a prioritization of the needs of Irish people and for culturally sensitive services.

- The supervisor shared his previously gained expertise of working on collaborative projects with communities.
- Some prestige and authority was gained from working with independent (non-Irish) researchers at Warwick University and the partnership improved acceptability of the findings and chances of finding sustainable solutions.
- Steering group members acquired further skills on how to conduct research, more specifically, on how to conduct interviews.

From the researcher's point of view, the advantages of using a "collaborative" approach are:

- The CIS greatly facilitated access to suitable interviewees; this included elderly Irish people who may not have otherwise participated in the research because they may be difficult to make contact with and might not have trusted an 'academic' researcher from outside the Irish community²⁹. Over one-half of the respondents were recruited by the CIS.
- The CIS provided the interview location. Interviews took place at the Coventry Irish Society, which is on safe "community territory".
- The researcher learned from community representatives' professional and community knowledge. This includes "local theories" for Irish health inequalities.

²⁹ First generation Irish people are considered a "hard to reach" community because they are a difficult community to access for research purposes owing to their particular socio-demographic, economic and migration profile. This includes problems of acculturation or assimilation and experiences of discrimination in the wider British society, social isolation in old age, a disadvantageous socio-economic status (e.g. low education levels and income), health problems associated with the elderly (e.g. limited mobility), and mental health problems. In addition to limiting their physical ability to partake in health research and making these research participants difficult to make contact with, the above factors may lead this community to have a particular distrust of educated young academic researchers who are British or simply outsiders to the Irish community, and may lead to low levels of self-esteem which further compound their unwillingness to participate in research. Having an Irish CIS gatekeeper who has an extensive understanding and experience in working with this Irish population considerably improved access to this population since it provided the opportunity to establish greater trust with the specific community (Calamaro, 2008).

Drawing on their knowledge, community members made helpful inputs into the research strategy and the topic guide (see data collection section below) and commented on some of the research findings, thus assisting with the interpretation of the data. This increased the quality of the research evidence.

- Steering group members conducted half of the interviews. Having knowledge of the Irish culture and community, Irish interviewers could be more sensitive to issues coming up and prompt on the most relevant issues. Also, Irish respondents might talk more freely to community members, feeling more at ease talking to people from their own community. This may have increased the validity of the accounts through the use of private, as opposed to public, accounts, thus improving the quality of the research evidence.

- The CIS organised and helped fund a local conference to disseminate the findings of the “collaborative approach” and will publish the full report of the findings on the CIS website when it is completed.

- Steering group members shared the enthusiasm and passion about the research and put time and effort into the research.

However, the collaborative approach also came with some disadvantages:

- There was some loss of control over the research
 - It was difficult to control the pace of the project (O’Leary, 2004, chapter 10). There was a need to depend on others to get things done, and a constant need to follow-up.
 - There was some unevenness in the quality and length of the interviews (see data collection section below); this was partly the result of allowing the steering group members a certain degree of autonomy to enhance their feelings of ownership.

- The recruitment of participants through the CIS gatekeeper created some selection biases (see sample recruitment section below).
- Participants interviewed by Irish steering group members may have felt compelled to give responses that were “socially acceptable” to the Irish community. Moreover, Irish interviewers may seek insufficient clarification because of assumptions created by their shared experience. This may have decreased the validity and quality of the accounts.
- Finally, keeping the steering group going required a lot of effort.

To conclude, the positives of this approach greatly outweighed the negatives. It led to the collection of a substantial amount of data and to many valid and interesting findings. I am very grateful for this collaboration and believe this approach is worth pursuing. However, there were some problems, which can be regarded as “lessons” for the future. More consistency in the approach used and in the findings could have been obtained through giving steering group members more interviewing training

Sample

By providing a “thick description” of the processes of sample selection, data collection, analysis and interpretation, thus making them more “transparent”, the reader will be able to verify for himself/herself that the conclusions drawn in this study hold “credibility” and consider their robustness and “transferability” to other settings (Lewis & Ritchie, 2003).

Negotiating Access

As noted above, access to participants was greatly facilitated by working in collaboration with the Coventry Irish Society (CIS), through a steering group. One of the agreements reached by the partnership was that, by virtue of having the most

contact with the Irish community, the task of negotiating access to participants would largely lie within the hands of the CIS, although efforts would be made on the part of all steering group members, including myself, to find alternative recruitment strategies.

Sample Recruitment

Thirty-two people were interviewed. They voluntarily partook in the research and were not remunerated. About two-thirds of the sample was recruited by the Coventry Irish Society, more specifically by the main “gatekeeper”, a second generation Irish outreach worker at the Coventry Irish Society (CIS), and half of these were recruited from within the CIS itself, including CIS clients attending the counseling service or the socials/luncheons, members of staff, and volunteers. Participants were purposely selected based on the criteria listed below:

- Generation and year of migration: half of the participants had to be first generation Irish, i.e., born in Ireland (Republic of Ireland or Northern Ireland), and to have come to England/Coventry in the 1950s, ‘60s, ‘70s and the other half had to be second generation Irish, i.e., born in England/Coventry, and the children of individuals who fit the above characteristics.
- Gender: there had to be an even gender split within generations (“symbolically” representative of the target population)
- Place of residence: participants needed to have lived or be currently living in Coventry for a significant period of time (following the request of the Coventry Irish Society). Due to this criterion, Irish travellers were automatically excluded from the study population. This exclusion was intentional since the Irish travellers form a distinct population which faces different socio-economic and health problems from the rest of the Irish community. The research recognises the invisibility of this

community in academic research and policy and the pressing need for further research to be conducted on this population.

Although respondents were purposely selected based on the criteria listed above, the “handpicking” (O’Leary, 2004, chapter 8) of participants by the CIS gatekeeper created a selection bias since respondents were on the whole more likely to self-identify as Irish and be part of the Irish community. This selection bias may have resulted from the CIS gatekeeper recruiting participants within his circle of friends or acquaintances in specifically Irish locations, including Irish social clubs or pubs or the Irish Coventry Society, which tend to be frequented by individuals who identify as Irish. These individuals are also more likely to belong to the Irish community both as a basis for and consequence of going to these Irish places. Moreover, first generation Irish CIS clients were more likely to be in the lower social classes, and those attending the counseling service more likely to be in poor health. Conversely, second generation Irish CIS outreach workers were occupationally advantaged.

However, since diversity of background was deemed important in order to explore the importance of various conditions for producing good or ill health, efforts were made to maximize the inclusion of diverse groups or to obtain, what Denmark et al. (2002) call, “extremely varied cases”, by broadening sample recruitment strategies, and to reach people who were less embedded in the Irish community.

Thus, a bit less than a third of the sample were identified with the help of a short article posted in the Coventry Evening Telegraph, advertising for “Irish people who moved to Coventry in the 1950s and 60s and people whose parents are Irish and moved to Coventry at that time” to take part in a study on Irish health. The remaining respondents were recruited via a short article posted in the Irish Post, the snowballing technique, an intra-Primary Care Trust (PCT) e-mail and by steering group members.

These recruitment strategies produced a more diverse sample with respect to social class and membership in the Irish community. Still, these approaches came with their own biases. Indeed, first and second generation Irish who see themselves as completely English and do not *feel* Irish are unlikely to come forward to participate in the research after reading a newspaper article asking for Irish respondents. Moreover, PCT professionals tend to be more knowledgeable about health. In addition, “volunteer” sampling induces a type of non-response bias whereby the people who volunteer are likely to be quite distinct from those who do not (O’Leary, 2004).

While this research recognized that qualitative research cannot, by and large, be generalized on a statistical basis, it endeavored to obtain a “symbolically” representative sample, which contains the diversity of dimensions and constituencies central to explanation (Lewis & Ritchie, 2003). While the research was on the whole successful in maximizing sample inclusivity on key dimensions and constituencies (see below), it recognizes that a major limitation to achieving “symbolic” representativeness was an element of non-response on the part of people who did not at all see themselves as Irish (none of the respondents completely rejected their Irish heritage) and on the part of those who were born in Northern Ireland (all but one of first generation Irish respondents were born in the Republic of Ireland) or were of Northern Irish parentage (only three second generation Irish respondents had one or both parents born in Northern Ireland). Although the sample distribution largely reflects that of Coventry³⁰, this non-response bias affects the generalisability of the findings and prevents an exploration of the generative mechanisms underlying the health inequalities faced by the Northern-Irish born and the second generation Irish who completely reject their Irish heritage.

³⁰ The great majority of first generation Irish people in Coventry (90%) are born in the Republic of Ireland, Census data (cf. FIS, 2007b; Table 3.1)

None of the respondents reported being Protestant; with the exception of a few non-religious people they were all Catholic, which is to be expected since the majority of respondents were from the Republic of Ireland or had parents from the Republic of Ireland. With regards to the few respondents of Northern Irish descent, the predominance of Catholics over Protestants may be related to the fact that Irish Catholics in Northern Ireland were pushed to migrate to England because of ethno-sectarian and political tensions in Northern Ireland. These tensions, which began in the 1920s and culminated in the “Troubles” in the late 1960s, resulted from conflicts between Protestants/Unionists and Catholics/Nationalists over the British constitutional status of Northern Ireland. Threatened by Catholics/Nationalists, whom they viewed as determined to form a united and free Ireland, the British Government gave preferential treatment to Northern Ireland’s Protestant/Unionist majority in employment, housing and other fields (Hennessey, 2001). Discrimination against the Irish Catholic minority in Northern Ireland by the Protestant majority led Irish Catholics in Northern Ireland to be socioeconomically disadvantaged when compared to Northern Irish Protestants. Moreover, Irish Catholics were “forced” via verbal and physical abuse to leave predominantly Protestant Northern Irish towns by the Protestant majority.

In retrospect and in light of the Irish population demographics in Coventry, the Steering group including the researcher and the CIS gatekeeper should have made special efforts to access Northern Irish Protestants; this could have permitted an analysis of the disparities in socioeconomic position, ethnic identity and migration experiences between Northern Irish Catholics and Protestants with implications for health.

Sample Characteristics

The final interview sample comprised 32 people and was equally divided among first and second generation Irish men and women; all had lived or were currently living in Coventry. First generation Irish respondents were aged between 60 and 80 and second generation Irish respondents between 30 and 47, except for one respondent aged 60 (table 4.2).

As stated above, all first generation Irish men and women respondents, except for one (born in Northern Ireland), were born in the Republic of Ireland (table 4.2). All but two of the second generation Irish respondents were born in Coventry (most spent their entire lives there); there was some variation in Irish parentage, although nine of the sixteen had both parents born in the Republic of Ireland (table 4.2).

All first and second generation Irish respondents, but two, were currently residing in Coventry; respondents were quite spread out within the greater Coventry area (table 4.3).

There was a reasonable amount of variation in marital status amongst the respondents (table 4.2). All but one of the first generation Irish respondents, and about half of the second generation Irish respondents, had children (table 4.2). Not surprisingly, the parents of the first generation Irish respondents were nearly all deceased. Eleven of the sixteen second generation Irish respondents had lost at least one parent, most often their father. The most common causes of death for fathers were heart attacks or strokes.

Not unexpectedly, most first generation Irish respondents felt Irish (table 4.2). The ethnic identifications of the second generation were more varied (table 4.2), with a greater number expressing mixed feelings about their ethnic identity, especially men.

It is significant that none of the second generation Irish respondents, even those who felt English, completely rejected their Irish heritage.

The vast majority of first generation Irish respondents were retired, mostly from health-related and factory occupations (table 4.4), which is typical of first generation Irish women and men respectively. The vast majority of men worked in routine occupations, in the car industry. Also, many worked in the construction industry during intermittent periods of their lives as a means of securing income when there were no openings in the factories. More than half of the first generation Irish women worked in the lower professional and managerial occupations as nurses or in the routine occupations as support workers and care assistants. A large proportion also worked in the factories, often for electrical companies. However, two of the women and one of the men had achieved social mobility during their lives; they worked or had worked as counselor for a college, deputy manager of a hotel and mental health nurse, respectively.

The socioeconomic profile of the second generation Irish was more varied than that of the first generation (table 4.4); while many displayed upwards social mobility and worked in professional occupations (e.g. teacher, counselor, lecturer), three respondents were unemployed, one respondent worked in the routine and manual occupations, and a significant number had discontinuous career paths, i.e., they worked in routine and manual jobs prior to transferring to professional occupations, often as a result of leaving school at 16 to find a job.

With respect to health, a fairly high proportion of first and second generation Irish respondents suffered from a limiting long-term illness, high blood pressure and/or poor mental health. However, a reasonable amount of variation in health status can be observed within and between the generations.

With regards to physical health, men tended to fare more poorly overall than women and the first generation more poorly than the second. Six first generation Irish men and five first generation Irish women in the study were currently in poor physical health, suffering from at least one longstanding limiting illness, with many reporting two or more conditions (table 4.5).

Not surprisingly, because they were younger, the second generation people in the study were physically healthier than the first generation on the whole (table 4.5), but the proportion in poor physical health was still relatively high: six of the sixteen second generation Irish men and women were in very poor health and suffered from two or more limiting conditions.

The great majority of people in the study, both first and second generation, men and women, had poor mental health (table 4.6). They suffered from depression, stress, worry or low self-esteem and oftentimes from a combination of these problems. In addition, many had suffered from additional mental health problems in the past.

Table 4. 2: Sample: Socio-Demographic Characteristics

	1 st gen. Irish women (x8)	1 st gen. Irish men (x8)	2 nd gen. Irish women (x8)	2 nd gen. Irish men (x8)
<i>Age</i>				
30-38			5	3
39-47			2	5
60-65	3	1	1	0
66-80	5	7		
<i>Place of Birth</i>				
R. of Ireland	8	7		
N. Ireland	0	1		
Coventry			7	7
Other UK town			1	1
<i>Irish parentage</i>				
2 R. Irish-born parents			5	4
2 N. Irish-born parents			2	
1 R. Irish-born / 1 N. Irish-born parent				1
1 R. Irish-born/ 1 English- born parent			1	3
<i>Ethnicity</i>				
Feels Irish	7	5	5	3
Feels Irish and English	1	1		3
Feels English			2	
Confused			1	2
Response not clear		2		
<i>Marital Status</i>				
Married	4	5	4	4
Cohabiting				1
Re-married		1		
Separated/divorced		1		1
Widowed	3	1		
Single (never married)	1		3	2
Unknown			1	
<i>Children</i>				
None	1		3	2
1-2	1	4	5	4
3-5	6	4		
Unknown				2

Table 4. 3: Sample: Place of Residence

	1 st gen. Irish women (x8)	1 st gen. Irish men (x8)	2 nd gen. Irish women (x8)	2 nd gen. Irish men (x8)	Total
<i>Coventry</i>					
Coundon	3	1	1	1	6
Stoke		2		3	5
Wyken	2			1	3
Stoke Aldermoor	1		1		2
Spon End		1		1	2
Foleshill		1			1
Canley Gardens		1			1
Stivichall		1			1
Wolveley		1			1
Courthouse Green	1				1
Keresley			1		1
Whitley			1		1
Wolston			1		1
City Centre			1		1
Wallenhall Wood				1	1
Allesley Village				1	1
Green Lane	1				1
<i>Outside Coventry</i>					
Bedworth			1		1
London			1		1

Table 4. 4: Sample: Occupation (NS-SEC*)

	1 st gen. Irish women (x8)	1 st gen. Irish men (x8)	2 nd gen. Irish women (x8)	2 nd gen. Irish men (x8)
<i>Professional and Managerial</i>	3	1	5	4
CAPS system administrator				1 ⁱ
Nurse	2 ^a	1 ^d		
Welfare/social worker			2	
Teacher			1	1
Lecturer				1 ^j
Counselor			1 ^f	
Energy code analyst			1	
Assistant/deputy manager	1 ^b			1
<i>Routine and Manual</i>	5	7		1
Support worker/care assistant	2			
Factory worker	3 ^c	5 ^e		
Construction work		1		
Parts warehouse man				1
Aircraft fitter		1		
<i>Other</i>	0	0	3	3
Pub/club singer				1 ^k
Housewife			2 ^g	
Unemployed			1 ^h	2 ^l

* NS-SEC 3 class version: professional and managerial occupations incl. higher and lower managerial and professional occupations; routine and manual occupations incl. routine, semi-routine and lower supervisory and technical occupations. For first generation Irish respondents who are retired (N= 13) or semi-retired (N=3), prior full-time occupation is recorded. For second generation Irish respondents, current occupation is recorded.

^a. One of these women is currently working part time as a counselor; worked as a nurse for 35 years.

^b. Retired from working as a deputy manager of a hotel; worked in a factory when was younger

^c. One of these women currently works part-time as a cleaner.

^d. Qualified as a mental health nurse at 44; was a factory worker before that.

^e. Three of the men did building work when younger; one of them is currently working part-time as a lollipop man.

^f. Worked in several routine jobs prior to working as a counselor (incl. factory work).

^g. One of these women worked as bank relief worker and the other as a nurse, before they had children.

^h. Unemployed for ~ 1 month from working as a criminal assistant

ⁱ. Worked in several routine jobs prior to working as a CAPS system administrator (incl. building work)

^j. Worked in a furniture store for 12 years prior to working as a lecturer

^k. Worked as a porter for many years prior to singing full-time

^l. One of the men is recently unemployed from working in hospitality; the other has been unemployed for 8 months; previously worked as a foreign English teacher and before that worked in manual jobs (incl. building work)

Table 4. 5: Sample: Physical Health Status

	1 st gen. Irish women (x8)	1 st gen. Irish men (x8)	2 nd gen. Irish women (x8)	2 nd gen. Irish men (x8)
<i>Current Physical Health</i>				
No current major physical condition	1	0	4	4
One current major physical condition	2	2	1	1
Two or more current major physical conditions	5	6	3	3
<i>Past physical health</i>				
No past major physical condition	2	1	3	5
One past major health condition	1	2	2	2
Two or more past major physical conditions	5	5	3	1
<i>Type of physical condition*</i>				
Atherosclerosis (MI, stroke etc.)	0	2	0	0
Hypertension	3	6	2	0
Other Cardiovascular ^a	2	4	0	0
Back Problems ^b	3	1	1	3
Arthritis	1	1	1	2
Other Musculoskeletal ^c	3	2	1	1
Cancer & Blood ^f	2	0	1	1
Endocrine/metabolic ^h	3	3	1	0
Gastrointestinal ^d	2	4	1	3
Genitourinary ^e	1	3	3	0
Respiratory ^f	4	1	2	1
Miscellaneous ⁱ	2	3	2	2

*Number of people with any one of these conditions

^a Other Cardiovascular conditions: low blood Pressure, bad circulation, vein problems, other heart problems

^b Back Problems: sciatica, flat spine syndrome, disc problems, lumbago

^c Other Musculoskeletal conditions: fibromyalgia, osteoporosis, carpal tunnel syndrome, knee problems, foot condition/problems.

^f Cancer & blood conditions: skin cancer, cervical cancer, lymphoma and hemophilia B

^h Endocrine and metabolic conditions: high cholesterol, diabetes, overactive thyroid, high insulin/testosterone, hypoglycemia and gout

^d Gastrointestinal conditions: stomach problems, irritable bowel syndrome, gallbladder/gallstones removed, hepatitis C marker

^e Genitourinary conditions: prostate problems, vasectomy, overactive bladder, hysterectomy, ovary removed, genital abscesses, difficult pregnancy (Hyperemesis)

^g Respiratory conditions: sinus problem, asthma, emphysema, industrial disease; ⁱ Miscellaneous conditions: psoriasis, eye problems, ear problems/deafness, gum problems and memory loss

Table 4. 6: Sample: Mental Health Status

	1 st gen. Irish women (x8)	1 st gen. Irish men (x8)	2 nd gen. Irish women (x8)	2 nd gen. Irish men (x8)
<i>Current Mental Health</i>				
No current mental health problem	1	0	2	2
One current mental health problem	2	2	1	0
Two or more current mental health problems	5	6	5	6
<i>Past Mental Health</i>				
No past mental health problem	4	4	6	2
One past mental health problem	3	3	1	6
Two or more past mental health problems	1	1	1	0
<i>Type of Mental Health Problem</i>³¹				
Mild depression	3	4	3	2
Severe depression	4	3	3	5
Anxiety/worry	6	7	5	5
Low self-esteem	1	1	1	2
Stress	4	4	7	6

³¹ The researcher was only able to distinguish levels of severity for depression because certain subjects reported specific events or symptoms which are associated with severe depression (e.g. hospitalisation, weight loss, seclusion). Advice was obtained on these criteria by a physician with experience in depression research. Given that the patients' health histories were self-reported, the researcher did not feel confident in ascribing levels of severity to other conditions in the majority of cases.

Data Collection: Semi-Structured Interviews

The research conducted semi-structured interviews, that is, interviews

Conducted on the basis of a loose structure consisting of open-ended questions that define the area to be explored, at least initially and from which the interviewer or interviewee may diverge to pursue an idea or response in more detail. (Britten, 2006, p.13).

Interviews were based on a topic guide (see Appendix A) setting out the key topics to be covered during the interview and key prompts for each topic. Interview topics covered life experiences or key influences on health, derived from the literature and input of steering group members³², e.g. childhood circumstances, education and work experiences, migration, ethnicity, religion, social support and discrimination, as well as health experiences, e.g., mental health, physical health and health-related behaviours. [Thus, health status is self-reported.] Respondents were also asked their opinion on what affects their health and Irish health in general.

However, the structure was sufficiently flexible to permit topics to be covered in the order most suited to the interviewee, to allow responses to be fully probed and explored and to allow the researcher to be responsive to relevant issues raised spontaneously by the interviewee (Legard, Keegan & Ward, 2003, p. 141). From the onset of the interview, respondents were encouraged to talk freely about their life and health experiences and efforts were made to ask questions in a way which was conducive to this (2003). The semi-structured aspect of the interviews ensured that a set of topics would be covered but also allowed the emergence of unforeseen themes.

Efforts were made to ask clear questions, avoid leading questions and to conduct sensitive interviews by adopting an empathetic but neutral stance, reassuring respondents about confidentiality from the outset, engaging in general chat before

³² Steering committee members suggested several changes to the topic guide. For instance, they suggested that interviewers prompt on the issue of Catholic guilt and on first generation Irish respondents' experiences of poverty as children in Ireland, e.g., whether they walked around barefoot in the summer. They also changed the wording of prompts to make them more user-friendly

beginning the interview, telling respondents that there are no right and wrong answers and that all views have value, reassuring them when needed that the information they are providing is interesting and valuable, and acknowledging the interviewee's emotional response where it occurs (Legard et al., 2003).

Due to recognition of the importance of a lifecourse approach to health, especially in the case of migrants who will have been through a number of life-course transitions and may have suffered from significant deprivation during their childhood (Nazroo, 2001; Nazroo, 2003), the interviews chart respondents' health and life experiences across their lives. Such an approach can reveal the cumulative accumulation of disadvantage during a lifetime.

Interviews were tape recorded in order to capture the data in its natural form (Legard et al., 2003). Moreover, this allowed the interviewer to devote their full attention to listening to the interviewee and to probing in depth (2003). Interviews lasted from 45- 90 min and took place at the Coventry Irish Society in a private and quiet room. Participants were offered tea and sometimes biscuits when available.

Participants were given, and taken through, an introductory letter informing them about the research, including issues such as confidentiality, and thanking them profusely for their participation (see appendix B).

As mentioned above, owing to the collaborative nature of the research, steering group members conducted half of the interviews and I conducted the other half, including the four pilot interviews. Steering group members were trained on how to conduct semi-structured interviews during a half-day training workshop. They were taken through the topic guide by myself and my supervisor and given a copy to keep. They were given tips on how to conduct semi-structured interviews and were then put in pairs to practice their interview skills and learn how to use the tape recorder.

A broad cross-perception between participant and researcher takes place (Lewis, 2003, p. 65) during the interviewing process, which may affect the validity and reliability of the accounts provided. Indeed, while some people argue that the ethnic matching of researchers and participants is helpful to the dynamic of data collection during interviews, others point out its limitations (2003).

Cultural affinity between Irish participants and Irish steering group interviewers may have been helpful to the dynamic of data collection, resulting in the latter having a better understanding of participants' accounts, of the language they used and of the nuances and subtexts (Lewis, 2003). Having insider cultural knowledge of the Irish community, they could be more sensitive to issues coming up and could prompt on the most relevant issues. Moreover, Irish respondents might feel more at ease to talk freely to community members.

Secondly, the use of Irish interviewers could redress power imbalances based on ethnicity. Indeed, owing to a power imbalance between the Irish, particularly the first generation, and the British, tied to a history of British colonialism of Ireland, having British individuals conducting interviews with the first generation Irish would not have been conducive to open discussion, especially on the topic of discrimination (Lewis, 2003). For this reason, the two British steering group interviewers were matched with second generation Irish respondents for two of the three interviews they conducted.

On the other hand, having Irish steering group members interviewing Irish participants may have been problematic for different reasons. Irish participants may have felt compelled to give responses which were "socially acceptable" to the Irish community. On some sensitive issues, participants may have found it more helpful to speak with someone who is clearly outside their community (Lewis, 2003).

Moreover, there is danger that insufficient clarification is sought by Irish interviewers because of assumptions created by their shared experience (Burgess, 1984; Hammersley & Atkinson, 1995; Thompson, 2000, as cited in Lewis, 2003). This was apparent in some of the interviews. Participants may also hold back from giving fulsome accounts, relying on the interviewer to draw on their own background (Lewis, 2003).

Finally, other important identities may also influence the participant's "reading" of the researcher (Hammersley & Atkinson, 1995, as cited in Lewis, 2003, p. 66). Efforts were made to match interviewees and interviewer on gender and on age, by getting first generation Irish steering group members to interview first generation Irish respondents and second generation Irish steering group members to interview second generation Irish respondents. For practical reasons, however, it was not always feasible to match all the interviews. For example, I conducted half of the interviews; my younger age may have affected the way respondents' interacted with me (O'Leary, 2004, chapter 4). It is difficult to know whether this age differential made respondents feel more comfortable, affording them a somewhat dominant position in the interviewing process, or less comfortable, when combined with my position of researcher and my higher education levels.

Since all steering group members worked in the professional occupations, full occupational matching could not be done. This is a shortcoming of the research, in particular as it pertains to first generation Irish respondents who in the main had worked in the routine and manual occupations. Differentials in education and social class may have affected the interview dynamics with first generation Irish respondents finding it difficult to discuss some topics, in particular, related to education or work experiences.

In response to participants who did not automatically presume that I was French because of my French accent and specifically asked me where I was from, I explained that I was half French and half British by nationality, but felt mostly French because I had lived in France for many years and had a French accent³³. This often established a connection between myself and first generation Irish participants, who could relate to having an accent and feeling different from the British majority, and between myself and second generation Irish respondents, who were born in England but felt Irish. However, being aware of my partly British roots, some participants may have elected to portray the British in a better light and to hold back some information on experiences of discrimination and oppression.

Having several relatively inexperienced steering group members conducting interviews may have affected the quality of the interviews and thus the validity and reliability of findings. Interviewer consistency is important in maximizing the efficiency of the framework analytical approach adopted in this research. Issues included insufficient probing, the use of leading questions, differences in the approach used to cover interview topics, some being given less emphasis or even omitted, and differences in the ability to make respondents feel fully at ease. Overall, however, the interviewers had good people skills. Moreover, they were provided with ongoing feedback on the interviews they conducted and a noticeable improvement in interview technique was observed throughout the interviewing period. Finally, some of the issues highlighted could have been mitigated by giving steering group members more training on how to conduct interviews and on the topic guide.

In general, I was relatively consistent in adhering to the topic guide for the interviews which I conducted, although I also occasionally used some leading

³³ I tried to avoid telling the participants about my ethnic background because of the importance of portraying oneself as being objective and neutral in order to minimize intrusion on the generation of fulsome and authentic accounts (Lewis, 2003).

questions and sometimes failed to probe comprehensively on all topics, in large part because of time constraints.

Transcription

Half of the interviews were transcribed by me. A trained transcriber was paid to transcribe the other half and was sworn to confidentiality. Extensive efforts were made to transcribe the interviews in full and verbatim. This included the keeping of the language used by the participant, including words of “dialect” (e.g. “meself”). However, there were instances in which the trained transcriber and I were unable to clearly make out words or even part of sentences which were mumbled or muffled by respondents, or enunciated with a strong Irish accent (this particularly relates to some first generation Irish respondents). This unfortunately resulted in the loss of some potentially valuable information and explains the relatively frequent use of the “unclear” comment in the interview quotes. While the clarity of the recordings could have been improved by having Irish Steering Group members transcribe the interviews they conducted or by way of consulting with them in relation to unclear passages, these options were not viable alternatives in the research since Steering Group members expressly stated not having the time to transcribe interviews.

Transcripts were anonymised:

- Names of respondents, and of people mentioned during the interview, were replaced by fictitious names
- Names of workplaces, hospitals and universities, and street names and numbers were deleted
- Only ward of residence in Coventry was kept for place of residence
- Only year of birth was kept for date of birth

– Only ward of birth for Coventry-born respondents and county of birth for Ireland-born respondents were kept for place of birth

It is significant that even after applying the processes of anonymisation outlined above, quotations, speech mannerisms and context may still provide enough information to identify participants, and the researcher may not always be able to predict which data could lead to identification (Richards & Schwartz, 2002, as cited in Goodwin, 2006). In addition, recruitment of respondents from one research location (here, Coventry) and research that features the circumstances and events that have given meaning to an individual's life can further increase the odds of participant identification (Goodwin, 2006). All these factors have led some to question whether the standard ethical expectations of complete anonymity and confidentiality are appropriate or even feasible for all forms of research (Boman & Jevne, 2000, as cited in Goodwin, 2006).

Analytical Approach: Framework Analysis

A systematic in-depth coding of the interviews was achieved using NVivo 7, a computer assisted qualitative data analysis software (CAQDAS). NVivo 7 was chosen because it is user friendly, facilitates the management, organization, coding and annotation of large amounts of textual data, and allows improvements in rigour and consistency, thereby making qualitative data analysis easier, more efficient, systematic and transparent (Gibbs, 2002). An important criticism of CAQDAS is that, by fragmenting the data into coded chunks, the analysis can lose touch with the context in which the data was generated (Pope, Ziebland & Mays, 2006). By displaying the immediate context of the extract by including the lines of text or

paragraph that surround it, NVivo 7 partially addresses such concerns (Pope et al., 2006).

Data from the interview transcripts was analysed using a framework approach (Pope et al., 2006). This approach is increasingly used in health care research. It is strongly based on the original accounts and observations of respondents but starts deductively from the main aims and objectives already set for the study. The analytical process is similar to that of thematic analysis but is more explicitly and strongly informed by a priori reasoning (2006). The topic guide used to collect data informs the analysis and is slightly more structured than would be the norm for most qualitative research. Using the framework approach, the themes identified from the literature and the critical realist and socio-historical model could be worked into both the design of the interviews (topic guide) and the analysis of the data. The approach is systematic and designed for transparency (2006).

Framework analysis has five stages (Pope et al., 2006):

Stage 1: Familiarisation with the data

Stage 2: Identifying a thematic framework: i.e., identifying all key issues, concepts and themes by which the data can be examined. This is done by drawing on a priori topics derived from the aims and objectives of study (listed in the topic guide) as well as issues raised by respondents themselves and views or experiences that recur in the data. The research identified several key and sub-themes or generative mechanisms of Irish health experiences and/or inequalities (see box 4.2 below). The new themes emerging from the data are listed in *Italic* in box 4.2 and include respondents' perception of influences on life experiences (see below for an explanation of colour coding). This theme included respondents' discursive knowledge of the impact of British colonialism and a world capitalist economy on

identity and structural components of ethnicity. Since, as mentioned above, the theme of colonial links emerged directly from the interviews, from respondents spontaneously mentioning these links, and did not feature in the topic guide, the researcher does not feel that the interviewers directly influenced this discussion.

However, it is conceivable that they indirectly influenced this discussion because a broad cross-perception between participant and researcher takes place (Lewis, 2003, p. 65) during the interviewing process. Being interviewed by Irish steering group members could redress power imbalances based on ethnicity, and therefore make Irish respondents feel more comfortable discussing these colonial links. In addition, Irish interviewers could inadvertently encourage a discussion of this topic via verbal or non-verbal cues. Alternatively, it is also feasible that Irish participants could have felt more comfortable discussing these links with a French researcher such as myself who is an outsider from both the British and Irish communities as they were less likely to have felt compelled to give answers which were socially acceptable to either of these two communities. Finally, since there were very few participants interviewed by British interviewers, it is unlikely that the participants were discouraged to discuss these colonial links either by verbal or non-verbal cues.

Stage 3: Indexing: i.e., applying this comprehensive thematic framework to all the data.

Stage 4: Charting: i.e., rearranging the data according to the appropriate part of the thematic framework to which they relate and assembling charts. Charts contain distilled summaries of views and experiences for each theme with entries for several respondents. In this research, charts were produced for the four main populations of interest, first and second generation Irish men and women, respectively. With the exception of the theme of migration experiences, which only pertains to the first

generation Irish respondents, the same themes can be found across the four populations of interest. The produced charts cover hundreds of pages, hence the need to index by theme (see Appendix C for an extract of the type of table created to chart the results for second generation Irish women³⁴).

³⁴ This chart differs from a typical chart created within a framework analysis approach in that 1) respondents are presented across the columns and themes across the rows, 2) instead of creating an individual chart for each theme, I created an overall chart for each generation and gender (e.g. first generation Irish woman) which encompasses all the themes and sub-themes and includes the main socio-demographic characteristics of the respondents, spouse and parents.

Box 4.2: Identifying a thematic framework

- ❖ General profile of respondent and family information
 - General profile
 - Family information
- ❖ Childhood circumstances
 - Financial situation (S)
 - Growing up and upbringing (incl. *childhood abuse or neglect*)
 - Health experiences
- ❖ Migration experience (first generation Irish respondents only) (S)
- ❖ Education, work experiences and financial situation
 - Education and work experiences (incl. unemployment) (S)
 - Financial situation (S)
- ❖ Coventry and the neighborhood
 - Feelings about the neighborhood and community
 - Irish contribution to Coventry
- ❖ Social support and networks (I)
- ❖ *Married life and relationship experiences* (incl. spousal divorce, separation and loss)
- ❖ *Other life changing events* (incl. family illness, disruption or death)
- ❖ Beliefs about life, cultural and religious beliefs and experiences, and discrimination
 - Beliefs about life (incl. optimism about life) (I)
 - Cultural beliefs and ethnic identity (I)
 - Discrimination (S)
 - Religious beliefs and experiences (I)
- ❖ Health experiences, behaviours, beliefs and attitudes
 - Experience of health professionals /services (S)
 - Beliefs/attitude towards seeking medical help (I)
 - Family health history
 - Health behaviours/lifestyle (I)
 - Respondents' definition of being "healthy"
 - Health situation (incl. physical conditions and general health)
 - Mental health (incl. depression, worry, stress, self-esteem)
 - Respondents' opinion of influences on health*
 - Respondents' opinion on what affects Irish health*
- ❖ *Perception of influences on life experiences** (incl. respondents' mention of interactions between various themes and discursive knowledge of impact of British colonialism and a world capitalist economy on identity and structural components of ethnicity)
- ❖ *Irish services – comments and recommendations*

Stage 5: Mapping and interpretation: i.e., using charts to map the range, and nature of, the phenomenon, create topologies and find associations between themes with a view to providing explanations for the findings. The process is influenced by the original research objectives, the conceptual framework and the themes that have

emerged from the data. Four general features of “Framework” aid explanatory analysis (Ritchie, Spencer & O’Connor, 2003):

- easy access to the synthesized data so that it can be continually revisited
- the ability to look within cases across a range of different themes and phenomena
- the ability to move rapidly between thematic and case-based analysis because of the matrix display
- the ability to not lose sight of the raw data and meanings assigned by participants to a phenomena

This research uses the charts it created to explore the influences or generative mechanisms of Irish health experiences and/or inequalities. Informed by its conceptual framework, only the themes/mechanisms which directly relate to ethnicity as structure, to ethnicity as identity, and to the concept more generally, are given separate consideration (see themes in red in box 4.2: (S) denotes themes which relate to ethnicity as structure, (I) denotes themes which relate to ethnicity as identity, * denotes themes which relate to the concept more generally). Some themes (in green) were not given separate consideration but were drawn upon to complement the above themes and provide additional possible explanations for the findings.

Owing to the vast amount of data (over 350,000 words in the combined transcripts) and the infeasibility of interpreting or conveying all the information, a difficult decision was made to largely exclude from the analysis the themes (in blue; box 4.2) deemed to be less directly relevant to the study’s main theoretical concept of ethnicity as structure and identity, as defined previously, and to specific issues of the Irish. The research does, however, recognize the general importance and relevance of

these themes to inequalities in health (cf. Brown and Harris' 1978 study of the social origins of depression) and the indirect structuring of life changing events by ethnicity and disadvantage.

The data was examined using this new theoretical framework (see box 4.3 below), with the following aims in mind:

- Explore the relative contribution of themes or generative mechanisms, which relate to ethnicity as structure and ethnicity as identity, to Irish health experiences, across two generations of Irish men and women
- Explore the ways in which the various mechanisms, which fall under ethnicity as structure and ethnicity as identity, interact with one another to impact Irish health in a positive or negative sense.
- Explore the resiliency of the Irish community
- Explore the interplay between structure and agency within both dimensions of ethnicity
- Explore individuals' perception of, and response to, events
- Explore respondents' discursive knowledge of the relevance of British rule and a world capitalist economy to structural and identity aspects of ethnicity, and their knowledge of influences on health.

Box 4.3: Final Thematic Framework

Main themes

- ❖ Ethnicity as structure
 - Socioeconomic position
 - childhood financial situation
 - education, work experiences and adult financial situation
 - discrimination experiences
 - migration experiences
 - experiences of health professionals and services
- ❖ Ethnicity as identity
 - ethnic identity
 - cultural beliefs
 - beliefs
 - beliefs about life
 - beliefs about seeking medical help
 - lifestyle
 - social support and networks
 - religious beliefs and experiences
- ❖ Respondents' discursive knowledge
 - individuals' perception of influences on life experiences
 - individuals' opinion of what affects health in general and
 - individuals' opinion of what affects Irish health

Complementary themes

- ❖ General profile of respondent and family information
 - general profile
 - family information
- ❖ Childhood circumstances
 - growing up and upbringing
 - health experiences
- ❖ Coventry and the neighborhood
 - feelings about the neighborhood and community
 - Irish contribution to Coventry
- ❖ Comments on Irish services

For each main sub-theme of the structure and identity components of ethnicity and for each complementary sub-theme, dimensions of the phenomenon were identified and data was categorized according to these dimensions, by looking within the row/theme and across the columns/cases on all four charts for each population of interest. Data was examined and categorized separately for first and second generation Irish respondents if the dimensions of a phenomenon differed substantially across generations. This generated a description of the structural and identity/cultural profile of first and second generation Irish men and women respondents in the study and included respondents' experience of events, individual perception of and/or response to, events.

Patterns and associations within the data (including contradictory ones) between two or more phenomena or sub-themes and within subgroups³⁵ (e.g. first generation women respondents) were explored, by investigating the charts and looking first within the columns/cases and then across all the columns/cases within the selected themes. This search was sometimes facilitated by connections or links mentioned by respondents, recorded under the theme of perception of influences on life experiences, or hypothesized in previous studies.

This analysis permitted an examination of the ways in which the various sub-themes or mechanisms within both dimensions of Irish ethnicity, i.e., structure and identity, interact with one another, and are connected to some complementary themes such as childhood upbringing and the general profile of respondents (socio-demographic characteristics). The ways in which structural aspects of ethnicity underlie identity/cultural ones and the latter exacerbate or mitigate the impact of the former were explored. The resiliency of the Irish community was explored by

³⁵ In the current research, the four main subgroups were first generation Irish women, first generation Irish men, second generation Irish women and second generation Irish men.

examining specific interactions whereby a mechanism or theme, usually related to ethnicity as identity, interacts with another mechanism or theme, usually related to ethnicity as structure, to mitigate its negative impact on health. The interplay between structure and agency within each dimension of ethnicity was explored by looking at both the ways in which mechanisms may precondition other mechanisms and the capacity for individuals to make decisions or to act beyond these preconditions.

Respondents' discursive knowledge of the impact of British rule and a world capitalist economy on both structural and identity aspects of ethnicity, i.e. on the migration, discrimination, socioeconomic and identity experiences of the Irish in England, which falls under the theme of individuals' perception of influences on life experiences, was explored. This analysis also draws upon the complementary theme of the Irish contribution to Coventry.

Sub-themes which fall under the two main themes of ethnicity as structure and ethnicity as identity were linked to health outcomes by outlining the pathways through which they may affect health, derived from the literature, and by drawing on respondents' discursive knowledge of influences on health (individuals' opinion of what affects health in general and what affects Irish health in particular).

Attempts were then made to explain why the identified associations exist. This was done by selecting individual cases and reviewing the charted data in the rows relevant to the linked phenomena and repeatedly interrogating the cases at the individual level. A similar analysis was conducted for the main sub-groups. In some cases, no obvious explanations could be found in this way and explanations were built from other evidence or interrogations of the data, including explicit reasons or accounts, inferring an underlying logic, using common sense, or drawing on previous

studies. Particular attention was given to avoid imposing knowledge of a topic on the data for explanations that they do not support³⁶.

In developing descriptive and explanatory accounts, two internal validation methods were used, the “constant comparative method” (Silverman, 2000) whereby hypotheses are derived from one part of the data and tested on another by constant checking and comparison across different cases, and “deviant case analysis” whereby deviant cases are not forced into classes or ignored but used as a resource in aiding understanding (Clayman and Maynard, 1994) (as cited in Lewis & Ritchie, 2003).

Politics, Ethics and Reflexivity

The study complies with the British Sociological Association and the University of Warwick ethical guidelines. *Informed consent* was obtained at the beginning of each interview and during the course of the research study. Interviewees were deemed competent³⁷ and autonomous³⁸ (O’Leary, 2004, chapter 4). They were honestly informed prior to the interview about the collaborative research and the intended use of the results. They were also told that 1) the interviews would last about 45-90 min and would be tape-recorded, 2) they would be expected to talk about their life and health experiences, while being guided in this process by the interviewer who would ask a series of questions, and 3) some of the questions were personal and they did not have to answer them (O’Leary, 2004, chapter 4). This process was assisted by the use of an introductory letter (see Appendix B). Moreover, respondents were provided with the contact details of the interviewer and informed of their right to discontinue their participation. They were told, prior to the interview, that they would be mailed their

³⁶ The discussion in the two latter paragraphs draws upon Ritchie et al. (2003) chapter, “Carrying Out Qualitative Analysis”

³⁷ i.e., to have the intellectual capacity and psychological maturity necessary to understand the nature of the research and their involvement in it

³⁸ i.e., able to make self-directed and self-determined choice

anonymised transcripts for approval and asked to provide a postal address³⁹ for this purpose. The transcripts were subsequently mailed to participants, together with a letter thanking them for their invaluable contribution to the research, reminding them of their right to withdraw from the research or ask for further editing or anonymisation of their transcripts, and listing contact details. Interviewees were not coerced or induced to take part in the research by an offer of money or other reward (O'Leary, 2004).

Participants were guaranteed *confidentiality*⁴⁰ prior to the interview and told that this would be done by not revealing the participants' identity in public, in the transcripts or in written work, via an anonymisation of transcripts. *Confidentiality* was further guaranteed by making sure that the transcripts were stored securely, separately from participants' personal information, in line with the requirements of the Data Protection Act 1998, and by agreeing to eventually destroy the raw data.

Since a collaborative research approach was taken, additional ethical provisions had to be made; all steering group members had to abide by the ethical considerations of informed consent and confidentiality. Moreover, it was decided that a community interviewer would not interview someone they knew, or a family member of someone they knew. Finally, it was agreed that ownership of the data would remain with the doctoral student, but be freely usable by the CIS in anonymised form (transcripts of tapes, not the original tapes themselves). Only the doctoral student and their supervisor (Dr Mick Carpenter)⁴¹ have access to the full list of interviewees and their contact information, together with the list matching each respondent's real name and fictitious name. Each of these documents is stored in a separate location.

³⁹ The vast majority did.

⁴⁰ As discussed on page 20, it may not be possible to fully guarantee confidentiality.

⁴¹ Dr Carpenter was selected because he is a permanent staff member of the University Of Warwick Department Of Sociology, and is readily contactable by members of the Coventry Irish Society. The CIS will thus have ongoing access to the data if required.

The research may have caused some *harm to the participants* since the narration of one's life story may cause respondents to relive unpleasant memories or emotionally trying times (O'Leary, 2004, chapter 4) and result in psychological or emotional distress in the form of anxiety or depression. Efforts were made to reduce this potential harm by providing informants with the researcher's contact information and mailing them their transcripts to reduce anxieties around confidentiality. One respondent pulled out of the research and asked for her information not to be used. Moreover, to reduce harm in the form of damage to self-esteem or self-respect, which could result, among other things, from educational differentials between the researcher and participants (in particular first generation Irish participants), an endeavor was made to conduct the interviews in a non-judgmental, empathetic and respectful manner. A benefit of working collaboratively with the CIS was that participants who needed support to deal with life difficulties could be referred to the CIS for free counseling. At least one respondent took advantage of this referral and is now a CIS client.

To ensure the integrity and authenticity of the knowledge produced, which is an important ethical responsibility of the researcher, I, the researcher, endeavored to suspend initial judgments and check my interpretation of events and experiences with "insiders", or people from within the Irish cultural reality (O'Leary, 2004, chapter 4), here, Irish steering group members⁴². This can be seen as a form of external validation and is especially important to illuminate potential biases associated with the researcher's specific attributes, socialization experience and different cultural reality (2004).

⁴² This could only be done for some events and experiences. See section on collaborative approach

Moreover, conscious of the impact of my position of power as a researcher and within a culture (O'Leary, 2004, chapter 4), I worked towards creating a relationship between the researched and myself built on trust and mutual respect, which may increase the authenticity of the data by making the researched feel comfortable enough to expose themselves and provide candid data (2004). Also, as discussed above, efforts were made to match interviewees and interviewers on important attributes when possible. Furthermore, throughout the interviews, when in doubt as to what had been said, I asked respondents to confirm that my interpretation was correct (2004). In addition, I endeavored to give accurate research accounts and to be as transparent as I could in the reporting of the research process and its shortcomings (2004), with respect to both the quantitative and qualitative research.

Finally, problems of *personal safety* were avoided by interviewing people at the Coventry Irish Society.

This chapter has discussed the methodology used by the research to answer its main research questions. The following three chapters present the research findings.

Chapter 5: The Irish Health Disadvantage in England: An Exploration of the Demi-Regularity through an Extensive Analysis of the Census 2001 SARs

Introduction

The purpose of this chapter is to present the findings of the extensive research, which supplements the existing Irish health literature and addresses the first research question. The chapter is divided in two parts. The first part presents the findings and conclusions derived from a “positivist” or empiricist statistical investigation of Irish health trends. Recognising the limitations of the former analysis within a critical realist frame of reference, the second part of the chapter engages in a critical realist critique of the conclusions drawn and reinterprets the main findings in a way that is consistent with a critical realist perspective, to simply illustrate the demi-regularity that Irish people have poorer health than British people and provide clues to its generative mechanisms.

Part One: The Irish Health Disadvantage

Background

Although there is clear evidence of the existence of Irish health inequalities in England, on a variety of health indicators (see chapter 3), the Irish have been largely neglected when compared to other ethnic minority groups in England and relatively little attention has been paid to their health needs, either in academic research or in public policy.

Moreover, the two most recent studies on Irish health (FIS, 2007a; Natarajan, 2006), available at the time of writing, either did not or only partially adjusted for socioeconomic factors, respectively (see chapter 3), and presented health data only for the overall Irish population, but not by country of birth. However, previous studies on mortality (e.g. Harding & Balarajan, 2001) have shown important differences in particular between the first and second generation Irish. In addition, many of the studies, by using Irish country of birth, Irish parentage or Irish Catholic descent, as proxies for Irish ethnicity, demonstrated the existence of an association between the objective dimension of Irish ethnicity (ethnicity as structure), or ascribed ethnicity, and poor health but failed to take into the account the subjective dimension of ethnicity (ethnicity as identity), or self-identified ethnicity.

However, it can be argued that identity is a key component of ethnicity (Nazroo, 1998) which should therefore be incorporated in studies evaluating the impact of ethnicity on health (see chapter 2). Recognising the potential importance of ethnicity as identity to ethnic differences in health and its lack of empirical investigation, Nazroo researched the impact of the identity component of ethnicity on self-reported poor or fair health for the Caribbean and Asian ethnic minority populations in the UK but did not find evidence of an independent relationship between ethnic identity and health (Karlsen & Nazroo, 2002a).

To the author's knowledge, there has been no quantitative study conducted to date to investigate the impact of Irish identity on self-reported health. Unlike the above study (Karlsen & Nazroo, 2002a), which conceptualized ethnic identity mostly based on responses to questions on behaviours and attitudes, the current study operationalises Irish identity by using responses to a question asking respondents to define their own ethnicity, i.e., self-reported ethnicity. This is presumed to at least

partially reflect respondents' self-identification with Irish culture and community. However, there is evidence that people may take ethnicity to mean nationality or country of birth (Walter, 2002, as cited in FIS, 2007a). This is especially pertinent to second generation Irish people and first generation Irish people from Northern Ireland. Thus, self-reported ethnicity may reflect both structural and identity components of ethnicity.

Objectives of Study

The three main aims of the present study are to first use a fairly recent dataset, the Census 2001 SARs (ONS [a]), to provide current evidence on Irish health inequalities in England, focusing on self-reported general health and limiting longstanding illness, and breaking down the “white Irish” population by country of birth; second, determine, by controlling for several key socio-demographic and economic factors whether or not there is an Irish health disadvantage for the first and second generation Irish people living in England; and third, explore, by using self-reported ethnicity, a more subjective indicator, whether there is an Irish ethnic identity effect which operates on health.

Methodology (see chapter 4)

Results

Descriptive Statistics

The demographic, socio-economic and health profile of the self-reported “white Irish”, and then of its subcategories, the first generation Irish Republic, first generation Northern Irish and second generation Irish, are compared to that of the “white British” general population in tables 5.1, 5.2 and 5.3. The data show that the first generation Irish (from both the Republic of Ireland and Northern Ireland) report

higher rates of limiting long term illness and of “not good” health than the white British. While the health disadvantage of the first generation Irish Republic can possibly be attributed to their older age profile and their socio-economic disadvantage, particularly with regards to social class and educational qualifications, this does not appear to be the case for the first generation Northern Irish, who display a favorable socio-economic profile on these indicators.

The second generation Irish have a health profile which is quite similar to that of the white British but a much lower proportion of elderly people and a better socio-economic profile in some respects than the white British population, which would generally be expected to result in a much better health profile. The proportions of first generation Northern Irish and first generation Irish Republic who described themselves as “white Irish” or “white British” are shown in table 5.4. Interestingly, 73% of the Northern Irish born selected the latter category compared to 9% of the Republic Irish born.

Table 5. 1: Socio-Demographic Characteristics of “White Irish” Population and Country of Birth Subcategories in Census 2001 SARs, Compared to “White British”

Socio-demographic Indicators (% of population)	Ethnicity and Country of Birth				
	White Irish	"White Irish" Republic Irish born	"White Irish" Northern Irish born	"White Irish" UK born	White British (UK born)
Age	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
16 to 29	12.7	8.7	17.3	24.1	20.6
30 to 44	23.6	17.1	27.7	43.4	27.6
45 to 64	37.2	42.3	32.5	21.9	30.7
65 and over	26.6	31.9	22.5	10.6	21.1
Sex	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
Male	46.5	44.2	51.7	52	48.2
Female	53.5	55.8	48.3	48	51.8
Marital status	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
Single (never married)	27.9	22.2	31.2	45.7	29.4
Married (1st marriage)	43.6	47	38.5	34.6	43.2
Re-married	4.7	4.9	5.9	3.5	7.8
Separated (but still legally married)	3.6	3.8	4.6	2.8	2.3
Divorced	9.1	9.2	9.3	8.6	8.6
Widowed	11	13	10.4	4.9	8.8

Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Table 5. 2: Socio-Economic Characteristics of “White Irish” Population and Country of Birth Subcategories in Census 2001 SARs, Compared to “White British”

Socio-economic indicators (% of population)	Ethnicity and Country of Birth				
	White Irish	"White Irish" Republic Irish born	"White Irish" Northern Irish born	"White Irish" UK born	White British (UK born)
Social class	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
Higher Professional and managerial	8.6	6.8	12.6	13	7.8
Lower Professional and managerial	19	16.1	22.5	27.2	18
Intermediate occupations	6.6	5.9	5.7	9.7	9.2
Small employers and own account	6.7	7	5.1	6.4	6.8
Lower supervisory and technical	5.6	5.6	5.2	5.8	7.4
Semi-routine occupations	9.4	10	8.3	7.8	11.5
Routine occupations	8.7	10	7.9	4.9	9.2
long term unemployed	1.2	1.2	1.4	1.4	0.8
Full-time student	3.9	2.4	5.6	8.1	5.4
Other (Never worked, not known)	30.2	35.1	25.7	15.7	23.9
Highest educational qualification	<i>Base = 15675</i>	<i>Base = 10745</i>	<i>Base = 1450</i>	<i>Base = 3480</i>	<i>Base = 931991</i>
No qualifications	37.9	46.1	29.9	16.1	29.5
Level 1/2/3	30.7	25.8	28.6	46.6	45.5
Level 4/5	24.7	20.5	35.5	33.2	17.9
Other qualifications/level unknown	6.7	7.6	6.1	4.1	7.1
Industry	<i>Base = 13232</i>	<i>Base = 8784</i>	<i>Base = 1278</i>	<i>Base = 3170</i>	<i>Base = 826399</i>
Manufacturing	10.9	11.4	10.6	9.4	16
Construction	11.2	12.6	7.9	8.5	6.8
Wholesale and retail trade, repairs	12.1	12.3	12	11.6	17.5
Real estate, renting and business	13	11.9	14.3	15.8	12
Education	8.6	7.5	12.4	10.2	7.8
Health and social work	16.1	17.6	13.6	13	10.8
Other	28.1	26.7	29.2	31.5	29.1
Household housing indicator	<i>Base = 17048</i>	<i>Base = 11920</i>	<i>Base = 1535</i>	<i>Base = 3593</i>	<i>Base = 1016865</i>
Overcrowded, no bath/shwr wc or heat	17.3	17.4	17.1	16.8	12.8
Tenure of accommodation	<i>Base = 17048</i>	<i>Base = 11920</i>	<i>Base = 1535</i>	<i>Base = 3593</i>	<i>Base = 1016865</i>
Owens home(outright or mortgage/loan)	64.7	63.8	61.3	69.2	73.7

Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Table 5. 3: Self-reported Health of “White Irish” Population and Country of Birth Subcategories in Census 2001 SARs, Compared to “White British”

Health indicators (% of population)	Ethnicity and Country of Birth				
	White Irish	"White Irish" Republic Irish born	"White Irish" Northern Irish born	"White Irish" UK born	White British (UK born)
Limiting long-term illness	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
Yes	27.1	29.5	26.5	19.5	22
No	72.9	70.5	73.5	80.5	78
General health	<i>Base = 17523</i>	<i>Base = 12250</i>	<i>Base = 1605</i>	<i>Base = 3668</i>	<i>Base = 1037770</i>
Not good	15.8	16.9	17.1	11.3	11.2
Good or fair	84.2	83.1	82.9	88.7	88.8

Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Table 5. 4: Ethnicity Distribution of Census 2001 SARs First Generation Irish Population by Country of Birth

Ethnicity (%)	Born in the Republic of Ireland	Born in Northern Ireland
	<i>Base = 13607</i>	<i>Base = 6195</i>
White Irish*	90.0	25.9
White British**	9.4	72.3
Other	0.6	1.8

* People who consider themselves Irish regardless of country of birth

** People who consider themselves British regardless of country of birth

Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Regression Analyses

Self-reported General Health

A binary logistic regression analysis of the effect of stating having an “white Irish” ethnicity, as opposed to a “white British” ethnicity, on self-reported general health showed that the “white Irish” continue to be significantly more likely than the “white British” to report a “not good” as opposed to a “fair or good” general health (odds ratio 1.66, $p < .01$, table 5.5). This effect remained statistically significant after controlling for all the above demographic and socio-economic factors, even though this led to a reduction in the “white Irish” odds ratio (odds ratio 1.21, $p < .01$).

Another binary logistic regression analysis (table 5.5) revealed that all three “white Irish” groups, i.e., first generation Irish Republic, first generation Northern Irish and second generation Irish, were significantly more likely ($p < .01$ or $p < .05$) than the “white British” to report a “not good” as opposed to a “fair or good” general health, before and after controlling for the above demographic and socio-economic factors. It is interesting to note that the odds ratio of the first generation Irish Republic was considerably reduced in the final model, when all the demographic and socio-economic factors were introduced (from 1.81 to 1.12), with the biggest drop occurring after the introduction of age and sex (model 2) (see table 5.5). On the other hand, the odds ratio of the second generation Irish increased considerably when all the demographic and socio economic factors were introduced (from 1.13 to 1.49), with the biggest increase occurring after the introduction of age and sex (model 2) (table 5.5). The odds ratio of the first generation Northern Irish was only slightly reduced when the demographic and socio-economic factors were introduced (from 1.85 to 1.62), which means that the above factors can only partially explain their increased likelihood of having a poor self-reported general health.

In order to further investigate the existence of an ethnic identity effect on the self-reporting of poor general health, a binary logistic regression analysis was conducted to determine whether or not the Irish born in Northern Ireland who classified themselves as Irish (i.e. the “white Irish” born in Northern Ireland) were statistically significantly more likely than the Irish born in Northern Ireland who classified themselves as British to report poor general health (see table 5.5). The same analysis was not conducted for the Irish born in the Republic of Ireland since the great majority (90%) classified themselves as Irish (see table 5.4) or for the second generation Irish since the Census 2001 SARs does not provide information on Irish parentage (in this study, the second generation Irish were identified by considering those individuals who stated having a “white Irish” ethnicity and were born in the UK). The analysis revealed that the Irish born in Northern Ireland who classified themselves as Irish were statistically significantly more likely than the Irish born in Northern Ireland who classified themselves as British to report poor general health, before (odds ratio 1.55, $p < .01$) and after controlling for the above demographic and socio-economic factors (odds ratio 1.44, $p < .01$) (see table 5.5).

Table 5. 5: Logistic Regression Analysis of the Effect of the “White Irish”, “First and Second Generation Irish” and “Northern Irish Ethnicity” Variables on Self-reported General Health in SARs, Before and After Adjusting for Demographic and Socioeconomic Variables

		Model 1^a		Model 2^b		Model 3^c	
		Regression Coefficient (SE)	Odds Ratio (95% CI)	Regression Coefficient (SE)	Odds Ratio (95% CI)	Regression Coefficient (SE)	Odds Ratio (95% CI)
Overall Ethnicity ref cat: "white British" (born in UK)							
	"White Irish" (born in NI, RI or UK)	0.506*** (0.023)	1.66 (1.58-1.74)	0.349*** (0.024)	1.42 (1.35-1.48)	0.193*** (0.025)	1.21 (1.15-1.27)
First and second generation Irish (classify themselves as Irish) ref cat: "white British"							
	Overall significance	***		***		***	
	"White Irish" Republic Irish born	0.596*** (0.027)	1.81 (1.72-1.91)	0.321*** (0.028)	1.38 (1.31-1.45)	0.115*** (0.029)	1.12 (1.06-1.19)
	"White Irish" Northern Irish born	0.614*** (0.073)	1.85 (1.60-2.13)	0.573*** (0.075)	1.77 (1.53-2.05)	0.483*** (0.081)	1.62 (1.38-1.90)
	"White Irish" Second generation	0.126** (0.056)	1.13 (1.01-1.27)	0.350*** (0.058)	1.42 (1.27-1.59)	0.402*** (0.061)	1.49 (1.33-1.68)
Northern Irish born who classify themselves as Irish vs. those who classify themselves as British	Northern Irish born who classify themselves as Irish	0.450*** (0.090)	1.57 (1.31-1.87)	0.530*** (0.092)	1.70 (1.42-2.04)	0.387*** (0.101)	1.47 (1.21-1.79)

^aModel 1 is an unadjusted analysis; ^bModel 2 is an analysis adjusted for demographic variables (age and sex); ^cModel 3 is an analysis adjusted for age, sex, marital status and socio-economic variables (social class, educational qualifications, housing tenure, industry type and household housing indicator)

*** p < 0.01; ** p < 0.05; * 0.05 < p < 0.1. Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Self-reported Limiting Long-term Illness

The binary logistic regression analysis on self-reported limiting long-term illness (table 5.6) showed that the self-reported “white Irish” were significantly more likely than the “white British” to report a limiting long-term illness (odds ratio 1.46, $p < .01$, see table 5.6). After controlling for the demographic and socio-economic factors, the effect remains statistically significant ($p < .05$) but the magnitude decreases substantially (odds ratio 1.05).

A further binary logistic regression analysis (table 4.6) revealed that the first generation Irish Republic and first generation Northern Irish were significantly more likely than the white British to report a limiting long-term illness as opposed to none ($p < .01$). However, after controlling for the above demographic and socio-economic factors, it is the first generation Northern Irish and the second generation Irish who were significantly more likely than the “white British” to report a limiting long-term illness (odds ratio 1.20, $p < .05$ and odds ratio 1.36, $p < .01$ respectively). Model 2 (table 5.6) shows that the second generation Irish became statistically significantly more likely to report having a limiting long-term illness when the demographic factors (age and sex) were introduced, an effect which continued to gain statistical significance when the socio-economic factors were introduced (model 3). In contrast, the first generation Irish Republic were no longer significantly more likely to report a limiting long term illness after controlling for the socio-economic factors (model 3, table 5.6). However, it should be noted that the odds ratio had already considerably dropped in model 2, after age and sex were introduced. This implies that their increased likelihood of reporting a limiting long-term illness is explained both by their older age and disadvantaged socio-economic profile.

In order to further investigate the existence of an ethnic identity effect on the self-reporting of a limiting long-term illness, the same analysis, previously conducted for the Northern Irish born on self-reported general health (see above), was conducted for limiting long-term illness. Although the Irish born in Northern Ireland who classified themselves as Irish were statistically significantly more likely than those who classified themselves as British to report having a limiting long-term illness before controlling for the demographic and socio-economic factors (odds ratio 1.26, $p < .01$), and after controlling for age and sex (model 2), this relationship was only borderline statistically significant after controlling for the socio-economic factors (odds ratio 1.19, $p = .051$) (model 3, table 5.6). A stepwise binary logistic regression revealed that the correction for housing tenure was the determining factor in this decrease in statistical significance for the Irish born in Northern Ireland who classified themselves as Irish (results not shown).

Table 5. 6: Logistic Regression Analysis of the Effect of the “White Irish”, “First and Second Generation Irish” and “Northern Irish Ethnicity” Variables on Self-reported Limiting Long-term Illness in SARs, Before and After Adjusting for Demographic and Socioeconomic Variables

		Model 1^a		Model 2^b		Model 3^c	
		Regression Coefficient (SE)	Odds Ratio (95% CI)	Regression Coefficient (SE)	Odds Ratio (95% CI)	Regression Coefficient (SE)	Odds Ratio (95% CI)
Overall Ethnicity							
ref cat: "white British" (born in UK)	"White Irish" (born in NI, RI or UK)	0.376*** (0.019)	1.46 (1.40-1.51)	0.192*** (0.020)	1.21 (1.16-1.26)	0.047** (0.022)	1.05 (1.00-1.09)
First and second generation Irish (classify themselves as Irish)							
ref cat: "white British"	Overall significance	***		***		***	
	"white Irish" Republic Irish born	0.493*** (0.023)	1.64 (1.57-1.71)	0.167*** (0.023)	1.18 (1.13-1.24)	-0.029 (0.025)	0.97 (.92-1.02)
	"White Irish" Northern Irish born	0.322*** (0.064)	1.38 (1.22-1.56)	0.271*** (0.067)	1.31 (1.15-1.50)	0.186** (0.073)	1.20 (1.04-1.39)
	"white Irish" Second generation	-0.017 (0.046)	0.98 (.90-1.08)	0.261*** (0.047)	1.30 (1.18-1.42)	0.310*** (0.051)	1.36 (1.23-1.51)
Northern Irish born who class themselves as Irish vs. those who class themselves as British							
ref cat: Northern Irish born who class themselves as British	Northern Irish born who class themselves as Irish	0.230*** (0.076)	1.26 (1.08-1.46)	0.307*** (0.080)	1.36 (1.16-1.59)	0.174* (0.089)	1.19 (1.00-1.42)

^aModel 1 is an unadjusted analysis; ^bModel 2 is an analysis adjusted for demographic variables (age and sex); ^cModel 3 is an analysis adjusted for age, sex, marital status and socio-economic variables (social class, educational qualifications, housing tenure, industry type and household housing indicator)

*** p < 0.01; ** p < 0.05; * 0.05 < p < 0.1. Source: 2001 Census: Sample of Anonymised Records (SARs) (Licensed) (England, Wales, Scotland and Northern Ireland)

Discussion

The present study shows that the Irish people living in England continue to face, up to recent times, substantial health inequalities when compared to their British counterparts. Findings emerging from the Census 2001 SARs demonstrate the persistence of an ethnic health disadvantage for the first and second generation Irish people living in England with respect to two health indicators, self-reported general health and limiting long-term illness. The self-reported “white Irish” in the SARs were shown to have poorer health on both health indicators, after controlling for key demographic and socio-economic factors.

This main finding of an Irish health disadvantage is consistent with the existing literature on this topic, including studies using mortality as a health outcome (Marmot et al., 1984; Raftery et al., 1990; Harding & Balarajan, 1996; Harding, 1998, Harding & Maxwell, 1997, Harding & Balarajan, 2001, Wild & McKeigue, 1997) and the majority of those using limiting long-term illness (Owen, 1995, FIS, 2007a) and poor general health (Abbotts et al., 1997; FIS, 2007a).

Further insight into the impact of demographic and socio-economic factors can be obtained from the analysis of the subcategories of Irish populations. For both self-reported limiting long-term illness and poor general health, the increased risk of the first generation Irish people from the Republic greatly diminished when demographic and socioeconomic factors were taken into account, and indeed became no longer statistically significant after housing tenure was introduced in the case of limiting long-term illness. This is most likely a reflection of the socio-economic disadvantage faced by the first generation Irish people from the Republic in England. Conversely, the second generation Irish showed an increased risk for both health outcomes when the demographic and socioeconomic factors were taken into account; in the case of

limiting long-term illness, the difference from the “white British” only became statistically significant after adjusting for demographic factors, most likely because their health disadvantage was concealed by their younger age profile. The first generation Irish people from Northern Ireland show a substantially increased risk of both self-reported poor general health and limiting long-term illness; this risk decreases somewhat after controlling for demographic and socioeconomic factors but remains statistically significant.

Among other studies which distinguished between different generations of Irish populations, two identified similar differences in health profile, with the excess mortality of the first generation Irish from the Republic being explained by socioeconomic indicators but not that of the first generation Irish from Northern Ireland nor that of the second generation Irish (Raftery et al., 1990; Harding & Balarajan, 2001). Moreover, Harding and Balarajan (1996) found a health disadvantage in the second generation, which persisted after controlling for social class, car access and housing tenure. The current study concurs with these findings. In contrast, Harding and Maxwell (1997) and Marmot et al. (1984) found a health disadvantage in the first generation, even after adjusting for social class. However, both studies used a general “Irish born” category and did not distinguish between the Northern Irish and Republic Irish born. The present evidence shows that it is important to look at sub-populations separately as there appeared to be a persistent health disadvantage for the first generation from Northern Ireland, when compared to the White British, which was not present for the first generation from the Republic of Ireland, once the data was adjusted for demographic and socioeconomic factors.

The finding of a persistent significant relationship between being “white Irish” born in the Republic of Ireland and poor self-reported general health in the SARs,

even after controlling for demographic and socioeconomic factors, is difficult to reconcile but could be linked to the use of a more subjective indicator of health in this study. Indeed, the present study differs from those quoted above in that it used the measure of self-reported general health provided by the SARs, as opposed to mortality. Self-reported general health may reflect a wider range of health problems, including mental disorders, which may not necessarily lead to mortality. If this is the case, it may be a better indicator of Irish health issues than mortality alone, especially considering the high rates of mental illness reported for this population (see chapter 3).

Several alternative explanations for the discrepancy noted above could be put forward but most appear unlikely. Firstly, the criticism that self-reported health data is inaccurate is not supported by some studies which have demonstrated a high level of agreement between disease incidence based on self-reporting and on medical examinations (Blaxter, 1987), and between self-reporting and doctor diagnosis of specific conditions (Bennett et al., 1995) (ONS, 2000). Indeed, the majority of the results from the current study concur with other studies which used objective health indicators. Secondly, the possibility that the Irish may “complain” more about their health is contrary to the finding of high levels of stoicism for the Republic Irish born, especially men (Scanlon et al., 2006; chapter 7 of thesis). Thirdly, linguistic difficulties in the understanding of the health question are not an issue for the Irish, as opposed to many other ethnic minority groups in England (Natarajan, 2006).

On the other hand, differences in cultural interpretation of the self-reported general health question between members of Irish and English groups are possible, with the two ethnic groups assigning different meanings to general health descriptors. The differences in cultural interpretation may be increased due to the subjectivity of

the identity-related “white Irish” measure, which is likely to reflect more profound socio-cultural differences than country of birth alone.

The study provides evidence to support the postulate that both components of ethnicity, i.e., structure and identity, affect Irish self-reported health. Firstly, significant results were derived from using the “white Irish” variable, which may reflect both structural and identity components of Irish ethnicity. Secondly, the Northern Irish born who see themselves as Irish were found to be significantly more likely than the Northern Irish born who see themselves as British to report a poor general health. A possible explanation for this finding is that the former suffer from the inability to build an “authentic” and positive sense of self, owing to an ongoing colonial relationship between Northern Ireland and England (Leavey et al., 2007).

To the author’s knowledge, no other quantitative studies have evaluated the relationship between the identity component of ethnicity and health for the Irish population in the UK. Nazroo researched the impact of the identity component of ethnicity on self-reported poor or fair health for the Caribbean and Asian ethnic minority populations in the UK but did not find evidence of an independent relationship between ethnic identity and health (Karlsen & Nazroo, 2002a). As previously discussed, Karlsen and Nazroo (2002a) conceptualized ethnic identity mostly based on responses to questions on behaviours and attitudes whereas the current study operationalised Irish identity simply using responses to a question asking respondents to define their own ethnicity, which is presumed to reflect respondents’ self-identification with Irish culture and community. The present study is almost certainly the first to demonstrate the existence of an ethnic identity effect on health for the Irish in England, thereby strengthening the rationale that ethnicity should be more sensitively conceptualised in studies to include both components.

Certain limitations of the study should be born in mind when interpreting the results. Firstly, as discussed above, the use of self-reported or subjective measures of health may not be as robust as the use of objective health outcomes. Secondly, the socioeconomic indicators used in this study may not reflect the entirety of the structural disadvantage faced by the Irish in England such as discrimination experiences (Nazroo, 2003). Thirdly, as discussed in the methodology chapter (chapter 4, see footnote 21), the Census 2001 SARs may suffer from an under-representation of second generation Irish (Walter 2002, as cited in FIS, 2007a), and possibly Northern Irish born, since the ethnicity question is imperfect. This may create bias and lack of generalisability of the findings since only the respondents who clearly identify themselves as Irish (and understand the ethnicity question) are reflected in the data. Finally, as with any correlational study, there is always the possibility that the relationship between “ethnic identity” and health may be spurious and explained by other factors, which have not been controlled for in this study.

Conclusion

Notwithstanding the potential limitations of the study, certain conclusions appear to be justified. Firstly, the poor self-reported health of the first generation from the Republic of Ireland can be largely attributed to their disadvantaged socio-economic position in England. On the other hand, for the first generation Northern Irish and the second generation Irish, there is something more about being Irish, other than age, sex, marital status and socio-economic position, which makes them significantly more likely to report a poorer general health. In particular, the self-assigned ethnicity (British or Irish) of the first generation Irish from Northern Ireland has a significant impact on their self-reported health. The findings of this study thus provide support

for the case that both elements of ethnicity, structure and identity, affect Irish health in Britain. In addition, a strong argument emerges for using more sensitive indicators of ethnicity than country of birth or parentage in health research. While the self-reported ethnicity question may lead to an under-enumeration of second generation Irish and Northern Irish born, it nonetheless permitted the discovery of significant health differences between certain Irish subpopulations and the general white British population in England. This type of question may therefore have value for further research.

Part Two: A Critical Realist Critique

Informed by a critical realist perspective, this section of the chapter revisits the above “positivist” analysis. It argues that while the analysis is helpful in providing good circumstantial evidence, it also fails, in many respects, to appreciate the complexity of the social world. It thus reinterprets the main findings in a way that is consistent with a critical realist perspective, and draws new conclusions.

Reinterpreted in this way, the findings can more clearly illustrate the demi-regularity that Irish people have poorer health than the British population and provide clues to its generative mechanisms.

Discussion

From a critical realist standpoint, many of the conclusions drawn in this “positivist” chapter, especially those of an explanatory nature, are seen as misleading. More specifically, it is argued that while logistic regression analyses may provide valuable circumstantial evidence, they cannot predict occurrences or anticipate concrete events nor can they answer questions of causation because reality is far too complex for that. Indeed, a very large number of mechanisms are active and they are

regarded as tendencies which can be reinforced, modified or suppressed in a complex interaction with other mechanisms in an open system. The result may be that they are not always empirically manifest. In addition, the motive for action is regarded as a causal mechanism alongside others (Danermark et al., 2002).

Consequently, when a quantitative analysis discloses an empirical regularity, this is neither a necessary nor a sufficient condition for explaining a phenomenon. Moreover, if an expected connection cannot be found, this does not infer that a causal force (mechanism) is lacking (Danermark et al., 2002).

Thus, it cannot be inferred from the empirical regularity of the Northern-Irish born still having significantly poorer health than the general “white British” population after controlling for age, gender, marital status and socioeconomic position that the generative mechanism of socioeconomic position is not an important mechanism for explaining the health inequalities faced by this population. Indeed, it may be that the mechanism of socioeconomic position is dormant or that it is active but prevented from full or partial empirical manifestation by counteractive mechanisms. Moreover, as noted above, the socioeconomic indicators used in the study may not capture other dimensions of socioeconomic position such as living in a racist society or work-related stress associated with higher level occupations.

Hence, based on the logistic regression analyses, demographic and socioeconomic factors should not be dismissed or accorded less importance in explaining the poor health of these populations and should still be empirically investigated by intensive empirical procedures.

With respect to the second generation Irish, the empirical finding of their having significantly poorer health than the general “white British” population only after controlling for age, gender, marital status and socioeconomic position does not mean

that age is necessarily the generative mechanism underlying the differences in health between this population and the “white British”. Age may have interacted with many other mechanisms to produce this effect.

Moreover, it cannot be inferred from the empirical regularity of the Republic-Irish born no longer having significantly poorer health than the general “white British” population after controlling for socioeconomic position that the generative mechanism of socioeconomic position can fully account for the poor health of this population. Indeed, it may have interacted with other mechanisms, possibly confounded within the measures of socioeconomic position, to produce this effect.

Finally, it cannot be inferred from the empirical regularity of the Northern-Irish born who see themselves as Irish having poorer health than those who see themselves as British, even after controlling for demographic and socioeconomic factors, that there is necessarily an identity effect since all the generative mechanism controlled for may have been dormant or prevented from full empirical manifestation by counteracting mechanisms.

Empirical regularities should therefore simply be viewed as pieces in the jigsaw puzzle of searching for mechanisms or potentially as circumstantial evidence, not arbiters, and the extensive approach simply deemed capable of capturing contrasting demi-regularities between taxonomic groups by providing vital descriptive statistics and clues to the underlying generative mechanisms (Danermark et al., 2002).

Conclusion

From a critical realist perspective, only the empirical finding of the demi-regularity that the Irish people in England have poorer health than the general British population, together with the descriptive statistics indicating differences in age, socioeconomic status and health according to Irish ethnicity and country of birth (see

tables 5.1, 5.2 and 5.3), are viewed as entirely valid. Whether age, socioeconomic position or even ethnic identity, explain the key demi-regularity cannot be definitively established based on these regression analyses. However, these regression analyses, combined with the descriptive statistics, provide clues to the underlying generative mechanisms and suggest that the search for generative mechanisms should examine factors such as country of birth, age, socioeconomic position and ethnic identity, as they may be important.

Thus, mechanisms originating from the older age and socioeconomic disadvantage of the Republic-Irish born may contribute to the poorer health of this population when compared to the general British population, although it is likely that additional mechanisms also come into play. Conversely, mechanisms originating from the younger age and advantageous socioeconomic position of the second generation Irish, together with other interacting mechanisms, may counteract other mechanisms contributing to the poorer health of this population (e.g. related to ethnic identity) and prevent an empirical manifestation of the demi-regularity of second generation Irish in England having poorer health than the general British population.

Finally, the demi-regularity that the Northern Irish born have poorer health than the general British population, despite apparent advantages in terms of age and socioeconomic position, may suggest that more subtle generative mechanisms, which may counteract the above demographic and socio-economic influences, should be examined, including a possible ethnic identity effect. Also, the socioeconomic indicators used in this study may fail to capture other important dimensions of socioeconomic position, such as discrimination experiences and work-related stress, which could negatively impact the health of the occupationally successful Northern-

Irish born; hence the need not to dismiss the importance of the mechanism of socioeconomic position based on these findings.

In order to properly investigate the influences and generative mechanisms of Irish health inequalities and the complex interactions amongst them, in view of the complex nature of social reality, in-depth qualitative research, is needed (see chapter 4 p. 70 and 72). The following chapters present the results of the intensive component of the Coventry research which provides insight into the interacting tendencies (influences) and mechanisms which produce or alleviate Irish health inequalities through a critical realist analysis of the interview accounts of first and second generation Irish men and women in Coventry⁴³.

⁴³ As previously noted in the methodology chapter, all but one of the first generation Irish interviewees are from the Republic of Ireland so the intensive research is unable to provide further insight into the generative mechanisms responsible for the health experiences/inequalities faced by the Northern Irish born.

Chapter 6: Ethnicity as Structure

Introduction

This and the following chapter present the findings of the intensive research. The purpose of this chapter is to explore the relative contribution of the structural dimension of Irish ethnicity to Irish health experiences and inequalities in England, focusing on Coventry Irish people. In other words, to what extent can Irish health inequalities and/or experiences be attributed to the structural position of Irish people in England? Five facets of the structural position of the Irish in England, the political economy, migration, socioeconomic position, discrimination, and experience of the NHS, all of which were shown, in the literature review, to be important structural influences on the health of ethnic minority populations and/or on that of Irish people in England, are explored and their relative contribution as generative mechanisms of Irish health inequalities, assessed for first and second generation Irish populations in England. This is achieved by examining the structural position in England of a sample of first and second generation Irish men and women, exploring their discursive knowledge of influences on health, and outlining the pathways through which these structural factors may impact health, by supplementing the findings with evidence from the existing literature (see chapters 2 and 3).

This chapter is also concerned with exploring the ways in which structural aspects of ethnicity interact with identity-related aspects of ethnicity. Indeed, it is often difficult to entirely separate the influences of structural and identity components of ethnicity, as will be noted throughout the subsequent discussion. Nevertheless, the distinction is useful from a heuristic perspective, particularly in the presentation of the qualitative research findings, which have been divided accordingly into the current

chapter, which focuses centrally on the structural contribution of ethnicity, and the subsequent chapter, which focuses centrally on issues of ethnic identity.

Moreover, this chapter looks at the interplay between structure and agency within Irish people's "lived" structural experiences, and considers the negative and positive aspects of the structural experience of the Irish. Finally, since the research views the Irish community as resilient in the face of adversity, this chapter identifies the factors or generative mechanisms which may be protective of health, by mitigating the negative health effects of structural factors contributing to Irish health inequalities.

The Political Economy

The structural generative mechanisms of British colonialism and a world capitalist economy were described in the literature review, together with their relevance to Irish health inequalities in England. This section explores first and second generation Irish people's discursive knowledge and spontaneous mention of these mechanisms⁴⁴.

Findings and Discussion

British Colonialism and the Irish Economy

First and second generation Irish people in the study did not articulate the link between British colonialism and the poor status of the Irish economy (cf. (neo)-Marxian explanations of migration, chapter 2, p. 27), that is, they did not blame British rule for widespread poverty in Ireland or for putting Ireland in a peripheral position in the world economy although these connections have been documented elsewhere (see chapter 3, p. 43).

World-systems Theory

⁴⁴ Respondents were not prompted on these mechanisms but often alluded to them spontaneously as affecting their lives.

This section follows on from the previous one and connects the peripheral position of the Irish Free State in the world capitalist economy to its prolonged poverty and population exodus, long after its independence in 1922. World-systems theory provides a framework for this phenomenon within a capitalist world economy with Ireland being at the periphery due to its poor economic status, providing needed labour to the wealthy core of England (Hazelkorn, 1990).

There was a general understanding among the people in the study, especially on the part of the first generation, of some of the issues addressed by world-systems theory, but not of others. While the people in the study did not articulate a link between the peripheral position of Ireland in the world capitalist economy and prolonged poverty in Ireland, they expressed one between the former and population exodus. Indeed, many saw the decision to migrate to England to be heavily tied, on the one hand, to poverty and high rates of unemployment in Ireland (push factor), and, on the other, to a booming economy and abundant work opportunities in England and/or Coventry (pull factor) (cf. push-pull theory, chapter 2, p. 27),

My brother had already inherited the farm, my mother was still alive, my father was dead and it was time for me to, start to make moves, for my life, and, the opportunities in Ireland in those days [...] were little. There weren't many opportunities for jobs [...] whoever come to Coventry, this is '66 [...] some of the boom times had finished but a lot of it was still there. There were many, many factories in Coventry, big and small, and some employed, I suppose, up to nine thousand people, which, will always have vacancies [...] (Brian, 1st gen., man)

In accordance with other studies (see Leavey, 1999), the Irish people in the study described migration in the mid twentieth century as an economic necessity. In this sense, migration was heavily structured and there was little scope for agency or for making free choices,

The poverty was very bad in Ireland then, there was no work, there was no houses... that's why we had to emigrate, come, emigrate here, all of us, [...] [unclear] millions emigrated [...] not just to Coventry, all over the world, America and everywhere. (Mychaela, 1st gen., woman)

Some first generation Irish women migrated to England to train as nurses because, unlike in Ireland, nursing training was free there. According to Brenda, being forced to migrate for reasons of economic necessity was bound to have a detrimental effect on health,

The thing is that they're forced to emigrate [...] it wasn't that they made a decision and if you're forced to do something, that will have an awful effect on your health because you may not be even happy with it, but you have to because of the money situation and all the rest of it [...] (Brenda, 1st gen., woman)

Only a minority of Irish people, who were better off moneywise, felt they had a free choice to make (or true agency) with respect to migration. This was Brenda's situation. Although her father, then a policeman, could have paid for her to train as a nurse in Ireland, she decided to migrate to England in an unconscious desire to escape from her painful memories of childhood abuse.

Finally, some people in the study were conscious of the fact that Irish migrants provided much needed labour to Britain during the post-war period, which was essential to British capitalist expansion,

They've [Irish] contributed a hell of a lot, they, they've done work that [...] the ordinary Englishman wouldn't do [...] they've paved roads, they've built buildings [...] after the war, Churchill, begged them to come back to build up the country. (Tavis, 1st gen., man)

The Irish Economy, Socioeconomic Position in the UK and Self-esteem

The poor status and agricultural nature of the Irish economy meant that the majority of Irish migrants who came to England in the 1950s and '60s had no choice but to take up unskilled and poorly paid jobs in England, in part because they had little education and did not possess skills transferable in urban settings (cf. Tilki, 1994). This led to poor housing conditions. Some people in the study articulated this link,

I think they [British] think they [Irish] should come, take all the shitty jobs and, the cleaning jobs and the...the monkey jobs [...] that's all they ever given because the Irish had to work, weren't they? Because there was no work in Ireland [...] they had no choice, poorly paid, poor housing uh conditions [...] When I came over here, well, after school

[...] in the 60s, there was no education, so that's the only job you can do . [...] [In Ireland] as soon as you left school [...] you had to go to work to bring the money home. (Mychaela, 1st gen., woman)

Others tied the lack of education to secondary education not being free in Ireland at the time,

Education after primary school, education wasn't free, you had to pay [...] well, we couldn't afford it, my mother and father [...] so when I was 12 I had to leave school. (Paul, 1st gen., man)

According to Aaron, the poor status of the Irish economy in the 1950s had a negative impact on the self-esteem of Irish people who migrated at this time and on that of their children, with negative implications for the socioeconomic position of the second generation,

I think young, Irish people, with the tiger economy [unclear] [...] they have gained a sense of confidence that older Irish people never have [...] it was that sense of like you know you keep your mouth shut and, you you get on with it [...] I personally think that part of that [my lack of self-esteem] stems from being Irish...growing up within a, particular time and place in Irish households [...] [that] weren't particularly [...] arrogant or affluent. (Aaron, 2nd gen., man)

British Colonialism, the “Troubles” and Discrimination Experiences

Some people in the study had a good understanding of Irish history and tied anti-Irish oppression and discrimination to British rule (cf. Miles, 1982; Hickman, 1995),

We were put down for years and years, we were put down by the British thing, I don't want to ruin the man too much because I made me living there . . . in this country, but . . . they had us under the thumb there. (Tavis, 1st gen., man)

Although some second generation Irish people had been discriminated against by the Irish-born and called “plastic paddies”, i.e., “fake Irish people” (cf. Hickman et al., 2005), none explicitly articulated a link between these experiences and British imperialism (cf. chapter 3).

Some people blamed British rule for the “Troubles”,

The Irish people [...] they don't get on with Northern Ireland people [...] the Free State didn't like the Belfast people [...] because they [...] stayed [pause] in their part, because they were under the British rule [...] because they were getting everything British [...] and yeah, at that time, they were better off, but now, it's turned... and the Free State is better. (Mychaela, 1st gen., woman)

The “Troubles”, in turn, were held responsible for anti-Irish discrimination in Coventry by many first and second generation Irish men and women in the study,

When the, there was problems in Ireland with the IRA [...] people were looking over very suspiciously then and...they were not friendly, they were not welcoming then, I don't think. (Paul, 1st gen., man)

He [father] said in the workplace um he was alienated [...] because of this Irish thing and the IRA I think he received an awful lot of racism in the workplace [...] especially around the Birmingham bombing time you know my dad being called Pat and from Belfast [...] he fitted all the stereotypical IRA (unclear) and Catholic as well so [...] we [were] more or less like, feared, yeah because they really did believe that my dad had some kind of involvement in it [IRA]. (Leslie, 2nd gen., woman)

And many felt they had to keep a low profile,

When the bombing started in Birmingham you had to play, if you had any sense you had to try and keep a low profile, it was a very, very sticky time for, for us. (Jack, 1st gen., man)

Leslie attributed the poor mental health and subsequent death of her father to the Troubles,

He [father] said that he was very angry and bitter about having to leave, Ireland, as a result of the troubles [...] and he was the eldest of nine [...] the responsibility [...] to be the man of the house was, was given to him at [...] about 12, so as a result of this and the troubles, my mum said that whilst he was in Belfast he used to sleep with a knife, that he couldn't get uh uh a good night sleep because he was frightened of the door being put through [...] he ended up dying of a, a heart attack which was stress-related [...] so believe that he was very highly stressed at a very young age. (Leslie, 2nd gen., woman)

The “Troubles” and Migration

Some people in the study drew a link between the Troubles in Northern Ireland, the religious conflicts between Protestants and Catholics, and Irish migration experiences. Migration was forced for religious and political reasons and again, there was little scope for agency or free choice,

Mum and dad [...] were asked to leave Ireland [...] just before 1970, around that time and the Troubles, um mum is Protestant and dad is Catholic and um they were living in a Catholic area [...] because of the troubles they were told it would be best if they left so [...] [they] moved over here [...] didn't actually move into any of the Catholic communities [...] because of mum's religion so ended up living in boarding houses [...] (Leslie, 2nd gen., woman)

As for my father [...] his father worked in (unclear 21) shipyard [...] in Belfast [...] he was er stoned because he was Catholic and er told to leave the job so he came to England as well as taking the family. (James, 2nd gen., man)

British Colonialism and Irish Identity

Some people in the study commented on the damaging impact of British colonialism on the Irish culture and language, both seen as important aspects of an Irish identity,

It's done a bit late for me [...] but a lot more people should [...] get their language cause it's official now to have the Irish language [...] you turn on the Irish program and it's all in Gaelic [...] and it's lovely listening to it, especially when, see we didn't get taught much about it because, you know, we were under the British all the time [...] and there was no, I mean you [...] were even getting shot for wearing green. (Hogan, 1st gen., man).

Others commented on the impact of British colonialism on Irish identity (cf. Kelleher & Hillier, 1996; Greenslade, 1992),

Why should we lose our identity, we're, we're, we've got a unique culture of our own and we have got er, this and that and the other that no other country in the world has, and erm, we were put down for years and years, we were put down by the British thing [...] (Tavis, 1st gen., man)

None of the people in the study expressly linked British colonialism to issues of ethnic identity faced by the second generation Irish who have to defend charges of inauthenticity from both the English and the Irish-born (cf. Hickman et al., 2005). Issues of identity will be explored in greater depth in the chapter on ethnicity as identity.

Conclusion

Support for the relevance of the structural generative mechanisms of British colonialism and a world capitalist economy to structural and identity related aspects of Irish life and subsequent health experiences is found in the accounts of participants, who articulated links between 1) British colonialism, the “Troubles”, forced Irish religio-political migration to the UK, experiences of anti-Irish discrimination in

England for the first and second generation, and issues of ethnic identity for the first generation and 2) a world capitalist economy, forced Irish economic migration to the UK and a poor socioeconomic position in England for the first generation, with negative ramifications for that of the second.

Participants also linked a world capitalist economy, Irish migration patterns and the recreation of Irish community support structures (see migration section below). Finally, they linked the “Troubles”, the poor status of the Irish economy and forced economic migration to poor Irish health. However, they did not articulate other important pathways, including the initial pathway between British colonialism and poverty in Ireland.

Migration Experiences

This section explores the generative mechanism of migration. Because Irish migration in the mid-twentieth century was strongly shaped by structural forces (see previous discussion), it is seen as a largely structural phenomenon and will be examined in this chapter. All three phases of migration, pre-migration, migration and post-migration, can affect the health of the Irish migrant, and hence contribute to Irish health inequalities, since they will occur alongside social and economic upheavals (Nazroo, 2003; Bhugra & Jones, 2001; Williams, 2002).

Findings and Discussion

The great majority of first generation Irish men and women in the study felt compelled to migrate to England in the 1950s and ‘60s for reasons of economic necessity. This lack of agency or free choice may have negatively impacted their health (see above section),

I know, where I should have like to have stayed, but I couldn't stay because I, economically it would have been bloody suicide for my people, I was forced to leave the land of my birth and I am bitter about that (Jack, 1st gen., man)

Most migrated on their own⁴⁵, when they were in their late teens or early twenties, and single⁴⁶. This is consistent with other studies (Leavey, 1999; Leavey et al., 2004). It is significant, however, that while Leavey et al. (2004) found poverty, in keeping with the current study, to be a push factor to migrate for both Irish men and women, they also noted an additional motivation to migrate on the part of the women, in that it offered a chance to escape the diminished probability of marriage which was essential for a fulfilling social existence in Ireland. In the current study, none of the first generation Irish women mentioned this reason for their migration.

The need to migrate for dire economic reasons combined with the geographical proximity between Ireland and England meant that the great majority of first generation Irish people in the study had a poorly planned migration, which Ryan et al. (2006), in a study of Irish migrants in London, found to be associated with subsequent depression.

Only two first generation Irish women in the study, Brenda and Maeve, who had come to England to train as nurses, had had a well planned migration. They had obtained approval from their parents and had pre-arranged employment and accommodation in England. The hospital was to take care of everything for them from the moment they arrived,

The people who used to come to nursing ages ago, they'd have people to great you, when you, you came [...] and you had people to settle you in [...] check up on you, show you

⁴⁵ A minority of the men and women in the study came over to England with their parents when they were about 10 years old. Their parents had migrated for economic reasons. One first generation Irish woman came over with friends.

⁴⁶ Two first generation Irish women were married prior to the migration; one came over with her husband when she was thirty and the other joined her husband in England when she was twenty. Both women were working in Ireland in factories prior to the migration. This is somewhat hard to reconcile considering that at that period in time women could no longer work in Ireland once they got married because of the marriage bar.

around the place [...] show you where the nursing school was [...] try to give you all the routine sort of thing [...] (Brenda, 1st gen., woman)

Maeve had also prearranged to travel from Ireland to England with friends and other girls going to the same hospital. This made the migration experience and settling in easier, and may have been protective of health.

However, things did not always go this smoothly....,

The morning that I left Ireland, I was really, really upset [...] I cried all the way to [...] Coventry [...] When I came to Coventry [...] nobody [from the hospital] came to the airport [laugh] to meet me [...] I remember it so it must have had an effect on my life [...] then discovered there was no bed for me and I was supposed to be living over the doctor's quarters [...] I found that very difficult because [...] I hadn't known the place, trying to find [unclear] [...] I was [...] terribly lonely. (Brenda, 1st gen., woman)

...and migration meant a disruption of close family ties (Scanlon et al., 2006), with negative health repercussions.

Setting the above cases aside, the great majority of first generation Irish men and women in the study came to England and Coventry in search of employment,

No uh... I had nothing secured. In those days when you come to Coventry uh...oh not just Coventry, to any city, you walked around the city looking for jobs. (Brian, 1st gen., man)

This is consistent with other studies on the "old wave" (1950s) migrants (Jackson, 1963 and Ryan, 1990, as cited in Leavey et al., 2004). Thanks to a booming manufacturing economy and the need to rebuild Coventry, they were able to secure jobs in Coventry very quickly (cf. Ahmad and Bradby, 2007), principally in the car and electrical factories but also in the construction industry (men) and in the hospitals (women). These jobs were mostly unskilled and badly paid (cf. Tilki, 1994),

I got a job straight away, we uh, we just [pause] went around to different factories and they just kept saying what experience have you but I had no experience [...] and uh got a job at [manufacturing factory], was only here two days. (Megan, 1st gen., woman)

A booming economy in Coventry since the 1930s also meant that most of the people in the study had social contacts, i.e., friends or family, there, and hence somewhere to stay when they first came to Coventry. Indeed, by the 1950s and '60s,

numerous Irish people had already migrated to the city to find work. According to Brian who had several relations in Coventry including a sister, brother in law and nephews,

In those days, a lot of Irish families followed one another. There was a great need to do it, unlike now. (Brian, 1st gen., man)

Having family and friends in Coventry partially counteracted the social isolation felt by the Irish migrant in a foreign country and was especially important in a context where it was difficult for the Irish migrant to secure accommodation owing to anti-Irish stereotypes and discrimination,

When I came to England first [...] they put notices up uh saying at the boarding house no Irish wanted, they didn't want them there, whether they thought they drank too much or what, but you were all charged with the same. (Melinda, 1st gen., woman)

However, a number of people, men in particular, eventually encountered difficulty finding accommodation, sometimes because of the itinerant nature of their job. They came across anti-Irish signs on lodgings and were forced to stay in hostels for the Irish,

The Irish wasn't welcome at all [...] they had hostels here for us [...] it just carried on then just after, the war and everything they kept it up you see 'no Irish need apply' there was no 'digs'. (Hogan, 1st gen., man)

The housing conditions in the lodgings or hostels were often terrible. Both men and women were affected,

We would go out most evenings to different parts of Coventry looking for accommodation for her [sister] and I can remember vividly going up Hillfields [...] that was the only place that was advertised [...] and I said 'well' [...] 'it's a room' [...] she said 'oh I'll have this' [...] she was only in about two or three days she came back and said 'terrible' [...] 'the blankets are damp' [...] 'the woman is terrible, the place is awful' so we had to go looking again. (Maeve, 1st gen., woman)

Quite a few people in the study attributed the poor health of Irish migrant men and their bad drinking habits to their having to stay in lodger houses, where the housing conditions were not good,

I guess they've suffered a lot as well because [...] they couldn't get proper digs and they wouldn't be eating properly would they years ago, they'd just be drinking. (Melanie, 2nd gen., woman)

The pub provided an escape from overcrowded and unwelcoming digs, and was the only place to socialize after a long day's work. This is consistent with other studies (Tilki, 2006). Unfortunately, going to the pub meant having a drink,

The main port of call became the Pub and it wasn't because they were all drinkers that's a lie, it was only because [...] they weren't made welcome to stay home, and if they had their mothers and fathers with them there wouldn't have been so many fellas that got lost by the way with drink, the landladies of this country have a lot to blame for that. (Jack, 1st gen., man)

In common with other studies (Tilki, 2006; Scanlon et al., 2006), the pub was described as a place where one could interact with other Irish people and cope with social isolation, homesickness and loneliness. Drinking was one way to “feel like you belonged” and also “cope with missing Ireland” (Scanlon et al., 2006, p. 335),

Ah a lot of them [migrant men] were home sick as well you see, and they came over here and there was nowhere to go only the bloody pub [...] (Tavis, 1st gen., man)

Thus, pub drinking was described as being heavily structured by the migration experience. By offering a sense of community, the pub may have had, in some respects, a protective effect on health. Moreover, the pub provided employment contacts (cf. Leavey et al., 2007; Tilki, 2006),

We went out for a drink that night and we met [...] a Dublin man, and he was just starting a business on his own, and he said to me, ‘you're just the man I'm looking for can you help me out?’ and I said, ‘if I like, I'll go with you for a fortnight’ [...] he was putting in vats in a Brewery in Birmingham, so he picked me up the next morning [...] (Jack, 1st gen., man)

In contrast with Leavey et al.'s study (2007), there was no explicit evidence in the accounts of drinking being used by the Irish migrant as a way of coping with a poor socioeconomic position more generally, including “hurtful” experiences of anti-Irish discrimination, although it is likely to be the case.

Unlike the Irish migrant men in Leavey et al. (2004) study, who often worked in construction jobs that demanded constant relocation and prevented stability in

accommodation and in social or personal relationships, the Irish migrant men in the current study were generally able to secure long-term factory jobs in Coventry on account of it being a major manufacturing centre. This afforded them some stability; all got married, formed a family and left the hostels to move into often low-quality council-owned rented housing. Also, unlike the Irish women in Leavey et al. (2004) study, who were able to settle down, get married and form a family as a result of working in accommodation-tied occupations, the Irish women in the current study were largely able to do so by securing long-term jobs as factory workers or hospital support staff.

In contrast, Eric knew of men who never got married and lived in damp lodging houses over the years. They still led the same unhealthy lifestyle and Eric was convinced it would lead to their death,

A lot of the Irish people here... [...] men especially, uh they didn't get married [...] lived in lodger's house here, over the years, on damp conditions [...] undernourished and all that [...] I know [unclear] quite a few, right? [...] gone back in the 50s, they were all in lodger's houses and these fellers working on the buildings [...] and going right to the pub after working, drinking and... [...] when they'll come up to the age [...] like me now [...] they're either dead or they're down there in the pub [...] I don't know about the women, I know about the men. (Eric, 1st gen., man)

Finally, post-migration factors may have also affected the health of this generation of people. The very fact of being a migrant and being away from home and one's roots can have a negative impact on health, a connection articulated by some people in the study,

I've been trying to work this one out for some time, as to why [the Irish have poor health] [...] is it because they're living in this country away from their roots, having been disturbed [...] I think it might be [...] when you are away from your roots, I think that has an affect [...] on your health even [...] and perhaps people are living in this country because they've had to come to this country, had to find work and various things and although there are many Irish communities, I think that might answer it. (Oliver, 1st gen., man)

You could say, [Irish poor health] it's from, because they are living away from home [...] and they're drinking more and all that [...] (Finn, 2nd gen., man)

This is especially pertinent to the wave of Irish migrants considered here since the great majority would have preferred to stay in Ireland if their economic circumstances would have permitted it. As a result, and in accordance with other studies (Leavey et al., 2004), most remained nostalgic about Ireland, their childhood and the Irish way of life,

I used to love going to my grandparents and my grandmother and they were only up the road, so even as a little lad I was able to run up and it was just nice and again my father had seven sisters so I knew most of them [...] I miss that kind of life [in Ireland], that kind of life was very nice and comfortable you know. (Oliver, 1st gen., man)

The above factors combined with experiences of anti-Irish discrimination in England prevented many Irish migrants from feeling at home in England and led to many feeling as if they were foreigners in a country they had lived in for the greater part of their existence,

We're people that had to leave Ireland because we couldn't make a living in our own country and were reared and will die in a land as a for-, not matter what it is- it's not your home [...] even though I've got my family here and I'm totally accepted here [...] I've read all my life and lived all my life as a foreigner [...] it doesn't make you feel great, you live with it and you go along with it, just as if it doesn't exist, but it's not great because I was called Paddy for a lot of years [...] that wouldn't have happened if I was in Dublin [...] these are little things that people don't even know happens to you when you're living in another man's land, because it is another man's country [...] I was forced to leave the land of my birth and I am bitter about that. (Jack, 1st gen., man)

This is consistent with Leavey et al. (2004) who found the older Irish migrants in her study to clearly differentiate between settlement and belonging. While there was an acceptance of having a family and other ties in England, they did not feel part of English society; as one of their participants said, "I'm settled but I don't belong" (p. 773). This might be due to a historical national grievance and experiences of poor acceptance and hostility from the host community on the one hand, and to a need for cultural familiarity, on the other. The negative health implication of the stress brought on by the Irish participants' sense of "not belonging" in Britain was emphasized by Scanlon et al. (2006), who linked it to increased cancer incidence.

Moreover, being a migrant may also indirectly impact the health of the first generation Irish people in the study through its effect on attitudes towards seeking medical care...

People feel slightly more cut off from the mainstream society and that erm, you know, leads to their unwillingness to go to doctors and things like this or to participate in erm, health programs. (James, 2nd gen., man)

...and on attitudes towards the provision of medical services,

I think [it] is a characteristic especially of the older [Irish] generation erm that erm they don't want to make a fuss and they accept what they're given [...] that's the way they, they think, that's the way my mum thinks anyway [...] I think there's some sort of thing of [...] you come to England and you know this is the country that erm you should respect and erm do as your told sort of thing [...] (James, 2nd gen., man)

Megan appeared to have lower expectations of what constituted good medical care as a result of growing up in Ireland; she reported being simply grateful for receiving free care, since medical care in Ireland was too expensive for many people, "I've, I've very grateful for the help I get, yes" (1st gen., woman). Alternatively, this may have been a "socially acceptable" answer, since, as an Irish migrant, she may not have wanted to appear ungrateful towards the country which gave her a living.

Given that Irish people in Coventry are now more dispersed across the city than they were initially in the '50s, the lack of an Irish community system where neighbours help each other and support one another may also affect the health of the Irish migrant through generating feelings of social isolation in old age,

Now I [...] I don't go nowhere special to meet them [Irish people] or anything because I don't go to pubs anymore so I'm out of circulation, so I only bump into them [...] there's nobody you could go in and say 'I've got a problem' you know, there's nothing like that (Hogan, 1st gen., man, widower)

Finally, many Irish migrants suffered from the negative health repercussions of a poor socioeconomic position in England, as a result of Ireland's peripheral position in the world economy, possibly exacerbated by anti-Irish discrimination in England affecting work opportunities. This is discussed further in the next section.

Conclusion

The evidence shows that pre-migration experiences (including forced economic migration - seen by respondents as being heavily shaped by structural factors and as leaving no scope for agency - disruption of family ties and the absence of a well-planned migration), migration experiences (including difficulty finding accommodation, anti-Irish signs on lodgings, anti-Irish discrimination more generally, inhospitable, damp and overcrowded lodger houses and pub drinking) and post-migration experiences (including being away from home, feeling like a foreigner in England and a persistent disadvantageous socioeconomic position in England including poor housing conditions, experiences of anti-Irish discrimination, and social isolation in old age) may negatively impact the health of the first generation Irish.

The people in the study made important connections between migration experiences and poor Irish health. Some linked the poor health of Irish migrant men and women to pre-migration factors such as forced economic migration and others to post-migration factors, including being away from home and one's roots, being reluctant to seek medical care on account of feeling cut off from mainstream society, having lower expectations of what constitutes good medical care given that medical care was not free in Ireland, and being accepting of the doctor's diagnosis resulting from the belief that migrants should not complain.

Others attributed the poor health of Irish migrant men and their bad pub drinking habits to migration factors such as their having to stay in dismal lodger houses where they did not feel at home and to their being homesick. Still others believed Irish migrant men suffered from poor health because of a combination of living in damp lodging houses and leading an unhealthy bachelor lifestyle where they worked hard during the day, drank in the pub at night, and did not eat properly.

Factors which may have protected some first generation Irish people from the negative impact of migration on health included the presence of social networks in England, owing to a concentration of Irish people in Coventry, the ability to easily secure jobs because of a booming economy, the more stable nature of factory jobs, getting married, and paradoxically maybe even the pub by offering a sense of community. Interactions were observed between dimensions of ethnicity as structure, with the nature of the world capitalist economy leading to specific Irish migration patterns, and to an ability to secure employment in England easily, and also between ethnicity as structure and ethnicity as identity, with specific Irish migration patterns leading to a concentration of Irish migrants in Coventry and thus to Irish community support, including social contacts for Irish migrants, with positive health implications. Social contacts in Coventry would have partially counteracted feelings of social isolation and helped Irish migrants find accommodation in a context where this was especially difficult owing to anti-Irish stereotypes and discrimination. Another interaction is thus visible between identity and structural components of ethnicity, with community support at least partially counteracting social isolation and the effects of anti-Irish discrimination.

Irish migration patterns also led to the establishment of Irish pubs, which have negative (drinking), but also maybe positive (employment contacts, Irish cultural connection, community support) health implications. An interaction between ethnicity as structure, here, migration experiences, including staying in dismal lodging houses and feeling socially isolated and homesick, and ethnicity as identity, here, lifestyle choices, including heavy drinking habits and a poor diet, was also found. The manufacturing nature of the Coventry economy meant that many people in the study were eventually able to secure stable factory jobs, form a family, and move to council

housing where they could enjoy proper meals and feel more at home. Thus, socioeconomic position (stable jobs), which relates to ethnicity as structure, may partially counteract difficult migration experiences (also relating to ethnicity as structure), and poor lifestyle choices, which relate to ethnicity as identity.

Gender differences were observed, with the women who came to England to train as nurses generally experiencing easier migration experiences since they had already secured accommodation and employment in England via a well-planned migration. Moreover, their socioeconomic position was generally better than that of the other Irish migrants who worked in manual occupations. Finally, unlike the men, Irish migrant women in general did not adopt “unhealthy” pub drinking habits.

Socioeconomic Position

This section explores the contribution of the generative mechanism of socioeconomic position, in particular childhood poverty, education, occupation, absolute or relative deprivation, work and unemployment, to Irish health experiences and/or inequalities. It also explores the linkages made by Irish respondents between these factors and health.

Childhood poverty

Childhood poverty has been shown to negatively impact health in later life through numerous pathways. This section focuses on material and psychosocial pathways of ill health, that is, on absolute and relative deprivation, as discussed in chapter 2 on p. 14. The indirect impact of childhood poverty on health through its effects on educational choices and opportunities, and consequently adult socioeconomic position, will be discussed in the next section.

Findings and Discussion

First Generation

The vast majority of first generation Irish men and women in the study grew up in the Republic of Ireland in the early part of the Twentieth century, when poverty was widespread in both rural and urban areas. Many Irish people suffered from inadequate nutrition, overcrowding and poor heating, which could have predisposed them to poor health in later life,

[We] were very poor, very poor and hungry, very, not moaning about it though. (Hogan, 1st gen., man, Dublin)

The old place [...] was an old swamp [...] she was scratching and scraping all the time [...] We lived sort of on Potatoes half the time [...] I was born in County Galway, in [...] a little village [...] in [...] a small thatched cottage and there was only one, one room, up, and one room down [...] there was nine of us [...] we slept on straw one after the other and we had [...] to sleep across the bed like that [...] there was [...] four of us [...] in the bed [...] (Tavis, 1st gen., man)

Many were able to psychologically survive this significant material deprivation by adopting indispensable coping strategies, including uncomplaining and long-suffering ways of thinking. When Mychaela was asked if she found her childhood financial situation to be stressful, she replied,

Well, [...] people didn't think like that in them days because [...] you had to get on with it because there was no other choice, was there? (Mychaela, 1st gen., woman)

In this way, they used their agency to survive. Some first generation Irish people in the study suffered from life-threatening health conditions as children, which may have been tied to significant material deprivation. For example, Erina and Marta nearly died of whooping cough.

The people in the study provided interesting lay discourses of mechanisms. Some linked conditions of extreme poverty in Ireland, including malnourishment, dampness and severe financial worry, to poor health,

Me uncles and aunties died of TB but there was TB in Ireland in the 40s [...] me grandfather, he got TB [...] you do [lose a lot of people because of TB], yeah, in Ireland,

because [...] we had no food, had no [...] vitamins in the body in order [to fight it]. (Eric, 1st gen., man)

I think our house must have been damp she said when they moved in, she [mother] contracted Rheumatism and it of course turned into Rheumatoid [...] she was thirty seven when she died. (Maeve, 1st gen., woman)

I was born in Dublin [...] I have uh four sisters and two brothers, my mother never went to work [...] my father [...] was just a salesman for shoes [...] there wasn't a lot of money when I was young, no [...] my mother had a difficult time and she died when she was 49 with cancer [...] I think they had a lot of worry [...] short of money, financial [...] and trying to rear the family [...] (Melinda, 1st gen., woman)

Within a discourse mixing feelings of nostalgia and regret, Gary attributed his back problems to making hay by hand the traditional way in Ireland as a child,

I think it's a harder life over there [Ireland], if you've made hay all day that's where you actually cut it, you turn it, cause I've actually done it the old fashioned way because there was no machinery available [...] I loved them days, but it was very hard back breaking work, which probably accounts why I've got back problems now. (Gary, 2nd gen., man)

Aaron (2nd gen., man) directly linked Irish poor health to childhood poverty, to “growing up in Ireland where they were very poor”.

Thus, the relevance of the concept of absolute poverty or significant material deprivation for the childhood experience of many first generation Irish people in the study has been demonstrated, as well as its perceived effects on health.

On the other hand, Wilkinson's concept of relative deprivation (1997, 2000), which ties childhood poverty to poor health via psychosocial pathways, i.e., through the experiences of low social status and poor social affiliations (as cited in Scambler, 2002) may be less relevant to the experience of this generation of people. Indeed, Ireland in the mid-twentieth century was afflicted with widespread poverty, which meant that people generally perceived themselves to be on a financial par with others,

We didn't realize we were poor because everybody was in the same position [...] nobody had very much and you just got on with it and I just think it was good grounding actually, give you a good work ethic. (Neve, 1st gen., woman)

However, a minority of participants had come to realize that some people were better off. For these people, the concept of relative deprivation was applicable and they may have suffered from some of its effects,

I didn't realize that we were living in that poverty (unclear) because everybody around me was exactly the same [...] I didn't know that people didn't have a dinner every day, I thought they only got a dinner Sunday [...] the reason that I found out that was a fella from school, I went to his house [...] he was sitting down having their dinner, and I said, 'what are you doing having your dinner it's not Sunday'? And I didn't know [...] that was the poverty level and you don't go much bloody lower than that. (Jack, 1st gen., man)

Second Generation

The majority of second generation Irish people in the study grew up in Coventry and came from working-class families. Their fathers were car factory workers, carpenters, plasterers, builders, or labourers, and their mothers were housewives, nurses, care assistants or support workers. The standard of living of the second generation was better than that of the first and they had adequate clothing and food. However, occupational earnings were low and many families struggled to break even. They had to go without things and make sacrifices. Some houses were inadequately heated,

We weren't like in poverty, it was like uh...we had food...but yeah it's kind of like [...] my mum would make my dad a chop [...] and we'd have like sausages or something, and I'd [unclear] always think "[...] I'd love to have that chop" [...] she'd probably go [...] without things, because she couldn't afford it [...], she kept a tight budget [...] we didn't have central heating [...] it was cold in the morning [...] it used to go ice on the windows [...] (Finn, 2nd gen., man)

Some people in the study felt financial tension at home, which sometimes led to domestic violence,

[The financial situation was] poor [...] we would have the two older sisters' hand me downs and it would be a very special thing if we got a new dress [...] obviously we'd get some socks and shoes, the basic necessities [...] [the financial situation was] very stressful [...] definitely, a lot of tension, a lot of physical violence... (Lisa, 2nd gen., woman)

Hence, absolute deprivation materialized itself differently for second generation Irish children and their families in the context of a developed English economy where

the national standard of living and quality of life expectations are higher. Financial sacrifices, stress and tension at home appeared to be further compounded by living in a neo-liberal (cf. Coburn, 2000) and consumer driven society where material temptations abound and mass-marketing strategies instill in parents a desire to buy more trivial goods. Indeed, it led some families in the study to go into debt, with negative health implications for the children,

They [parents] had enough money to get by although sometimes there were some periods when they would struggle [...] I remember them you know, having problems erm my mum er tended to like er you know lots of things around that she couldn't really afford and she'd get into debt [...] (James, 2nd gen., man)

Besides, given that the second generation Irish people in the study grew up in a highly unequal English capitalist society with respect to income distribution, one may expect, following Wilkinson's argument (1996), them to have suffered from the effects of relative deprivation as children and to have felt socially isolated on this basis since they came from working class backgrounds. The evidence appears to suggest, however, that being embedded within the Irish community where there was not a lot of affluence, and going to Catholic schools, may have led them not to perceive themselves as relatively deprived,

At the time I guess it [financial situation] was very similar, to all of those around me, to all of my friends because um when I was in primary and junior [Catholic] school, every, every child in the class apart from one [...] had at least one Irish parent so there wasn't a great deal of affluence about. (Aaron, 2nd gen., man)

It was only after going to senior school that Leslie began to realize how poor she was,

Everyone was in the same situation, it was only when I went to senior school that one of girls said 'I can't play with you anymore because you're from Willenhall' and that was, the end of it [...] and all of them were wearing blazers you know could afford these blazers so to me was a definite divide between who had money, who didn't. (Leslie, 2nd gen., woman)

For Leslie, embeddedness in the poor working class area of Willenhall provided protection from the effects of relative deprivation by leading her to think that she was

no worse off than anybody else. However, as soon as she went to senior school, she was ostracized as being from “Willenhall” and began to perceive herself as relatively deprived. The resultant experience of low social status and of poor social affiliations may have affected her health. Had she gone, like Aaron, to a Catholic school, where the pupils were predominantly Irish and from working class backgrounds, she may not have suffered from the effects of relative deprivation.

Some second generation Irish people in the study expressly linked childhood poverty in England to poor mental health. Unlike the previous lay discourses which focused on the effects of malnutrition and poor housing and living conditions in Ireland, the emphasis this time was on financial tension and stress. Lisa found her financial situation growing up to be “very stressful”. James remembered his father suffering from poor mental health because of the financial situation, which, in turn, may have affected his own mental health,

I remember him [father] walking around being tense all the time [...] because he was working so much [...] and he used to worry too much about you know money and stuff like that. (James, 2nd gen., man)

Conclusion

Both generations suffered from material deprivation growing up, with negative consequences for childhood and adult health. However, the Irish economy was poor and still under-developed in the mid-twentieth century whereas the English economy was booming and in full capitalist or neo-liberal expansion. Hence, for the first generation, childhood poverty took the form of dire material deprivation, with people being denied the very basic necessities of life, such as food and healthy living conditions, whereas for the second, it took the form of financial sacrifices, tension and stress at home, since people had oftentimes little more than the basic necessities of food and clothing. Placed within the context of a developed society where the national

standard of living and quality of life expectations are higher and within that of a neo-liberal and consumerist society where material temptations abound, being denied access to many goods may have created additional tension and stress at home, not least by indebting people, with negative health repercussions for the second generation Irish children.

With respect to relative deprivation, the evidence indicates that growing up embedded within a financially deprived Irish community may have protected both generations from its effects on health, to varying degrees. The great majority of the first generation Irish people in the study perceived themselves to be on a financial par with other people growing up, owing to widespread poverty in Ireland, with only a minority coming to realize that others were better off. Regarding the second generation, embeddedness in financially deprived areas, amidst many other Irish people, protected them at least in part from the effects of relative deprivation on health. For those who ventured out of this community, however, relative deprivation would become a reality, with possible negative health implications. On the subject of relative deprivation, an interaction is thus observed between ethnicity as structure, i.e., childhood poverty, and ethnicity as identity, i.e., community embeddedness.

The people in the study linked conditions of extreme poverty in Ireland, including malnourishment, dampness, severe financial worry and physical labour as a child, to poor Irish health. Some also linked financial tension and stress at home in England to poor mental health.

Education

Levels of educational attainment can negatively impact health by impacting adult socioeconomic position, including employment and income levels, and psychological well-being, including levels of self-esteem.

Findings and Discussion

First Generation

The educational choices and opportunities of the first generation Irish people in the study were heavily structured by the poor status and agricultural nature of the Irish economy, resulting in many obtaining no more than a primary school education.

Indeed, once the children reached working age, the parents relied on them to help on the farm and/or find a job and either bring money home or make their own way in life.

These pressures impacted their educational choices,

The bits that my people were getting together, I was a drag on that, so the quicker I could get away, the better, and me going [...] away to join the Airforce at a ridiculous age, I didn't know at the time that I was their salvation. (Jack, 1st gen., man)

What's more, high unemployment rates in Ireland or the expectation of working on the farm, or of inheriting the farm (only the eldest son), led many to not see the point in getting an education,

We had to finish school at 14 [...] then uh you had to work on the farm [...] so you never used your education (Megan, 1st gen., woman)

The early legal school leaving age in Ireland at the time, set at 14, and secondary education not being free, further militated against obtaining more education.

Finally, women's educational choices were influenced by their responsibilities of family care, the marriage bar⁴⁷, and gender role expectations of the time. Some went into nursing because it was an acceptable occupation for women,

I wonder what I would have been if, if I'd had been encouraged, because maths would have been, my subject [...] The whole system was a little [...] skewed [...] in those days, I kind of felt there was three major jobs [for women] [...] [teaching, nursing and university] [...] University [...] would be [...] [for] people that were very, very rich [...] I chose nursing but I had chosen it long time before they chose for me because they were trying to make me a domestic economy teacher. (Brenda, 1st gen., woman⁴⁸)

⁴⁷ up until 1973, women were forced to resign from the civil service when they got married so they could concentrate on bringing up a family and, by making scarce jobs available, allow men to fulfill their breadwinner's role

⁴⁸ Brenda was one of the few first generation Irish people in the study to go to secondary school, father was a policeman

Some women in the study were sent to technical college after primary school where they were taught how to become good housewives. Sometimes, technical college was a fall back option for women in times of high unemployment,

I couldn't get a job in Ireland because uh it was so many people unemployed so my father then sent me to technical college till I was 16 [...] I learned how to cook and different things like that [...] that's what girls did then, knitting, sewing and cooking and things. (Melinda, 1st gen., woman)

Finally, the first generation Irish people who came to Coventry when they were still young fared slightly better educationally; most attended secondary school and some of the men did apprenticeships in machine tool fitting.

Low levels of education not only impacted the socioeconomic position of the first generation Irish people in the study but also their levels of self-esteem, with negative health implications,

I don't think the older generation was [...] confident and all that [...] I think they, now, the young people are more confident [...] which is better really for them [...] because there's more...education. (Mychaela, 1st gen., woman)

Hence, the educational choices and opportunities of the first generation Irish people in the study were heavily structured by living in Ireland at a particular time and place, leaving little scope for agency or free choice. It is significant, however, that after years of working in "typically Irish" occupations in England, two first generation Irish people in the study demonstrated upward educational and career mobility in their forties, with positive health implications. Brenda obtained a diploma in counseling/psychotherapy whilst working as a nurse; the three year course was a turning point in her life because she is now better able to cope with her depression, precipitated by childhood abuse. After years of working in semi or unskilled jobs, Oliver took advantage of a three year unemployment period to train as a mental health nurse and qualified at 44, a job he felt was very successful.

Second Generation

Despite coming from working-class backgrounds, the second generation Irish people in the study were generally better educated than the first generation, with many going to university. This is consistent with other studies that have documented the upwards educational mobility of the second generation Irish population in England (Hickman et al., 2001; FIS, 2007a; Heath & McMahon, 2005). While this shows considerable agency on their part, here defined as the ability to change the status quo...

I was the first, born in the family, [...] to pass a degree and that's had a knock on effect where as others in the family, cousins, have now gone on to study, further education [...] (Leslie, 2nd gen., woman, social worker)

...the importance of structural factors, or of coming from a working class background, should not be dismissed since several second generation Irish people followed in the footsteps of their parents and left school at the legal age to find a job or obtain basic vocational training. Some of these resumed their schooling several years later, but others never did. Finally, a minority went straight through to University but dropped out because of unplanned pregnancies.

The accounts suggest that a determining factor in influencing second generation Irish respondents' decision to drop out of school at 16 versus going to university may have been the educational aspirations of parents, relatives and/or peers. For example, Conner had gone straight through to University and was now a physical education teacher. Despite being embedded in a predominantly disadvantaged Irish community and coming from a working class background, he had parents and relatives who had high career aspirations for him and who pushed him to succeed,

[My parents] were very good aspirational I think [...] all the family were, cause me father would get the [...] Conor Tribune on a regular basis [...] it would be 'oh look at your cousin he's a doctor, look at this' you know 'she's a lawyer' sort of stuff, so it was very [...] competitive [...] I think they always felt that they had such a tough existence they

just wanted to make sure that their own had a slightly easier existence shall we say [...] (Conner, 2nd gen., man)

This example is consistent with Modood's argument that ethnicity may work as "cultural-social capital" or "ethnic capital" (2004, p. 101), and be partly responsible for the upwards educational mobility of "second generation" migrants, through "migrant parents getting their children to internalize high educational ambitions and to enforce appropriate behaviour", with the help of significant relatives and other community members⁴⁹ (2004, p. 87; Zhou, 2005).

In contrast, Aaron dropped out of school at 16, and worked in a furniture store for several years until he eventually got fed up with the job and decided to resume his schooling. He obtained a PhD and now works as a lecturer, thus demonstrating significant upwards social mobility and agency. Like Conner, Aaron was embedded within a disadvantaged Irish community. Unlike him, however, he was not surrounded by Irish people who had high educational and career aspirations. He justified his decision to drop out of school as follows,

I left, I was suppose to stay on [laugh] and do A-levels and uh but [...] those were the days where not many people stayed on [...] so [my brother and] all of my friends really were leaving and [...] so, my uh friend Ben uh had got a job in a furniture shop and he said 'why don't you just come along for the summer?' (Aaron, 2nd gen., man)

Thus, at 16, Aaron's educational choices were influenced by the low educational and career aspirations of his community of peers. Embeddedness in a disadvantaged Irish community also led to low levels of self-esteem (see p. 247), which could also negatively impact educational choices. Although Aaron has been working as a lecturer for several years, the negative effects of low self-esteem persist,

I still work on the premise that someone is going to walk up to me any day and say 'excuse me but we know you're flawed now get out'. (Aaron, 2nd gen., man)

⁴⁹ Conclusion based on British South Asian and Chinese populations.

James' account suggests that it is not only parental and peer educational aspirations and expectations that matter but also those of the schools. James felt let down by the streaming process in the Catholic school he went to. He was expected to fail and he left school with no qualifications, which had a profound effect on his self-confidence,

As soon as you were like thirteen they were like 'well you're some sort of stupid guy who should be doing these er exams for stupid people and er then other people can go and do O levels and A levels' [...] there was no objectivity to it [...] it was just 'you're not good enough and you are good enough'. (James, 2nd gen., man)

It was much later, after years of working in manual jobs, that James' English flatmates convinced him to enroll on a three year University communications course, following which he obtained a Teaching Certificate.

Finally, for some of the slightly older second generation Irish women in the study, educational choices and career aspirations were influenced by the gender role expectations of the time. Elizabeth, for instance, justified her decision to leave school at 17 and to get a job at the bank in this way,

If you had any sort of bits of brains at all, you were a nurse and if you didn't you were a hairdresser [laugh] [...] there was no [...] aspirations of [...] getting a high powered job or anything like there is today [...] in them days [...] you went to school and you got married and you had children and you looked after them and that was it. (Elizabeth, 47, 2nd gen., woman)

Conclusion

The vast majority of first generation Irish people in the study obtained very little education, their educational choices and opportunities being heavily structured by the poor status of the Irish economy, leaving little scope for agency. In addition to affecting their self-esteem, a link articulated by some, low levels of education led to a disadvantageous occupational position, denoting an interaction between these two dimensions of ethnicity as structure, with possible negative health consequences. Yet,

some demonstrated agency in their mid-forties by obtaining further education and securing professional jobs in England, with positive health implications.

A relatively high proportion of second generation Irish men and women held higher education degrees when compared to the first generation, providing support for the notion of agency, here defined as the ability to change the status quo, and for that of “ethnic capital”, with positive health implications. However, a significant number also dropped out of the educational system right after secondary school, their educational careers conditioned by the disadvantageous socioeconomic position of the Irish community and the low educational and career aspirations of their community of peers, the streaming process in Catholic schools and gender role expectations. While some resumed their schooling years later, showing considerable agency, others did not, with negative implications for lifetime socioeconomic position and health.

Ethnicity as identity was found to interact with ethnicity as structure in ways that could have either positive or negative effects on the educational choices of the second generation Irish. Firstly, being Irish, embedded within a supportive community, may counteract a disadvantageous family socioeconomic background to positively impact educational choices through the “ethnic capital” it can confer. Secondly, embeddedness within the Irish community may reinforce the negative impact of a disadvantageous family socioeconomic background on educational choices via increased exposure to people with low educational and career aspirations, and via lowered self-esteem.

Occupational Disadvantage and the Health Gradient

Evidence of a social gradient in health, with people in manual occupations, or even lower-ranked office workers, being at higher risk of serious illness and premature death than those in professional and managerial occupations, has been

summarized in chapter 2, p. 14. Both material and psychosocial causes have been shown to contribute to these differences and their effects extend to most diseases and causes of death (Wilkinson & Marmot, 2003). Moreover, it has been established that cumulative social class disadvantage increases one's likelihood of dying young (Davey Smith et al., 1997).

Findings and Discussion

Both generations of Irish people in the study suffered from social class disadvantage at least at one point in their lives. The vast majority of first generation Irish people suffered from cumulative social class disadvantage from birth to retirement; they had fathers who worked in manual jobs, their first job was manual and so were the subsequent ones. In Coventry, the men and women in the study predominantly worked in the car and electrical component factories. Several of the men spent intermittent periods in the construction industry, as a means of securing income when there were no openings in the factories, and some of the women worked as support workers and care assistants. Their socioeconomic position was therefore heavily shaped by their social structure and class background.

However, some social mobility was observed amongst the first generation Irish women with a few working in the professional occupations as nurses at the time of their first job in England. Moreover, a handful of first generation Irish people were able to break the cycle of socioeconomic disadvantage later on in their life, thus demonstrating enduring capacity for agency. For example, Neve went from working in a factory to working as a Deputy Manager of a hotel and Oliver from working in various factories to qualifying as a nurse at 44.

While the second generation Irish people in the study mostly came from working class backgrounds, a substantial number were able to display agency and “break the

cycle” by securing jobs in the higher and lower professional and managerial occupations (e.g. counselor, lecturer, social worker, nurse and IT technician). This is consistent with other studies (Hickman et al., 2001; Heath & McMahon, 2005) which found upwards social mobility for this generation. However, several began their working careers in routine and semi-routine occupations, showing the potency of structural factors, before obtaining the current professional and managerial jobs they were in now. For instance, Fred and James worked in construction, Melanie in several factories, and Aaron and Theresa as sales assistants, prior to working as CAPS systems administrator, foreign English teacher, counselor, lecturer and outreach welfare worker, respectively. Finally, some second generation Irish people were never able to break the cycle of socioeconomic disadvantage and always worked in routine and semi-routine occupations. For instance, Melvin had worked in hospitality and called himself "a jack of all trades" because he had done many other jobs such as roofing and plastering, and Gary was a warehouse man.

The practice of organizing work around the family, especially common among the first generation, which often meant the women worked part-time or not at all (at least until the children were of school age), further compounded social class disadvantage because it meant that families had to rely on one wage instead of two.

Conclusion

Social class disadvantage, especially when it is extended over the lifecourse, can be expected to affect health; the longer people live in stressful economic and social circumstances, the more they will suffer from physiological “wear and tear” and poor health in old age (Wilkinson & Marmot, 2003). This is especially so for the first generation, the majority of whom suffered from cumulative social class disadvantage, from birth to retirement. A minority of first generation Irish people were able to break

this cycle and secure professional jobs, demonstrating enduring capacity for agency. The negative impact on health of social class disadvantage can be expected to be tempered for the second generation since many were able to break the cycle of social disadvantage during their lives, at one point or another.

Adult Absolute or Relative Deprivation

This section looks at the adult financial situation of the first and second generation Irish people in the study and focuses in particular on issues of absolute and relative deprivation.

Findings and Discussion

First Generation

Owing to their concentration in low paid routine occupations in England, the first generation Irish people in the study experienced enduring absolute socioeconomic disadvantage. This is consistent with other studies (Hickman & Walter, 2007; FIS, 2007a). Most struggled a lot to get by when they came over to England,

In my single days, we had to...send home money to Ireland, to our parents [...] it was our duty [...] so we really, um, survived here because we had to send the money back [...] the wages wasn't very good but you send a pound, a week [...] when I worked on the [factory], [the wage] was 5 pound and you had to pay 1 pound 50 for room [...] and for food, you just strayed through [...] you walked everywhere [laugh]. (Megan, 1st gen., woman)

The financial struggle continued throughout their working lives. Eric's wife, then a factory worker, was anxious about the financial situation,

She'd say oh the bills are coming in, I said, well, they'll be paid, don't worry [...] right? [...] She'd get a bit stressed but... (Eric, 1st gen., man)

Others suffered from tremendous financial hardship ever since they were forced to retire early from their work on health grounds. Hogan had struggled to provide for his family after he had to give up his job as a builder in his forties because of a severe

heart condition, living thereafter on sickness benefits and his wife's earnings as a part-time cleaner,

It was hard like but [...] as I said we was always the type that could manage [...] make it out, I mean you'd nothing else to do [...] you couldn't, you had to live on the breadline [...] [but] the kids didn't go hungry, the house didn't go short. (Hogan, 1st gen., man)

Finally, some had struggled to make ends meet during intermittent periods of unemployment. This is discussed below on p. 193.

Housing and living conditions were also poor. While none of the people in the study were currently living in lodging houses, many had in the past and Eric knew of people who still did, with negative health implications,

A lot of the Irish people here... a lot of them, men especially, uh they didn't get married [...] lived in lodger's house here, over the years, on damp conditions [...] and uh, undernourished and all that [...] (1st gen., man)

The people in the study had moved to rented accommodation, often in local authority housing, after getting married, because they could not afford to buy a house (cf. Hickman & Walter, 1997). According to Maeve, living in poor council housing was bound to have a negative impact on Irish health,

I think a lot of them [Irish] today in their seventies are in pretty poor health [...] I was [...] [reading] about this woman and her water was cut off for six days and she kept ringing up [...] see a lot of them are in council houses, most of them I think were [...] there's very few in their own private houses because of course you needed a deposit and it was an enormous amount [...] in the fifties, well they didn't have that, and then the council gave them a house well of course you're living anywhere the council want to put you [...] the conditions then deteriorate from day one. (1st gen., woman)

Hogan was living in low quality rented housing (cf. Scanlon et al., 2006) and it was having a serious impact on his physical and mental health,

Worries, I'm having it today [...] the landlord [...] he's English and I'm living there and the roof is [...] pouring into me bedroom and [...] we can't get in touch with him [...] I haven't the central heating [...] I've only got two gas fires [...] down below and nothing upstairs [...] in the winter you have to get into bed quick [...] I landed up in hospital with stress [...] he [landlord] was annoying me so much that he was driving me round the twist, yeah, and I couldn't take no more so I went in hospital then [...] (1st gen., man, retired and a widow)

Some people in the study attributed Irish poor health to the poor socioeconomic position of the Irish in England, in particular the first generation,

[The reason for Irish poor health is] fundamentally poverty [...] it's because they, they have been amongst the poorest of groups [...] even those Irish people who have, gone on to, perhaps have more secure [...] standards of living [...] had to contend with poverty for quite substantial periods of their time and also growing up in Ireland where they were [...] very poor. (Aaron, 2nd gen., man)

The above account matches these of first and second generation Irish participants in Scanlon et al. (2006) study who linked the high cancer incidence of the older Irish-born in Britain to lifelong socioeconomic disadvantage, beginning before migration in poor rural Ireland and continuing in Britain.

And yet, there was a tendency on the part of first generation Irish respondents to report just needing the basic necessities and being content with their financial situation, as a result of growing up in poverty in Ireland and living on the breadline,

The money is nothing... [...] as long as I've always what I maintain, as long as you [...] enough food on the table [...] a nice bed to lie in [...] a clean bed [...] and [...] you don't owe anybody any money [...] you paid your bills [...] and that's all you need [...] that's how I always looked at it... back at home, in Ireland, when we [unclear] that's all we ever had. (Eric, 1st gen., man)

While it is possible that these people were mostly content with their financial situation, it is also likely that the mass marketing strategies to which they were exposed in England would have tempted them to want more (cf. quote from James in 3.1 above). However, given that they lacked the means to buy these “extras”, they retained the uncomplaining ways of thinking that they had picked up in Ireland as children so as to psychologically deal with the financial harshness of everyday life. Perceiving their financial situation in this way may have partially protected them from the negative health effects of relative deprivation and social disadvantage, although the “material” effects of the latter persist from a critical realist viewpoint.

In contrast, a few first generation Irish respondents appeared to be doing better financially than others, either because they had progressed to more highly paid

occupations (cf. previous section) or had partners who had, and they owned their homes. Neve, for instance, who was now retired from her hotel Deputy Manager job, owned her home and commented on looking forwards to going on a few nice cruises. In addition, some first generation Irish people earned more by working nights. Tavis, for instance, worked nights at the factory and never missed a shift, while his wife worked as a home help. He described his financial situation as “good” and said they had “not been short of anything”. However, his perception may have been influenced by growing up in extreme poverty in Ireland.

Finally, some reported feeling more financially secure in old age than they had been during their working lives, thanks to their pensions. Mychaela, for instance, had two private pensions, an old age pension and a widow’s pension, and did not find it difficult to “make ends meet”. She had worked as a care assistant and her husband in a business counting bills. However, in common with other studies, the great majority only received a modest old age pension owing to persistent low socioeconomic status, intermittent employment history (for some) and sporadic pension contributions (Haringey Council, 1990, as cited in Tilki, 1994). It is likely that several of these people reported being content with their financial situation in old age because they had lower material expectations as a result of years of childhood and adult socioeconomic disadvantage, so they did not require much to be happy and were now at least enjoying some financial security.

Second Generation

Absolute disadvantage was generally less of an issue for the second generation Irish people in the study since many secured professional and managerial jobs with good wages. Many described their financial situation as “good”. On the whole, they were living in good housing and some owned their homes. Leslie, for instance,

worked nights as a social worker and lived in an affluent Coventry neighborhood, which she described as, “very affluent, very typical Emmerdale farm kind of... place one shop yeah a few pubs very quaint.”

Fred, who worked as a CAPS system administrator, believed his job paid well and said, “I earn enough money, there’s always food on the table and we can have nice holidays and a reasonable car”. Interestingly, none of these people compared their financial situation to others.

However, absolute disadvantage was an issue for some second generation Irish people in the study, at least at one point in their lives. Claire wanted to go back to work because although her husband was a systems project manager, they were still struggling financially to put their children through University,

If we haven’t got that responsibility of financing the children of course he can relax a little bit more, we could get to pay our mortgage and there’s less financial burden, there’s all that responsibility [...] (Claire, 2nd gen., woman)

Theresa was an outreach welfare worker and a single mother. She wanted to move out of the “downtrodden” council estate she was in but could not afford to do so. This clearly affected her mental health,

The area I’m in, it’s really run down and...there’s some really silly people out there [...] it’s a council estate, it’s really unsafe, crime levels are quite high, it’s a lot of people on drugs and so you just tend to keep yourself to yourself...I’ve always lived there [...] it’s [...] downtrodden and horrible and I don’t really want my daughter to be brought up there to be quite honest so... (Theresa, 2nd gen., woman)

Prior to becoming a lecturer, Aaron had worked in a low-paying job in a furniture store for twelve years,

I was in a pretty crappy job I mean [...] I worked in an expensive [...] furniture shop [...] the wages were pretty poor [...] the wages were, always a bit poor. (2nd gen., man)

Elizabeth was a housewife and her husband was a car factory worker. She was in a similar situation to that of most of the first generation and akin to them, reported being content with her financial situation because she did not need much to be happy.

She made a point of saying that while many compare their financial situation to that of others, leading them to perceive themselves as worse off and to want more, with negative effects on health (cf. the relative deprivation argument), one can be content with one's financial situation by not comparing it to that of others and thinking in more modest and accepting, ways, with positive health implications,

I think these days, now there's too much, oh you got to have this, you got to have that [...] the way I think is, well, you can only sleep on one bed at a time [...] so what's the point in having a ten bedroom house? [...] and he's...[...] got a 4 by 4 and I want a 4 by 4 and I think, I don't, I'm not bothered [...] some people [...] they have to have everything [...] I [...] think [...] I have enough to drink [...] I'm happy enough with meself [...] I do what I want to do [...] (Elizabeth, 2nd gen., woman)

Three second generation Irish people in the study were currently unemployed and therefore struggling financially. This will be discussed below p. 193.

Conclusion

The interview accounts suggest many first generation Irish people suffered from absolute disadvantage (including low earnings and poor housing conditions) throughout their lives. Evidence of the negative impact on health of absolute disadvantage was provided in the accounts, with some people blaming their poor housing conditions for their poor mental health and others attributing Irish poor health, in particular that of the first generation, to a poor socioeconomic position (prolonged poverty, low earnings and living in poor council housing). This material deprivation may have directly affected the physical health of this generation. Moreover, there was some evidence of a negative impact on mental health with some people feeling anxious or stressed about money and making ends meet.

Although absolute disadvantage was generally less of an issue for the second generation since several had secured professional jobs, it remained an issue for some at least at one point in their lives. Some of these people were living in downtrodden council estates, which, they felt, affected their mental health.

With respect to relative deprivation, the interview accounts suggest that this was not a problem for some first and second generation Irish people owing to a tendency to declare themselves to be content with the basic necessities and to refuse to compare themselves to others. This was seen by some first generation Irish people to be a result of growing up in poverty in Ireland. While it is possible that the first generation Irish people in the study were truly content with their financial situation owing to their lower material expectations, one could expect that, after being exposed to mass marketing strategies in England for many years, they would have wanted more; instead it seems they kept the uncomplaining ways of thinking that they had adopted in Ireland as children as coping strategies to psychologically deal with the financial harshness of everyday life. These ways of thinking may thus be an “Irish” cultural adaptation to structural subordination in Ireland and/or a class effect. The second generation Irish people who adopted the same modest and accepting ways of thinking may have picked them up in childhood from their parents.

These ways of thinking may promote resilience, and at least partially protect Irish people from the effects of relative deprivation. An interaction is thus observed between ethnicity as structure, i.e., socioeconomic disadvantage, and ethnicity as identity, i.e., Irish uncomplaining ways of thinking.

Work

Work was shown to impact health via the nature of the task, social relationships in the workplace, levels of demand and control, pay, work conditions and safety precautions, and/or stressful work experiences (Wilkinson & Marmot, 2003).

Unemployment will be discussed in the next section.

Job Satisfaction: Routine and Semi-Routine Occupations

Findings and Discussion

Some first and second generation Irish people who had worked in routine and semi-routine occupations⁵⁰ denounced the boring and repetitive nature of the tasks,

I found it [work] [...] upsetting and demoralizing [...] except the uh occasional one [...] I just didn't like the jobs in... [...] it is, monotonous, monotonous task...yeah [...] just wasn't interested [...] it's just getting a job to pay [...] me way home and rest [...] you had to have a job to live. (Paul, 1st gen., man)

and the low pay,

Women didn't get very big wages at the [electrical company] or at the [another electrical company]. (Melinda, 1st gen., woman)

It is significant that among the first generation, none of the women complained of the boring nature of the tasks and none of men complained of the low pay. On the contrary, some first generation Irish women enjoyed working because it gave them a sense of purpose,

If I didn't come here two days a week [to work as a cleaner] I'd be, gone doo la li [...] you mighten even get out of bed in the morning [...] you think well now I'll get out, I'll get my clothes ready for the morning and, get all prepared [...] I feel I'm doing myself good [...] (Erina, 1st gen., woman)

And some even liked the fact that the factory tasks were easy and simple and did not require much decision-making, possibly because they lacked self-confidence, "they [factory tasks] were very good, very easy actually." (Erina, 1st gen., woman).

Conversely, despite the rather low factory wages,

The fallacy that [...] car workers earned big money wasn't the case you know, I'm sure the, the wage [...] wasn't the lowest [...] well I know it wasn't that, good. (Aaron, 2nd gen., man)

Some of the first generation Irish men who worked in factories were pleased with the pay since they were earning more than on the buildings, where they had previously been employed. They thus had a different perception of what constituted a low pay.

⁵⁰ The vast majority of first generation Irish people in the study had worked in routine and semi-routine occupations. A significant number of second generation Irish people had also worked in these types of occupation prior to working in the professional and managerial occupations they worked in now

We were on piece work in the factory, I got a lot more money than in the bloody buildings, so I was pleased. (Tavis, 1st gen., man)

Hence, there was a gender difference in the perception of tasks amongst the first generation, with the men finding the tasks repetitive and boring and the factory pay to be “good” and the women finding the tasks good and easy, and the pay “poor”. This may have had a differential impact on health.

Finally, some first and second generation Irish men working in the manual occupations felt there were too many work demands made and too little control over the tasks,

It started getting stupid like um, it was only two of us [...] to do all, all the office moves, [...] you don't have time to do it in two hours [...] that's when I used to get a bit stressed out with it with the staff [...] (Finn, 2nd gen., man, porter)

In contrast, one individual who worked as a warehouse man felt respected at work, which contradicts popular notions that semi-routine occupations do not provide gratification,

I'm very well respected at work so I feel good [...] I learnt the release and watched everyone else do it and I tried an experiment one day [...] I then figured out 'well hold on I can make the runs what size I want, and still have only twelve dealers maximum' so I did it without telling anyone and they were all amazed [...] [the] production rate went up 80% because everyone was finding the runs so easy to do, I've always been proud of that. (Gary, 2nd gen., man)

More importantly, many first and second generation Irish men and women in the study enjoyed the sociable aspect of their work; the friendly work atmosphere “kept them going”, and may have partially counteracted the negative impact on health of working in monotonous, and sometimes stressful manual jobs,

It was alright [not stressful] because I had a laugh with some of the women there [...] I quite enjoyed my time really there, it was a bit menial job but it was something. (Melanie, 2nd gen., woman)

Oh it's work [builder], it was a great crack because there was a big crowd of Irish there working you know, all your own and everything [...] [the boys] were great [...] (Hogan, 1st gen., man)

Conclusion

More people working in the routine and semi-routine occupations reported being satisfied with their jobs than would have been expected considering the boring yet demanding nature of the work, low levels of control, and the low pay. Amongst the first generation, some men perceived the pay to be good, while women generally perceived it to be poor; on the other hand, men typically found the work boring and repetitive, but some women found it enjoyable because it was easy. Thus, gender may affect the perception of work experiences and modify their impact on health. It is possible that the first generation Irish women simply enjoyed being able to work given the limited work opportunities for them in Ireland. A substantial number of men and women reported being satisfied with their jobs because of the friendly atmosphere at work. Thus, social support in the workplace may promote resilience and partially counteract the documented negative impact on health of the factors listed above.

Job Satisfaction: Professional and Managerial Occupations

Findings and Discussion

With respect to people working in the professional and managerial occupations⁵¹, the great majority of men and women had high levels of work satisfaction. Some obtained a sense of affirmation and gratification from their work,

If I'm teaching, you know, I get, even if it is not a particularly positive response, I get, some response [...] there's a sense of, affirmation now you feel good [...] I get, reasonably well rewarded [...] I do get some satisfaction from...[being a lecturer].
(Aaron, 2nd gen., man)

Some were well-respected and well-known at work,

[I am] quite well-known within my job, I'm a primary school teacher [...] everybody in the whole school there's such a community that [...] it's just nice to know that they all know who you are and, your reputation and things... (Hazel, 2nd gen., woman)

Some liked the greater responsibility they were given and the good pay,

⁵¹ The majority of second generation Irish people in the study worked in professional and managerial occupations. A minority of first generation Irish people did.

The thing is they're not paying me for what I do, they're paying me for what I know [...] it is, quite an easy job really to be fair [...] it pays well to be fair, yeah, certainly. (Fred, 2nd gen. Irish man)

Some felt their job boosted their self-confidence and that their analytical skills had improved as a result of their job,

I work with the (unclear) mental health problems and learning disabilities [...] I think it answers an awful lot of questions when you're working in that, environment, you, you become very analytical, you have to, um so you, you just take what you've learned from there and [...] naturally use it, with your own family. (Leslie, 2nd gen., woman, social worker)

As with those who were working in routine and semi-routine occupations, some professional workers liked the social aspect of their jobs,

I enjoyed the patients on the ward [...] it used to be great laugh, on the ward [...] you don't get that now either but the patients and the nurses used to have, just have a laugh. (Brenda, 1st gen., woman)

Some saw the positive impact of working and of job satisfaction on health,

It [counseling job] helps my health, it's helped me get through the last five months [...] my work here [...] it's been good therapy for me. (Melanie, 2nd gen., woman)

Nevertheless, some of the people in the study who worked in professional and managerial occupations had been, or were currently, dissatisfied with their jobs. Some found it to be emotionally draining,

I used to feel burned out and that's the reason why I left days [...] I was working as a residential social worker then [...] I left days because then an element of care had gone. (Leslie, 2nd gen., woman)

Others (had) felt too removed from the real world,

I've worked in regulations for seven years now and I want to change, I'm thinking of maybe going into the charity, non-profit sector [...] I'd prefer [...] going into a job where I feel like I'm making more of a difference and the job I'm doing at the moment, I'm a small cog in a bigger machine and I don't really see the end result of what I do [...] (Ysabel, 2nd gen., woman)

Conclusion

Although the majority of the people working in the professional and managerial occupations were satisfied with their job, some were not. Since most of the people working in the professional and managerial occupations are second generation Irish,

high job satisfaction could be expected to have a positive impact on the health of this generation of people, an effect highlighted by some. However, for those who reported low job satisfaction, a negative effect on health could equally operate.

Work Conditions

Findings and Discussion

There is ample evidence in the interview accounts that poor and unsafe working conditions have contributed to the poor health of the Irish population in England (cf. Aspinall, 2001, as cited in Tilki, 2006), in particular for the wave of first generation Irish people considered here, heavily concentrated in occupations which carried an increased risk of occupational injury (cf. Hickman & Walter, 1997). Indeed, many first generation Irish men and women in the study worked in factories, on the building sites, or in the health sector as nurses or support workers. Several drew a direct link between their health problems and the poor working conditions,

I went to work for the [electrical company] and I was there 16 and a half years [...] until I got an industrial disease [...] I was breathing in fumes [from the] silkscreen printing [...] I got this industrial disease um ear, nose and throat problems, from breathing in fumes (Melinda, 1st gen., woman)

Jack blamed the noise levels at the aircraft engine company for his being slightly deaf in his right ear. Tavis had an enlarged heart as a result of working on the buildings and doing a lot of heavy lifting. Mychaela further denounced the lack of safety precautions in the workplace,

I gave up work [care assistant] because I've got [...] sciatica in me back and arthritis [...] I have carpal tunnel [...] from the lifting [...] because [...] we hadn't got hoists or [...] sliding sheets, nothing like that, they had to lift the people. (1st gen., woman)

In common with other studies (Scanlon et al., 2006), a sizeable portion of men and women from both generations attributed Irish poor health in general to work-related factors,

Because they've done [...] manual jobs, didn't they? [...] I don't think your health is the same when you work outside [...] they always have to do the, the heavy work [...] a lot

of them have worked in hospitals, places like that [...] on the roads, building the roads [...] well it abuses your body, doesn't it? (Mychaela, 1st gen., woman)

...including working very hard for long hours,

I suppose it's got a lot to do with [...] working long hours [...] there was a big influx of the Irish in the fifties, sixties and seventies [...] they worked long hours [...] out in all elements [...] hard working and working six seven days a week, so obviously that would have a detrimental effect on you in later years in terms of your bones and [...] and heart conditions and stuff [...] (Ysabel, 2nd gen., woman)

Some of the people working in the professional occupations as nurses, before safety precautions were put in place, also suffered from occupational injuries,

I was 35 years into nursing... and towards the end of my nursing career, a pretty bad break went to my back because simply from lifting people [...] uh constant lifting and all the rest of it that nurses used to do, in those days, uh you know repetitive, strain [...] (Brenda, 1st gen., woman)

Finally, some of the second generation Irish people who had worked in routine and semi-routine occupations also suffered from occupational injuries,

I've got a bad back because of [...] lifting [...] really really heavy furniture [...] I have a, a long-term back problem and [...] I don't think my joints are in the best of condition in my legs because I think that that just the amount of lifting that you have to do [...] (Aaron, 2nd gen., man)

Conclusion

Many participants in the study, especially those from the first generation, who tend to be overly concentrated in manual occupations which carry an increased risk of injury (cf. Hickman & Walter, 1997), but also some second generation Irish people, reported suffering from poor health due to poor and unsafe working conditions. In common with other studies (Scanlon et al., 2006), they also articulated a link more generally between poor working conditions (including working in manual jobs, working in terrible conditions on the buildings and working long hours) and Irish poor health.

Perceived Stress

Findings and Discussion

A third pathway through which work can affect health is stress (Wilkinson & Marmot, 2003). Perceived work-related stress affected people working in both the routine/ semi-routine and professional/ managerial occupations.

Some people working in routine and semi-routine jobs, across the two generations of Irish men and women, reported suffering from work-related stress,

When I worked [as a care assistant], I was under a lot of stress because you had lots to look after and you haven't got the time to do it [...] and you couldn't care the way you should have cared...because, the way they looked at them people [...] they were numbers and you had so many to look after... (Mychaela, 1st gen., woman)

Perceived stress appeared to be a more prominent issue for people working in the professional and managerial occupations, and was reported by the majority of second generation Irish people,

The one [job: energy code analyst] I'm in at the moment yes [it is stressful], because it involves a lot of going along to industry meetings and representing the regulator, we're challenged a lot on policy decisions we make, so we have to do our homework a lot and cover a lot of ground [...] I get stressed out about getting things done [...] meeting deadlines [...] I want to give off my best and sometimes I get stressed out about how they [managers] may see me in doing my job [...] I do unfortunately worry about that sometimes. (Ysabel, 2nd gen., woman)

Some of these people suffered from work-related stress partly because they lacked self-confidence, which Aaron elsewhere linked to growing up within the Irish community,

I became a module leader [...] it's a very intensive week long module and [...] I decided I was going to teach most of it so the, the two week run up to it was [unclear] I don't have any real confidence [...] I just assume everything is just gonna go bullocks [laugh] [...] so it's, it's a bit nerve racking [...] I thought I was getting a migraine one night I really just thought I was gonna... (Aaron, 2nd gen., man)

Several first and second generation Irish men and women noted the negative impact of work-related stress on their health,

I don't sleep very well, I haven't slept well for a few years. (Ysabel, 2nd gen., woman, suffered from work-related stress and worry)

I get very anxious at times I've quite a stressful job [lecturer], and [...] I don't sleep well [...] I know that, the anxiety that I, I get a lot of indigestion and uh...[...] I've suffered with irritable bowel for [...] at least ten years really, on and off, so...it's stress related so I

know [...] that there are costs [...] particularly around not sleeping [...] (Aaron, 2nd gen., man)

However, having supportive work colleagues and friends helped some cope with work -related stress,

If you let things get to you [...] you can [feel stressed] [...] I'm fortunate enough that [...] I've got a really close family [...] a great husband [...] all those things really, help you get through each day. (Hazel, 2nd gen., woman)

Conclusion

Perceived stress appears to affect the health of both generations of Irish people, working in both routine and professional occupations. While the perceived stress of the first generation often resulted from time pressures, the perceived stress of the second generation usually resulted from high levels of job responsibility and accountability. However, perceived stress appears to be an even greater issue for the second generation, with several noting its negative impact on their health.

Some second generation Irish people suffered from the health impact of work-related stress partly because they lacked self-confidence, which was elsewhere linked to growing up within the Irish community. Here, an interaction is visible between ethnicity as identity (Irish community embeddedness), and ethnicity as structure (work experiences) with negative health implications. Again, but only for some, social support may promote resilience and be protective of health, by counteracting some of the negative impact of work-related stress.

Unemployment

Although unemployment can protect against work hazards, it can also put health at risk; unemployed people and their families suffer a substantially increased risk of illness and premature death (Wilkinson & Marmot, 2003). Unemployment affects health via its financial consequences (especially debt) (2003), and the loss of many

psychological benefits of work including self-esteem, physical and mental activity, social status, interpersonal contact and “traction” (Bartley et al., 1999). Moreover, unemployment is in itself a stressful and disturbing life event, which may lead to an increase in hazardous health behaviours (1999).

Findings and Discussion

The majority of first generation Irish people in the study had no difficulty finding work in Coventry during the 1950s to 1970s, due to the boom of the motor and construction industries. The economic expansion meant that in spite of discrimination, Irish migrants could secure initial employment and move jobs easily (Ahmad & Bradby, 2007),

Oh God no [it was not difficult to find building work], you could work from one to the other, you could have [...] four jobs in the one day. (Hogan, 1st gen., man)

We, you can go from one [factory] job to the other, you could walk out of one job and into another [...] (Erina, 1st gen., woman)

Nevertheless, some first generation Irish people in the study did experience a period of unemployment, ranging from a few months to ten years, and this had a negative impact on their financial situation and their health. According to Tilki (1994), the Irish were always among the first to be laid off when times got hard,

Oh finding a job is [unclear] it is [exasperated sigh] well, you feel a bit depressed [...] because [...] you got a little bit of money [...] but you're afraid to spend it [...] because you won't have nothing left, see, and you've got a family [...] you have two kids, eh? [...] and you've got to keep them going [...] (Eric, 1st gen., man, unemployed for a few months)

Melinda was unemployed for about ten years after she was forced to resign from an electrical company in the 1980s because of an industrial disease. She could not find work because of the economic decline. Moreover, she had to avoid cigarette smoke and fumes, which were a problem in most factories. Consequently,

[I] just had to manage on what I got [...] I got a small industrial injury pension [...] from the National Health [...] I couldn't do anything only just feed myself and pay my gas and..., yeah [...] it was [very stressful] (1st gen., woman)

However, being brought up in dire circumstances in Ireland, she was able to cope, “I was brought up that what you can’t afford, you do without [...] so I didn’t go into debt”.

The majority of the second generation Irish people in the study were in employment. However, three individuals were currently unemployed and some respondents had experienced unemployment in the past. Being unemployed affected their financial situation and their health, bringing about stress, worry (including financial worry), poor self-esteem, and pushing some to drink,

It’s stressful not having a job yes because I don’t want to get into one of those ruts where you wake up and you think ‘what do I do’ [...] thank god I’ve been busy, the last three weeks [...] but now [...] I’m trying not to think it’s too stressful because if I keep thinking like that then it’ll get me down, so I’m thinking ‘well there’s always a way out’ [...] of course it [money] does [worry me], but, it’s probably at the back of my head. (Lisa, 2nd gen., woman, unemployed for three weeks from criminal assistant job)

[I drink] what erm maybe seven pints a day [...] which is quite a lot [...] it’s since I’ve been back [from working as a teacher in Poland] just the frustration of not working as well you know with my arm going bad [...] and then my shoulder [...] I can’t do sports erm and I can’t erm do work [...] cause I’m living on benefits [...] that’s just ridiculous [...] it’s no money at all and then erm not doing any sort of training [...] so [my self-esteem is] definitely lower. (James, 2nd gen., man, unemployed for nine months)

Unemployment was however a positive turning point in the lives of some first and second generation Irish respondents, as it pushed them to obtain further training or education and make a positive career change. Unemployment spurred Oliver, a first generation Irish man, to receive training in counseling and then in mental health nursing in his forties. Theresa, a second generation Irish woman, saw unemployment as a positive experience because it drove her to get a better education to escape from the rut she was getting into. She is now working as an outreach welfare worker.

Like Lisa (see above), some second generation Irish men and women reported coping with the negative feelings of being unemployed by staying positive,

I try not to get stressed about things, at all, [...] I just push it aside [...] under the carpet... [...] I mean I’m not a psychologist [...] but I think [...] it’s it’s a grey matter isn’t it? So

it's a major thing in life, it controls you [...] so, just try and be positive [...] (Melvin, 2nd gen., man, recently unemployed)

Others were able to cope with unemployment because of the social support they received or were receiving,

But I had [...] some friends that uh were good to me, you know, took me out for meals and... [...] and did some work for me and that, you know. (Melinda, 1st gen., woman)

Conclusion

The minority of first and second generation Irish people in the study who had been or were currently unemployed were deeply affected by this experience and many highlighted the negative impact unemployment had on their health. They reported that, in addition to causing financial hardship, unemployment had a direct impact on their health, bringing about depression, stress, worry and poor self-esteem; some were pushed to drink. Yet, despite being a stressful and distressing experience, unemployment pushed some people in the study to obtain further education and seek a better career, with positive future health implications; thus, two aspects of ethnicity as structure interact.

Finally, some factors were found to possibly promote resilience and protect some against the negative health effects of unemployment. Childhood poverty in Ireland may protect the first generation Irish by enabling them to better cope with material deprivation, indicating an interaction between two aspects of ethnicity as structure, i.e., childhood poverty and unemployment. Positive thinking and social support may also promote resiliency, denoting interactions between two dimensions of ethnicity as identity and ethnicity as structure.

Discrimination

This section focuses on the generative mechanism of discrimination and explores its contribution to Irish health experiences and/or inequalities. Two forms of discrimination can be distinguished, interpersonal or direct, and institutional or indirect. This section mostly elaborates on the former type of discrimination since, by virtue of being usually directly perceived, and experienced, it more readily surfaces in respondents' accounts. The latter type of discrimination tends to be more invisible since it is embedded in organizational structures. Still, respondents' awareness of this "deeper" generative mechanism is explored. Finally, this section looks at the linkages made by respondents between discrimination and health.

The negative impact of racism on mental and physical health has been shown in many studies as reviewed in Chapter 2. Interpersonal ethnic discrimination may impact health directly through pathways of stress (Karlsen, 2007) and an individual embodiment of social risks (Krieger, 2000). Institutional racism may affect health indirectly through its role in structuring the social and economic disadvantage faced by ethnic minority groups, including differences in opportunities for housing and employment (Karlsen, 2007). Also, experiences or perceptions of racial discrimination may shape ethnic identity (Jenkins, 1994) and cause ethnic minority people to feel excluded and disadvantaged compared to others, with negative health implications (Wilkinson, 1996).

Finally, the impact of discrimination on health is contingent on many factors pertaining to the agency of the victim, including their perception of the discrimination, the use of coping techniques, and the internalization of the blame for the incident (see e.g. Karlsen & Nazroo, 2002b; Karlsen, 2007), and on the extent of integration of the victim within an area (Chakraborty & McKenzie, 2002).

The First Generation

Findings and Discussion: Experiences of Discrimination

The great majority of first generation Irish men and women in the study experienced anti-Irish discrimination in England at some point in time (cf. Hickman and Walter, 1997) and many were affected by it. Anti-Irish discrimination was especially rife in the '50s and '60s, when the people in the study came over to England,

When I came to England first [...]...then the Irish were looked down on, in the 60s [...] and the 50s...we were always tarnished [...] oh it did hurt a little bit inside but you wouldn't show it... (Paul, 1st gen., man)

Negative stereotypes of the Irish included their being stupid, not well-educated, having large families and living on the state,

They [English] come along and say that the Irish are thick, that was a great thing here in England [...] the Irish are all thick uh, have no background [...] discrimination would be people saying to me: "but we're educated better than you", no, we're educated [...] they [...] would say it that I was stupid but I have not got meself to believe it [...] I remember being on a [...] district nursing sister's course [on contraceptives] and [...] one woman [...] said: "oh all Irish people, they always have big families", she [tutor] discriminated in that way [...] I was aggravated by that [...] (Brenda, 1st gen., woman)

Ah [...] there's always discrimination against the Irish, I think [...] because [...] they [English] think that you haven't paid, into the national health and all that, but they forget that we have been here forty years [...] and you paid your dues... but they look at you as if you're getting something for nothing. (Mychaela, 1st gen., woman)

Numerous snide remarks were directed towards the Irish; they were talked about pejoratively, and called names. Many felt belittled by it,

I often told them to cut out, (unclear) when they used to call you Paddy, or Pad, "come here Paddy" [...] "oh sorry, oh you don't mind me calling you Paddy"? "course I do calling me Paddy [...] Frank is your name, I call you Frank" [...] "well" they said "we call Jocks, the Scotch people [...] and they don't seem to mind" [...] ["well"] I said "I flippen well mind" [...] so they were inclined to [...] and they were always sort of, the thick Paddy, and all that crack [...] course it made you feel little [...] of course it did, I didn't like it, no way. (Tavis, 1st gen., man)

Moreover, overt institutional anti-Irish discrimination affected the employment prospects of some...

I was a tool maker and went after jobs several things and I found that as soon as you opened your mouth 'oh yes what do you want Paddy' [...] Paddy was described as a labourer on the fields, a ditch digger, a man on the road, a drinking [...] (Ryan, 1st gen., man)

...and prevented many, especially men, from securing suitable accommodation,

The Irish wasn't welcome at all, they had signs in the window even 'no Irish need apply' [...] you had to go in the hostels, they had hostels here for us [...] I went this side of Nottingham and I went in there with [...] two [...] Scotch lads [...] and she let me talk away there and she said 'we don't take Irish, we can take them two' [...] (Hogan, 1st gen., man)

Anti-Irish animosity soared in the 1970s during the IRA events and the bombings in Birmingham and Coventry. Coventry was described by many first generation men and women as not so friendly or welcoming then, "it was a very, very sticky time for, for us, you know" (Jack, 1st gen., man)

You would hear it on the bus [...] people discussing about it and saying: "we've got them next door to us, they seem alright but I don't want nothing more to do with them" [...] you'd hear that...[...] it was [tough], yeah. (Megan, 1st gen., woman)

Several people experienced anti-Irish discrimination in the workplace,

When I was on the home health in the 1970s [...] there was a lot of trouble with the Bombing in Birmingham [...] and...a couple of people that I went to...new clients [...] they'd say: "are you Irish?" I'd say: "yes, yes I am"... "Don't want your type in here!" (Megan, 1st gen., woman)

If someone was shot especially, he'd [factory boss] come in and give out as much as because I was Irish that I was in on it. (Melinda, 1st gen., woman)

According to some, institutional anti-Irish discrimination in the workplace persisted throughout the years, extending beyond the 1970s,

To be honest [...] I don't know about anyone else, but in Coventry, you never got a promotion if you were Irish [...] I worked there [as a care assistant] for 24 years [...] I've never [...] seen, one person, Irish person, being promoted [...] (Mychaela, 1st gen., woman)

Overall, while some felt that the situation had improved, others felt that interpersonal and institutional anti-Irish discrimination was still a reality today and the negative view of the Irish still lingered. Feeling ostracized and pejoratively

categorized by the English may continue to affect their health, “ah [...] there's still a click in them there and there.” (Tavis, 1st gen., man),

They still do [have a negative view] [...] well at me age now I don't think anyone takes any notice but [...] well when they hear you talking [...] you're easier to arrest than anyone else, you're the one they pick out in the crowd if you were to open your mouth [...] oh ay yeah, even today.
(Hogan, 1st gen., man)

Finally, experiences of racial discrimination and ethnic categorization may have caused this generation to feel excluded when compared to others (Wilkinson, 1996) and shaped their ethnic identity or the way they viewed themselves by leading them to internalize this pejorative external definition (Jenkins, 1994), with negative health implications,

I've [...] lived all my life as a foreigner [...] it doesn't make you feel great, you live with it and you go along with it, just as if it doesn't exist, but it's not great because I was called Paddy for a lot of years [...] (Jack, 1st gen., man)

Conclusion: Experiences of Discrimination

The majority of first generation Irish people suffered from anti-Irish discrimination in England. Numerous personal accounts of experiences of interpersonal, and to a lesser extent institutional, anti-Irish discrimination, in particular in the 1950s, '60s, and '70s, were provided and can be expected to have affected the health of the first generation directly, through biological effects of stress, and indirectly by impacting socioeconomic position, including employment prospects and living conditions. Thus, two dimensions of ethnicity as structure, i.e., anti-Irish discrimination and socioeconomic position, interact. There is also an interaction with ethnic identity which will be taken up further in the next chapter.

It also appears that even today a number of first generation Irish people continue to feel negatively perceived by the English and vulnerable to discrimination, with negative health implications.

Findings and Discussion: Response to Discrimination

The actual impact of anti-Irish discrimination on health is contingent on many factors pertaining to the agency of the victim, including responses to racism, e.g. whether or not one perceives the ethnic discrimination as discrimination, the use of coping techniques, the internalization of the blame for the incident, and the extent of integration of the victim within an area.

According to some, whether or not one experienced or perceived anti-Irish jokes or comments as being discriminatory very much depended on attitude and outlook, or agency, “it depends on how you take it though, isn't it?” (Marta, 1st gen., woman),

I just take them [Irish jokes] in the context that they're meant [...] with a pinch of salt really [...] [I don't feel discriminated against], not at all [...] a lot of other people perhaps would [...] but I don't, [it's how you see it]. (Neve, 1st gen., woman)

However, taking the jokes with a “pinch of salt” may have been a coping mechanism for some to cope with the hurtfulness of it all. Some admitted to keeping quiet or laughing along with the jokes as a coping strategy,

Just say, if something went wrong, say: “well, you're thick!” and...things like that and a lot you'd hear [unclear] at the hospital years ago [...] we'd just laugh it off with them because, otherwise, you would get upset. (Megan, 1st gen., woman)

I love Irish jokes [...] I think when I was younger at first then you do feel it [you feel a bit awkward as a young lad], but you get over that [...] I always say you grew up in a factory because of the attitudes and [...] the Mickey taking [...] and you learnt to accept that [...] you took it in good sport [...] if you laugh with people it's much easier, if you let them get on top of you and get annoyed then you lose [...] yeah [it was a coping strategy] [...] oh I laughed with them yeah [...] (Oliver, 1st gen., man)

Others, however, kept quiet because they felt powerless being white skinned,

No matter what you said, you were put down anyway so...[...] they couldn't admit to it, but if you were black [...] your discrimination deliberate would fall over backwards [...] I used to fight but I was, wasting your time [...] because you're on your own. (Mychaela, 1st gen., woman)

On the other hand, a few people in the study responded to anti-Irish discrimination by speaking up,

I was listening to that [anti-Irish jokes at the workplace] for months and months, and one day I said to him [doctor] [...]: “well, I know the Irish are everywhere you go, but...what

would you do without them? They do your dirty work for you, they build up your cities and they do your nursing, cheap rate" [...] "they're your go-fers for everything, the Irish" [...] "so, you know, I am tired of you running them down" and I said [...] "I don't want to hear it again!" (Megan, 1st gen., woman)

Some of the men responded to the anti-Irish comments and jokes by getting into fights,

That was always the same, 'what are you doing over here'? [...] you got fed up with them niggling you, oh there was always fights [...] yeah [I would fight], if they kept on, yeah yeah of course. (Hogan, 1st gen., man)

Very few people in the study spoke up during the Troubles, afraid of the repercussions of doing so,

You start to think, you know, be careful what you're saying [...] you sort of think, 'don't let anybody know I'm Irish' I think that was a protection [...] (Oliver, 1st gen., man)

However, a minority did, displaying considerable agency,

We were getting the stick every night [at the factory] [...] off this one, particular one [...] about the IRA, murderers [...] I turned round to her and I said 'who owns Northern Ireland' and she said 'we do', I said 'you bloody clear it up and don't tell me about it' and that stopped the battle. (Marta, 1st gen., woman)

Some responded to anti-Irish discrimination during the Troubles by trying to rationalise it and partly internalizing the blame for the incidents,

I have to say [...] that the English people were very, very tolerant, in the main [...] I was expecting a lot more backlash than I got really, but er, you got the odd one that would say 'Irish bastards' and all this kind of thing, but [...] I suppose they were justified in what was happening [...] (Jack, 1st gen., man)

Finally, a few people may have been in denial of discriminatory treatment, perhaps out of a desire to be integrated in English society or to retain a feeling of control over their lives (Ruggiero, 1995),

None [discrimination] at all [...] People have told me, that they did but [...] unless you see it for yourself, you're never sure [...] there's Irish jokes and that was a bit of a laugh at work really [laugh] [...] I was never treated anyway but good [...] by Coventry buses, there was never a word or anything that I could pick up on even...you were Irish... you can't have this job...I was treated exactly the same as everybody else [...] I was born in Ireland so I am Irish but I have the greatest of respect for Coventry and for England because it has [...] given me a living for forty years [...] I can't undernose up with that. (Brian, 1st gen., man)

These different responses, indicative of respondents' agency, may have mitigated or worsened the impact of anti-Irish discrimination on health (see chapter 2, p. 20).

Finally, integration within an area or embeddedness in the Coventry Irish community was seen by some to protect them or their family against anti-Irish discrimination through reducing their exposure to prejudice, thus having a protective impact on health,

There's always bigots [...] when I first came to Lancashire...I found that more so there but [...] not so much in Coventry, never...[...] because there's a big Irish population in Coventry [...] so [...] you mix only with the Irish [...] Gaelic football, I played that for that club [...] and that's when [...] I went for a drink...[...] I mixed mostly with Irish people. (Paul, 1st gen., man)

We were a large family around and [...] we didn't really go anywhere [...] [so] they [parents] were shielded from anything that, and I don't think they would really have been aware of it [anti-Irish discrimination related to the bombings] to be very honest with you. (Neve, 1st gen., woman, came to England at 9 with her parents)

Similarly, although Maeve gave a different explanation, being embedded in a predominantly Irish workplace may have protected some against anti-Irish discrimination,

It [hospital] was very comfortable and I've been very happy there [...] it was all Irish accents [...] it was quite homely [...] I didn't feel I was in a different country [...] Oh well, not erm [I did not experience anti-Irish discrimination] [...] being a nurse [...] they knew that they needed us [...] we were always in uniform and [...] we just had that respect, that we were able to carry on, that it didn't really matter. (Maeve, 1st gen., woman)

Conclusion: Response to Discrimination

The negative impact of anti-Irish discriminatory acts on health is at least partly contingent on the perception of, and response to, such acts, i.e., individual agency. Some chose to perceive the jokes as being non-discriminatory while others partly internalized the blame for the racist incident. A minority protested against the discrimination and thus displayed considerable agency, here defined as the ability to challenge the social structure. In contrast, others felt their white skin constituted a barrier to effectively mobilizing against anti-Irish discrimination.

Two interactions have been observed between ethnicity as structure and ethnicity as identity, with anti-Irish discrimination (structural component) impacting health via affecting social constructions of ethnic identity, and embeddedness in the Irish community (identity component) protecting some from the negative health effects of anti-Irish discrimination (structural component).

The second generation

Findings and Discussion: Experiences of Discrimination

Compared to the first generation, relatively few second generation Irish people reported experiencing direct discrimination in relation to general anti-Irish stereotypes and prejudices,

Growing up [...] school taunting sort of thing [...] you'd always have someone taking the mickey out of you for being Irish [...] especially if, they want to hear you play a bit of music or, they think 'oh she's, she's good' so...(Hazel, 2nd gen., woman)

There was twelve people on the course [...] there was myself and [...] another guy [...] he was Irish descent as well and he [teacher] spoke to us in a different way completely to the other people or he was insulting to us [...] he just blatantly didn't like, he was trying to force us off the course, because we were Irish [...] he was just an out and out racist. (James, 2nd gen., man)

However, second generation Irish people were on the whole more likely to experience a more covert form of anti-Irish discrimination, taking the form of “good humour”, or “name calling”. According to Melvin,

Yeah [I experienced discrimination] [...] not so much as malice or, but you get it, I frequent a club in Coventry [...] and they're all [...] English [...] and they, “dirty paddy” and all that stuff, they, it's humor, I throw it back in their face [...] this is probably more Scottish than Irish, it's the ginger hair, but they see me as Irish and, 'I can tell you're a paddy, you're a Mickey and all that' but again it is in good humour um I've never had, not even a shout in the street [...] (2nd gen., man)

A number of second generation Irish people experienced particularly strong anti-Irish discrimination in relation to the IRA events in the 1970s,

You do get [...] the IRA thing if you're Irish type of thing [...] that always [...] tends to raise its head quite a lot if people know you're Irish. (Tom, 2nd gen., man)

Many were affected by it and some believed it affected their mental health. Some were discriminated against growing up in Coventry, at home and at school,

We moved to Willenhall [...] received a fair bit of racism there [...] I think it was a fear [...] my two other sisters were incredibly bullied at school by a family that were in the street who were very anti-Irish uh one evening their mother put [a brick] through the window [...] (Leslie, 2nd gen., woman)

At the time of the bombing in Coventry [...] even our neighbours and we'd lived beside them for... twenty years, they didn't talk to us [...] (Elizabeth, 2nd gen., woman)

Claire felt discriminated against by her English father in law, in 1983, shortly following the IRA events,

[Father in law:] 'So your parents are from Ireland, does that mean they're in the IRA' [...] I was fuming and said 'they're from the South [...] and I was so angry. (2nd gen., woman)

Some were discriminated against in the workplace,

I was working in the shop and [...] the manager had told me he wouldn't speak to me anymore because of the bombings in London [...] he was blaming the [IRA activities] [...] for sure, because he said 'your name's Irish isn't it'? [...] I just thought he was a stupid idiot and I thought I'd leave the job anyway. (James, 2nd gen., man)

The second generation Irish experienced a particular form of discrimination, this time by the Irish born. They were made to feel that they were not Irish because they were born in England, and were sometimes called "plastic paddies" (cf. Hickman et al., 2005). They were clearly affected by this type of discrimination, which had negative implications for their sense of identity and "sense of coherence" and, therefore, for their psychological and physical health (Elstad, 1998) (see chapter 7). This discrimination took place both in England...

I was in [club] one time and I just [...] put a green jacket on, called "Eire" you know Ireland across there and this [Irish] bloke said to me um, "see look at that you've got that on and you were born here, weren't you?" I said "yeah", he said, "it's just [...] like the um Pakistani lads [...] who go on about Pakistan and they're all born here" so he was kind of slagging me a bit [...] I couldn't say anything about that, could I? I couldn't defend myself [...] I was thinking, "well he's right because I'm not Irish, am I?" but... (Finn, 2nd gen., man)

You see, I had a different experience [during the IRA events] because I worked for [bank] [...] which is an Irish bank uh but they discriminated against me because I [...] “wasn’t Irish” [laugh]. (Elizabeth, 2nd gen., woman)

...and in Ireland,

When I was younger my granny [...] was a very hard ticket [...] we’d be known as the English lot, that, that had more effect on me, that wasn’t nice [...] and I would be thinking ‘so’ [...] I know I’m family, but I’m still English and they are Irish, sometimes hatred and anger overtake. (Lisa, 2nd gen., woman)

Finally, some second generation Irish people in the study suffered

indirect/institutional discrimination and were denied rights on the grounds of not

belonging to a distinct ethnic minority group. Tom, for instance, was not able to get

some time off work to go to church,

Your day off for the week has to be the day you’re going for your appointment, you can’t say ‘can I nip out for an hour’ [...] but [...] I’ve always argued that point with the religion, I’ve said if I were a different religion [...] you’d have to let me go but because I’m just [...] Irish Catholic [...] (2nd gen, man)

This affected him, with possible negative health implications, since religion was an integral part of his life.

The majority of second generation Irish people thought there had been an

improvement in the perception of the Irish over recent years,

I think it’s very fashionable now [...] to have [...] [the] Irish descent [...] Jeremy Irons [...] was desperate to prove that there was Irish descent there, he lives in Cork now [...] they like the accent, they like the Irish people. (Claire, 2nd gen., woman)

It’s all to do with this Celtic Tiger, and it used to be, the bog hoppers and they’re thick [...] now that people are getting Irish people in the workplace who are actually programming their computers for them, it’s sort of overturning that perception. (Gary, 2nd gen, man)

However, some believed the English still had a negative view of the Irish and anti-Irish stereotypes persisted (this included some of the same people who held the above view), such as that of the Irish being terrorists, “thick”, and taking English people’s jobs,

Oh you hear it all the time [that Irish people are thick] [...] you overhear it in conversation [...] (Gary, 2nd gen., man)

Like you get people being racist about the Polish [...] it was my cousin's says the Irish are the white blacks [...] they're coming over, they're taking our jobs [...] ⁵² (Leslie, 2nd gen., woman)

Second generation Irish people's perception of how Irish people are currently viewed by the English may affect the way they see themselves and whether they view themselves as excluded when compared to other groups, which may negatively impact their health (Wilkinson, 1996),

You know you're not English [...] that's for sure [...] you can be made to feel that way as well at times. (James, 2nd gen., man)

In addition, many second generation Irish people were cognizant of the fact that their parents had experienced anti-Irish discrimination in England,

I suppose my dad when he came over the only thing he had was in the B&B, it was [...] 'No dogs, no blacks, no Irish' which was quite common place though, wasn't it? [...] in the '50s. (Melvin, 2nd gen., man)

Coventry [bombing], my dad got pulled for that actually [...] he was on his way home from work and cause they noticed his Irish accent [...] he was interviewed over that [...] but he had nothing to do with it. (Tom, 2nd gen., man)

Some believed anti-Irish discrimination negatively impacted the health of their parents,

When he [Lord Mountbatten] died he said they [factory workers] wouldn't talk to him at all, just because of his Irish connections [...] it did [affect his health] at the time [...] he drank quite a lot at that time. (Tom, 2nd gen., man)

I would definitely, looking back, think my mum and dad must have been under so much stress and I'd say it was [...] definitely the racism [...] [particularly the] 70s [...] as a result of [clears throat] of everything going on there [...] it was every stress-related heart problems, blood disorders, anything [...] [even] increase in headaches, anything to do with stress and anxiety definitely, coming over here definitely [...] He [dad] said in the workplace um he was alienated [...] because of this Irish thing and the IRA I think he received an awful lot of racism in the workplace, came out with a lot of psoriasis, stuff that all kind of stress-related [...] (Leslie, 2nd gen., woman)

Lastly, some second generation Irish people attributed poor health to anti-Irish discrimination,

⁵² this quote deserves separate mention as the notion that the Irish are the "White Blacks" and, like them, are taking over the host country's jobs presupposes that the Irish, like the "Blacks", are less entitled to these jobs by virtue of ethnicity and birthplace. For both groups, this mode of thinking may be a legacy of colonialism and the resultant inferiorisation of certain groups driven by the political economy (Ratcliffe, 2004).

It [discrimination] can do a lot to alienate a culture (Gary, 2nd gen., man)

Discrimination [...] I mean living with some of those anxieties around discrimination (Aaron, 2nd gen., man)

Conclusion: Experiences of Discrimination

Several second generation Irish people in the study reported experiencing discrimination, in a more or less direct fashion. Some experienced anti-Irish discrimination by the English in relation to general anti-Irish stereotypes and prejudices. Unlike the first generation, however, they were more likely to experience anti-Irish discrimination under the guise of “jokes”. Others experienced discrimination in relation to the IRA events. Moreover, some suffered from anti-Irish discrimination by the Irish-born in relation to being second generation Irish. Finally, some put up with indirect discrimination, being denied specific minority rights, such as being able to observe their religion.

Anti-Irish discrimination, in its various forms, could have affected the health of this generation of people, directly, through an embodiment of risk, and indirectly, by affecting their socioeconomic position, religious (and cultural) practices, ethnic identity or sense of self (see below for further discussion), and causing them to feel ostracized. Thus, interactions are visible for the second generation between anti-Irish discrimination and other structural dimensions of ethnicity (i.e., socioeconomic position and social isolation), and also between anti-Irish discrimination and identity components of ethnicity, (i.e., ethnic identity and religious practices).

Many second generation Irish people knew that their parents had experienced anti-Irish discrimination in England and some believed this negatively impacted their parents' health. Others were aware of effects on their own health.

Although the majority of second generation Irish people thought there had been an improvement in the perception of the Irish overtime, some believed the English still

had a negative view of the Irish and anti-Irish stereotypes persisted, resulting in feelings of exclusion.

Findings and Discussion: Response to Discrimination

Second generation Irish people responded differently to the discrimination they faced; some spoke up about it and others kept a low profile, particularly during the IRA bombings. These different responses, which pertain to individual agency, may have modified the impact of anti-Irish discrimination on health. Some felt having an English accent protected them from anti-Irish discrimination,

When I was at work, because I'd got an English accent I was okay, but once I'd expressed that I was Irish, I felt sort of like the gap widened [...] nobody said anything [...] I just had that feel about it. (Melanie, 2nd gen., woman)

With regards to “Irish jokes”, as with the example of Melvin quoted above, the vast majority reported that they did not find them to be personally offensive because they were told in “good humour” and were not meanly intended (although they often recognized that they could affect “other people”),

I've heard lots of Irish jokes but...I mean... I don't really take them offensively unless [...] they [friends] just sit there and tell a joke and [...] I find it funny and so I laugh [...] I know that people do find things offensive and they get really, really offended by it but... [...] I've never been in a situation where anyone said anything to make me feel that way. (Theresa, 2nd gen., woman)

I don't mind the Irish jokes, but it's when it gets personal and they think oh you're Irish, you're stupid [...] I didn't [experience that] but I know my parents did. (Elizabeth, 2nd gen., woman)

Despite an awareness of their prejudicial meaning, some argued that the jokes should be taken with a “pinch of salt”, because, ultimately, they were “only jokes”,

Right, ok [laugh] yeah [I came across Irish jokes], um I tell people off if they tell me an Irish joke [...] but [...] you can't take these things too seriously I mean all people have fun made out [...] if people are small minded enough to think that all Irish people are terrorists or farmers or live in the pub [...] or got drinking problems [...] that's their loss. (Fred, 2nd gen., man)

According to Jenkins (1994), however, “there is no such thing as ‘just’ a joke and ethnic jokes are no exception.” (p. 211): they can lead the ethnic group to internalize

the terms in which another group defines it and assimilate that categorization into their identity (1994). Since the Irish joke or categorization is pejorative, this may have negative implications on health, possibly leading Irish people to see themselves as stupid, even if it is on a subconscious level.

Not taking the jokes personally or taking them “with a pinch of salt” may have been coping strategies adopted by some to distance themselves from them and avoid getting upset, with implications for health. It may also have been a strategy to “fit in” or retain a feeling of control over their lives

I'd probably laugh along with it [Irish joke] [...] I think it's down to the individual, it's how you look at it [...] how would you react if someone turned around to you and told you an Irish joke, you will see him everyday... and what's your reaction to it? (Melvin, 2nd gen., man)

Only a minority of people in the study reported finding the Irish jokes to be discriminatory and distasteful, regardless of the context in which they were told,

It was when you were at school you'd hear them [Irish jokes] [...] I dare say I would have told the jokes meself, but in late teens and early twenties [...] I kind of resented people making jokes of that nature. (Conner, 2nd gen., man)

At the other extreme, a small minority did not understand how anyone could see the Irish jokes as discriminatory and saw no harm in telling them,

I tell Irish jokes myself and [...] I don't see any harm in them because [...] a lot of Irish comedians, tell them don't they? (Finn, 2nd gen., man)

Hence, while most second generation Irish people in the study encountered Irish jokes, they reacted differently to them and adopted different coping strategies.

Finally, while the health of these people is likely to have been affected by anti-Irish discrimination, working, studying or living in a predominantly Irish environment may have protected some against anti-Irish discrimination from the English,

Myself no [I did not experience discrimination], because I was younger and I suppose those I mixed with would be of Irish descent anyway and at school because Catholic school and, I don't think so. (Claire, 2nd gen., woman)

When I was up in St Annes [...] say you do something wrong and it's 'oh it's cause he's Irish' [...] but you don't tend to find that in Coventry as much because I only find this out because I moved away. (Tom, 2nd gen., man)

Conclusion: Response to Discrimination

People's agency or responses to discriminatory acts, for instance, how they respond to the Irish jokes and whether or not they speak up about being discriminated against, may have altered the impact of the structural factor of anti-Irish discrimination on health, in positive or negative ways (see chapter 2, p. 20).

It is noteworthy that, despite an awareness of their prejudicial meaning, many reported not finding Irish jokes to be personally offensive because they were told in "good humour", and as such, they argued, should not be taken offensively but with a "pinch of salt". Not taking the jokes personally or "with a pinch of salt", however, may have been coping strategies adopted by some to distance themselves from them, retain control over their lives (Ruggiero, 1995), and avoid getting upset, with implications for health. It may also have been a strategy to "fit in". Thus, like the first generation, factors pertaining both to the social structure and to individual agency thus appear to be relevant. Moreover, akin to the first generation, an interaction between ethnicity as structure and identity may operate, with Irish jokes negatively impacting second generation Irish people's sense of ethnic identity, through their internalization of the anti-Irish comments expressed in the Irish jokes, with possible negative health consequences.

Finally, two dimensions of ethnicity as identity, i.e., having an English accent and being embedded in a predominantly Irish environment, may have protected some second generation Irish people against anti-Irish discrimination from the English, which relates to ethnicity as structure.

Experience of the National Health Service (NHS)

This section looks at Irish people's experience of the National Health Service and explores the relative contribution of the generative mechanism of dissatisfaction with, and experience of, NHS health services to Irish health inequalities. Although not the fundamental determinant of health inequalities, it is seen as an important structural determinant of health inequalities since it is tied to the structural position of Irish people in England and plays a role in shaping health disparities.

Indeed, dissatisfaction with health services and the NHS can negatively impact health and lead to health inequalities through affecting trust in medical professionals, medical help seeking behaviour, and making people reluctant to seek medical care, and thus affecting access to, and use of, health services. Moreover, a negative experience with health professionals and services can be directly damaging to health by causing mental distress, as well as by making people feel disrespected and misunderstood. Finally, medical negligence, misdiagnosis and improper treatment and care can directly affect physical health.

Findings and Discussion

Although there was a tendency on the part of the people in the study, especially first generation Irish men, to stress the positive aspects of their health experiences, the research uncovered quite a high level of dissatisfaction with health professionals and services; the great majority of first and second generation Irish men and women reported at least one negative experience of health professionals and services, either personally or indirectly through their parent or spouse, or both. The most common complaints voiced across the two generations of Irish men and women related to

medical negligence or malpractice, lack of bedside manner, and overall dissatisfaction with the NHS.

People who had suffered from medical negligence or malpractice had suffered, or had loved ones who had suffered, from diagnostic error, improper treatment and/or improper provision of care, with obvious physical health consequences. To give some examples, Melinda's (1st gen., woman) skin cancer was not detected soon enough leaving a big scar on her forehead and Tom (2nd gen., man) who suffered from hemophilia B, had a doctor who failed to pick up on a bleed in his knee, which cost him four months off work. Leslie's (2nd gen., woman) father's physical ailments were dismissed as psycho-somatic when they were signs of a heart attack.

Some people in the study were not properly treated for their condition. Paul, for instance, was given the wrong medication. Some people in the study had witnessed their parent or spouse being improperly cared for at the hospital or at the home they were in and it had affected their mental health at the time,

The last, two years, of my dad's existence in the home, it it was [...] terrible [...] so many problems [...] they never knew even who I was and who my father was [...] it was upsetting, very upsetting [...] trying to get through to people and then being accused of being aggressive, which I was, because I was so upset and so angry of getting no answers [...] (Melvin, 2nd gen., man)

Accounts of poor bedside manners included lack of compassion, empathy and genuine interest in patients, lack of ability to listen, lack of time for patients, poor communication skills, dismissiveness and rudeness,

I find them very abrupt [...] they just want to kind of deal with you and that's it [...] I've got to move on to the next one [...] they don't seem to uh, they haven't got [...] a mannerism that, I feel that I could, open up to or talk to. (Elizabeth, 2nd gen., woman)

Dissatisfaction with health services included hospitals being too busy and understaffed, nurses being under-qualified, and having to wait a long time for an appointment, a prescription, an operation, or a home visit,

I think the service is crap [...] it's [...] such a, a cruel system [...] they're dying and they still have to make an appointment [...] that's...crap [...] when I did go up and see somebody [...] to [have] my general health looked at [...] I wanted to see a nurse because I knew that she could fulfill everything that I needed and the next thing I was, sent to a non-qualified nurse [...] and I [...] really kind of find myself getting angry [...] (Brenda, 1st gen., woman)

Irish participants in Scanlon et al. (2006) study also frequently mentioned long waiting times to see a GP and rushed appointments as a problem. Some of the people in the study spoke up and claimed their rights, thus demonstrating agency,

I had that [stomach bag] for three years nearly, and I went [...] to get it reversed [...] they kept putting me off [...] so I said, 'well I'm not having this', and I went to see my MP [...] he wrote them a letter and in a week I had an appointment [...] to go into the bloody hospital to get it off, so [...] I'm lying on the trolley waiting to go down for the operation [...] and [...] the man that was gonna operate on me stomach [...] said, 'you're a very, very lucky man' [...] 'if you'd not have come down there', he said, 'you wouldn't have got out because [...] we couldn't have saved you, your heart would have gone' [...] 'you'd have been dead'. (Jack, 1st gen., man)

Less common complaints included distrust in the professional knowledge of health professionals, invasiveness of alcohol services, lack of public health information, lack of a nursing home for younger elderly people and a lack of understanding on the part of health professionals of mental health issues,

Doctors are doctors, they're people like you and me, they only know so much, you know, they're not miracle workers, I don't, it's not that I don't trust them, I know they can get it wrong. (Lisa, 2nd gen., woman)

I phone them [Coventry Alcohol Advisory Service] up and [...] I said '[...] what sort of thing do you do here?' and she said [...] 'what we want to erm find out is erm the kids involved and dddd...' and I was like oh my god [...] that sort of invasiveness [...] it's nothing to do with them whether there's kids involved or not [...] [I was put off straight away] definitely. (James, 2nd gen., man)

I was glad in a way I was changed because the other Doctor, it's terrible, he's retired now, he used to have a cigar in his, like this [...] and he used to say 'oh you're fine, tranquilisers' and he wrote me off for more tranquilisers and I shouldn't have been on tranquilisers [...] no he did not [understand mental health problems] [...] then of course they wash their hands out of you when you go to the Doctors in the hospital [...] it's difficult with mental health problems [...] (Maeve, 1st gen., woman)

The above issues, which affect access to and quality of care, may be more class, rather than ethnicity, related, affecting many Irish people in the study because they are located in the lower, or lower middle, social classes, and cannot afford to bypass NHS

services by purchasing a private insurance plan. Yet, some people in the study made other complaints about NHS professionals which suggest that at least part of the dissatisfaction with NHS services is a specifically ethnic or Irish experience of health care; some talked of discriminatory attitudes on the part of health professionals towards the Irish, of language/accents misunderstandings and of a lack of cultural affinity between Irish patients and non-Irish doctors.

Indeed, a cross section of first and second generation Irish women and men in the study also believed health professionals and services were prejudiced against the Irish and failed to understand the Irish accent, with consequences for health,

You do get comments like the stereotypical Mick type comments [at the doctor's] [...] not so much about me I guess but other people. (Aaron, 2nd gen., man)

I rang him [doctor] up and he said: "get him [husband] to the phone" and I said: "but he's not here, he's at work" [...] and he said: "he's at work?" and I said: "now, you told him it were ok" but he said: "but he shouldn't be at work, he's bloody ill" [pause] [...] my husband was still at work because... [...] the doctor misunderstood him [...] with being Irish... [...] he thought me husband was going out walking but he [...] was going to work. (Mychaela, 1st gen., woman)

About eight people in the study, principally from the first generation, were asked whether they felt having an Irish doctor would make a difference to them. Half believed that Irish doctors would be better because they would be easier to talk to, would understand them better, including the Irish accent, they could talk about Ireland, and would have an instant connection,

Do you believe [...] an Irish practitioner is, to the Irish people, is essential? [...] absolutely [...] I think the Irish have got something that a lot of countries haven't got [...] an awful lot of nurses came [from Ireland] [...] so they, they obviously care about people some way [...] the community [...] has a sense of caring [...] that might come back from the famine [...] people were poor and [...] had to huddle together [...] I think that they do, have an awful lot to give uh because of their personality [...] they will talk and they are interested [...] so I think, yes, I think that a practitioner [...] that people who know the culture obviously [...] is better [...] if an Irish person meets an Irish person [...] there's a connection, immediately. (Brenda, 1st gen., woman)

The other half said that it would be worse, would not make a difference or did not know because they never had an Irish doctor. Oliver, for instance, believed it would

be worse to have an Irish doctor because he got on very well with his English GP and knew two Irish GPs who were judgmental towards elderly and mentally ill people.

Finally, two people commented on having been, or currently being, very happy with their Irish doctor.

Conclusion

Although there was a tendency on the part of the people in the study, especially first generation Irish men, to stress the positive aspects of their health experiences, the findings reveal fairly high levels of dissatisfaction with health services and professionals, across the two generations of Irish men and women in the study. The most common complaints voiced across the two generations of Irish men and women related to medical negligence or malpractice, lack of bedside manner, and overall dissatisfaction with the NHS. While the above complaints may not be specific to the Irish population in England, some Irish people in the study voiced other complaints which were clearly Irish-specific, including a prejudicial attitude on the part of health professionals towards the Irish, and their failure to understand the Irish accent, both of which could lead to improper treatment and care.

Dissatisfaction with, and negative experiences of, health professionals and services could negatively impact the health of these people, via three main pathways: by making people reluctant to seek medical care; by causing mental distress, i.e., feelings of anger, anxiety, hurt and stress, and making people feel disrespected and misunderstood; and by directly affecting physical health, evidence of which was presented. Some people who were highly dissatisfied with English health professionals believed that having Irish health professionals would be better since they would have a cultural connection or affinity, leading to better doctor-patient communication. An interaction can thereby be observed between ethnicity as structure

and ethnicity as identity, with part of the dissatisfaction with health services possibly tied to differences in culture.

Overall Summary

This chapter has explored the relative contribution of the structural dimension of Irish ethnicity, i.e., of the political economy, migration, socio-economic position, discrimination, and experience of the NHS, to the health experiences and inequalities of a sample of first and second generation Irish people in England. It also addressed some other aspects of the second research question, specifically related to the interaction of ethnicity as identity with structure, and the interplay between structure and agency. The overall conclusions are presented in chapter 8.

The following chapter will focus on the contribution to Irish health inequalities and/or experiences of the identity component of ethnicity, i.e., the identity/cultural related aspects of being Irish in England.

Chapter 7: Ethnicity as Identity

Introduction

The purpose of this chapter is to explore the relative contribution of the identity and cultural dimension of Irish ethnicity to Irish health experiences and inequalities in England. This is achieved by examining the processes of identity formation, beliefs, lifestyles, religious and community support experiences of a sample of first and second generation Irish men and women in England, exploring respondents' discursive knowledge of influences on health and outlining the pathways through which these identity/cultural factors may impact health, by supplementing the findings with evidence from the existing literature (see chapters 2 and 3).

While this chapter focuses on identity-related aspects of ethnicity, it also explores the interactions between identity and structural aspects of ethnicity since cultural identity is not independent nor monolithic but linked to structure within a critical realist framework. The ways in which the agency of individuals with respect to identity-related aspects of Irish ethnicity is conditioned by the social structure will also be investigated.

Finally, since the research sees ethnic/cultural identity as having both negative and positive effects on health, and the Irish community as not simply victims of structural forces, but also resilient in the face of adversity, the final aim of this chapter is to depart from previous research, which has tended to emphasize the negative aspects of culture, and thus to stigmatise and victim-blame ethnic communities, by drawing particular attention to the generative mechanisms which may be protective of health at the level of the community and individuals. In parallel, possible negative influences

on health tied to ethnic identity and culture are explored but not overlaid by recognizing their interaction with structural forces.

Processes of Identity Formation

This section is concerned with exploring the relative contribution of Irish processes of identity formation and its consequences to Irish health experiences and inequalities. Studies on minority members have indicated that a strong ethnic identity is associated with better psychological well-being, possibly acting via the mitigation of the damaging effects of discrimination and negative stereotypes (see Abbu-Rayya 2006). Conversely, a weak and insecure ethnic identity may negatively impact the psychological well-being of ethnic minority members, and subsequently their physical health, through the internalization of negative stereotypes or images as these are projected onto them by members of dominant groups (2006).

Some authors attribute the poor mental health and especially high rates of suicide of first generation Irish people in England to their inability to establish an authentic identity or sense of self (see chapter 3). They argue that Irish migrants have felt obliged to suppress an “Irish” identity which has been negatively valued and represented in Britain (Leavey et al., 2007) and forced to accept the negative image the colonizers have of them (Fanon, as cited in Greenslade, 1992, see chapter 3, p. 62). Some suggest that the formation of enclaves in certain parts of the UK by the Irish-born may offer some degree of protection against mental distress (Brent Irish Mental Health Group, 1986 in Clarke, 1998) and help in the maintenance of a more positive Irish identity. According to Fanon (Greenslade, 1992, p. 215), however, the migrant can only “bury him or herself” in the migrant community to a certain extent (see chapter 3, p. 61)

Findings and Discussion

First Generation

The majority of the first generation Irish people in the study, all but one of whom came from the Republic of Ireland, identified themselves as being Irish,

It's innate in you, it's in the very roots of you, I'll always be Irish and it will never alter.
(Brenda, 1st gen., woman)

I am Irish and although I've lived here for nearly 50 years but I'm still Irish [...] I was born in Ireland [...] and I wouldn't try to deny whatever Irish, never. (Paul, 1st gen., man)

Well, I'm Irish [...] I can't be English [...] I can't say I'm French [...] I can't say I'm Scottish, I'm Irish [...] proud to be Irish. (Eric, 1st gen., man)

With the exception of three individuals⁵³, the people who identified as being Irish were embedded within the Irish community in Coventry and had several Irish friends. They generally participated in distinct Irish cultural practices, a basis of a strong expression of group membership (Modood, 2003) and were generally involved with the Coventry Irish Society (CIS), the Church (the women especially) and/or the Irish social clubs and pubs or Irish sport clubs (the men particularly). By mostly interacting with Irish people, and minimizing contact with the English community (cf. Clarke, 1998), they were able to retain links to the Irish culture and possibly maintain a more positive sense of Irish identity, which may be protective of health.

However, the fact that many were defensive about being Irish and adamant that they were “proud” to be Irish, which demonstrates agency, could be taken as indication that they felt that the Irish identity was threatened and devalued in the first

⁵³ These people, Brenda, Mychaela and Hogan, thought very highly of the Irish community but were not part of it (see Irish community support section). This may have led to a lowered sense of self through maximized contact with the English community and minimized contact with the Irish community. Indeed, for these people, having few or no Irish contacts meant that their social encounters almost exclusively revolved around the majority population, with whom they came into contact when they went to the shops for instance. They would then be reminded of their cultural inferiority, a legacy of the historical relationship between the English and the Irish (Greenslade, 1992). Little contact with the Irish community meant that they could not draw on community resources to resist the worse effects of this historical relationship.

place and had internalized the “negative external definition” or the negative image the British colonizers had of them (Greenslade, 1992). According to Jenkins (1994),

The very act of defying categorization, of striving for an autonomy of self-identification, is, of course, an effect of being categorized in the first place. The external definition *is* internalized, but paradoxically, as the focus of denial. (p. 217)

Most revealing is Tavis’ statement,

Why should we lose our identity [...] we’ve got a unique culture of our own and we have got er, this and that and the other that no other country in the world has, and erm, we were put down for years and years [...] by the British thing [...] they had us under the thumb there [...] they went over and they shot mine [...] well that makes you bloody think doesn’t it like [...] oh God of course it is [important to remember where we come from], if you lose your identity [...] you’ve got nothing then [...] you’re a way out [...] out on a branch haven’t you? (1st gen., man)

It is not difficult to see how the inclination on the part of first generation Irish people in England to want to defend and assert an Irish identity which has been pejoratively categorized and is trapped with notions of inferiority, subconsciously internalized by these people throughout the years, may have a negative impact on their health.

Although most strongly resist the possibility of a British identity, a minority of first generation Irish people in the study reported having mixed feelings regarding their ethnic identity and thinking of themselves as Irish and British,

I like to think of myself as Irish, but I’m not as Irish as some, and I think that’s because I’ve been in England a long time and had a lot of my schooling in England [...] perhaps both [Irish and British] would be the answer to that [...] because I love the Irish but I’ve got some very good English friends so I’d fit in either. (Oliver, 1st gen., man)

The only reason I put down Irish, is, obviously, I was born in Ireland so I am Irish but I have the greatest respect for Coventry and for England because let’s face it [...] it has given me a living for 40 years [...] I can’t under nose up with that. (Brian, 1st gen., man)

I lived here in England longer than I lived in Ireland so...I’m a mixture of the two [...] [I would say I am] Irish and English, yes [...] I put born in Ireland but I’m really classed as British now, I have a British uh pension, old age pension and that [...] a lot of people [...] can have two nationalities, can’t they? (Melinda, 1st gen., woman, also has a British passport)

While Melinda appears to have confused ethnicity with nationality, the reasons given by Oliver and Brian for thinking of themselves as Irish and British do not set

them apart from the other people in the study. Indeed, all the people in the study had made a living in England, and others had done some of their schooling in England, but still felt Irish. On the other hand, Oliver and Brian were not as embedded within the Irish community as the other first generation Irish respondents, Oliver because he was married to a British woman and Brian because he had lost the support of a lot of his Irish friends and half of his family following a nervous breakdown. In contrast, however, they appeared to be more integrated within the British community. More probing would be needed to obtain a better understanding of why these particular individuals have a different, and more positive, disposition towards the English community.

Second Generation

The evidence suggests that issues of identity are also pertinent to the second generation Irish in Britain, although they take a slightly different form. According to Hickman (1995), second generation Irish people in England face cultural pressures to become English and reject Irishness; while some give in to these pressures, others find the means to assert their own Irish identities. Of the second generation Irish pupils in Catholic schools whom Hickman (1990) interviewed in the mid-1980s, 81% gave their identity as “Irish” or “of Irish descent”. However, Ullah (1985) found the second generation Irish pupils he interviewed in Catholic schools in the early 1980s to adopt a range of identities, with the majority (56.3%) saying they were half English, half Irish.

The second generation Irish people in the present study also adopted a range of identities. About half felt completely Irish,

I like to be Irish [...] I feel I'm Irish [...] (Melanie, 2nd gen., woman)

They tended to have had an Irish upbringing...

I do [think of myself as Irish], yes [...] it's the way I've been brought up really, it's uh everything that, I was taught, I was taught by two Irish people [...] they were great [...] positive [...] very loving, very faithful people [...] [ethnicity isn't to do with where I was born] [...] it's more about what's inside really [...]...so I am Irish [...] it's more to do with, that sort of, ethos that they [parents] [...] had themselves and they just passed it on to us five [...] (Hazel, 2nd gen., woman)

... where they learned to appreciate the close family ties and sense of togetherness, which Ullah (1985) describes as very important for the development of a collective and positive sense of identity,

I had lots of cousins here in Coventry and [...] in Ireland as well [...] a lot of them came over here as well [...] we'd all meet up and visit one another [...] you visited your aunts and your uncles at least once a week [...] and we were quite, quite close as a family. (Elizabeth, 2nd gen., woman)

They were embedded in the Irish community...

I've got a good friend base [...] quite well-known within my job, I'm a [Catholic] primary school teacher so, got a lot of contacts [...] with the Irish community [...] I've always played that [Irish music] all growing up, my parents wanted us to have the cultural side [...] I brought it [Celtis] into [...] several schools now. (Hazel, 2nd gen., woman)

...Or had been as children,

Up until I left school um [...] it's probably a bit naïve but, because everybody was Irish, it didn't feel like I was living in a British society more than it's probably the other way round [...] because everybody I interacted with, my teachers, many of them were Irish [...] when we left school we used to go to um an Irish club (Aaron, 2nd gen., man)

Thus, being exposed to positive elements of the Irish culture growing up, including close family ties, and shielded from external negative stereotypes by being embedded in the Irish community, may have helped these second generation Irish people develop a positive sense of Irish identity and pride, which may be protective for health.

While most had taken part, as children, in distinctive Irish social, cultural and/or religious activities or practices, several no longer did but nonetheless continued to feel strongly Irish. They were proud to be Irish, identified with certain group labels, were fond of the Irish culture, and had a positive image of the Irish. Modood (2003) calls this type of identity an "associational identity" (p. 82); unlike the ethnic identity

implicit in distinctive cultural practices which might be unconscious and taken for granted, its strength lies in it being a conscious and public projection of identity, asserted with much pride and sometimes politicized (2003). These individuals tended to view the Irish people as being friendly and as having a natural capacity to enjoy themselves, more so than the English,

I haven't met many people that have the same loopy attitude as the Irish [...] oh very welcoming but then they're used to spreading out around the globe so they'll talk to anybody. (Claire, 2nd gen., woman)

They're [Irish] probably going to the pub the same [as the British] but, the Irish kind of seem to enjoy themselves better [...] or have a sing song at the end of the day or during the day when the British just sit sit down and, be mis..., be miserable like [...] (Finn, 2nd gen., man)

According to Tajfel's theory of social identity, comparing the minority group favorably with the dominant group and rejecting the latter's negative image of the Irish may have helped these individuals establish a new and positively valued sense of identity and derive a sense of pride in their ethnic origins (Tajfel and Turner, 1979, as cited in Ullah, 1985, p.315), with benefits for their health.

It is significant that only slightly more than half of these people ticked the Irish ethnicity box on the Census 2001 forms and they were all women. The other half did not tick the Irish ethnicity box but the British box for two main reasons. Firstly, although they identified with being Irish and were proud of being Irish, they took "ethnicity" to mean "country of birth",

I'd put English, because I was born in England [...] you've got to, because you were born in this country and my father's English [...] oh I'd put Irish then, I didn't know that [ethnicity meant self-identification with a culture] [...] I thought it was where you were born [...] I love Cider Brown, I love all the Irish food, I'd like to go and live over there [...] (Gary, 2nd gen., man)

Secondly, although they felt Irish, some men and women had difficulties in asserting an Irish identity because they were afraid of being discriminated against and called a "plastic paddy" by the Irish-born since they were born in England and not in Ireland,

I refer to myself as sort of technically English but as culturally and spiritually Irish [...] I grew up everybody was Irish [...] I tick “white” whatever it is British [...] because [...] there is that sort of [...] plastic paddy type of um... [...] everybody who’s [...] ever flown over Ireland can somehow claim some kind of connection to it [...] I do [...] feel I I think growing up within the community I grew up in [...] I am quite significantly different to other people [...] it’s a dilemma [...] it’s the notion of you know I do, see myself as [...] Irish heritage I mean very much so. (Aaron, 2nd gen., man)

Finn was indirectly called a “plastic paddy” in a club by an Irish man after he wore a green jacket with “Eire” written across it (see previous chapter p. 205). It affected the way he viewed himself and led him to question his Irish identity, with negative health implications,

I couldn’t say anything about that, could I? I couldn’t defend myself [...] I was thinking, “well he’s right because I’m not Irish, am I?” but... [...] yeah, I do feel kind of Irish, I I support the Irish football team and everything, I sing the Irish songs and all that but... [...] I feel Irish like [...] (2nd gen., man)

Thus, although they had a strong Irish sentiment, the above people struggled with respect to the ethnic identity label they could apply to themselves, feeling unable to call themselves Irish, since the Irish-born were differentiating and opposed their Irish identification. They did not confer them membership in the Irish group with negative implications for group identification (Modood et al., 2002) and for health. Similarly, McCarvill (2002) found that while the second generation Irish respondents he interviewed in Birmingham could formulate a form of identity which included an Irish dimension, their ability to articulate this identity publicly was strictly influenced by other people’s perception of them.

The people in the study labeled themselves as “English” not because they felt culturally English but because first, they believed they were “technically” English since they were born in England and second, could label themselves as “English” without facing English opposition, since English people were more incorporating.

Thus, they were placed in a similar situation to that of Hickman et al. (2005) participants, i.e., they were caught between two hegemonic domains, England and

Ireland, the former being incorporating, denying the difference of “Irishness” and the latter being differentiating, denying of commonalities with people of Irish descent. Unlike them, however, they did not appear to be experiencing difficulties in asserting a hybrid identity but rather in asserting or articulating a sole and only Irish identity. Feeling unable to call themselves Irish despite feeling Irish and having a positive image of the Irish may have a negative impact on their “sense of coherence” and therefore on their psychological and physical health (Elstad, 1998).

The other half of the second generation Irish people in the study were either puzzled about their ethnic identity (3), reported feeling both Irish and English (3), or reported feeling English (2). Overall, the men were more likely than the women to report having mixed feelings about their ethnic identity though further research would be required to determine whether this is a more general pattern.

Two people appeared to be confused about their ethnic identity. Tom and Leslie had been discriminated against both by the Irish-born in Ireland and the English-born in England and therefore did not find the English or the Irish communities to be inclusive or accepting. Heavily affected by the attitudes of those around them, they did not know what their ethnic identity was,

People in this country see me as Irish and people in Ireland see me as English, so I'm sort of er a mongrel if you like, [...] I'm in between the two it's like I'm not actually found anywhere cause over there I've got an English accent but over here everybody knows my name is [Irish] and considers me Irish, everybody sees me as Irish [...] they even call me “paddy” at work [...] but over there [...] I'm the English one. (Tom, 2nd gen., man)

Well, this is a strange thing because, growing up in England, we were always classed as Irish, when we went to visit family, we were always classed as English, so what are we [laugh]? (Leslie, 2nd gen., woman)

James had suffered anti-Irish discrimination in England and, despite initially claiming that he felt both Irish and English, was reconsidering his answer,

I'd say both [Irish and English] to be honest, erm, although [...] from the age of 16 I've felt more and more Irish, culturally and recognising that I've got more in common with erm other people of Irish descent and Irish people erm and they tend to be in my social

life you know [...] you're not English [...] that's for sure [...] you can be made to feel that way as well at times [...] (James, 2nd gen., man)

These responses are consistent with Ullah's (1985) finding that confusion about ethnic identity among his respondents was related to their position in England as "the second generation of a negatively portrayed minority" (p. 317). This may negatively impact their health.

In contrast, the three men in the study who appeared to have a positive relationship with both the Irish and English communities reported feeling both Irish and English. They got on well with their families in Ireland, who made them feel at home when they visited, and had either not recently encountered the Irish jokes in England or were prone to taking them in good "humour". On the whole, they appeared successful in forming a coherent sense of identity, which may be positive for their health. While Fred felt,

Half and half really [...] because mum is English and Dad is Irish and I am English as well, I was born in this country [...] but I am very proud of my Irish family as well [...] mum's family [...] either weren't living in Coventry or had died so there wasn't really any input from that side of the family to make me more English, all the input is from Dad's side of the family who were all Irish [...] [laugh] I [...] support England in every other game they play, apart from when they play Ireland [...] so not a typical paddy who would want England to lose all the time [...] so a strange mix really, yeah. (Fred, 2nd gen., man)

Melvin and Conner felt a greater allegiance to one culture over the other. Melvin felt both Irish and English but more Irish than English ever since he had been to Ireland a few years ago,

I personally as an individual now, I'd, I'd probably class myself more Irish than English cause [...] my future in law [unclear] she bought me this Irish rugby top [...] I'm wearing it proud and I, I love it [...] because I know what my background is and just from that visit to Ireland [to mum's town a couple years ago], just seeing a few things is brought [...] to light more and I feel more Irish now than I used to um...[...] I am also English, I am an English supporter sort of thing. (Melvin, 2nd gen., man)

Conner had always identified with being English but with age was gaining a greater sense of pride in his Irish heritage and reported feeling both English and Irish,

I see myself as English to be honest with you but as I get older I'm more, I've become increasingly disillusioned with what I see in society and I know it's fairly nostalgic and surreal but [...] when we go over to Ireland and we come back I just think the people are so much more friendly and such a nicer society that [...] at times I feel, not that I am Irish, but, yeah I'm proud of the fact that I've got Irish parents I think I'm a mixture of both but if you were to toss a coin I'd come down as being English. (Conner, 2nd gen., man)

The evidence suggests that the ethnic identifications of the above people were not static in time or place (Halls, 1992, as cited in Nazroo, 1998) and were tied to the amount of contact they had had with the cultural community in the preceding years.

Finally, both Lisa and Ysabel classed themselves as English because they had more experience with the English culture, either throughout their lives,

I'd put English but I'm British [...] to me it's [...] the culture as such that you've had the most experience of living in [...] I've had the English culture [...] obviously we always went back to Ireland often and whatever else, but [...] we were never forced into that [the Irish dancing] [...] [or] to go to Church, we were brought up to be quite relaxed, quite neutral (Lisa, 2nd gen., woman)

Or at present,

I suppose when I was living in Coventry I associate being more Irish than English, going to London, I think I've probably swayed more to being English, because of the people I've worked with are mainly English [...] people know me as being English [...] if I was surrounded by [...] an Irish community I'd probably feel more part of and associate more with being Irish (Ysabel, 2nd gen., woman)

Clearly, Ysabel's ethnic identity was not fixed and had changed over time because she had changed place of residence and was no longer embedded in the Irish community.

It is significant that neither Lisa nor Ysabel rejected their Irish heritage or tried to hide it. Moreover, neither appeared to view the Irish negatively or feel ashamed of being Irish,

The majority of people [...] say 'God I love the Irish they're so warm, they're so friendly' and they are. (Lisa, 2nd gen., woman)

I believe [it is important to preserve the Irish culture] yes, absolutely [...] there's a lot of culture there in comparison maybe to the English [...] and I think it would be sad to see that culture die, because it brings people together, Music, Religion so forth [...] (Ysabel, 2nd gen., woman)

Hence, in this particular sample of people, skewed towards the Irish end of the spectrum⁵⁴, the people had generally been successful in rejecting the negative image of the Irish group. Although Lisa and Ysabel had attempted to “pass” to the dominant group, as Tajfel and Turner (1979) would say, it did not seem to be in an effort to avoid the “unpleasant psychological implications” of being a member of a devalued group (as cited in Ullah, 1985, p. 315). Rather, it appears that Lisa and Ysabel chose to identify as English as a coping strategy, Lisa because she had been made to feel that she was not Irish by her family in Ireland, and Ysabel because she now lived and worked in London so could not presently be part of the Irish community, but instead needed to integrate in an English environment.

Conclusion

The above findings point to the complexity and difficulty of forming a positive and coherent sense of ethnic identity or asserting it for Irish individuals in England. This may affect their psychological well-being (see introduction; Abbu-Rayya, 2006).

While ethnic identity tends to be portrayed as a largely internal process, associated with individual agency, the above accounts support the contention that it is not entirely self-constructed but heavily influenced by the wider society (Karlsen & Nazroo, 2002a). Modood et al. (1997) summarize the argument well, “ethnicity, is ‘interactive’ – shaped partly by its original heritage and partly by racism and the political and economic relations between groups in Britain” (p. 9). In the current study, structural factors such as British colonialism and discrimination appear to underlie processes of identity formation and to play quite an important and harmful role in shaping them. By making the first generation Irish in Britain feel somewhat inferior and devalued and denying the second generation Irish a sense of belonging

⁵⁴ See discussion on sample selection biases on p. 93.

within the English and/or Irish communities (Jenkins, 1994), discrimination may negatively impact the ability of both generations of Irish people to form a coherent/authentic and positive sense of Irish identity due to the conflict between their desire to retain positive notions of Irishness and the extrinsic devaluations of their ethnic self-image. This conflict is damaging to health. Hence, an interaction is visible between ethnicity as structure and ethnicity as identity, with discrimination impacting Irish processes of identity formation, and the latter exacerbating the negative effects on health of discrimination.

However, British colonialism and discrimination do not completely shape the identity of first and second generation Irish people since many continue to derive pride in being Irish. This shows enduring capacity for community agency.

Individual agency appears to be facilitated by embeddedness in the Irish community, which minimizes first generation Irish people's contact with the British majority population and gives them community resources to draw upon. This may partially help them resist the negative image the colonizer/English have of them and avoid feelings of inferiority prompted by encounters with the British community, thus helping them maintain a more positive sense of Irish identity, which may be protective of health. In this way, embeddedness in the Irish community (identity component of ethnicity) may mitigate some of the negative effects of British colonialism and discrimination (structural component of ethnicity), on Irish people's sense of identity and belonging (ethnicity as identity), and be protective of health.

A similar mitigating effect appears to operate for the second generation. Indeed, by exposing them to positive elements of the Irish culture and shielding them from the negative stereotypes found in the wider social structure, embeddedness in the Irish community appears to help second generation Irish people develop a strong and

positive sense of Irish identity and pride, which may be protective for health (see introduction; Abbu-Rayya, 2006). More unexpectedly, the combination of embeddedness within the Irish community and anti-Irish discrimination from the wider society may also lead to a strengthening of the Irish identity by alienating people further from the British culture and bringing them closer to the Irish culture. Thus, embeddedness in the Irish community (ethnicity as identity) interacts with British anti-Irish stereotypes (ethnicity as structure) to positively impact second generation people's sense of identity and belonging (ethnicity as identity).

However, through increasing their chances of being discriminated against by the Irish born, embeddedness in the Irish community may also negatively impact the second generation's capacity for agency by adding obstacles to ascertaining a positive sense of Irish identity, with negative health implications. The denigration on the part of the Irish-born of an Irish identity for the second generation via the use of the term "plastic paddy" may in turn stem from Irish-born people's inability to reconcile a dual British and Irish identity owing to conflicting British-Irish relations under British colonialism. Thus, Irish processes of identity formation appear to be the outcome of a complex series of interactions between structural and identity components of ethnicity.

Above and beyond issues of identity formation, the identity component of Irish ethnicity may affect the health of Irish people in Britain via cultural and social aspects of being Irish, by shaping beliefs, influencing lifestyle, and structuring religious beliefs and experiences, and perceptions and levels of social support.

Irish People's Cultural Adaptations and Beliefs

This section explores the contribution that beliefs, held by a number of Irish people, make to Irish health experiences and inequalities. A significant number of

people in the study mentioned certain beliefs about life and health that they personally held, or believed Irish people commonly held; while some of these beliefs may be protective to health, others may be detrimental to it.

Findings and Discussion

Being Content with one's Material Situation

Despite being socioeconomically disadvantaged, there was a tendency on the part of some first and second generation Irish people in the study to report not needing much and being content with their financial situation. The potential health mitigating effects of this belief, which may be an “Irish” cultural adaptation to structural subordination in Ireland and/or class effect, via its impact on the Irish experience of relative deprivation, was discussed in the section on adult absolute or relative deprivation in the previous chapter on p. 181, 184-85. Some people in the study thought thinking in this way had a positive impact on their health.

Having a Positive Attitude and Outlook on Life

In common with other studies (Sproston & Bhui, 2002), several Irish people in the study, particularly the second generation, believed it was important to have a positive outlook and attitude on life. It is unclear where this belief originated from but, similarly to the belief of being content with one's financial situation, it may be an “Irish” cultural adaptation to structural subordination in Ireland and/or a class effect, resulting from growing up in difficult circumstances.

Several people stressed the positive impact on health of being positive,

I think being happy is good for your health I think if you're you know generally positive.
(Aaron, 2nd gen., man)

She's [mother] had scans with her heart [...] it runs through her family [...] but apart from that my mum is very much an optimistic so I don't think, she allowed things to, physically affect her that much. (Leslie, 2nd gen., woman)

We're a family of [...] positive thinkers really and we try to just, push things aside, unless it's something major [...] we [...] try to keep smiling, and have the crack and enjoy life really, and I think that's probably why, in all respects, if you look at my father's side of the family, there's [...] not really any illness. (Melvin, 2nd gen., man)

Keeping positive helped some accept chronic conditions...

I would say that I am quite healthy [...] I know that anything could happen to my back uh but [...] I just don't go there because [...] it's essential, when there's something wrong with you, that, that you kind of don't dwell too long on it [...] so how do I see my health? I would say that I'm, in fairly good health then. (Brenda, 1st gen., woman)

And others cope with unemployment and its negative impact on health,

[My mental health is] quite good really I suppose er, erm, I'm quite positive anyway [...] I do obviously erm get down sometimes but I try not to, I try to stay positive. (James, 2nd gen., man, unemployed for nine months)

Thus, being positive may mitigate the negative health effects of socioeconomic disadvantage and other adversity, and thus be protective of health⁵⁵.

Being Stoic in Illness

Some people in the study believed being stoic in illness and not going to the doctor was an Irish trait, particularly associated with first generation Irish men, which had negative health repercussions,

They [Irish] won't go near doctors, most of them they just suffered it out and that's it, especially in the younger crowd when they come over [...] I was very rare at the doctors when, up to forty [...] when I collapsed [...] I was only on the list because I had a family [...] I didn't believe in it either [...] work it out, work it off, if there was something wrong with you, you'd have to have something broke [...] then you'd go to the doctor, like if you had to be taken to the hospital, you didn't go, no, that's the only reason why that [health] statistic is there [...] they're terrible bad for going to the doctors [...] they're the same as me dad [...] how many times has he seen the doctor, oh only the once but it was too late (Hogan, 1st gen., man)

While there may be some truth to the above statement, it is important to cautiously interpret it as Hogan's interpretation of the events may have been shaped by prevailing Irish stereotypes.

Interestingly, first generation Irish men respondents were most likely to report having been stoic in illness, not "complaining" about their health and not going to the

⁵⁵ This does not mean that it can wholly counteract the material effects of socioeconomic disadvantage, which persist from a critical realist perspective.

doctor. Many of them only now went to the doctor regularly because they had suffered from a major health condition, which had changed their beliefs and attitude toward seeking medical help. This finding of stoicism, which should still be interpreted with caution, is consistent with prior studies (see Kelleher & Hillier, 1996) and, in particular, with that of Scanlon et al. (2006) who found a greater sense of stoicism towards accessing health care services among the older Irish, and Irish male delay in seeking medical health care attention to be linked to their perceived “macho” image and reluctance to show any “weakness” (Scanlon et al., 2006). In other words, “going to the doctor’s for softies” (2006, p. 336).

Alternatively, as demonstrated in other studies, stoicism in illness on the part of the first generation Irish may be attributable to childhood experiences of help-seeking behaviour in Ireland, where people delayed seeking medical care because of the financial implications (Scanlon et al., 2006; McFarlane & Kelleher, 2000, as cited in Scanlon et al., 2006). Thus, the belief of stoicism in illness may have originated as a cultural response to structural deprivation in Ireland.

Finally, it is possible that Irish men’s machismo or reluctance to show any weakness in general or with respect to health, i.e., their stoicism in illness, may partly be a response to structural deprivation in Ireland, since in order to provide, or help provide, for their family, and survive, they had to be strong and continue to work even though they were ill.

Although sparse, evidence of stoicism in illness was also found for first generation Irish women, and second generation Irish men and women,

I lost a lot of weight when I was first pregnant, I couldn’t eat I felt sick, so I basically just put it down to being worn out, tired, and then when I had him I had another one [genital abscess] there and that was extremely painful, yet again I didn’t inform the health visitors straight away, I’m one of these that, I wouldn’t complain as such [...] I just don’t [go straight to the doctor], I just see whether I can beat it myself [...] I’d rather try and do that first [...] (Lisa, 2nd gen., woman)

The majority of first generation Irish women, and second generation Irish men and women, were not stoic in illness and believed in the importance of readily seeking medical help when needed. When they were reluctant to go to the doctor, it was for other reasons, some of these structural such as dissatisfaction with health services (see section on “Experience of the NHS” in chapter 6).

Other beliefs about Health and Medical Care

Other beliefs about health and medical care, which were highlighted by some of the people in the study as being specific to the Irish in particular to the first generation, and held partly responsible for Irish poor health, included *not valuing health and neglecting oneself* (mostly Irish men),

I think they [Irish] do neglect themselves [...] [the magazine] said that the, the Irish neglects themselves there, and some of them dies young [...] I suppose they don't [...] value health [...] but erm, it's very sad in some ways [...] a lot of them dies young [...] they certainly do [...] and I think it's [...] lack [...] of not looking after themselves and when they do get bad, taking the proper medication and, eat proper food and don't be supping it up in the pub all the time. (Tavis, 1st gen., man)

Again, the above statement should be interpreted with prudence as it could reflect Tavis' internalization of prevailing stereotypes and blame for poor health. A gender effect is also visible whereby this belief was mostly attributed to men. Irish men's reported tendency to neglect themselves may be tied to their distinct migration experience (see previous chapter).

Another belief about health which was tied to Irish families involved *keeping illnesses hidden and covering things up*,

I've come across them [Irish people who suffered from dementia] [...] but again to a certain extent Irish families seem to cope with that [...] I think cover it might be a better word, try to cope with it as opposed to letting other people cope with it but eventually they give in and professionals have to come in. (Oliver, 1st gen., man)

According to the older Irish participants in Scanlon et al. (2006) study, this “culture of secrecy” or need on the part of Irish people to keep illnesses “secret” is a consequence of illness being seen by Irish families as a sign of weakness and as

something that brings “shame” and “stigma” to the family (2006, p. 331). This mode of thinking may have deeper structural origins.

Finally, other people in the study attributed Irish poor health to Irish people *being too accepting of the doctor’s diagnosis*. According to James, the origin of this attitude was structural; first generation Irish people accept what they are told and adopt a passive attitude at the doctor’s because they are migrants and believe that it is not their place to complain about medical care,

A lot of [Irish] people [...] I think is a characteristic especially of the older generation erm that erm they don’t want to make a fuss and they accept what they’re given [...] that’s the way [...] they think [...] she’ll [mother] describe you know the symptoms and [...] her doctor [...] will say to her erm that’s just old age [...] get on with it [...] she’d say it [‘I’m not sure about this’] to me [...] not to the doctor [...] I think it’s just the [...] conditioning of erm, to accept erm, what she’s told really, to accept the deal [...] I think [...] you come to England and you know this is the country that erm you should respect and erm do as your told sort of thing (James, 2nd gen., man)

This is consistent with other studies (Pender & Lavery, 1997; Kelleher & Hillier, 1996) who suggest that the Irish perception of themselves as second class citizens may be partly responsible for their unwillingness to make demands on the health care system. However, according to Scanlon et al. (2006) study, older first generation Irish people living in Ireland also adopted this “learned passiveness” and “deferential” attitude to health care professionals, and looked for the doctor to make decisions for them.

Conclusion

A significant number of people in the study reported that they personally held, or believed Irish people in general held, certain beliefs about life and health. While there may be some legitimacy to their statements, the socially defined or constructed nature of the latter needs to be recognized. Some of these beliefs, such as being content with one’s financial situation and having a positive outlook on life, may have a positive impact on health and mitigate some of the negative health effects of structural

disadvantage, whereas other beliefs about health and medical care, such as stoicism in illness, not valuing health, keeping illnesses “secret” and being too accepting of the doctor’s diagnosis, may have a negative impact on health, and exacerbate the negative health effects of structural disadvantage through affecting access to, and use of, health services. The above beliefs were linked by the people in the study to good health and poor Irish health respectively.

Some of these beliefs, such as being content with one’s financial situation and stoicism in illness, may have been shaped by ethnicity as structure, i.e., by poverty in Ireland where people lived on the breadline and delayed seeking medical care because of the financial implications, and may therefore constitute a cultural adaptation to structural deprivation in Ireland. Stoicism in illness may also be related to ethnicity as identity or to a “culture of masculinity”. Finally, it may be linked to a complex interaction between the two. Similarly, not valuing health, neglecting oneself and being too accepting of the doctor’s diagnosis may either be Irish traits, with deep structural origins, and/or a consequence of being a migrant (see previous chapter, migration section). Irish beliefs thus appear to have deep structural origins and to be the product of a complex interaction between structure and culture.

Irish Lifestyle: A Culture of Drinking and Fried Breakfast?

This section investigates the contribution of a supposed “Irish lifestyle” to Irish health experiences and inequalities. The negative effects on health of leading an “unhealthy” lifestyle are widely known and include an increased risk of cardiovascular disease, lung cancer and cirrhosis of the liver, conditions particularly prevalent within the Irish community (see chapter 3, p. 39-40).

Findings and Discussion

In the study, a significant number of men from both generations reported substantial alcohol use. This is consistent with several studies which have documented high rates of alcohol consumption for first and/or second generation Irish people in England, especially men (e.g., Becker et al., 2006; Greenslade et al., 1995; Tilki, 2006, see chapter 3 p. 50). The majority of first generation Irish men had been heavy drinkers for the greater part of their lives,

I drank like a fish [...] I won't tell a lie and say I don't drink an all, I do, I have a glass of wine and [...] the odd glass of beer [...] but in the main [...] I'm not a drinker as such but in, in by gone years I drank with the best of them [...] I don't think it done me any good (Jack, 1st gen., man)

Most had only cut down on their drinking in old age for health reasons. One was still drinking heavily. All but one of the second generation Irish men drank, of which two were social “binge” drinkers and two heavy drinkers. First and second generation Irish women, on the other hand, were more likely to be abstainers or light drinkers, although there was some evidence of social “binge” or “heavy episodic” drinking⁵⁶ among some of the second generation Irish women who would engage in regular drinking sessions leading to intoxication with their friends on weekends.

Moreover, many Irish men and women in the study, from both generations, were smokers. This is consistent with other studies which have documented high rates of smoking among the Irish people in England (e.g. Abbotts et al., 2004b; Wardle, 2006). Half of the first generation men had been smokers in the past (two heavy, two light to moderate), but had now given up. While most of the first generation Irish women had never smoked, two were current heavy smokers and one was a former

⁵⁶ According to the British Medical Association, recent common use of the term 'binge' refers to a single drinking session intended to, or actually leading to, intoxication. A pattern of repeated 'binge' sessions is commonly referred to as 'binge drinking' or 'heavy episodic drinking'. The UK Prime Minister's Strategy Unit (PMSU) defines a 'binge' as drinking over twice the recommended guidelines for daily drinking (BMA, 2009).

heavy smoker. About half of second generation Irish men and women were light to moderate smokers; one man was a heavy smoker and two women and one man had given up smoking relatively recently.

Many people in the study, first and second generation, men and women, attributed Irish poor health to an unhealthy lifestyle, in particular drinking and smoking,

A lot of Irish people drink a lot and don't look after their health and smoke a lot (Neve, 1st gen., woman)

Maybe we like a drink a bit more than anyone else (Gary, 2nd gen., man)

There was a [Irish] chap [...] he used to play cards with em [...] he was always drink, smoke, a heavy smoker [...] and he just went like that, he was found dead in the flat [...] quite a few of them was found dead er, recently [...] in their accommodation, Irish chaps. (Tavis, 1st gen., man)

Quite a few people talked of an Irish drinking culture,

All the [Irish people] I met do [drink], yeah [laugh] [...] they like to go out and [...] enjoy themselves [...] they [parents] like to go out and have a good laugh and have a drink [...] none of us drink in the house it's only sort of socially [...] but then I've got some relatives in Ireland, one in particular and all he ever does is drink [...] there was an uncle as well, that died for a drink so I think it is, part of the Irish culture as well, drinking problems. (Theresa, 2nd gen., woman)

Or Irish way of life,

Again, if I'm going to be, stereotyping, is it drinking, is it the fried breakfast in the morning, is it the lard sandwiches that were forced down your throat [unclear] I don't know, that would probably be the only thing [...] it's passed on, but then [...] if I was brought up on that [...] I would like to think that I wouldn't do that [pass it on to my children] [...] knowing obviously the effects of what it can do in later life but um, I think it is [...] the Irish way [...] (Melvin, 2nd gen., man)

It is important, however, to be critical of these claims since these views may be socially constructed, shaped by existing Irish stereotypes, and therefore more or less truth-like. Moreover, to link Irish people's drinking and smoking habits to simple differences in culture is to ignore the role of structural factors in underlying both culture and behaviour. Tilki (2003) maintains that the tolerance of heavy drinking in the Irish culture has deep structural origins with heavy drinking developing in Ireland

as a culturally acceptable way of coping with structural difficulties, which go back to colonialism (as cited in Tilki, 2006).

In line with the above argument, a sizeable fraction of the people in the study brought up, after further reflection, structural reasons for Irish drinking, including migration and work experiences, which they saw as conditioning Irish people's drinking and eating habits, thus displaying a critical realist understanding of deeper generative structures,

I think [...] there's an emphasis on drink in the Irish people in the UK, drink culture [...] absolutely yeah [Coventry as well] [...] I know a lot of people, Irish second generation who've got drink problems, if not myself so erm [...] they [Irish friends] do get in to a little bit of trouble erm, but mainly [...] they tend to have like er blow outs every now and again er, when they go drinking, on a mad drinking session erm after an argument with their wife or whatever [...] it seems to be a way of letting off steam [...] of releasing [...] erm, cause they're hard workers [...] (James, 2nd gen., man)

They [Irish] drink too much, yeah [...] you could say [...] it's [...] because they are living away from home but [...] what about people [...] who'll have a drink in Ireland [...] I think it's just uh... [...] [a cultural thing], I think the Irish like to drink [...] oh my dad [...] he used to, be in the pub all the day and [...] [then] he'll be, having a sing song [...] I think a lot as well, like my dad when he was younger and [...] other blokes have told me as well [...] when they were first moving here [...] they [...] lived in digs [...] four or five and all to get in [...] [this] one room [...] and so they'd work all day, and [...] then they'd go to the pub, so doing that all the years, I think [...] it [the drink] just got into their [...] system [...] it just got control of them. (Finn, 2nd gen., man)

Similarly, Elizabeth gave a structural reason for the Irish fried diet,

All the fry ups [laugh] [...] I really do believe it [Irish poor health], stems from that [...] the older generation, they're all like heart attacks and stroke [...] in Ireland, years ago, all they had to survive on [...] was potatoes [...] and milk [...] you were lucky to get an egg [...] there was [...] very little meat [...] but [...] as they became more affluent they were able to afford [...] as [...] the children got older and were able to work...therefore they had a, better [diet] [...] (2nd gen., woman)

Conclusion

The evidence suggests that an “unhealthy” lifestyle, in particular drinking, smoking and the fried breakfast, may contribute to Irish health inequalities in England. Many first and second generation men in the study were found to have drunk heavily and/or to currently drink substantial amounts of alcohol, respectively, and two thirds of the people in the study had smoked in their lifetime. Gender

differences were observed for alcohol consumption, with Irish women more likely to be abstainers or light drinkers, although there was some evidence of social “binge” drinking among the second generation Irish women.

Most people in the study attributed Irish poor health to an unhealthy lifestyle, in particular to heavy drinking and smoking, and quite a few people talked of an Irish drinking culture or way of life. It is important to recognize the socially constructed nature of these claims.

While lifestyle choices are often connected to individual agency and to culture, the data shows that many of the lifestyle choices made by the people in the study were influenced by the social structure (cf. Karlsen & Nazroo, 2002a). Indeed, for the first generation, lifestyle choices seem to be a product of the combination of structural vulnerability factors related to migration and work and of cultural attitudes with deep structural origins (see above, p. 239). This is consistent with other studies on Irish alcohol consumption (Greenslade et al., 1995, Leavey et al., 2004; Tilki, 2006). Thus, drinking is brought about by structural factors and intensifies their negative health effects. Gender differences in drinking for the first generation, with heavy drinking in pubs being common practice for the men but not for the women, may suggest that heavy drinking is also related to a culture of masculinity, where keeping one’s liquor is a sign of manhood (Greenslade et al., 1995; Tilki, 2006). This needs to be placed within an Irish structural context of high unemployment, where men struggled to establish their manhood through work. In contrast, smoking habits do not appear to be gendered. More probing on smoking would be needed to draw further conclusions.

With respect to the second generation, lifestyle choices seem to be the product of structural factors including work and of a combination of Irish and British cultural attitudes, where heavy drinking for men and social “binge” drinking for men and

women is tolerated, respectively; indeed, this pattern of drinking habits was observed among this generation. However, despite being conditioned by structural and cultural factors, lifestyle choices were not completely bounded by it. Indeed, a minority of first generation Irish men in the study had always been light drinkers and some second generation Irish men and women did not drink at all, thus displaying agency.

Belonging to the Irish Community

This section considers the relative contribution of Irish community support to Irish health experiences and inequalities, which has tended to be neglected in favour of a focus on “negative” cultural influences. Social support has been shown to positively affect health directly by increasing perceptions of control over the environment, and providing an assurance of self-worth, and indirectly, through exerting a “buffering” effect whereby practical or emotional resources help moderate the impact of acute and chronic stressors on health (Stansfeld, 1999). In addition to providing social support and buffering, Halpern (1993) found ethnic group clustering to have a protective effect on health by reducing exposure to direct prejudice. Finally, the social support structure may encourage healthy or unhealthy behaviours, depending on group practices (Stansfeld, 1999).

Findings and Discussion

The concentration of many Irish migrants in Coventry, as a result of the post-war economic boom in the Midlands, enabled the formation of a stable community with its own networks of support. Indeed, ethnic concentration in Britain,

Has allowed the development of community networks, economic activity, community resources, reaffirmation of positive self-identity and resources for its maintenance [...] Such concentration potentially acts as a buffer against prejudice and racism, provides role models, accords status to individuals for skills or knowledge not acknowledged outside

the community, offers social and moral support, and provides resources for the recreation of community⁵⁷. (Ahmad & Bradby, 2007, p. 800)

In some ways, Coventry resembles the Queen's Park/Kensal Rise area of London, which Malone (2001) described as a "community saved", with a salutogenic effect on the health of Irish migrants living there (see chapter 3 p. 60).

Many Irish people in the study, across two generations of men and women, obtained needed levels of social support through belonging to the Irish community in Coventry. According to Brenda, the Irish community is exceptionally giving, possibly because it developed in response to structural deprivation,

The [Irish] community [...] has a sense of caring [...] that might come back from the famine [...] people were poor and [...] had to huddle together [...] they do, have an awful lot to give uh because of their personality [...] they will talk and they are interested (Brenda, 1st gen., woman).

Many felt it was very important to belong to this "bounded" community and recognized the positive effects on their life and health of belonging to this community,

I'm a primary school teacher so, got a lot of contacts [...] with the Irish community [...] She [mother] was 57 and she suffered a stroke [...] just amazing [...] it was testament the, the Irish community, how many people came, to the funeral [...] it was huge, same for my father actually, very much, how community comes out and support [...] for family, when they are bereaved [...] it's incredible really [...] oh just that support that you need [...] the network that you really rely on. (Hazel, 2nd gen., woman)

I have [got a lot of Irish connections in Coventry] [...] I've got no end of friends [...] you get to know more people in the pubs than anything [...] and the Church [...] I think it's great [to have this big network of friends] [...] (Tavis, 1st gen., man)

I live in Coundon now [I feel more of a sense of community in Coundon] far more, certainly [...]...living in an area where there's far more, Irish people and supportive, that are closer, yes certainly makes you feel more at ease, yeah [it has an impact on my health], definitely. (Fred, 2nd gen., man)

Irrespective of generation or gender, they valued being part of a relatively culturally homogeneous and understanding social network of Irish people, with whom

⁵⁷ The research also recognises the negative effects of this ethnic concentration which took place in the most deprived areas of Britain, with consequences for housing, employment, educational aspirations, public amenities, and health and welfare services. This phenomenon is relevant to the situation of the Irish in Coventry who were overly concentrated in the deprived areas of the city. Irish people now appear to be more spread out within Coventry, possibly as a result of first generation Irish people passing away and second generation Irish people demonstrating social mobility and moving to more advantaged areas of the city.

they had things in common, including similar ways of thinking, a common cultural and historical background and shared understandings. This led to feelings of instant connection and closeness,

Yeah [laugh] [I have mostly Irish connections] [...] we think the same way [...] you understand...it's like [...] if I go up to me cousins in Ireland and I only see them once a year but it feels like [...] I've never been away from them, you can start a conversation, there's no awkwardness there because [...] you seem to be on the same wavelength [...] (Elizabeth, 2nd gen., woman)

Nearly all my friends are Irish [laugh] [...] I've been more close to Irish people [...] we come from the same background and the same culture so...we know one another [...] saying that, I have some very good English friends as well [...] but I feel more close to me Irish friends. (Paul, 1st gen., man)

According to Paul, an instant connection develops between migrants from the same country because they feel estranged in a foreign land,

[If] there was a French girl working in an office next to you [...] would you feel uh allegiance with her, wouldn't you? [...] because you go and talk to her [...] about back home and...things you did...well, that's how it was with the Irish here [...] that's how...immigrants are [...] to seek out their own, won't they? [...] try and feel at home a bit, and be with them. (1st gen., man)

Moreover, some cherished their Irish connections because they liked the Irish culture and friendliness,

I like the Irish, I mix more with Irish people, I like the Irish kind of, way [...] the Irish culture [...] [the] sing songs [...] the Irish [...] way just seems more, more friendly and [...] if there's Irish people in the pub, and if I'm singing, I feel better than if it's all, a completely English crowd...[...] the Irish [unclear] come asking for this song [...] they just seem more, more interested [...] even people like me [...] just feel more...[...] [connected] yeah. (Finn, 2nd gen., man)

Others, however, were not embedded within the Irish community and did not have the social support they needed. Despite having a couple of good friends and neighbours (mostly English), and a supportive family, some first and second generation Irish respondents, particularly women, missed the Irish community spirit they had known as children, in Ireland or Coventry. They described the Irish community as one which can be trusted and will be there for you “24/7”, where people are open, helpful, accepting, friendly, and happy to receive you at their house

and have “a cuppa and a chat”. This reportedly sometimes had negative impacts on their health.

It's [neighborhood] nice, it's quiet [...] [but] there's less of that community spirit than there was in the sixties and seventies, it's very sad, I do miss that and especially [...] not working you do miss that [...] there's not many of my generation still do it [go to Irish dances], there are some [...] but they have married other people of Irish descent [...] growing up there was a lot of Irish descent people there [...] so we're used to popping in and out of people's houses and having a cuppa [...] and having a chat, so [...] I really do miss that sense of community [...] There's some girls [...] I've seen occasionally from school of Irish descent but because I don't go to church anymore and once you leave taking your children to the school gate you don't see people there either. (Claire, 2nd gen., woman)

In Coventry, you always know that there's a community [...] to fall back on, that [...] will be there for you twenty four hours, seven days a week [...] in London even though you have your friends [mostly English] [...] you can[t] just call them up out the blue, it's a bit more distant. (Ysabel, 2nd gen., woman)

Brenda had friendly neighbours but believed it was not the same as in Ireland. She missed the Irish community spirit she had known there and believed community was very important for health,

Having friends and support, yes absolutely [it has an effect on your health], community is very, very important. (1st gen., woman)

She and Claire had been deeply affected by the lack of Irish community support when they were pregnant, with negative health repercussions,

The postnatal depression was...I always felt that it was the lack of support in the background, that there was nobody here, around me [...] I think that, that I was going through alone and [...] I was struggling [...] there was a kind of isolation about it because, it was so unlike Ireland, but if you were in Ireland, everybody would be helping everybody else but...it wasn't like that here... [...] it was very isolating. (Brenda, 1st gen., woman)

Aaron had a couple of good English friends but had a preference for having Irish friends because he felt more akin to Irish people, since he grew up within the Irish community,

People that I now knock around with haven't got...Irish heritage [...] unfortunately [...] I haven't got many um...Irish connections [...] I think there's [...] a difference, there's an arrogance amongst some of my English friends that, none of my Irish... [...] I grew up everybody was Irish [...] I do feel I think growing up within the community I grew up in [...] I am quite significantly different to other people. (2nd gen., man)

In addition to having little if no interaction with the Irish community, some respondents from both generations had no (or few) friends and limited family support. This could be very damaging to their health. Mychaela was a widow; she was not part of the Irish community and did not feel integrated in British society. Not only had she suffered from anti-Irish discrimination in the past but, being a migrant, she was struggling to come to terms with differences in culture,

I've got me son and daughter here [...] Me son [...] and me grandson lives with me [...] I have no friends, I don't bother with friends [...] [cough] I've always been alone so it doesn't bother me [cough] [...] no [I don't feel part of British society] [...] to me the Irish people talk to you [...] they're more friendly people than they are here [...] here, they talk to you but they want to know all your business and [...] [then] they turn their head [...] I still find that. When the woman across the road, when my husband died, came over, she gave me a card, and her husband died and she said: "I've been there, done that" I went to Tesco's one day and she, she turned her head, she refused to talk to me [...] so I thought [...] I won't speak to her again [...] I'd rather stay alone [...] now she tries to talk and I just ignore her. (Mychaela, 1st gen., woman)

Gary and Hogan had lost touch with the Irish community since they no longer went to the pub. Gary had no family except for his wife and step-children and no friends. His parents were dead and his siblings were unsupportive,

[There aren't many Irish people in my neighborhood] [...] not that I know of [...] I'm not much of a mixer no [...] I basically go to work and that's it I don't go out much [...] no [friends in the area] it's because I don't go out to the pub, so I never made any [...] when I met Dana, I [...] moved to a different area [...] so I lost touch with all them [previous friends] and I've never bothered using this local pub [...] because my wife didn't like it [...] (Gary, 2nd gen., man)

Hogan was a widow and if it was not for organizations like the CIS, he would feel very socially isolated,

There was pubs here [...] but [...] now [...] because I don't go to pubs anymore [...] I'm out of circulation, so I only bump into them [Irish friends], and when I bump I even coming here [CIS] then, or up to the other place. (Hogan, 1st gen., man)

Finally, Melinda (1st gen., woman) had come to England on her own and had never been married and thus had no family in Coventry. She believed having Irish friends was very important and obtained most of her Irish connections through the church and the Coventry Irish Society's socials.

For many of the above individuals (e.g. Claire, Brenda, Aaron, Gary and Hogan) having a “strong” Irish identity but not being surrounded by large numbers of Irish people could have negative health repercussions (Halpern & Nazroo, 2000; Neeleman & Wessely, 1999).

In contrast, a minority of people did not feel having Irish connections was important. They did not feel as Irish as the other people in the study and had principally English friends, whom they felt were supportive,

So perhaps both [English and Irish] would be the answer to that [ethnicity question] [...] because I love the Irish but I've got some very good English friends so I'd fit in either [community] [...] It's nice that they [Irish] keep their own culture, now that's not something I've kept with [...] I don't join Irish clubs [...] because you think about drinking clubs and [...] I've never liked sitting in a Pub like all night [...] Most of them [my friends] are British I would say [...] yes [my wife is British] [...] no it [having Irish connections] doesn't make any difference. (Oliver, 1st gen., man)

Like Oliver, Conner had mostly English friends, whom he was close to. His [Irish] family was living in Ireland and he had little contact with them,

All my [Irish] family is over in Ireland [...] I've got a lot of close friends who are not from an Irish background but because my father was one of very, very few from his own family who came over to England [...] I do regard myself as a bit of an outsider [...] the only time I really communicate with the majority of them [Irish family members] is [...] via a Christmas card. (Conner, 2nd gen., man)

Finally, for some people in the study, belonging to the Irish community was not always beneficial and it could negatively impact their health. It could lead to low-self-esteem...

I don't have a great deal of self-confidence [...] [pause] yes possibly [it affects my health] [...] you don't see yourself as having much self-worth I think that [...] part of that stems from being Irish...growing up within a, particular time and place in Irish households [...] I think young, Irish people, with the tiger economy [...] have gained a sense of confidence that older Irish people never have [...] it was that sense of like [...] you keep your mouth shut and, you you get on with it [...] so [...] it's not particularly good for [...] [that] generation in terms of how they feel about themselves um...(Aaron, 2nd gen., man)

...Bad drinking habits....

My friends are almost exclusively Irish [...] probably in a way that might be er [affect my health], it could be [...] if they're asking me out for drinking all the time [...] so that could be one thing. (James, 2nd gen., man)

...And a sense of alienation,

I used to go to the CYMS up there but I found it very cliquish [...] what I didn't like about some of the Irish was they were always poor Ireland poor [...] they didn't realize what they [English people] went through in the war [...] no idea, course I was here as a child [...] (Ryan, 1st gen., man)

Conclusion

The great majority of respondents felt it was important to belong to the Irish community or at least to have Irish connections. They recognized the distinct character and benefits of Irish community support, which may have developed as a response to dire structural deprivation in Ireland; and felt more connected to Irish people; some admitted to not feeling integrated within British society (cf. Mychaela).

Many belonged to the Irish community in Coventry, which was able to develop in large part owing to Irish migration patterns (denoting an interaction between structural and identity components of ethnicity), themselves tied to the world political economy and to Coventry being a major manufacturing centre, and which shares many of the features of a “community saved” (see above discussion, Malone, 2001). Consistent with studies which noted the positive health effects of having a strong Irish identity and being surrounded by people with a similar background (Halpern & Nazroo, 2000), these people felt belonging to this community had a positive impact on their life and health through helping them feel more at home and through the support provided by a relatively culturally homogeneous, understanding and reliable network. Thus, community support may mitigate some of the negative health effects of being a migrant or an ethnic minority.

However, others were unable to establish these connections and/or were missing the Irish community spirit they had once enjoyed, with negative health implications (Neeleman & Wessely, 1999), a link articulated by some people in the study. Reasons included not going to Church or the pub, not bringing the children to the Catholic

schools, having a British husband, migrating alone and living outside Coventry. These structural factors strongly constrained the agency of these individuals who wanted to belong to the community but were unable to. In addition, some of these people were socially isolated and had no or few friends or family, compounding the negative impact on health of not belonging to the Irish community. They felt alienated from British society for various reasons including anti-Irish discrimination and differences in culture. Thus, two dimensions of ethnicity as structure, discrimination and migration, shaped experiences of social support in England.

On the other hand, a minority of the people in the study did not think having Irish connections was very important and obtained needed support from the English community. These people tended to feel less Irish than most, and to feel more integrated within British society. In this sense, ethnic identity may influence people's perception of what constitutes adequate social support, including whether or not belonging to the Irish community is considered important, with people who strongly identify as Irish considering it to be so and people who feel less Irish and more English being satisfied with having a couple of close English friends. Thus, for the Irish population in England, the impact of belonging as opposed to not belonging to the Irish community on health may be contingent upon ethnic identity, denoting an interaction between two dimensions of ethnicity as identity.

Finally, some people felt belonging to the Irish community could also carry negative health implications, leading to poor self-esteem, bad drinking habits and a sense of alienation.

The Irish and the Roman Catholic Religion

This section looks at the generative mechanism of religion and its contribution to Irish health experiences and inequalities. The beneficial effects of religion, and more

specifically of Church attendance, prayer, and intrinsic religiosity, on health have been documented (see chapter 2; e.g. Koenig, 1992). Proposed pathways include a supportive religious community with a common world view, a feeling of inner strength/peace, and a sense of meaning and hope, all of which may act as a buffer against stressful life events and medical illness (see chapter 2). Religion may also impact health by affecting alcohol consumption (e.g. Mullen et al., 1996). Finally, it may negatively impact psychological health through generating anxiety and fear due to beliefs in punishment (e.g. hell) for wrongdoing and fostering low self-esteem through generating unhealthy levels of guilt (Schumaker, 1992).

Findings and Discussion

All the people in the study, with the exception of a few, were baptized and raised as Roman Catholics⁵⁸. While many reported having strong religious beliefs and a positive relationship with religion (particularly first generation women, followed by first generation Irish men), a substantial number had put their religion into question and/or did not practice their religion (particularly second generation Irish men, followed by second generation Irish women).

First Generation

The great majority of first generation Irish people in the study, women in particular, reported having strong religious beliefs and a positive relationship with the Roman Catholic religion. Their faith was very important to them; it had a positive influence on their life and health and provided them with inner peace,

In a way I get that inner peace when I go to church and find it balances my life up.
(Maeve, 1st gen., woman)

⁵⁸ It is significant to note that none of the people in the study reported being Protestant (see p. 95)

I...think, what it [religion] gives me [...] it gives me peace of mind, the Church... [...] it's hard to explain [...] but it's a great peace of mind. (Brian, 1st gen., man)

They believed God was there for them and they could turn to prayer in times of need,

All my life he [God] supported me, my faith is very important to me. (Brenda, 1st gen., woman)

My religion makes me feel very happy [...] I believe in it so much, and I pray a lot, and I think that helps me. (Erina, 1st gen., woman)

Religion helped them cope with difficult life events,

I couldn't without my religion, I don't know how people do but I couldn't. (Neve, 1st gen., woman)

This finding contrasts with that of Sproston & Bhui (2002) who found religion to be least obvious as a method of coping among Irish respondents when compared to Black Caribbean and South Asian respondents. However, this could be because their Irish sample was mostly comprised of second generation Irish people.

The first generation Irish generally went to Church on a regular basis and found the Church to be an important source of social support and motivation, with positive health implications,

Yes yes [it is a very supportive community], I'm in the choir in the church as well, I've been in the same church now for nearly fifty years [...] mmm yes [it's family]. (Maeve, 1st gen., woman)

I do [have strong religious beliefs], yes. Uh...I've gained a lot from...going to mass [...] last Sunday morning [...] I felt really, no motivation to even get up out of bed but I...do, I hate to miss mass... [...] and I went to the 9 o'clock service and I gained a lot from it, now it could be just going out even [...] meeting people but...(Brian, 1st gen., man)

While religion conferred many benefits to the above individuals, and therefore appeared to be protective of health, having strong religious beliefs and a positive relationship with the Roman Catholic religion could also have negative health consequences. Indeed, Maeve had a nervous breakdown after three of her children failed to get married in the Catholic Church,

I have [been hospitalized for a break down] for three weeks when [...] three of them got married within, in three years [...] and then we had three children born, I think it was an accumulation of things, the old problem of not getting married in the Catholic church,

none of them did [...] and it [...] did hit me a lot and my husband, he's a convert so erm, that was quite a tough time, I probably shouldn't have worried but I do, and that's [...] the kind I am. (Maeve, 1st gen., woman)

Moreover, although all reported not suffering from Catholic guilt, here defined as the negative feelings which stem from the failure to fulfill one's duty towards God of always doing the right thing, it is possible that they were conditioned to think in a certain way,

I've brought that [subject of Catholic guilt] down with people and said: 'you know, a lot of that stuff isn't the reality of the situation and you've been conditioned in such a way', people will not agree to that, but [...] you can show them, how they're conditioned to it, 'have you ever thought about it?' (Brenda, 1st gen., woman)

And had never questioned their religion,

No [I don't feel Catholic guilt]. I always thank God that we, we were brought up to our belief and we never ever lost it and I always think, God was on our side because [...] we brought back that belief with us, all the way, and would never question it. (Megan, 1st gen., woman)

Indeed, apart from two people, none of the first generation Irish people who reported having strong religious beliefs and a positive relationship with religion had questioned their religion. Two factors may be responsible for this. Firstly, these strong religious beliefs were deeply ingrained in their minds before they came over to England on account of being brought up in the Republic of Ireland in a country governed by religious norms (Phádraig, as cited in Kells, 1994) and where the Roman Catholic religion was widely accepted and uncontested (Kells, 1994),

Obviously being born in Ireland everybody, 99% are Catholics, er, the routine was [...] the power was, no matter what else happened, you always went to Mass on Sunday [...] (Jack, 1st gen., man)

Secondly, following Hannay (1980) who found religious allegiance to act as a stabilizing factor for minority groups distant from their cultural base, including Catholics of Irish extraction, with positive health consequences, religion and faith may have also played an important role for the Irish migrant in England; while everything around them was changing and they were now in an unfamiliar and

sometimes hostile environment, their faith was constant and always there for them to draw on. Moreover, the Catholic Church, which was well established in Coventry as a result of the concentration of many Irish migrants in the city...

I don't know how many Catholic churches there would be in Coventry if there wasn't any Irish living over here, about half of what there is now I imagine. (Fred, 2nd gen., man)

...may have provided a refuge for the Irish migrant, especially women. Indeed, while several of the men went to the pub to cope with difficult migration experiences, including homesickness, social isolation, dismal housing, and anti-Irish discrimination (Leavey et al., 2007; Tilki, 2006), the women may have found a safe haven in the socially-acceptable institution of the Church; there, they could feel safe (including from anti-Irish discrimination), partially reconnect with the Irish culture, reinforce a positive sense of Irish identity and meet other Irish women with similar values, and thus partially counter their homesickness and social isolation. It was thus in their interest to hold on to their religious beliefs and not question them. Moreover, Roman Catholic institutions assisted the Irish migrant in upholding their religious beliefs and faith and thus had positive implications for their sense of identity, since "religion is one aspect of cultural inheritance and identity and, more broadly, of life experience"; it may help the Irish migrant have a clear sense of him/herself as different from the English people he/she lives among (Kells, 1994, p. 18).

Due to a generally unquestioning attitude towards religion, the response on the part of many first generation Irish respondents that they did not suffer from Catholic guilt, since they did the best they could to live the way they should, should be interpreted with caution. Indeed, there was evidence that they may suffer from the effects of Catholic guilt, even if it is on a subconscious level, with negative health implications,

I try and...not have guilt really...I think if you live like you should, you, you shouldn't have guilt [...] [unclear] I feel that way [that I lived the way I should], yes. (Melinda, 1st gen., woman)

Further support for this contention is provided by Scheper-Hughes (2001) in her anthropological study of mental illness in rural Ireland in the 1970s,

Irish children are [...] psychologically “walloped” by the continual reminder of sin and eternal damnation as well as through the equation of human motherhood with the divine motherhood of Mary [...] With the Immaculate (and bleeding) Heart of Mary as their role model, Irish mothers are artists in the guilt-inducing techniques of moral masochism, and the old woman wields control over the lives of her children [...] long after they can be effectively beaten with a cane. The results of this influence can be witnessed in the Irish youth's overly developed sense of conscience (p. 280-81).

Brenda was the only first generation Irish woman to maintain strong religious beliefs and a positive relationship with religion and yet to have questioned the Roman Catholic religion. She went to Church regularly and believed God was there to support her and yet, she disagreed with some of the church teachings and blamed the Church for installing Catholic guilt in Roman Catholics, who, she argued, were largely unaware of their religious conditioning (see Brenda's quote above). Analytical of her religious upbringing and conditioning, she had developed her own set of beliefs and did not suffer from Catholic guilt. Paul was the only first generation Irish man to maintain a positive relationship with the Church and yet to disagree with its position on divorce.

Overall, religion appeared to provide strength and meaning to the lives of first generation Irish people who had a positive identification with religion, with positive health implications.

In contrast, three first generation Irish men in the study had a negative or ambivalent relationship with the Roman Catholic religion. It is significant that none of the women did⁵⁹. For instance, Jack declared himself agnostic, he was bitter about the

⁵⁹ Only one first generation Irish woman in the study reported not being religious. However, due to insufficient probing, the reasons for it are unknown.

religion and denounced the pedophilia and class prejudice in the Roman Catholic Church. Tavis doubted God's existence, given the many catastrophes he had witnessed, wondered if he had been religiously brainwashed and doubted whether heaven existed. Yet, he read religious books, feared hell, suffered from Catholic guilt and believed religion negatively impacted his life because it was a worrier,

I'll admit now that I don't go to Mass [...] every Sunday now, I haven't been to confession for three or four years [...] I'm supposed to mind you [...] [religion impacts my life] because [...] it's a worrier [...] you begin to think like as you get older [...] what you're doing down through to life, and it should be all taken into account [...] you'd like to be the right side of the fence when you do snuff it [...] I don't want to go down there, meet that fella with [...] the pair of horns and the long tail and the pitch fork. (Tavis, 1st gen., man)

Both Jack and Tavis were embedded within the Irish community in Coventry.

While Jack appeared successful in rejecting the Roman Catholic religion, Tavis was not; he continued to have deep-seated religious beliefs because of his religious upbringing. Tavis' ambivalent position towards religion reflects the strength of structural factors in shaping religious beliefs and choices. Jack's apparent ability to reject the Catholic religion, however, may indicate enduring scope for agency or for making free religious choices.

Second Generation

The majority of second generation Irish people in the study, especially men, had a negative relationship with the Roman Catholic religion. For these people, religion appeared to constitute a source of strain and alienation, and most were no longer practicing. Many resented the religious indoctrination and guilt they had to contend with for many years growing up and stressed the negative impact religion had had on their life and/or on their health,

I think when I was younger I felt guilt and all sorts of responsibilities [...] you're frightened of what you couldn't do and what you could do [...] and then you get to thinking 'well who am I trying to please' you grow up and you think, oh I'm not that bad a person [...] a sense of responsibility all the time [...] please people [...] everybody, parents [...] the church, school [...] it's the Catholic and being brought up by nuns and

it's always your duty, you must do this [...] so [it affected my life] [...] you always had to be a good girl [...] (Claire, 2nd gen., woman, no longer practicing)

Yeah [I suffered from Catholic guilt] total, yeah, that's why I, carried with me I'm responsible for everything, I think we grew up in an era of [...] hell and damnation [...] [pause] I think [it had an impact on my health] it's all to do with that, the devils of self-esteem and things. (Aaron, 2nd gen., man, no longer practicing)

Brenda linked Irish poor health to Catholic guilt,

The Church has an awful lot to be responsible for [...] I love my Church and [...] God but [...] there's an awful lot of things that I, I would argue [unclear] against in the way that it is presented [...] [Catholic guilt] is the cause of the bad health of an awful lot of people, uh feeling guilty about this, that and the other and and the perception, it's to do with the education [...] (Brenda, 1st gen., woman)

In addition, some were skeptical of the institution of the Church and its religious teachings; Finn deplored the hypocrisy and contradictions of the Church, with the Church not authorizing divorce but granting marriage annulments instead. Claire denounced the pedophilia in the Catholic Church, its intolerance and it being a male domain. Most importantly, she felt the Church had lost touch with the people and with the true meaning of Christianity,

I don't go to church anymore because I got fed up with being sermonised [...] told from the pulpit by some male bachelor who hasn't got a clue about everyday life [...] one time there was a sermon about the collection plate [...] they were fed up with counting the [...] pences [...] don't put two pences in the collection plate, what they missed was [...] you give your children the spare change [...] so they [...] get used to giving [...] it annoyed me so much [...] I think that's what they miss, the story, the reason of Christianity. (2nd gen., woman)

Finally, some second generation Irish men and women doubted God's existence.

Those individuals tended to have had a difficult life,

I think it's logic [...] if there was a God out there and he was the almighty being that he proclaims to be there wouldn't be so much happening in this world. (Gary, 2nd gen., man)

Not really [religious] [...] yeah [I had a religious upbringing] [...] I just [...] thought about it and [...] the Jury's out on that Mary, I'm not quite sure [...] they said 'well God made us but who made God' [...] where did he come from, it's like the chicken and the egg isn't it? (Melanie, 2nd gen., woman)

Several second generation Irish people resented the fact that the religion had been imposed on them growing up, at home and at the Catholic schools they attended, leaving little scope for agency or for making free religious choices,

[I am] Roman Catholic yeah, non practicing [...] [religion impinged on my life] [...] obviously one's almost guilty of indoctrination I think, it was just forced down your throat so much when you were at school, particularly at Primary [...] (Conner, 2nd gen., man)

Going through the school thing, erm, it was just too much, the indoctrination was just too much, erm we weren't actually taught, we were told [...] we weren't allowed to ask questions [...] (James, 2nd gen., man)

Only a minority were able to display agency as children and make free religious choices. Melvin, for instance, described his religious upbringing as “relaxed”. Unlike his older brother who was sent to priesthood against his will, Melvin was given the option by his father of no longer going to Church when he turned thirteen. He took it, thus displaying agency. As a result, he did not believe religion impacted his life.

I can't turn around and say now the actual Catholic upbringing was terrible um it was relaxed uh I was given choices as well so, and at the right age I made the choices [...] he'll [brother] probably say completely differently, he went to a [...] priesthood uh and he rebelled from the actual thing (Melvin, 2nd gen., man)

Most second generation Irish men and half of the second generation Irish women in the study⁶⁰ eventually rebelled against the Roman Catholic religion in their teens or later on in their lives, and chose to no longer practice their religion, thus displaying agency. Yet, the evidence suggests that they may not have been successful in fully getting rid of their religious beliefs and feelings of guilt, with negative health implications. According to Aaron, religious beliefs and feelings of Catholic guilt are deep-seated and very difficult, if not impossible, to get rid of,

One of my close friends [...] is a Catholic [...] and we both sort of say but we both know that when push came to shove [...] if we thought we were near the end I think we'd both, there's this notion about what you know you growing up with it at that age it's very difficult to shake it off entirely. (Aaron, 2nd gen., man)

Indeed, it is likely that with the assistance of the large Irish community in Coventry and the Catholic schools, largely a result of Irish migration patterns, Irish migrant parents successfully got their children to internalize their strong religious

⁶⁰ Here, only six out of the eight second generation Irish women respondents are included since the other two were not baptized or raised as Roman Catholics; they had received a neutral religious upbringing.

beliefs. However, by virtue of living in England, second generation Irish children may have also gained, as they became older, some awareness of the fact that the Roman Catholic religion was contested, outside the Irish community. This may have led them to question their religious upbringing and prevented them from developing a positive relationship with religion. Instead, they developed a negative relationship with religion, with possible negative health consequences.

In contrast, half of the second generation Irish women and two second generation Irish men had a positive relationship with religion, they went to Church on a regular basis, and like the first generation, derived many benefits from it,

I try to [go to church]...[...] I certainly, I get a lot out of it spiritually so [...] I think it helps you on your journey really, keeps you going, you can talk to somebody [...] that's it [people are like-minded]. (Hazel, 2nd gen., woman)

Tom felt religion helped him have a positive outlook on life,

I'm quite religious yeah I do go to church [...] every Saturday [...] I think it helps me give a positive outlook in a way [...] [it helps me mentally] [...] if there's times when you're feeling down it does help doesn't it? [...] and if there's been deaths in the family and what not. (2nd gen., man)

They reported not suffering from Catholic guilt. Yet, like the first generation, they may have suffered from its effects despite claiming not to,

If you haven't done your best, well [...] all that you could have done...you would feel uh a sense of guilt [...] I don't [feel guilt] because I try and... do everything as I should do, as I believe [...] oh yes [It is difficult to always do things right] you can't do it the right way or you've um neglected something [...] I try and do it the, the proper way so that [...] I don't feel... guilty [laugh] [...] yeah, it, it does [affect your life], because it makes [...] your life uh a bit more [...] awkward [...] like if you're going to do a thing do it right [...] if you [...] slap it aside [...] you'll feel guilty then, which defeats [...] starting the thing all together [...] (Elizabeth, 2nd gen., woman)

Like the first generation Irish women, the majority of the second generation Irish women in the study who had a positive relationship with religion had not questioned their religion. Ysabel, however, only believed in half of the Church values. For instance, she believed there should be flexibility regarding the birth control pill. Yet, she was still in touch with her religion and went to church on a regular basis. While

both second generation Irish men were very much in touch with their religion and went to church on a regular basis, Tom had ceased going to Church for four years when he was eighteen, possibly questioning his religious upbringing.

Conclusion

The findings reveal that being a Roman Catholic may have both positive and negative effects on the health of the Irish people in the study. Irish people who had a positive relationship with religion said that it helped them cope with difficult life events, which almost certainly includes poverty and discrimination (thus mitigating some of the negative health effects of structural disadvantage), and provided them with moral support, inner peace and social support networks; some of them believed this had a positive impact on their health. This was especially pertinent to first generation Irish people, women in particular. For the latter, the Roman Catholic religion, which was well-established in Coventry as a result of Irish migration patterns, played the additional, very important, role of mitigating the negative health effects of migration-related factors by helping them counter social isolation and anti-Irish discrimination, reconnect with their culture and maintain a positive sense of Irish identity. Thus, several interactions are visible between structural and identity components of ethnicity, and among several aspects of ethnicity as identity.

The majority of first generation Irish people never questioned their religious beliefs, which may have been reinforced by structural factors in England such as migration (denoting another interaction between ethnicity as structure and identity). The minority of men who displayed agency and questioned it developed an ambivalent or negative relationship with religion.

The evidence shows that the Roman Catholic religion may have a negative impact on health by creating feelings of Catholic guilt and religious duty. This link was

articulated by some people in the study. While the first generation Irish people in the study who reported a positive relationship with religion reported not suffering from Catholic guilt, it is possible that they may have experienced such feelings on a subconscious level. Moreover, Maeve's concerns for her children not adhering to her religious beliefs precipitated her nervous breakdown.

Several second generation Irish people in the study, especially men, were no longer practicing their religion for the very reason that they resented the religious indoctrination and guilt they had to contend with growing up for many years, particularly since it had been imposed on them; these people stressed the negative impact religion had had on their life and/or on their health. Their religious choices growing up appeared to be heavily structured by going to Catholic schools and being embedded in a large Irish Roman Catholic community in Coventry. Only a minority of second generation Irish people in the study were able to display agency as children and make free religious choices. In addition, several second generation Irish people in the study were skeptical of the institution of the Church and its religious teachings, and some doubted God's existence.

Many second generation Irish people eventually rebelled against the Roman Catholic religion in their teens or later on in their lives, and chose to no longer practice their religion, thus displaying agency. Unlike their parents who grew up in Ireland in an environment where the Roman Catholic religion was widely accepted, this generation grew up in England where the Roman Catholic religion was contested; embeddedness in the Irish community could only partially shield them from the rest of society and increased exposure to this English environment as they became older may have led them to question their religion.

Yet, owing to the presence of a large Irish religious community in Coventry and to the many Catholic schools, previously linked to Irish migration patterns or structural factors, Irish migrant parents may have been successful in getting their children to internalize Catholic beliefs, denoting interactions between structural and identity components of ethnicity, i.e., migration and community networks, and two dimensions of ethnicity as identity, i.e., community embeddedness and religion. Consequently, second generation Irish people may have retained underlying religious beliefs and feelings of guilt, with negative health implications. Only a minority of second generation Irish people in the study, especially women, had a positive relationship with religion and derived various benefits from it.

Overall Summary

This chapter has explored the relative contribution of the identity dimension of Irish ethnicity, including Irish processes of identity formation or sense of belonging, beliefs, lifestyles, religious practices and support structures, to the health experiences and inequalities of a sample of first and second generation Irish people in England. It also addressed some other aspects of the second research question, specifically related to the interaction of ethnicity as structure with identity, including the ways in which the former shapes the latter and the latter exacerbates or mitigates the former, and to the interplay between structure and agency. The overall conclusions for this chapter and the previous two chapters are presented in chapter 8, which will conclude the thesis by bringing the main findings together and outlining some research limitations and policy implications.

Chapter 8: Summary and Conclusions

Introduction

Three years have passed since I first developed an interest in researching Irish health inequalities in England. I remember being taken aback by the statistics of Irish poor health and being eager to understand what underlay them. Despite consistent statistical evidence of Irish poor health in England, the reasons behind it, or underlying generative mechanisms, seemed to be only partly understood.

I therefore set out two main objectives for the research; to provide additional, recent, evidence on Irish health trends in England, and centrally, to explore the possible reasons for this health trend. Informed by a critical realist perspective and the model of ethnicity as structure and identity described by Nazroo and others, the research formulated the following two research questions,

1. What are the trends in socioeconomic status and ethnic health inequalities across the first two postwar generations of Irish people in England, in terms of the persistence of an Irish ‘health disadvantage’?
2. Using Coventry as a case study, to what extent are the health inequalities and experiences of the first two post-1945 generations of Irish men and women in England influenced by their structural position (ethnicity as structure), identity and cultural aspects of being Irish (ethnicity as identity), the interaction between these two dimensions, and agency?

To fulfill these research aims, the research used a mixed strategy design, which incorporates extensive and intensive approaches, compatible with a critical realist perspective.

The extensive research used data from the Census 2001 Individual Licensed SARs to provide answers to the first research question. Recognising the limited explanatory power of statistical analyses, the extensive research was eventually confined to providing further statistical evidence for the demi-regularity that Irish people have poorer health than British people in England and to drawing out contrasting demi-regularities in socio-demographic and economic status between the Irish and British populations to provide clues to generative mechanisms underlying the main health demi-regularity. Informed by the model of ethnicity as structure and identity, the extensive research used the Census 2001 more sensitive indicator of Irish ethnicity (which is seen to reflect both structural and identity aspects of ethnicity) to fulfill its objectives.

The intensive research formed the centerpiece of the research and provided answers to the second research question. It sought to deepen the understanding of Irish health inequalities in England and Coventry through employing a collaborative approach and applying the critical realist and socio-historical model of ethnicity as structure and identity (see conceptual framework, chapter 2) to thirty-two semi-structured “biographical” accounts of first and second generation Irish men and women in Coventry, analysed using a “framework” approach. Thus, the research aimed to link influences at the level of society to respondents’ appreciation of how they play out in their or other people’s daily lives and affect health, in order to explore the relative contribution of, and interaction between, influences arising from ethnicity as structure (e.g. socioeconomic position and discrimination) and from ethnicity as identity (e.g. sense of belonging, beliefs, and support structures), and associated mechanisms, to Irish health experiences and/or inequalities. The research was particularly concerned with exploring the extent to which the structural component of

ethnicity underpinned the identity/cultural component and the latter mitigated or exacerbated the effect of the former, but also appreciated the interactions between influences within each dimension of ethnicity. Moreover, it sought to investigate the interplay between structure and agency within Irish people's "lived" structural and identity/cultural experiences. Finally, the research attached particular importance to investigating the relevance of the socio-historical context to Irish life and health experiences.

These goals were achieved through exploring interviewees' structural and identity/cultural experiences, actions, beliefs, perceptions, discursive knowledge of pathways linking British colonialism and a world capitalist economy to Irish life and health experiences, and of factors affecting health. Nevertheless, in keeping with a critical realist perspective, the research recognized the limitations of qualitative accounts for uncovering the "real", owing to three domains of reality (see p. 70), and the different and socially mediated meanings individuals attach to their life and health experiences, including to "good" and "poor" health (Pilgrim & Bentall, 1999), and thus the need to go beyond people's accounts, and draw on the literature and existing theories.

The collaborative community-based participatory approach provided access to Irish "insider cultural knowledge" and to sometimes "hard to reach" Irish respondents for in-depth interviews (see footnote on p. 89). Through allowing an "insider" perspective of the Irish through the knowledge of community representatives, and supporting the agency of the Irish community by integrating knowledge generation with community and social change efforts that address the concerns of the community, this approach is consistent with a critical realist standpoint.

Now that three years have passed, I like to think that Irish health inequalities in England have gained more prominence and a greater number of academics as well as policy makers have become aware of this issue. I, certainly, have achieved a greater understanding of the Irish community in England and of their health needs, although more research is still needed.

The chapter summarizes the main extensive and intensive research findings, and reiterates some of the research limitations.

Extensive study

The extensive study supplements the existing literature on Irish health inequalities and shows, in accordance with most studies, that the Irish people living in England continue to face, up to recent times, substantial health inequalities when compared to their British counterparts. In other words, it provides support for the demi-regularity that the Irish people in England have poorer health than the general British population.

Findings emerging from the Census 2001 SARs demonstrate the persistence of an ethnic health disadvantage for the first and second generation Irish people living in England with respect to two health indicators, self-reported general health and limiting long-term illness. The self-reported “white Irish” in the SARs were shown to have poorer health on both health indicators, after controlling for key demographic and socio-economic factors. Given that a self-reported ethnicity indicator was used, but that it can only partially be presumed to reflect respondents’ self-identification with Irish culture and community since people may take ethnicity to mean nationality or country of birth (Walter, 2002, as cited in FIS, 2007a), this finding may reflect the effect of both identity and structural dimensions of Irish ethnicity on health.

The study further uncovered significant health, age and socio-economic differences by country of birth. The descriptive statistics show an increased risk of poor self-reported general health and limiting long-term illness for first generation Irish people in England from both the Republic of Ireland and Northern Ireland. They also suggest that while the health disadvantage of the first generation Irish Republic could possibly be connected to their older age profile and socio-economic disadvantage, particularly with regards to social class and educational qualifications, this does not appear to be the case for the first generation Northern Irish, who display a favorable socio-economic profile on these indicators. The logistic regressions analyses complement the descriptive statistics and show that while the increased risk of reporting poor health for the first generation Irish from the Republic of Ireland was generally diminished when age, sex and socio-economic factors were taken into account, this was not so for the first generation Irish from Northern Ireland whose increased risk of reporting poor health generally remained high even after controlling for the demographic and socioeconomic factors.

With respect to second generation Irish people, the descriptive statistics show that they have a health profile which is quite similar to that of the white British but have a much lower proportion of elderly people; this would be expected to lead to better health, considering that their socio-economic profile is better in some respects to that of the white British population. The logistic regression analyses once again complement the descriptive statistics and show an increased risk of poor health for the second generation Irish, but only after age, sex and socio-economic status are taken into account.

Moreover, the Northern-Irish born who see themselves as Irish were found to have poorer self-reported general health than those who see themselves as British, after

controlling for demographic and socioeconomic factors. This may indicate an identity effect whereby the former group may suffer from the inability to build an “authentic” sense of self (see p. 140).

The research began by drawing positivist-influenced conclusions from the regression analyses but then reinterpreted these in accordance with a critical realist perspective, emphasizing the “circumstantial” rather than “decisive” or “explanatory” nature of the evidence. Thus, from a critical realist perspective, these regression analyses, combined with the descriptive statistics, do not provide explanations for Irish health inequalities but rather clues to generative mechanisms of Irish health inequalities in England and suggest that the search for generative mechanisms should examine factors such as country of birth, age, socioeconomic position and ethnic identity. Thus, the extensive component provides answers to the first research question and clues to answering the second research question.

The limitations of the extensive study were previously discussed in chapters 3 and 4 so only some significant issues are reiterated here. From a critical realist perspective, these included the use of the imperfect Census 2001 SARs self-reported indicator for ethnicity, which leads to an under-representation of Northern Irish and second generation Irish populations; the inability to investigate the existence of an Irish ethnic identity effect on the health measures for the second generation Irish since the Census 2001 SARs do not provide information on Irish parentage; and the use of self-reported or subjective measures of health which may not be as robust as the use of objective health outcomes but may nevertheless constitute more sensitive indicators of Irish health issues.

Intensive Study

The intensive research provides empirical support for the theoretical model presented in the literature review, illustrated below in its finalised form in figures 8.1 and 8.2.

First, the intensive research concurs with the extensive one and reveals that both structural, and identity/cultural, influences contribute to the health experiences and inequalities of first and second generation Irish people in England. Moreover, the research shows that these influences contribute in both positive and negative ways, acting as modes of oppression and modes of being, and thus highlights the importance of considering positive cultural and structural factors in addition to negative ones. The above findings are illustrated in figures 8.1 and 8.2 which display the direction and strength of the different structural and identity influences on health, which emerged from the intensive research for first and second generation Irish people respectively, together with important gender differences (See legend for details of codes.). For instance, first generation Irish men were generally found, because of the itinerant nature of their first jobs in England, to be more likely than the women to have had difficult migration experiences, i.e., to have come across anti-Irish signs on lodgings and to find securing accommodation difficult.

Support for the influence on health of the structural and identity components of Irish ethnicity is provided through exposing people's discursive knowledge of influences of health (see figures 8.3 and 8.4) and through drawing on the existing health literature to reveal health pathways.

Secondly, the intensive analysis shows that structural and identity/cultural dimensions interact in complex ways, with structural influences underlying several identity/cultural influences, and the latter exacerbating and crucially mitigating the

negative impact of several structural influences on health (mitigating effects are displayed in figures 8.1 and 8.2 by an asterisk*). The findings thus stress the need not to view cultural identity as independent or monolithic but linked to structure, and to consider the social structure as a powerful force in shaping Irish health inequalities while recognizing the resiliency of the Irish community and its capacity to draw on cultural resources at its disposal to cope with adversity.

Thirdly, the research provides some support for the contention that British colonialism and a world capitalist economy are important root causes, or generative mechanisms, of Irish health inequalities through revealing people's discursive knowledge of pathways linking British colonialism and a world political economy to life and health experiences.

Finally, structure and agency are found to act as complementary and interweaving forces in shaping influences or generative mechanisms operating within each dimension of ethnicity.

The intensive findings also stress the significance of people's perceptions or socially constructed meanings of phenomena, since these were found to possibly influence the impact of generative mechanisms on health, without denying the reality of "material" effects.

The following sections examine the above points in more detail and provide illustrative examples. First, certain methodological limitations of the intensive study should be born in mind. These were discussed in chapter 4 and include selection biases of the Coventry interviewee population, in particular regarding ethnic identification, country of birth and religion, possibly resulting from specific recruitment strategies, including the key role of the CIS gatekeeper; having several relatively inexperienced steering group members conducting interviews, which may

have affected the validity and reliability of the accounts; the ethnic matching of Irish steering group interviewers and participants, while beneficial overall, may have also had unintended effects on the quality of the accounts; and the possible account bias introduced by my own personal characteristics. The collaborative community-based approach contributed to some of these limitations, but also significantly enhanced the overall quality of the research, as previously described.

The exclusion of some themes from the analysis (e.g. childhood abuse, spousal/parental divorce and loss, and family health history), which were deemed to be less directly relevant to the study's theoretical concept and/or to specific issues for Irish people (see p. 115), can be viewed as a significant limitation in that these biographical elements are important determinants of individual health, as demonstrated by Brown and Harris (1978) in their study on the social origins of depression. The model presented in the research is therefore open to criticism on the grounds that it is overly structurally deterministic and fails to take into account all the complexities of the individual's immediate social milieu or biographical elements of people's lives, which could help to explain individual variability in health within the sample. Nevertheless, the research does incorporate several elements which would constitute important "provoking agents" or "vulnerability factors" for depression (Brown and Harris, 1978) such as forced migration, unemployment, material deprivation, and absence of a supportive confiding relationship.

Future research could improve the model set out by the research by drawing on Brown and Harris' 1978 model of depression and paying greater attention to the individual factors which were omitted in the research and linking them with societal and structural factors. In this way, sociological theoretical perspectives (focusing on structurally-induced social stress) can be unified with more typically clinical

psychiatric perspectives (focusing on individual vulnerability resulting from earlier experiences) to better account for health inequalities.

Finally, although first generation Irish people have tended to be concentrated in disadvantaged Coventry neighborhoods, with negative health implications, the research was unable to formally investigate these ecological effects due to practical limitations.

The Relevance of the Socio-Political Context

The research previously set out the complex chain of events linking British colonialism and a world capitalist economy to Irish poor health in England⁶¹. In brief, British colonialism led to the poor economic status and peripheral position of the Irish state in the world economy. Poverty and high rates of unemployment in Ireland pushed many Irish people to migrate while the geographical proximity, free entry, booming economy and abundant work opportunities in the UK pulled them to come to England. However, possessing skills not transferable in urban settings, and little education, and coming to the land of their colonialist, they had difficult migration experiences, experienced discrimination (later exacerbated by the “Troubles” and IRA events), faced identity issues, and secured mostly unskilled and badly paid jobs, hence, their poor socioeconomic position in England, and poor health. This, in turn, affected the life and identity experiences of their children.

Some evidence that British colonialism and a world capitalist economy are important root causes or generative mechanisms of Irish health inequalities in England via their impact on both structural and identity dimensions of Irish ethnicity, including migration, discrimination, socioeconomic position and identity experiences, was found within the accounts of respondents who recognized or articulated several of

⁶¹ This discussion is limited to the post-feudal era (see commentary p. 47).

the above pathways. For instance, several respondents articulated links between the IRA events and anti-Irish discrimination in England, and between the migration patterns created by the nature of the world capitalist economy (with poverty in Ireland and a booming economy in England creating respectively a push and a pull to migrate) and the concentration of Irish people in English towns which offered employment (e.g. Coventry). Furthermore, some respondents linked these migration patterns to the recreation of community support structures (presence of Irish social contacts in Coventry upon arrival), which may have a protective effect on health (see p. 280).

However, consistent with a critical realist perspective which recognises people's limited awareness of generative mechanisms, other important pathways were not articulated, including the important initial pathway between British colonialism and poverty in Ireland.

Contribution of Structural and Identity Components of Ethnicity

Evidence that influences originating from both structural and identity-related aspects of ethnicity contribute to the health inequalities and experiences of the first and second generation Irish population in England was provided in the intensive chapters (see figures 8.1 and 8.2).

Figure 8. 1: Contribution of Structural and Identity-Related Dimensions of Ethnicity to Health Inequalities and/or Experiences of First Generation Irish Men and Women: Evidence from Intensive Research

Figure 8. 2: Contribution of Structural and Identity-Related Dimensions of Ethnicity to Health Inequalities and/or Experiences of Second Generation Irish Men and Women: Evidence from Intensive Research

Figure 8. 1: Contribution of Structural and Identity-Related Dimensions of Ethnicity to Health Inequalities and/or Experiences of First Generation Irish Men and Women: Evidence from Intensive Research

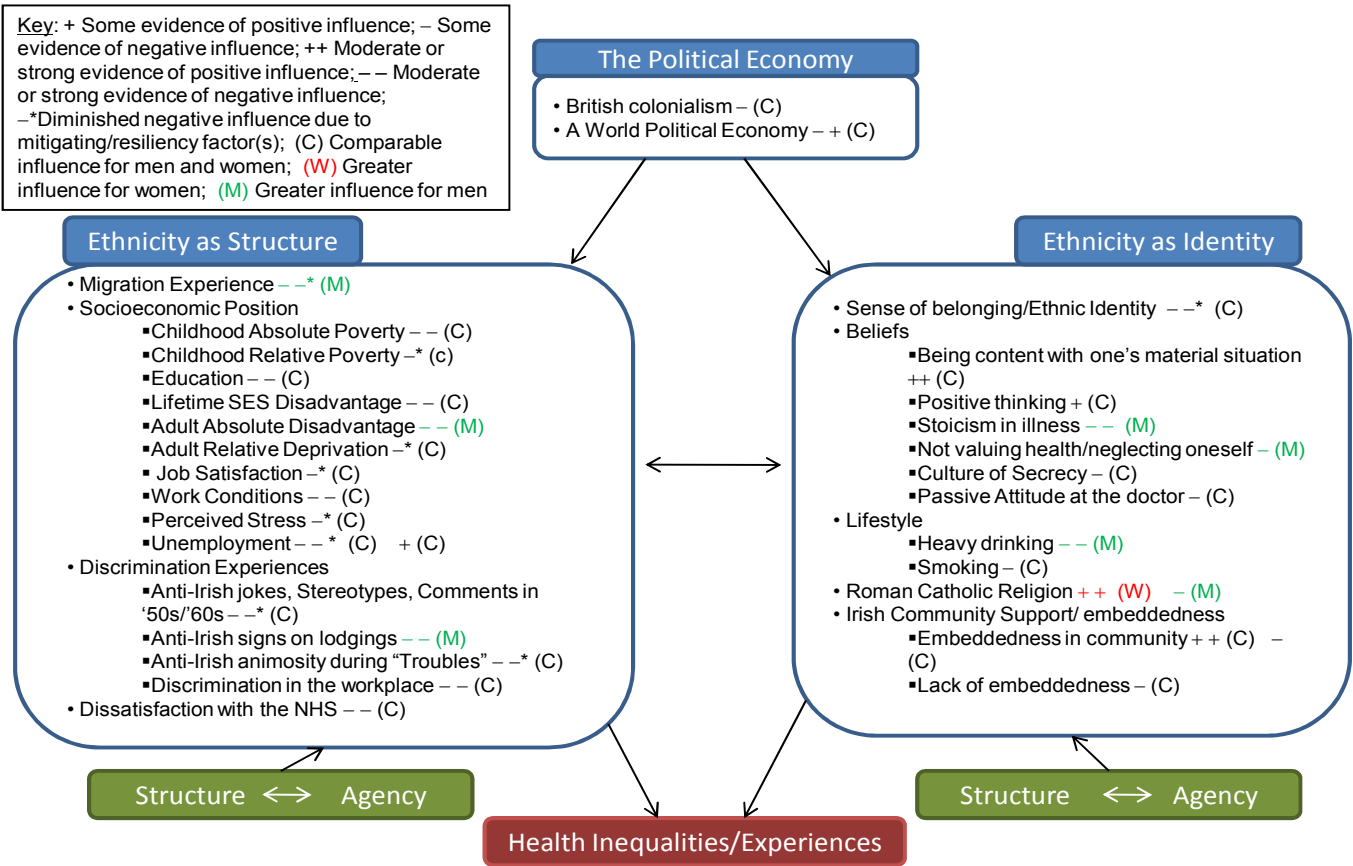
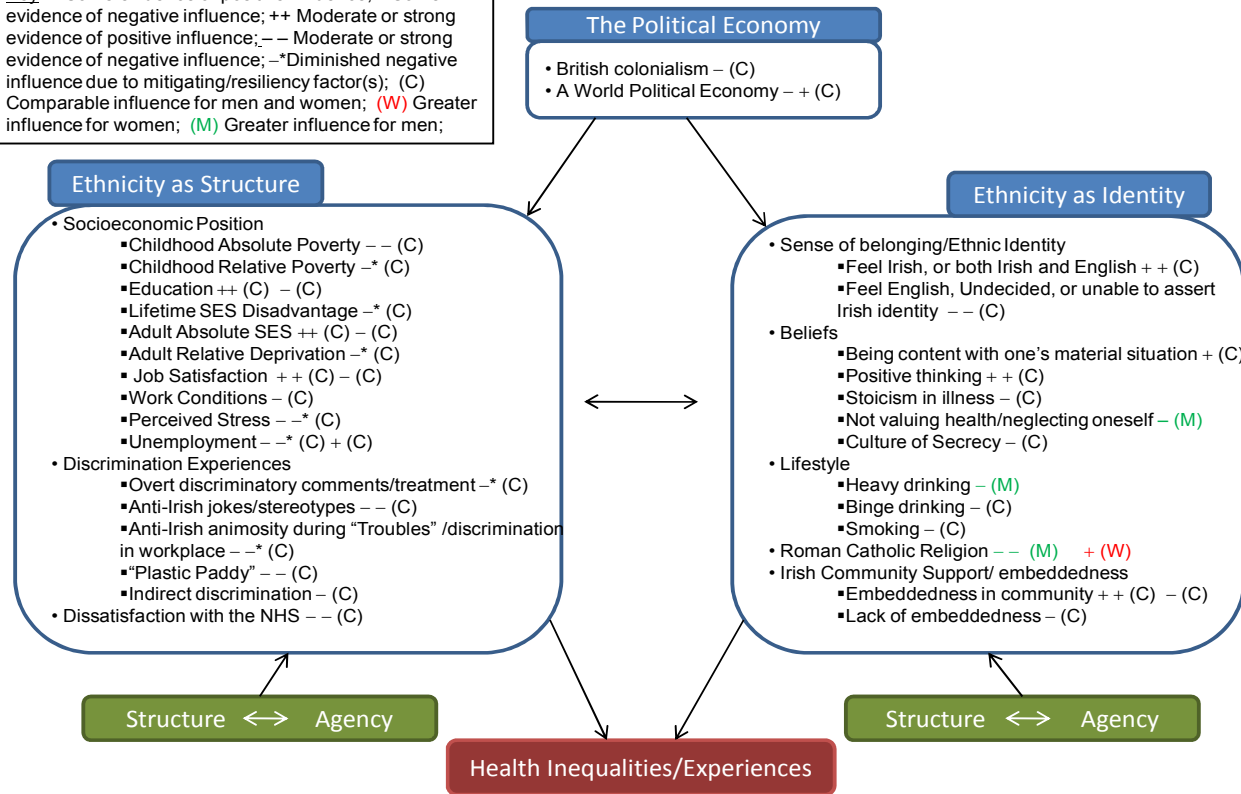


Figure 8. 2: Contribution of Structural and Identity-Related Dimensions of Ethnicity to Health Inequalities and/or Experiences of Second Generation Irish Men and Women: Evidence from Intensive Research

Key: + Some evidence of positive influence; – Some evidence of negative influence; ++ Moderate or strong evidence of positive influence; -- Moderate or strong evidence of negative influence; -* Diminished negative influence due to mitigating/resiliency factor(s); (C) Comparable influence for men and women; (W) Greater influence for women; (M) Greater influence for men;



The majority of the findings presented in figures 8.1 and 8.2 concur with the existing literature on the causes of Irish health inequalities in Britain, including studies which have documented:

1) the difficult **pre-migration, migration and post-migration experiences** of the first generation Irish, especially men, and have linked some of these experiences to poor mental health and heavy drinking habits (Leavey et al., 2004; Leavey et al., 2007; Ryan et al., 2006; Scanlon et al., 2006; Tilki, 1994; Tilki, 2006);

2) the disadvantageous **socioeconomic position**, including low levels of education, poverty, and poor working conditions, of the Republic-Irish born, in particular that of the bulge of the 1950s migrant population in England (e.g., Aspinall, 2001, as cited in Tilki, 2006; FIS, 2007a; Hickman & Walter, 1997; Owen, 1995; Tilki, 1994); and the educational and social mobility of the second generation Irish, who have a higher proportion of people in professional and managerial occupations and with higher levels of education (FIS, 2007a; Heath & McMahon, 2005; Hickman et al., 2001); studies have shown socioeconomic position to significantly contribute to the poor health of the first generation Irish from the Republic (e.g. Harding & Balarajan, 2001; Raftery et al., 1990);

3) experiences of interpersonal and institutional **discrimination** for the first generation Irish in the 1950s' and '60s (Hickman & Walter, 1997), and in the 1970s during the Troubles (Hickman & Walter, 1997; Hillyard, 1993, as cited in Hickman & Walter, 1997) and the use of the discriminatory term "plastic paddy" by the Irish born to describe the second generation Irish (Hickman et al., 2005); others have claimed the persistence of more covert forms of anti-Irish discrimination in England (Walter, 1999), including anti-Irish stereotypes and jokes (Hickman, 1995); the negative

impact of interpersonal and institutional discrimination on health via direct and indirect pathways has also been well documented (see chapter 2);

4) the complexity and difficulty of forming a coherent and positive sense of **ethnic identity** for the first generation Irish in England owing to an ex-colonial relationship (Kelleher & Hillier, 1996; Leavey, 1999; Leavey et al., 2007; Greenslade, 1992) and of forming or asserting it for many second generation Irish, because of the position they occupy in England (Hickman, 1995; Ullah, 1985; Hickman et al., 2005) and the different forms of discrimination they experience (see above). Also, in accordance with the above studies, other second generation Irish appeared successful in forming and/or asserting a positive sense of ethnic identity. Some of these studies suggest a link between these identity experiences and mental health, which has been demonstrated in both a positive and negative sense for other minority groups (see chapter 2).

5) high rates of **heavy drinking** for first and/or second generation Irish people in England, especially men (e.g., Becker et al., 2006; Greenslade et al., 1995; Harrison & Carr-Hill, 1992; Harrison et al., 1993; Tilki, 2006) and high rates of **smoking** for the Irish in Britain (e.g. Abbotts et al., 2004b; Wardle, 2006).

6) dissatisfaction with the **NHS**, including long waiting times to see a GP and rushed appointments (Scanlon et al., 2006).

Other findings in this thesis either differ from the existing literature, or supplement it by providing important insights on possible generative mechanisms.

Firstly, the current research explored some hereto little studied aspects of the **socioeconomic** position of first and second generation Irish people, including experiences of absolute and relative childhood poverty in Ireland and England respectively, work-related stress and job satisfaction in England. Indeed, this thesis

found “absolute” childhood poverty or childhood material deprivation to constitute an important negative influence on the health of both generations, although it materialized itself differently in two very different social contexts (see p. 169), while “relative poverty” or the effects of perceiving oneself to be worse off than others (Wilkinson, 1996) appeared to be less of an issue, owing to both generations growing up embedded in a relatively disadvantaged Irish community (see below).

The research also found high levels of work-related stress and high levels of job satisfaction to constitute important negative and positive influences respectively on the health of second generation Irish people; however, levels of job satisfaction for the first generation working in routine occupations were higher than expected, mostly due to supportive work environments, to some men perceiving the pay to be good, and some women perceiving the work tasks to be easy and enjoyable, with positive health implications (Wilkinson & Marmot, 2003).

Secondly, the research found substantial evidence that second generation Irish people experience a more covert form of interpersonal **discrimination** in England, which includes the widespread use of anti-Irish jokes and the use of the term “plastic paddy”. Although some first, and many second, generation Irish people reported not perceiving the Irish jokes to be discriminatory, since they were said in “good humour”, it is likely that viewing the jokes in this way was a coping strategy (see p. 196, p. 210). While it may mitigate the negative health impact of anti-Irish discrimination, it cannot wholly counteract its effects, which operate through an embodiment of risk (Krieger, 2000), through affecting ethnic identity and sense of self (Jenkins, 1994) (see p. 209), evidence of which was presented, and causing people to feel ostracized (Wilkinson, 1996). Thus, discrimination may constitute an important

negative influence on the health of second generation Irish people, a phenomenon which has been relatively under-researched.

Thirdly, some disparities from the literature were observed on the **ethnic identity** experiences of second generation Irish people in England. In contrast to Hickman et al. (2005), asserting a hybrid, Irish and English, identity, when placed between two hegemonic domains, England denying the difference of Irishness and Ireland denying of commonalities with people of Irish descent, was not a prevailing issue among this sample of respondents; more prevalent was the difficulty to assert a one and only Irish identity when placed in the above position. In addition, the second generation Irish respondents who asserted an English identity did not appear to do so to avoid the implications of being a member of a devalued group, as suggested by Tajfel and Turner (1979, as cited in Ullah, 1985) but rather in response to being denigrated an Irish identity by the Irish-born, or being unable to presently be part of the Irish community (e.g. living in London) (see p. 224).

Fourthly, few studies have researched the **beliefs** of first and second generation Irish people in England. Sproston & Bhui (2002) found the use of positive thinking to be a common coping strategy adopted by ethnic minority groups in England, including the Irish, but did not examine generational differences. The use of positive thinking as a coping strategy (see below) was found in the current study to be predominant for second generation Irish people. A novel finding in the current study was that the attitude of being content with one's financial situation was relatively common among the first generation and some second generation Irish people, and was an important mitigating mechanism (see below).

The current study found evidence of beliefs of stoicism in illness among the older Irish men in particular, consistent with some prior studies (see Kelleher & Hillier,

1996) but not with others (Abbotts et al., 1999a)⁶², of a need on the part of Irish families to keep illnesses “secret” and passive attitude at the doctor’s whereby Irish men and women are too accepting of the doctor’s diagnosis in common with Scanlon et al. (2006). Through causing Irish people to not complain about their health and go to doctor, and to not challenge the doctor’s diagnosis, or ask questions, these beliefs and attitudes could lead to untreated illnesses or to a refusal to take the prescribed treatment at home, with negative health implications. This belief component of ethnicity as identity could combine with the structural component of high levels of dissatisfaction with the NHS to contribute to an overall reluctance on the part of several Irish people to seek medical care, and consequently help contribute to Irish health inequalities.

Fifthly, the Roman Catholic **religion** was found to be an important and positive influence on the life and health of many first generation Irish people in the study, especially women, through providing a supportive religious community with a common world view, a feeling of inner strength/peace, and a sense of meaning and hope (these pathways were articulated by some people in the study), which is consistent with the general literature on this topic (e.g. Koenig, 1992; Powell et al., 2003). To my knowledge, only one previous published study has found a link between active religious allegiance and better mental, social and physical, health for Irish Catholic migrants, through its function as a stabilizing factor (Hannay, 1980). However, some first generation Irish men in the current study revealed feelings of Catholic guilt, which negatively impacted their health; one man described religion as a worrier because it induced feelings of fear in punishment (e.g. hell) for wrongdoing and for not going to confession. While none of the first generation Irish women

⁶² Abbotts et al. (1999a) conducted their study in the West of Scotland and used Catholic background as a proxy for Irish descent.

reported suffering from Catholic guilt, there is some evidence that they may have had such feelings (cf. Scheper-Hughes, 2001) but dismissed them, refusing to question their religion.

Similarly, religion was found to be a strong and negative influence on the life and health of many second generation Irish people, especially men, who resented the religious indoctrination and guilt they grew up with, a finding which has not previously been reported, to my knowledge. According to a second generation Irish male respondent, religion or Catholic guilt affected health through generating feelings of failure, owing to the inability of always doing the right thing, and thus impacting one's self-esteem.

Finally, Irish **community support** or **embeddedness** in the Irish community in Coventry was shown to have a strong and positive influence on the life and health of many first and second generation Irish people in the study, through the social support provided by a relatively culturally homogeneous, understanding and reliable group of people. This finding has previously only been reported for Irish migrants (Malone, 2001; Leavey et al., 2007).

Other ethnic minority studies have noted the negative impact on health of having a “strong” ethnic identity but not being surrounded by many people from the same ethnic background (Halpern & Nazroo, 2000; Neeleman & Wessely, 1999); evidence for the above is given in the current study for first and second generation Irish people in Coventry, women in particular. For instance, one woman linked her postnatal depression to a lack of Irish community support. In contrast, another first generation Irish woman, who also had a “strong” Irish identity, dealt with her lack of Irish community support, the recent death of her husband, and her lack of integration in British society, by rationalizing her situation and reporting being content with having

minimal social support. This coping strategy may mitigate the negative impact on health of lack of Irish community support, although its effects remain real.

Discursive Knowledge of Influences on Health

The people in the study ascribed their health experiences, or that of others, to a range of influences, linked to both structural and identity dimensions of ethnicity. This is illustrated in figures 8.3 and 8.4, for First and Second Generation Irish people respectively. Some individuals talked of “good” and “poor” health in very general terms, others mentioned specific physical illnesses or used the terms “depressed”, “happy”, “stressed”, “self-esteem” or “worry”. Owing to the socially and conceptually mediated nature of meanings, it is important to recognise that the people in the study may assign different meanings to the above concepts (Pilgrim & Bentall, 1999), while there may also be some degree of overlap. While respondents perceived some of the generative mechanisms of Irish health inequalities or articulated some of the pathways linking life influences to health, a fuller understanding of these generative mechanisms had to be derived from the literature since respondents’ articulation of these pathways was limited. This is to be expected since generative mechanisms do not belong to the empirical or experienced domain of reality but instead to the non observable domain of the real.

Figure 8. 3: Discursive Knowledge of Influences on Health (First generation Irish)

Figure 8. 4: Discursive Knowledge of Influences on Health (Second generation Irish)

Figure 8.3: Discursive Knowledge of Influences on Health (First Generation Irish)

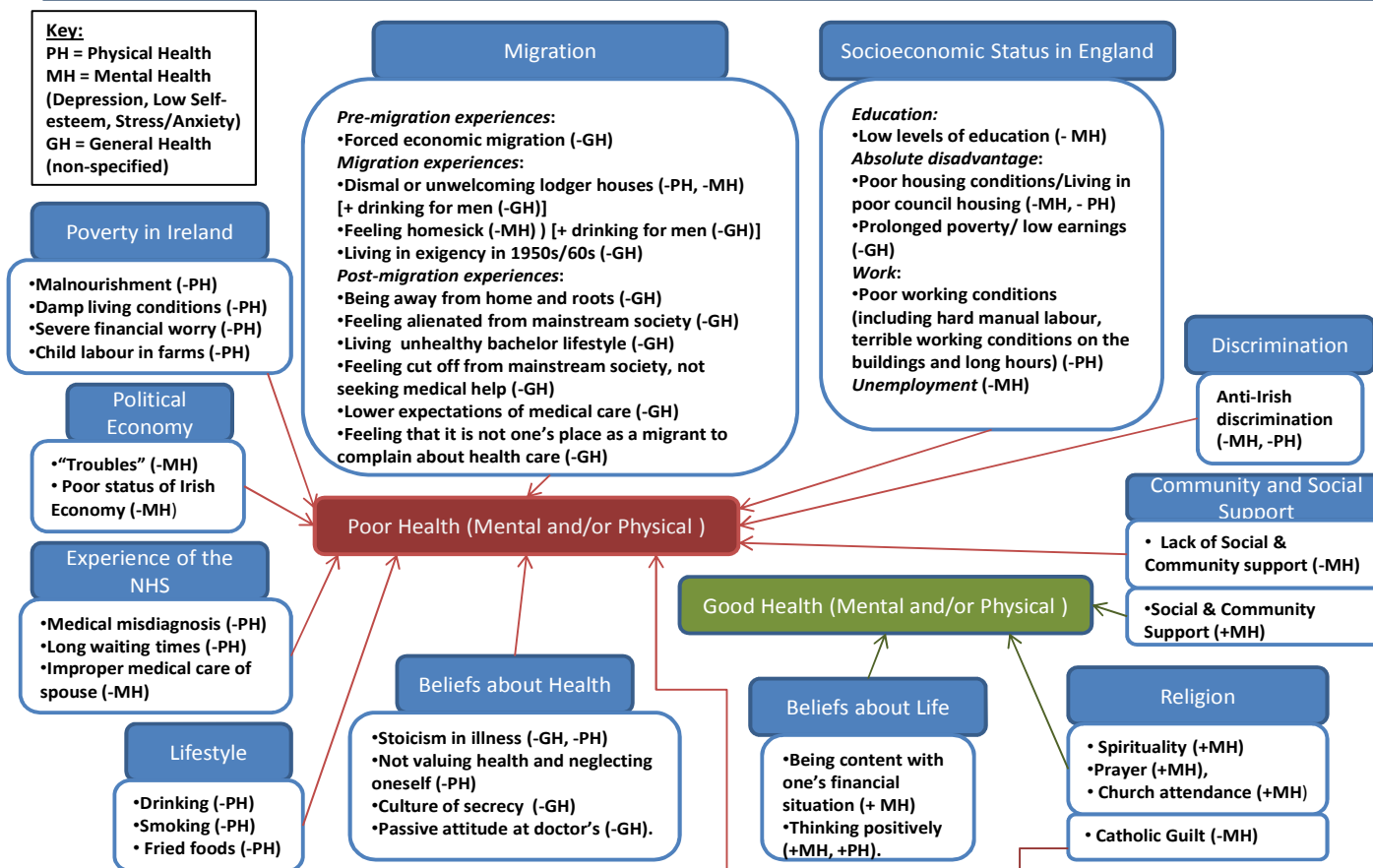
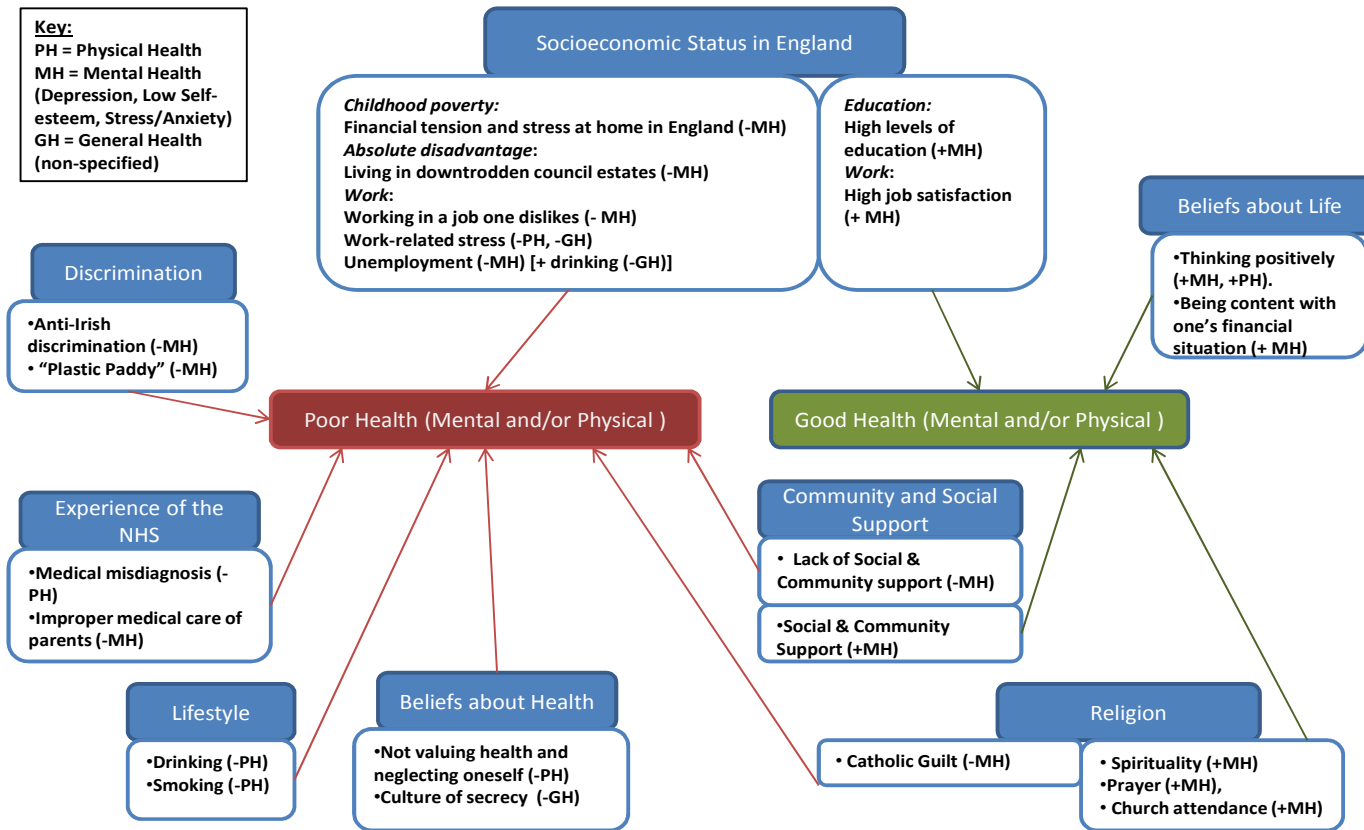


Figure 8.4: Discursive Knowledge of Influences on Health (Second Generation Irish)



Evidence of Interactions between Structural and Identity Components of Ethnicity, and of Resiliency of the Irish Community

There was frequent evidence in interviewees' accounts of interactions between structural and identity components of ethnicity, and also of interactions within each component. Structural dimensions of ethnicity were found to underlie or shape several identity/cultural dimensions of ethnicity, while the latter were found to exacerbate or mitigate some of the negative health effects of structural dimensions. The reader is directed to the conclusions of the previous two chapters for numerous demonstrations of these interactions. I will focus here on the type of interaction whereby a mechanism interacts with another mechanism to mitigate its negative impact on health (noted in figures 1 and 2 by the use of a * symbol). Such interactions are of particular interest to this study because they demonstrate the resiliency of the Irish community in England, that is, its ability to cope with adversity by actively drawing on resources at its disposal. Three mitigating mechanisms, which belong to the identity component of ethnicity, emerge from the intensive research: community support/ embeddedness, religion and "Irish" beliefs.

Community support/embeddedness, which relates to the identity component of ethnicity, or social support more generally, constitutes a particularly important mitigating mechanism in that it was found to potentially counteract some of the negative influence on health of several dimensions of the structural component of ethnicity (migration, socioeconomic position, and discrimination) and two dimensions of the identity component of ethnicity (ethnic identity/sense of belonging and religion).

With respect to migration, Irish community support structures in Coventry provided Irish migrants with social contacts and hence a place to stay when they first

came to Coventry, thus partially countering social isolation and the effects of anti-Irish discrimination (e.g. difficulty finding accommodation). The community offered meeting places in the form of Catholic Churches and Irish pubs and clubs, although the reliance on pub life also contributed to heavy drinking patterns (Leavey et al., 2004). To this day, Irish community support was found to continue to constitute an important source of social support for many Irish migrant men and women in the study, through helping them feel more at home (see second quote from Paul, p. 244), with positive health implications.

With regard to socioeconomic position, there was some evidence in interviewees' accounts that growing up embedded within a financially deprived Irish community, in Ireland and in England, may have alleviated the negative health impact of perceptions of relative deprivation. Moreover, in support for Modood's argument that ethnicity may work as "cultural-social" or "ethnic" capital (2004, p. 101), there was some evidence of migrant parents getting their children to internalize high educational ambitions, with the support of relatives and community members. In this sense, Irish social support may improve the lifetime socioeconomic position of this generation by counteracting some of the negative effects of a disadvantageous background on educational choices, with positive health implications.

Social support in the workplace made working fairly enjoyable for some first generation Irish people interviewed and thus partially counteracted the negative impact on health of monotonous manual jobs. This is consistent with studies which have documented the positive impact on health of a supportive work atmosphere (Wilkinson & Marmot, 2003). Finally, social support helped some first and second generation Irish people cope with work-related stress and unemployment, through the practical and emotional assistance it provided.

Concerning discrimination, embeddedness in the Irish community in Coventry shielded some first and second generation Irish people from a number of experiences of anti-Irish discrimination, in particular during the “Troubles” in the 1970s, with a potentially protective effect on health. This is consistent with Halpern’s (1993) study which found ethnic group clustering to have a protective effect on health through reduced exposure to prejudice.

As regards ethnic identity/sense of belonging, embeddedness in the Irish community in Coventry may help the first generation Irish maintain a more positive sense of Irish identity, which may be protective of health, by minimizing their contact with the British community and anti-Irish discrimination. This is consistent with Leavey et al. (2007) who found a low rate of mental illness among a sample of Irish migrants who were strongly embedded in London’s Irish community and had maintained a positive Irish identity.

Second generation Irish people could also develop a more positive sense of Irish identity from being embedded in the Irish community, through being exposed to positive elements of the Irish culture and shielded from the negative stereotypes.

The presence of a concentration of many Irish migrants in Coventry enabled the establishment of Roman Catholic churches and Catholic schools, which led to a reinforcement of the significant religious component of Irish identity for both generations.

This brings us to the second important mitigating mechanism, **religion**. The Roman Catholic religion was found to potentially counteract some of the negative influence on health of several dimensions of the structural component of ethnicity, namely migration, socioeconomic position and discrimination. For the first generation, religion may act as a stabilizing factor (cf. Hannay, 1980) and protect the

women in particular from migration and post-migration related factors such as social isolation, and feelings of estrangement, and help reinforce of a positive sense of Irish identity, through the collective support gained from religious membership. Religious faith was also found to help many first generation, and some second generation, Irish people cope with difficult life events, including poverty and discrimination.

In addition, two **beliefs**, which are connected with the identity component of ethnicity, were found to be important mitigating mechanisms. Firstly, the belief that it is important to adopt a positive outlook on life, found especially among the second generation, was shown to mitigate the negative effects of socioeconomic disadvantage and other adversity on health for several Irish people, through helping them cope with difficult life events such as unemployment. Secondly, the belief or attitude, found especially among the first generation, of being content with one's financial situation and only needing the basic financial necessities to be happy may help some Irish people cope with the financial harshness of everyday life and their inability to secure more goods (see p. 181), and protect their health through mitigating the negative health impact of adult relative deprivation, a pathway articulated by a female respondent (p. 184). It is also important to recognize that the "material" effects of social disadvantage on health are real from a critical realist viewpoint.

Evidence of Interplay between Structure and Agency within Structural and Identity Components of Ethnicity

There was also frequent evidence in the accounts of interplay between structure and agency, within both structural and identity components of ethnicity. In other words, structure and agency were found to operate as qualitatively different and complementary forces; while the social structure was found to influence the behaviour of Irish people and condition the choices they made, Irish people were also found to

be capable of changing the social structures they live in and to make relatively “free” choices.

For instance, the educational choices of the second generation Irish people interviewed were found to be the result of both structure and agency. Indeed, despite coming from disadvantaged class backgrounds, a relatively high proportion of second generation Irish men and women held higher education degrees. This agency may have been facilitated by the “ethnic capital” conferred by some Irish families (see p. 174). In addition, some of the second generation Irish people who dropped out of the educational system right after secondary school, influenced by their disadvantageous class backgrounds and the low career aspirations of their community of peers, resumed their schooling years later, showing considerable personal agency.

Similarly, although widespread anti-Irish discrimination and animosity, especially during the “troubles” in the 1970s, pressured Irish people to keep a low profile in England, some found the courage to speak up against discriminatory acts or comments, thus displaying agency and assisting in changing the status quo.

Conversely, although identity aspects of ethnicity such as processes of identity formation and lifestyle tend to be equated with agency, there was evidence in the accounts that they are conditioned by the social structure. Indeed, ethnic identity was found to be not entirely self-constructed but heavily influenced by the wider society – “shaped partly by its original heritage and partly by racism and the political and economic relations between groups in Britain” (Modood et al., 1997, p. 9). Specifically, structural factors such as British colonialism (by making the first generation Irish in Britain feel inferior) and discrimination (by denying the second generation Irish a sense of belonging within the English and/or Irish communities) were found to play quite an important and negative role in shaping processes of

identity formation. However, many continued to derive pride in being Irish, particularly when embedded in the Irish community (see above), showing enduring capacity for agency.

Similarly, while lifestyle choices are often connected to individual agency and to culture, by both the general public and several people in the study whose views may have been influenced by prevailing stereotypes of the Irish drinker, the current study shows that many of the lifestyle choices made by the people in the study were influenced by the social structure (cf. Karlsen & Nazroo, 2002a). For example, the high rates of heavy drinking among the first generation, especially men, were found to be largely a product of structural vulnerability factors related to migration and work. These were combined with Irish cultural attitudes towards alcohol, including a tolerance of heavy drinking in pubs which may have developed as a way for men to cope with the structural difficulties associated with poverty in Ireland and assert their masculinity (Tilki, 2003, as cited in Tilki, 2006). Still, a minority of first generation Irish men in the study never drank heavily, thus displaying agency in relation to both structural and cultural factors.

Finally, religious membership was found to be the outcome of both agency and structure⁶³ since the decision to belong to a religion is made within the social constraints imposed on members of ethnic minority groups by their community. By virtue of growing up in the Republic of Ireland, the first generation Irish people in the study were automatically raised as Roman Catholics and received a strong religious indoctrination at home, at Church, and at Catholic schools. This led many to have deep-seated religious beliefs and to never question their religion. However, a minority of first generation Irish people in the study appeared successful in making their own

⁶³ The reader is reminded that the word “structure” in this context is understood to mean “the features of society which constitute a context for constraint or enablement” (Ratcliffe, 2004, p.7).

religious choices, displaying agency. As a result of growing up in England, many second generation Irish people came to question the Roman Catholic religion, but still possessed deep-seated religious beliefs as a result of the strong “religious indoctrination” they received at the Catholic schools they attended and at home; this conflict led to feelings of “Catholic guilt”, with negative health implications (see p. 280).

Although beliefs are often connected to individual agency and to culture, the current study shows that many of the beliefs about medical care expressed by people in the study, the socially constructed nature of which needs to be recognized, tended to have roots in the social structure. For instance, based on evidence provided by the people interviewed for this study (combined with the findings of Scanlon et al., 2006), stoicism in illness was found to be shaped at least partly by childhood poverty in Ireland, where people delayed seeking medical care because of the financial implications (see p. 234 for further discussion). Similarly, being too accepting of the doctor’s diagnosis was found to either be an Irish trait, with deep structural origins, and/or a consequence of being a migrant or “second class citizen” whereby one feels he/she should not make too many demands on the state (cf. Pender & Lavery, 1997; Kelleher & Hillier, 1996).

Some study findings highlight the importance of not dichotomizing structural components of ethnicity as “modes of oppression”, or as sources of strain and alienation, and identity components of ethnicity as “modes of being”, or as sources of fulfillment and meaning. For example, second generation Irish people worked in professional jobs from which they often derived high levels of job satisfaction.

Conversely, for many second generation Irish people, religion was felt to be something that was imposed upon them, and a source of strain and alienation.

Policy Implications

The current research, which was successfully conducted in collaboration with the Coventry Irish Society and other health professionals, has provided additional statistical evidence of an enduring “health disadvantage”. Most importantly, however, it has gone deeper than the statistics to reveal the lived health experiences of a sample of first and second generation “settled” Coventry Irish men and women. It has shown how “ethnicity”, as a form of structural disadvantage at the level of the wider society and a constructed identity at the level of the community, can be both a cause of health problems and a protection against them, and how these effects often occur in combination. More research, however, is still needed into the third generation and Irish travelling people.

With regards to the first generation, there is a large number of Irish people growing older, who are experiencing high rates of sickness and chronic disability due to accumulated socio-economic disadvantage and repeated discrimination. For some, a stoic attitude, combined with migration-related factors including feelings of “not belonging” within the wider British society, mean they are reluctant to seek help and may often feel alienated from services. For the second generation, there is evidence of substantial psychosocial/cultural dislocation, stress, and the adoption of potentially risky health behaviours. Both generations experience problematic identity issues, which are only partially offset by being part of a supportive Coventry Irish community.

While many of the factors producing a persistent “Irish health disadvantage” are linked to wider political and economic influences, this is compounded by lack of

action by national and mainstream agencies, who have over the years failed to adequately address the problems faced by the Irish community in England. This neglect has occurred alongside a lack of mobilisation on the part of Irish people who were afraid to speak up and claim their rights.

The research indicates the need for a stronger official prioritization of the health needs of Irish people in Coventry and for policy and practice interventions tailored to the rather different experiences and needs of first and second generations. There is considerable potential for both mainstream services to respond more effectively, and increase their outreach efforts to more effectively target the Irish community, and for more support to be given to specialist culturally sensitive services, including to the training of culturally sensitive health workers who are educated about the Irish culture, Irish racism and stereotyping. There is also a need for more concerted efforts on the part of local and national governmental agencies to put in place policy and practice interventions directed towards improving the socioeconomic position of first generation Irish people. This includes the funding of services which provide practical support to the Irish community, and help with benefit applications, disability claims, tax returns and housing issues. Finally, in tackling the problems, there is a need to address both positive and problematic aspects related to being Irish in England; in addition to tackling negative “lifestyle” factors and medical help-seeking behaviours, health promotion efforts should build upon community strengths and resilience, which include Irish community support structures, and, for many first generation Irish people, religion.

These findings, in turn, support a need for greater recognition of the positive role that an organization like the Coventry Irish Society can and does play, in providing day to day support, but also broader community development work that helps

strengthen bonds in ways that build bridges with the wider society. The research findings thus confirm the importance of such an intermediary organization, which has considerable experience and enjoys the trust of a broad spread of community members, to tackling the problems that the research has identified.

It may be worth commenting on some of the possible implications of the current economic downturn for Irish health inequalities in England. The “Celtic Tiger” has been severely impacted by the global recession, resulting in a very high unemployment rate (forecasted to rise to almost 17% in 2010 (ESRI, 2009)), and may take longer to recover than a country such as England which has a more stable and stronger economic, social and public infrastructure. This could lead to another wave of Irish migration in the near future which may result in a feeling of resentment on the part of English people who fear competition for jobs and therefore in a resurgence in anti-Irish discrimination, with negative socioeconomic and health implications for this population. Moreover, the demise of the “Celtic Tiger” may lead to a general decrease in the self-esteem of the Irish people who took pride in their country’s economic success, and in parallel, to a worsening in English people’s perception of the Irish people, with further negative implications for psychological well-being. These are further reasons for policy makers to prioritise actions to address the socioeconomic and health needs of Irish people in England.

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Appendixes

Appendix A

Topic Guide

- General Background Information (country of birth, when migrated, area of residence, age)
- Family Background Information (siblings, spouse, parents)
- Childhood circumstances (where grew up, health, money situation,)
- Socio-economic circumstances (education, jobs held, unemployment, associated feelings, stressful work conditions?, financial situation, difficult to make ends meet?, impact on health)
- Coventry (Do you like living there? Why?)
- Neighborhood circumstances (do you like it? Dislike it? Why? Only prompt if necessary: Safe? Clean, polluted? Easy access to health and sport facilities? Many Irish people?; Impact on health)
- Current Health (describe it, health problems?, definition of “healthy”)
- Health history (of respondent, of family)
- Feelings towards health (do you feel in control of your health? What do you think affects your health (family, friends, jobs, neighborhood?))
- Health-related behaviours (smoking, drinking, diet, exercise)
- Medical help-seeking behaviour (get medical help readily?)
- Experience of health professionals (negative? Positive? Relate well to Irish people?)
- Psychological and physiological aspects (Worry? Stress? High blood pressure? Feeling down? Self-esteem?)
- Ethnicity question (Irish, British, Maybe both?)
- Social support/networks (Irish connections? Bad? Good? Important to you? Impact on health?)

- Religion (what religion? Religious beliefs? Feel any guilt? Impact on life, on health?)
- Feelings about life (In control of your life? Optimistic about the future?)
- Discrimination experiences (How much did you experience it? How did you feel? What effects did it have on you? How did you tackle it?, fear of discrimination, feelings)
- Cultural beliefs (important to preserve Irish way of life?)
- Feelings about being Irish in British society (Need to keep quiet? (Events in Northern Ireland and bombings in Birmingham), do people have a positive view of Irish people?)
- How would you say Irish people have contributed to Coventry?
- Statistics have shown that the Irish in the UK tend to have worse health than white people generally. Why do you think that is? (lifestyles, material factors, psychosocial aspects?).
- Any other issue?

Appendix B

Introductory Letter

Dear interviewee,

Thank you for coming and agreeing to do this interview. Your help is very much appreciated.

This research project is about the health of the Irish people living in Coventry. My name is Marie and I am a second year PhD student at the University of Warwick. I am doing this research for my degree but I am also working with the Coventry Irish Society. I hope the research results will help to improve services for Irish people in Coventry.

I need to tape record this interview so that I can accurately report what you say. However, I can assure you that everything you say is confidential and that nobody will be able to identify you by what you say as in the write up people will be given fictitious names. I will be asking some questions which might be considered personal so I hope you are comfortable with this. Of course, you can decline to answer any particular question, if you are not. Would you like a copy of the transcript? If yes, then I will need your address.

Again, thank you for participating in this research. Please do not hesitate to contact me if you have any questions regarding the interview.

Yours sincerely,

Marie
m.clucas@warwick.ac.uk

Appendix C

<u>Second generation Irish women</u>								
	<i>Claire</i>	<i>Melanie</i>	<i>Elizabeth</i>	<i>Theresa</i>	<i>Ysabel</i>	<i>Lisa</i>	<i>Leslie</i>	<i>Hazel</i>
<i>Age</i>	43	60	47	30	32	35	32-33	32
<i>Current place Of residence</i>	Keresley, Coventry	Bedworth	Coundon, Coventry	Stoke Aldermoor, Coventry	London	Whitley, Coventry	Wolston, Coventry	City centre, Coventry
<i>Likes neighborhood and/or Coventry</i>	Not so much – misses Irish community spirit	Prefers Bedworth than Coventry; safer and quieter. Irish friends are in Coventry. Dislikes Cov bc associates it with bad memories.	Likes Coventry and her neighborhood very much. Neighborhood like a village. Would not live anywhere else.	Dislikes area of residence - downtrodden council estate, crime, unsafe, drugs. Wants to move out. Likes Cov; has many friends there, “it’s really up and coming now”	Liked Chapelfields, Cov bc had a lot of Irish families and friends there. Connection to Cov that she had as a child is lost. Cov is the past & a Ghost town vs. London who is hectic. Dislikes London area she lives in.	Cov is an “aggressive city”. Violence, aggressive people and back stabbers. Whitley is a nice area but dislikes it bc neighbors are close-minded, judgmental, her child was bullied, lacks Willenhall’s community spirit.	Loves her neighborhood very affluent. Moved there bc wanted her daughter to grow up in a good environment. Neighbors are great and her door is always open. Used to live in Stoke and loved it bc of the burst of the city.	Likes Coventry bc good friend base there, family and contacts with Irish community. “it’s always home” + outweigh –
<i>Place of birth</i>	Coventry	Northamptonshire	Coventry	Coventry	Coventry	Coventry	Coventry	Coventry

<i>Time spent living in Coventry</i>	All her life	30 years	All her life	All her life	24 years	All her life	All her life	All her life
<i>Ethnicity</i>	"I identify with the Irish". Ticks British bc born there.	Feels Irish. Ticks Irish ethnicity	Feels Irish. Ticks Irish ethnicity	Feels Irish. Tick British bc born in England. Feels false putting down Irish. If put down Irish would bother father, would probably call her "plastic paddy" in the "laugh sort of way". Would like to tick both (feels part of both communities)	Used to feel Irish in Cov. Feels English in London bc no Irish there. Ticks British	Feels more English bc grew up in England & had the most experience with the English culture. Ticks English. Is English with an Irish heritage. Northern Irish people are Irish, not British. Puts English not British.	Feels mixed, both Irish and English. Ticks British.	Feels Irish. Ticks Irish.
<i>Marital status</i>	Married for 22 years	Married	Married for 20 years	Single	Single	Single	Unknown	Married for 4 months
<i>Husband's ethnicity and occupation</i>	British Systems project manager	Scottish Owns a business but presently ill	Irish descent Manufacturing car company worker	Child's father is English	n/a	Child's father is of Irish descent	Unknown	Irish descent Unknown – good job
<i>Children</i>	2 boys	None	2 children	1 daughter	None	1 son	1 daughter	None
<i># of siblings</i>	2 brothers	1 sister	1 sister	4 brothers	1 sister	3 sisters	Sister of Lisa	4 siblings

Education, work experiences and financial situation								
<i>Occupation</i>	Will start job as assessor of care attendance	Full time counselor – at Irish society	Housewife and trustee at Irish society	Outreach welfare worker at Irish society	Energy code analyst	Unemployed	PT trained social worker (mental health) - works nights in health & safety.	Catholic primary school teacher
<i>Financial situation</i>	“a bit tight” worry about financial situation	Was good. Financial situation may have changed now that her husband is ill.	House paid off.	Not great – lives on a council estate.	Good. Has a professional job. Can afford to move to a nicer area in London.	Cannot be great bc L is presently unemployed Worry about financial situation.	L lives in an affluent neighborhood	Good. H has a good job and so does her husband. Bought a house.
<i>Education and training</i>	Left school at 16. Did not do A-levels. Orthopedic and general nurse and Homeopath training	Went to Art college but had to quit bc pregnant. Later on, did a 3 year counseling course at university.	Left school at 17. Did GCSE and 1 year of six form.	Went to college for community care. Had to quit bc pregnant. Took several courses (e.g. computer courses).	Has a MBA.	Left school at 16. Later on, took computer courses, few 0-levels, CSE and did youth training scheme.	Social work training -two years at college and a lot of in-house training. First in family to pass a degree.	4 year degree to qualify as a teacher.
<i>Past occupations</i>	FT nurse. After first child, has done many PT jobs.	Waitress, worked at electrical company, apprentice hair-dresser, manager of hair-dressing salon, worked	Worked at the Irish bank (only job) – was a relief staff worker for most of the time.	Worked at the co-op, at a market research company, for the city analytical services, at hospital as	Worked for a radio communication agency and for the office of the communications regulator (did MBA).	Office work, trainee hairdresser, worked for newspaper publisher in customer services, criminal assistant	Trained social worker (works with client groups since 17). Used to work as a day residential social worker.	Catholic primary school teacher (only FT job)

		at pub, factory worker.		support worker.		for a solicitor's office.		
Family information								
<i>Mother's country and county of origin, year of migration to England and occupation</i>	Ireland (county unknown) Migr.1957 Housewife Alive	Ireland (county Donegal) Migr.1947 Pub owner Age 89	Ireland (county Mayo) Migr. WWII Housewife Deceased at 86 - pneumonia	Ireland (county unknown) Migr. Early 60s Senior care worker Age 60	Ireland (county unknown) Migr.1967 Housewife Died recently at 59 - bronchial pneumonia & emphysema	Northern Ireland (Belfast) Migr. late 60s-early 70s Care assistant Age 60	Northern Ireland (Belfast) Migr. late 60s-early 70s Care assistant Age 60	Ireland (county Tyron) Migr.1965 British and common engineer Died 57 stroke in stem cell
<i>Father's country and county of origin, year of migration to England and occupation</i>	R. of Ireland (county Kildare) Migr.1959 Plasterer Alive	England (but was living in Ireland) Migr.1947 (came with M's mother) Pub owner Deceased - heart attack	Ireland (county Mayo) Migr.1947 Car factory worker Died at 70 (E was 24)- brain hemorrhage	Ireland (county unknown) Migr. Early 60s Builder Age 62	Ireland (county unknown) Migr.1962 Carpenter Age 62	Northern Ireland (Belfast) Migr. late 60s-early 70s Car factory worker Deceased at 56 - heart attack.	Northern Ireland (Belfast) Migr. late 60s-early 70s Car factory worker Deceased at 56 - heart attack.	Ireland (county Offaly) Migr.1964 Car factory worker Deceased – septicemia
Childhood circumstances								
<i>Childhood financial situation</i>	“we moved our way up” no worse than anybody else – Wilkinson – relative	Ok at her grandma's farm in Northampton. Both parents worked in manual jobs.	Was ok. Parents were successful in making ends meet. Didn't have a lot but well-clothed and fed. Went	No information	Was good. Quite secure. Father was good provider	“Poor”. Difficult to make ends meet. Stressful. Tension and physical violence at home (btw parents, btw	“Extremely tight”. Realized her family was poorer in senior school when she was ostracized bc she was from	“Quite comfortable” Not many financial issues.

	deprivation argument - "I think there was a lot though in the sixties like that nobody really owned their own homes"	Mother only PT. "we were tugging along quite nicely". "Very good" situation in Coventry – parents owned a public house.	on holiday every year. Reason for not going (e.g. buying a fridge).			siblings, father hit children quite often with leather belt).	Willenhall and her friends wore blazers and she didn't. Parents climbed the social ladder.	
<i>Childhood experiences</i>	Strict religious education and upbringing. Happy childhood surrounded by Irish community	Happy childhood in Northamptonshire. Things changed when came to Coventry at 16.	Happy childhood surrounded by close Irish family and friends	Happy childhood surrounded by very close Irish family and friends.	Happy childhood surrounded by Irish community.	Physically abusive household. Typical "Irish gypsy" upbringing. Didn't fit in at home & school. Liked neighborhood bc had many kids to play with.	"Stressful upbringing". Childhood packed with racism (neighborhood, school). Excluded from Irish community. Fear of father and of religion.	Very Happy childhood surrounded by large Irish family and Irish community
Health Experiences, behaviours, beliefs and attitudes								
<i>Current health conditions</i>	Asthma. Low blood pressure and low energy levels. High insulin & testosterone	Has high blood pressure. General health "my health now is okay, I just got over cancer	None. High blood pressure. Reading glasses. General health "I think I am	None. General health "fine... perfectly fine, nothing is wrong"	Bad circulation (cold feet and hands). Low blood pressure. General health "good"	Back problems limiting. Flat spine syndrome and fibromyalgia syndrome (stress causes back pain). Hay fever,	None General health "good"	None General health "it's alright, I'm not too bad"

	levels. Hypoglycemia General health “not bad, it’s ok, it could be better”	[lymphoma]”	quite healthy for the age I am”			asthma. Prone to genital abscesses Psoriasis (psychosomatic). Health “poor, declining every day”		
<i>Past health conditions (incl. childhood health)</i>	Gestational diabetes with 2 nd son. Hyperemesis during both pregnancies. Experienced stress with respect to nursing, combining work and family responsibilities and her children’s Health. Used to severely worry about that.	Cervical cancer (treated in time). Fibroids in the womb & hysterectomy at 40s, cancer found at 48. Lymphoma. Arthritis and a hip replacement recently. Had scarlet fever, mumps, chicken pox & tonsillitis as a child.	None	None	Had Meningitis as a child (4 years old). Was in and out of hospital for a couple months. Following the meningitis, developed a form of epilepsy “petit mal” and was on medication until 9 or 10. Then grew out of it.	Pneumonia in 2000. Mumps. Terrible back pains began when first had her period. Pain excruciating when pregnant. When first pregnant, was ill, couldn’t eat and lost weight. First genital abscess when was 5 months pregnant.	Had drug-related problems and mental health problems (depression). Poor mental health (worsened by work with mentally ill clients – now works nights, better). Had poor mental health growing up “stressed upbringing”	
...								

