

Who Knows, Who Cares?

Irish Health Inequalities in Coventry

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Executive Summary

1 Introduction: Researching Risk and Resilience among First and Second Generation Irish People in Coventry

- 1.1. This report presents the findings of a collaborative study between the Coventry Irish Society and the Department of Sociology, University of Warwick, conducted between 2005 and 2007, based on the doctoral thesis of Marie Clucas. The research sought first to update evidence in the light of the 2001 Census which, along with evidence from other parts of the country, shows a continuing Irish 'health penalty' and one that persists across different generations. The main aim, however, of the Coventry research was to explore the underlying reasons for this statistical relationship, through 32 narrative health interviews with 16 first and 16 second generation Irish men and women, in order to enable improved interventions.
- 1.2 The 'critical realist' approach sought to probe under the statistics to show the real impact of Irish health inequalities, told through the voices of the people experiencing them. The narratives sought to reveal the wider environmental influences or generative mechanisms of health and illness, incorporating the interviewees' own reflections on these issues. It looked not just at the risk factors for health, but also how community resilience helped to protect Irish people from harm. Policy makers and practitioners need to recognize both, helping to combat the one and strengthen the other, and above all avoiding a negative stereotyping that just portrays Irish people or people from other disadvantaged and discriminated against groups as simply 'victims'. The stories presented do not just draw attention to removable injustices, but celebrate people as heroes triumphing over difficult circumstances.
- 1.3 A distinctive feature of this project which may serve as a model for researching other communities was its collaborative nature. It was overseen by a Steering Group involving the Coventry Irish Society, who refined the research questions, facilitated access to interviews, undertook many of the interviews, and discussed the emerging findings. This approach overcomes some of the concerns that communities have about being researched by outsiders, facilitates access to so-called 'hard to reach' communities, and also utilizes insider knowledge to enhance the quality of the research.

2 An Unequal Bargain: Its Effects on the Health of Irish People in England and Coventry

- 2.1 There is ample evidence presented in the report of persistent and extensive health inequalities which, since they persist across generations, cannot be attributed to the temporary effects of migration. Despite this widespread evidence, the inequalities themselves have been neglected by policy makers and practitioners, even in a city like Coventry where Irish people form a substantial part of the population. Where it is noticed, lifestyle influences such as drinking habits are targeted, while poverty and discrimination are not, in ways that encourage victim blaming. They have thus been largely invisible externally, partly because of their white skin colour, and this has perhaps been compounded by the fact that the Irish community have not pressed their case as other groups, perhaps because the 'troubles' of the 1970s and '80s encouraged people to keep a low profile. However this is now changing, and through local organizations like the Coventry Irish Society (CIS) and national organizations like the Federation of Irish Societies (FIS), Irish people have been pressing strongly to have their health problems addressed.
- 2.2 In Coventry Irish people form one of the largest ethnic minorities, many migrating in the 1950s at the time of the boom in the postwar reconstruction of the city. Many came to work in the expanding car and engineering industries, transport and public services. Irish people thus played a central role in the city's prosperity and also in trade unions, business and political life. The interviewees in the study were proud of the contribution they had made. Migration stalled in the 1970s recession, though it continued in other places such as London. Irish people experienced discrimination, and in the context of the IRA's mainland bombing campaign, tended to keep a low profile. They were often hit hard by the recessions and deindustrialization of the city that occurred in the 1970s and '80s. Though there was a recovery from the 1990s, inequalities in the city remained wide, with health disadvantage an expression of these divisions. For example, areas like Wood End and Stoke Aldermoor, places where Irish people had made their homes, were badly affected by the migration of capital.
- 2.3 Thus the statistics uncovered by our research on Irish poor health in Coventry can be largely attributed to an 'unequal bargain' whereby Irish people contributed considerably to the prosperity of cities like Coventry but did not receive fair shares in return. Even in the years of boom they often did not share the general affluence, though it did enable them often to escape worse conditions in Ireland (the historical roots of which lay in its colonial legacy), and this disadvantage was exacerbated further during the years of economic decline. However their poor health cannot be entirely explained as the result of socioeconomic disadvantage. After taking this into account, other factors seem to be at work. Was this due primarily to the effects of discrimination, either directly or as a factor having more general and diffuse effects on wellbeing? What part did Irish 'culture' play in either exposing Irish people to health risks, or fostering their resilience? These were the complex issues that we sought to explore through the semi-structured health narrative interviews, drawing on the conceptual framework put forward by Nazroo (1997, 1998).

3 Research Findings from Interviews with Coventry Irish Health People

- 3.1 The analysis of the interviews shows that it is not easy to disentangle the effects of socioeconomic disadvantage, structural discrimination and cultural adaptations by Irish people themselves. Rather these influences interact in complex ways, and qualitative research interviews show these complexities in ways that statistical correlations cannot. In this section we seek simply to draw out some of the major points arising from them, rather than directly quoting from the powerful testimony of Irish interviewees, which readers can access by reading the full report.
- 3.2 For the first generation, one of the most enduring influences was the effects of childhood poverty in Ireland, which was often still fresh in people's memories. The enduring effects of this poverty on people's confidence was noted by many respondents, and also the impact it had in leading people to accept slightly better but still unsatisfactory life circumstances in England. These were often diverse, but a substantial number of men and women had worked in Coventry factories. Construction work figured among men, and nursing among women. These occupational experiences had caused a range of health problems, according to the interviewees. One of our key findings is then that occupational influences are particularly downplayed whilst attention is focused on 'cultural' and lifestyle factors. Construction work was also chronically characterised by insecurity, while factory work became so from the 1970s. The links between the health risks of poor work and unemployment thus reinforce each other. Women interviewees who had undertaken nursing in Coventry hospitals, also often complained of back trouble. On top of this, interviewees often noted the corrosive effects of discrimination on people's mental health and well being. They also recognized that 'stress' can also work through 'mind-body' pathways to cause physical illness too. Some found that when they challenged discrimination e.g. as expressed in Irish jokes, this had positive benefits.
- 3.3 Second generation Irish people interviewed on the whole enjoyed a better standard of life than their parents, though were still often either economically disadvantaged, or had found the struggle to rise in society had exacted a toll on them. They still felt they lacked confidence and experienced high levels of stress. Some however said that growing up in an Irish community where poverty was 'normal' had to some extent protected them from a sense of social exclusion. The experience of discrimination was more covert than that undergone by the first generation. Some of the respondents reported feelings of stress associated with the application of the label 'plastic paddies'. The label is a derogatory term, sometimes used by Irish born people to describe the second and subsequent generations. The use of which may evoke feelings of stress and anxiety in those seeking to express an Irish identity. They thus experienced a sense of dislocation and lack of belonging, caught between two 'hegemonic' domains of England and Ireland, which generated negative psychosocial effects. The Census question was also a matter of controversy and even confusion as it forced people to choose between a white British and an Irish identity. Some took ethnicity' to mean country of birth and others were reluctant to embrace an Irish identity which was seen as socially stigmatizing. These findings indicate that it is not just overt discrimination but perceptions of stigma that can have diffuse but negative effects on health and wellbeing.

- 3.4 Overall our research shows the complexity of 'cultural' influences. They are variable, may be partly a response to the disadvantage experienced in relation to the dominant culture, and can have positive as well as negative health effects. For example, Irish drinking is often seen as characteristic of male Irish culture, but there is evidence that this is complex issue, influenced by interaction with the wider environmental influences in the UK, for example that pubs were for first generation men major sources of support and job information for isolated migrant workers. There is conflicting evidence on the extent to which Irish people drink more in the UK than Ireland, and perhaps a need to avoid sweeping generalizations about either. Recent research in London and Dublin gives rise to concerns that Irish young people in the UK may be combining 'Irish' emphasis on quantity with an 'English' tendency to frequency. Evidence suggests a higher consumption of alcohol than among people from other ethnic minority groups, and men from both generations indicating the need for targeted and culturally sensitive services. Some Irish interviewees in our study did perceive Irish cultural traits such as heavy drinking and 'fried breakfasts', but stereotyping can occur from within as well as from without. They also associated the latter with positive features such as sociability and fun, or good 'craic', and Irish music and dancing. The first generation interviewees also expressed a 'stoical' approach to life that might have helped to promote resilience in the face of adversity. However this was also associated with a reluctance to seek medical help for illness among older people, which might be a matter of concern for policy makers. There was also a tendency for some interviewees to feel alienated from health services that were not regarded as sympathetic or user-friendly. Our research does not necessarily suggest that these experiences are exclusively 'Irish', but may be compounded by disadvantage and discrimination.
- 3.4 Our research certainly confirms the view that cultural support can have protective effects in circumstances where a group experiences considerable disadvantage and discrimination. Often this is at a very practical level, with examples given of how family and friends rallied round to help. However, it also corrected such stereotypes, as this support was not universally seen as available, particularly where second generation people have been geographically or upwardly mobile, or married outside the Irish community. For policy makers it means that they should not assume such support is available, as justification for limiting statutory provision. It also highlighted the role that Coventry Irish Society can and does play in helping to provide sources of identity and support when this may be fragmenting among Irish people themselves.
- 3.5 The research also showed the complex effects of religion on health and wellbeing. For those with religious faith, and particularly first generation women, it was a source of strength and also provided access to valued social networks. However some, more often men from the second generation, also referred to the negative effects on their esteem of what they called 'Catholic guilt', and expressed hostile feelings towards religious 'indoctrination' of the effects of the Church on their upbringing.

4 Conclusions and Policy Implications

- 4.1 Our research has found significant common patterns among Irish men and women of first and second generations, shaped by gender and generation, and by interaction with a wider environment characterised by disadvantage and discrimination. However it has also shown considerable diversity and difference among our 32 interviews. The first message for policy makers and practitioners then is to be aware of some of these patterns and their implications, but do not stereotype. Treat the person in front of you as a unique individual and not just a member of an 'ethnic minority group'. We have dug deep beneath the statistics to show the human picture, and revealed how Irish peoples' cultural adaptations to the circumstances they found in Coventry have helped to protect them against the adversity imposed on them by the wider society, but also to some extent put them at risk. Policy makers and practitioners therefore need to be aware of strengths as well as weaknesses, to seek to strengthen the first and combat the second. However they should not romanticize strengths, or blame the victims for problems whose source often lies in the wider society.
- 4.2 Our research indicates the need to tailor policy and practice interventions to the rather different experiences and needs of first and second generations. (This approach might also of course address findings within the third generation, though our research did not cover this ground.) As far as the first generation is concerned there is a demographic bulge of people growing older, who are experiencing high rates of sickness and chronic disability due to accumulated disadvantage. For some a stoical attitude means they are reluctant to seek help and may often feel alienated from services. For the second generation there is evidence of substantial cultural dislocation, stress, and the adoption of potentially risky health behaviors. This indicates the need for stronger official prioritization of the health needs of Irish people in Coventry, more education of health workers, and for outreach and culturally sensitive approaches. This in turn requires 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. Our new 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 our report has identified.

1 Introduction: Researching Risk and Resilience among First and Second Generation Irish People in Coventry

- 1.1 This Report is the result of a collaborative research project between the Coventry Irish Society (CIS) and the Department of Sociology at the University of Warwick, supporting the doctoral research by Marie Clucas, supervised by Drs Mick Carpenter and Simon Williams. The research involved quantitative analysis of 2001 Coventry Census data, and in-depth qualitative research into 'lived health experiences' of first and second generation Irish men and women in Coventry. It was conducted between 2005 and 2007 and the emerging results were presented to a major national conference held by CIS in the summer of 2008. This Report is an expanded version of this paper.
- 1.2 The existence of a significant 'health penalty' associated with Irish ethnicity is well known, as well as the fact that it does not just affect the first generation that came to a city like Coventry during the 1950s post-war boom, but also subsequent generations. There is a mass of statistics to support this, but much less convincing evidence on the underlying mechanisms involved that would help to lead to improved local and national interventions. This research is part of a growing trend towards probing underneath the statistics to tease out the processes involved, using qualitative evidence, as well as linking this to wider social influences. It should be read in conjunction with the available statistical evidence, especially the report on the 2001 Census results by the Federation of Irish Societies (FIS, 2007b).
- 1.3 The research thus used a 'critical realist' approach. This first sought to probe under the statistics to show the realities that people experienced in their daily lives and the health choices they perceived as open to them, and second go *beyond* statistics to show the wider environmental influences or 'generative mechanisms' (Bhaskar, 1975). Third, it sought to bring the two together, for example, to show through the narratives the big changes that affected people's lives, such as the poverty in post-colonial Ireland that prompted migration, the discrimination experienced in Britain, the impact of unemployment from the 1970s, and the uncertain identities experienced by the second generation from the 1980s. Our interviews also sought to uncover Irish people's own perceptions of the extent and causes of Irish health inequalities, and their awareness of these broader influences. It therefore involved an element of what has been called 'lay epidemiology' though the main purpose was to gather information (Hunt and Emslie, 2001).

- 1.4 The research adopted a sociological frame in seeing people as both socially constrained and enabled, the broader context in which people live shaping the degree of choice or agency open to them, linked to their own histories, knowledge and priorities. On the whole policy makers and practitioners do not pay sufficient attention to the wider influences or even when recognizing them focus on influencing people's individual lifestyles because their collective circumstances cannot be immediately changed. Thus our evidence points to problems such as ethnic disadvantage, structural poverty and inequality which require national government action. However, it seeks also to provide fine-grained evidence that will be useful at the local level in Coventry and elsewhere. In researching people's health narratives, it focused not just on risks but also 'resilience'. Much ethnicity research tends to focus on negative effects, often to the exclusion of protective or health promoting factors. This is particularly likely to be the case when the community in question, like Irish people, has generally adverse health indicators. Much resilience research was initially psychologistic, seeking to explain the 'compensatory' personal characteristics or 'assets' that enabled some individuals experiencing adversity to survive and flourish better than others. More recent research however has also drawn attention to communal 'resources' that in complex ways may reduce risk or promote health (Bartley, et al forthcoming).
- 1.5 Resilience research has dangers in that it can encourage blame as well as praise, and in both instances help to reinforce stereotypes of particular communities. Ethnicity research involves the danger that the role of 'culture' as a determinant of health inequalities will be exaggerated, ignoring or downplaying its interaction with other influences such as class or socio-economic position, gender, age and generation (Nazroo, 2001). This can mean that too much onus is put on communities themselves to address the health problems affecting them. The culturalist approach, with the best intentions, can also help to generate new stereotypes, for example that no Muslims drink and there are no Irish teetotalers. These are a poor guide to intervention, and a strength we think of the narrative approach taken in this research is in drawing attention to variable as well as common experiences of communities, and the unique history of each individual person. We firmly believe in a humanistic approach to health intervention at all levels which starts from an understanding of people's histories and experiences as constituting the 'realities' of their lives and this is what we hope comes across in this Report. Our approach in focusing on both risk and resilience also portrays people who are often capable 'heroes' triumphing over difficult circumstances and not just 'victims' of them. We hope that our findings, while alerting policy makers and practitioners to risks that need combating and resilience that needs reinforcing, should above all encourage them to ask questions without making prior assumptions.

- 1.6 It has been a great pleasure and education for us to work with the CIS. Although some interviewees came through external routes such as an appeal through the Coventry Evening Telegraph, most of our stories came through community members contacted through the CIS. The project therefore benefited from gaining access to Irish people who may not otherwise have trusted or revealed intimate and sometimes painful details of their lives to a university researcher. The 32 interviews, 8 men and women each from the first and second generations of Irish people in the city also took place on the 'safe' territory of the CIS office. The collaborative approach extended well beyond that, however. The research was guided by a Steering Group comprising members of the CIS and some health professionals who were also Irish themselves. Steering Group meetings helped to design the research schedule, to facilitate access, to receive and discuss initial findings. Some members of the Steering Group also conducted interviews, half of the total, following a training session we put on for them. The topic guide and interviews thus benefited from the cultural knowledge that members of the Steering Group were able to provide. The collaborative approach thus enhanced the quality of the research. It also increases the chance that some needed policy changes will take place in the light of the findings, through pressure by the CIS, which does not always happen with academic research. While we could not be sure whether we have a fully representative sample, we believe the interviews represent a good cross-section of Irish health experiences in Coventry. Because we accessed people through the CIS there may be some over-representation of first generation people with health problems.
- 1.7 One point emerging from our research is that there needs to be a combined health inequalities and health ethnicity approach, as a basis for improved interventions. On the whole, the two are often separated analytically and in practice. In particular health inequalities strategies often do not take sufficient account of ethnicity. For example, ethnic identity, beliefs, cultural and religious practices are missing from the influential Dahlgren-Whitehead model which informs health inequalities and public health strategy following the 1998 Acheson report. One way of achieving this is by exploring the complex interactions between ethnicity as 'structure' and 'identity' (Nazroo, 1998; Karlsen & Nazroo, 2002). 'Structure' refers to environmental factors that determine an ethnic group's disadvantaged socio-economic position and experience of discrimination. 'Identity' refers to cultural aspects of ethnicity such as sense of belonging, beliefs, lifestyle, support structures, cultural and religious practices. In practice of course it is hard to disentangle where one ends and the other begins, and our research, for example, into Irish drinking practices, shows that the two interact. In other words, a disadvantaged social position can help to produce adaptive behaviours that are problematic for health, which might appear on the surface to be freely chosen. One thing that is characteristic of Irish people, because they are white, is that there is a greater freedom of choice about 'electing' to belong to an Irish ethnic group. Our research shows considerable uncertainty about identity issues, particularly for second and subsequent generations which have some health implications.

- 1.8 Freedom of choice is thus both a burden and a boon. One effect of it is that Irish people in Britain have not pressed for recognition of their community's problems in the way that other groups have. For a variety of reasons they have therefore 'collaborated' in their own invisibility, and the British state has often been only too happy to oblige. This is changing particularly since the publication of a Commission for Racial Equality (CRE) in 1997 highlighting the discrimination faced by Irish people in Britain (Hickman and Walter, 1997). The Federation of Irish Societies (FIS) of which CIS is a member, have also been increasingly active and a notable success was the inclusion of an ethnic question in the 2001 Census. The research for this report shows that the reluctant responses to this question may be due to the fact that in requiring Irish people to choose an Irish identity over others, does not capture the complexities facing people of Irish descent in Britain, particularly of second and succeeding generations. It illustrates too perhaps the problems of admitting to being a member of an 'ethnic minority group' in a UK context. However, if a group does not press its claims, there is evidence that it will get overlooked. We therefore hope our report makes visible what has largely remained invisible about Irish people's health in Coventry. The broad narrative approach taken by the research also highlights the debt that is owed by Coventry to its largely uncomplaining Irish community.
- 1.9 This is not however the first time in the history of Coventry that efforts have been made to draw attention to the discrimination and disadvantage experienced by Irish people. In 1993 the City Council produced a Report which acknowledged the contribution of Irish people to the city and highlighted their substantial disadvantages. It pointed out that Irish community organisations often did not seek or were targeted for funding initiatives. Interestingly however, this only surfaced in the wake of public concerns at the time about an impending HIV/AIDS epidemic. While the report recommended better incorporation of an Irish dimension in its monitoring and training activities, and improved relations with Irish community organisations, it did not sanction specialist services or earmark significant additional resources (City of Coventry, 1993). There is little evidence that this report led to a sea change in the approach to public authorities in Coventry, and it is to be hoped that the publication of this report, which gives flesh to the problems and issues that were already fully identified in 1993, will provide an opportunity to revisit them at a time when health inequalities policies are now in place and race relations legislation has been strengthened. At the end of this report we look at the policy implications of the recent research and argue that while better mainstreaming – the approach advocated in 1993 – is one important requirement, there is a case for specialist Irish community provision to address risks and reinforce community health resilience.

This Report therefore addresses the 'Who Knows?' part of the question, in the hope that others in the city will respond to show who cares, and the opportunity to address longstanding health and social injustices will not be sidelined again.

2 An Unequal Bargain: Its Effects on the Health of Irish People in England and Coventry

- 2.1 Irish people living in England face a significant health disadvantage, when compared to the white British population, 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; Harding & Maxwell, 1997; Wild & McKeigue, 1997), limiting long-term illness rates (Owen, 1995; Kelleher & Hillier, 1996, FIS 2007a), self-reported health (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, 1997; Weich et al., 2004; Harding & Balarajan, 1996; Leavey, 1999). This health disadvantage has been shown to persist across generations of Irish people in England, extending into the third generation (Harding & Balarajan, 2001), and cannot be fully explained by age (Owen, 1995; FIS, 2007a) or socioeconomic class factors (Marmot et al., 1984; Raftery et al., 1990; Harding & Balarajan, 1996; Harding & Balarajan, 2001; Harding & Maxwell, 1997; Weich et al., 2004).
- 2.2 Despite consistent evidence of the existence of Irish health inequalities in England, the Irish have been largely neglected or 'invisible' (Bracken & O'Sullivan, 2001) 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. When the Irish have been noticed, the focus has tended to be on their drinking habits (Becker, Hills & Erens, 2006; Balarajan and Yuen, 1986, as cited in Abbotts et al., 1999a; Commander, Odell, Sashidharan & Surtees, 1999; Greenslade, Pearson & Madden, 1995; Harrison and Carr-Hill, 1992; Harrison, Carr-Hill & Sutton, 1993; Harrison, Sutton & Gardiner, 1997, as cited in Tilki, 2006), reinforcing the negative and long-standing stereotypes of the Irish as 'given to drunkenness' (Curtis, 1990, as cited in Tilki, 1994, p. 910). This has led to a victim-blaming approach, which can alienate Irish people further, and to a neglect of wider structural factors, including social issues of discrimination, deprivation (Tilki, 1994) and work hazards. Moreover, the focus on negative "risks" has occurred alongside a relative neglect of positive 'resilience' factors, with the Irish people viewed as passive victims when the Irish community can often cope with adversity by actively drawing on some community 'assets' such as social support from family and community (Bartley, 2006; Bartley et al, forthcoming) with positive health implications.

2.3 In addition the Irish are 'white skinned', and the dominant paradigm for understanding racism in Britain is constructed on the basis of a black-white dichotomy (Hickman & Walter, 1997, p. 7). This may have contributed to the 'invisibility' of Irish people to public agencies like the NHS and their own relative lack of mobilization on health, compared to other minority groups. A tendency has been noticed, confirmed by the current research, for first generation Irish people in particular, to keep their 'heads down' during the IRA bombing campaigns of the 1970s and 80s. However, things are now changing, particularly through the Federation of Irish Societies (FIS), and Irish community representatives are fighting for full recognition of the Irish as a minority group with a distinct culture and needs.

2.1 The Coventry Context

2.1.1 Coventry contains a large first, second and third generation Irish community (Hickman & Walter, 1997). In the 2001 Census, 10,401 individuals living in Coventry, 3.5% of the population, stated an Irish ethnicity, though the actual number of Irish people in Coventry is estimated to be much higher (FIS, 2007b). Even on this inadequate official count, it makes the Irish the second largest ethnic minority group in Coventry after the Indian ethnic group (FIS, 2007b).

2.1.2 Irish people have migrated to Britain for centuries. In the 1950s and 1960s, one of the largest waves of Irish migrants came to the UK in search of employment, particularly to the West Midlands, with Birmingham and Coventry as the main centres (Hickman & Walter, 1997, p.29). At this time Coventry had one of the most dynamic local economies in the country, thanks to the national importance of the motor industry and other engineering industries (e.g. machine tools and electrical engineering) (Dolan, 2003). In addition, the city needed to be rebuilt since it had been severely bombed during WWII, and a growing population led to also to a house building boom. Irish migrants contributed substantially to the rebuilding and economic expansion of Coventry; they worked in the construction industry, ran its buses and hospitals, and kept the factories going. Not surprisingly, then, the participants in the study expressed pride in the Irish contribution to the city.

- 2.1.3 In contrast to London, migration to Coventry stalled in the late 1970s due to the end of the industrial boom and the negative impact of recessions on the West Midlands. The 1970s were a difficult time for the Coventry Irish for yet another reason; the 'Troubles' in Northern Ireland and the Bombings in Birmingham severely impacted the Coventry Irish who as a result experienced acute anti-Irish animosity and discrimination. As the research interviews make clear, this discrimination magnified that resulting from existing anti-Irish stereotypes, prejudices and comments and led many Irish people in Coventry to keep a low profile and become defensive about expressing their Irish 'ethnic identity'. The crisis in the city in the 1980s, which manifested itself in the run-down, relocation or closure of many workplaces, high unemployment rates, and cuts in social provision (Dolan, 2003) led to a displaced first generation who lost out as manufacturing declined, and a second generation with somewhat disappointed expectations.
- 2.1.4 Although the city experienced a recovery in the 1990s, with the decline in manufacturing industries partially offset by the growth in the service, financial and high-tech micro-electronic sectors, inequalities remain wide; while middle-class commuters benefited from better-paid professional jobs, many city residents, particularly the semi- and unskilled, including many Coventry Irish, were left with often insecure, low-paid employment or experienced unemployment for a substantial period of time (Dolan, 2003). The flight of 'capital' from the city hit hardest on Coventry estates like Wood End and Stoke Aldermoor where significant numbers of Irish people lived. .
- 2.1.5 This experience has exacted a toll in terms of health. Irish people in Coventry experience higher levels of limiting long term illness and 'not good' general health than white British people (FIS, 2007b). Irish men of working age particularly experience relatively high levels of limiting long-term illness, and to white Irish men and women of working age who are more likely to rate their own health as being not good (FIS, 2007b). Irish poor health in England is at least in part a result of an "unequal bargain" with UK society under which they contributed more than they received in return. Despite their hard work and the long hours they put in, Census 2001 figures show that they are socioeconomically disadvantaged when compared to the white British population in regard to housing amenities and occupational profile, with a relatively high proportion working in skilled trades (men) and elementary occupations (men and women) (FIS, 2007b). This is because they were offered low paid, unskilled jobs, with poor working conditions. Another important factor affecting the first generation, which comes through in the interviews, is childhood poverty in Ireland, which can ultimately be traced back to the effects of British colonialism.

2.2. Conclusions

- 2.1.2 In summary, the analysis undertaken by Marie Clucas of the Census 2001 Individual Licensed SARs (ONS) show that the health disadvantage is persisting. 'White Irish'¹ people in England have a substantially increased risk of poor self-reported general health and limiting long-term illness, which cannot be fully accounted for by age, sex, marital status and socioeconomic influences. Moreover, the findings show significant differences by country of birth. The poor self-reported general health and increased risk of limiting long-term illness of the 'White Irish' born in Northern Ireland and those born in the UK (second generation Irish) was not fully explained by such demographic and socio-economic factors. In contrast, mixed findings emerged for the 'white Irish' born in the Republic of Ireland; while their poor self-reported general health persisted after taking into account socioeconomic factors, their increased risk of limiting long-term illness was largely explained by their socioeconomic disadvantage.
- 2.1.3 Apart from this evidence of a persistent social and health disadvantage of a significant sector of the city's population, little recognition has been given in Coventry to the existence of Irish health inequalities, let alone to the need for culturally sensitive services. Although Irish people have often played leadership roles in the city's politics, trade union and business life, they have rarely pressed their community interests. Community organizations like the Coventry Irish Society and Rehab UK are working to redress this imbalance, and hopefully will be able to use the research evidence in this Report to initiate change.

¹ Individuals who reported a white Irish ethnicity in the Census 2001; owing to the complexity of self-reported ethnicity, it is likely that second and third generation Irish people are under-represented in this figure (Walter, 2002, as cited in FIS, 2007).

3 Research Findings from Interviews with Coventry Irish People

3.1 The narratives we now discuss are selectively taken from the 32 interviews undertaken for Marie Clucas's doctoral research from 2005 to 2007. This report provides an outline summary and fuller results are presented in the doctoral thesis. As stated above we recognize that it is hard at times to disentangle the structural aspects of 'ethnicity', namely its link to socioeconomic disadvantage and discrimination, and the 'cultural' dimensions created by the community itself independently and sometimes in response to these pressures. Nevertheless, separating the two, and then looking for linkages, does seem a useful way of making sense of complex sets of influences and how they impact on people's lives and health experiences. We therefore start with the influence of ethnicity as 'structure', move on to look at influences of 'identity', before looking at interconnections between them.

3.1 Ethnicity as Structural Disadvantage

3.1.1 'Ethnicity as structure' refers to the socioeconomic position and discrimination experiences of the Irish population in England. The narratives show that many first generation Irish people suffered from childhood poverty in Ireland which can be traced to its pre- and post-colonial position on the periphery of the British economy (Crotty, 1986, as cited in Tilki, 1994, p. 909). Poverty was often extreme, with clear negative health implications for childhood and adult health (Berney, et al, 2000; Dike van de Mheen et al, 1998; Barker, 1998; Elstad, 1998; Scambler, 2002). Owen², a first generation Irish man who was bitter about being forced to leave Ireland for reasons of economic necessity and had undergone open heart surgery a few years back, grew up in conditions of extreme poverty in Ireland,

Unless you've lived at the level of poverty that I lived at, you would not believe it, er, and 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, we never had a dinner Monday [...] and the reason that I found out that was a fella from school, I went to his house one day in the week and 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, I didn't bloody and that was the poverty level and you don't go much bloody lower than that (Owen, 1st generation Irish man)

²All names are fictitious

3.1.2 The majority of first generation Coventry Irish interviewees were disadvantaged by factors such as education, income, working and living conditions. This is consistent with other studies (Hickman & Walter, 1997; FIS, 2007a). The negative health consequences of socioeconomic disadvantage in its various forms, especially when it is extended throughout the lifecourse, have been well-documented (Acheson, 1998; Davey Smith et al., 1997; Townsend & Davidson, 1982; Townsend, Davidson, & Whitehead, 1992; Scambler, 2002; Wilkinson and Marmot, 2003). The negative impact on one's mental health of having little education was highlighted by Rose, a first generation Irish woman who was now a widow,

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

3.1.3 Although most were now retired, a substantial number of the men and women interviewed had worked in the Coventry factories. Some men had also worked in the construction industry, often intermittently. Several women had worked as support workers and some had been nurses. Working in such occupations was associated with negative health impacts and a number of first generation Irish men and women in the study suffered from occupational injuries and ill-health. Like many other first generation Irish women, Rose had severe back problems as a result of working as a care assistant in poor working conditions for many years:

It's bad at the moment but it's been bad for a while since I gave up work because I've got [unclear], I got sciatica in me back and arthritis [...] I have carpal tunnel [...] yeah, from the lifting [...] because see, we had no aides and [unclear], we got them when I was leaving, like the few years, but we hadn't got hoists or we hadn't got sliding sheets, nothing like that, they had to lift the people [...] because I started there in 1970, 70 to 71, I started there so there wasn't the facilities (Rose, 1st generation Irish woman)

3.1.4 Many first generation Irish people in the study experienced anti-Irish discrimination particularly when they first came over in the 1950s-60s and in the 1970s during the 'Troubles'. The negative impact of discrimination on mental and physical health has been documented in many studies (see Williams et al, 2003). Michelle, a second generation Irish woman and social worker who had mental health problems in the past but had largely recovered, talked about the effect of internalized discrimination on health:

I would definitely, looking back, think my mum and dad must have been under so much stress and I'd say it was, it was definitely the racism [...] the 70s [...]] I think as a result of [clears throat] of everything going on there [...] it was every stress-related heart problems, blood disorders, anything, you know even headache, increase in headaches, anything to do with stress and anxiety definitely, coming over here definitely" (Michelle, 2nd generation Irish woman).

While many responded to the anti-Irish discrimination by keeping their heads down and adopting a low profile, especially during the troubled 1970s, some fought back. Carmel, a first generation Irish woman who said she was ‘reasonably healthy for my age’ had had to put up with Irish jokes at the workplace, decided to challenge Irish racism, following which the doctor at the hospital apologized and gave her flowers:

I was listening to that for months and months, and one day I said to him [...]: ‘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’ and I said: ‘they’re your golfers for everything, the Irish’ and I said: ‘so, you know, I am tired of you running them down’ and I said, you know, you know, ‘I don’t want to hear it again! (Carmel, 1st generation Irish woman).

- 3.1.5** Growing up, the standard of living of the second generation Irish people in the study was generally better than that of the first generation although they were still often economically disadvantaged. One would therefore expect the second generation Irish people interviewed to suffer from relative deprivation growing up, perceiving themselves to be worse off than others around them, which research indicates has negative health consequences (Wilkinson, 1997 and 2000, as cited in Scambler, 2002). The evidence appears to suggest, however, that being embedded in the Irish community as a child may have protected some against the effects of relative deprivation. Indeed, the very fact of growing up within the Irish community and being surrounded by Irish people who were similarly disadvantaged led several second generation Irish people interviewed to state they had low awareness of experiencing poverty:

At the time you don’t [sigh] 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 who was from um the West Indies, every child was uh, had at least one Irish parent so there wasn’t a great deal of affluence about... um it was a bit different in the secondary school but I didn’t, looking back, um... we went without quite a bit...we always had a car, which was um um not necessarily typical um and we always went on holiday once a year, often to Ireland [...] um but I uh I know that you know in the [unclear], in the scheme of things, money was, money was tight (Brendan, 2nd generation Irish man).

3.1.6 Several second generation Irish people interviewed worked in professional and managerial jobs. This is consistent with studies that have documented the upward social mobility of some second generation Irish people in Britain (Hickman, Morgan and Walter, 2001; Heath and McMahon, 2005). While some went straight to University, a number had left school prior to obtaining their A-levels, worked in manual jobs for some years and then decided to back to school and oftentimes to University. The educational and career choices of these people were conditioned by the socioeconomic position and educational disadvantage of the wider Irish community, parents and peers. Working in professional and managerial jobs had both positive and negative health implications for this generation of people, positive owing to the good income and job satisfaction associated with these type of jobs but also negative owing to high levels of work-related stress (Wilkinson and Marmot, 2003). Brendan explained how working as a teacher had a positive and negative impact on his health,

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 get [unclear] I do get some satisfaction from...[job] [...] I think that I get very anxious at times I've quite a stressful job, and I [...] I don't sleep well [...] the anxiety that I, I get a lot of indigestion and uh...[...] I've suffered with irritable bowel for, you know at least ten years really, on and off, so...it's stress related... (Brendan, 2nd generation Irish man)

The second generation Irish interviewees experienced more covert forms of discrimination. The vast majority had been the butt of Irish jokes and for several, it was a common occurrence. Conor, who is a second generation Irish man recently unemployed from working in hospitality, compared his experience of anti-Irish discrimination, i.e., Irish jokes and name-calling, to that of his father:

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 uh...I suppose my dad when he came over the only thing he had was in the B&B, it was, you know 'No dogs, no blacks, no Irish' which was quite common place though, wasn't it? [...] in the '50s [unclear] but me, personally um, just in just in fun, you know (Conor, 2nd generation Irish man)

Moreover, some second generation Irish people experienced discrimination by the Irish-born and were called 'Plastic paddies' or fake Irish people because they were born in England and not in Ireland, and some people interviewed were deeply affected by it. This indicates that the Irish community needs to take responsibility for the fact that it can make it hard for some of its members to express a positive Irish identity.

3.2 Ethnicity as Cultural Identity

- 3.2.1 Thus the evidence shows that it is often difficult for Irish people to form a coherent and positive sense of identity in England, with negative implications for psychosocial health (see Abbu-Rayya, 2006). Although the vast majority of first generation Irish people reported feeling Irish, their defensive attitude towards it may indicate that they see an Irish identity as a devalued identity and perceive themselves as inferior, even if on a subconscious level. This is because anti-Irish feeling and discrimination has deep historical and colonial roots (Greenslade, 1992).
- 3.2.2 In common with other studies (Ullah, 1985) second generation interviewees selected from a range of ethnic identities. Half reported feeling Irish but most put down 'English' on forms because they were either afraid of being seen as a 'plastic paddy' by the Irish-born or understood 'ethnicity' to mean 'country of birth'. Teresa, a second generation Irish woman who works in the community and stated she was a 'social binge drinker' on the weekends, felt Irish but struggled to assert her Irish identity, for fear of being seen as a 'plastic paddy':

I always tick British because I was born here [...] I do, yeah [feel Irish], I kind of, yeah, it's kind of weird but I feel false if I put Irish down because I was actually born here [...] I think it's changing now...but more so, I mean, I'm second generation Irish, so I mean obviously mum and dad always put down that they're Irish [...] and uh I think it bothers him [if I put down Irish], my dad would probably call me a plastic paddy [laugh] (Teresa, 2nd generation Irish woman).

This is consistent with the findings of Hickman et al (2005) that second generation Irish participants in her study felt caught between two 'hegemonic' domains, England and Ireland, both undermining claims to an ethnic identity. She defined the former as 'incorporating', generally denying the difference associated with 'Irishness' and the right to a separate ethnic identity, while the latter was 'differentiating', that is, denying common identities between people of Irish descent by use of the term 'plastic paddy'. The other half of the second generation Irish people interviewed either reported feeling Irish and English, were confused about their ethnic identity because they had been discriminated against both in Ireland and England, or reported feeling English because they had more experience with the English culture.

3.2.3 Another aspect of ethnicity as identity are behaviours said to be associated with Irish culture, lifestyle and beliefs. A number studies have documented the high rates of alcohol consumption among some first and/or second generation Irish people in England, especially men, (e.g., Becker, Hills & Erens, 2006; Greenslade et al., 1995; Harrison and Carr-Hill, 1992; Harrison, Carr-Hill & Sutton, 1993; Tilki, 2006). We discuss the extent to which this can be considered 'Irish' or conditioned by structural disadvantage is discussed in more detail below in 3.4. Among our interviews, a number of men from both generations drank more than recommended weekly amounts. Moreover, some of the interviewees themselves talked of a problematic Irish lifestyle including 'drinking culture' and of the 'Irish' fried breakfast:

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 I would say um [...] it's, it's passed on, but then obviously I think um if I was trying to pass, I mean I was never really brought up on that, but if I was brought up on that and I tried to pass it on to my, children, I would like to think that I wouldn't do that personally um knowing obviously the effects of what it can do in later life but um, I think it is, yeah I think it's the Irish way, I think (Conor, 2nd generation Irish man)

We must be aware here of the possibility that stereotyping can come from within as well as without. In addition, however, Irish lifestyle was also associated with a capacity to be social and enjoy oneself, compared to white British people, expressing one's identity through Irish music and dancing. These positive features of Irish communal life might help to promote health resilience and are often summed up as 'craic', defined as 'fun, enjoyment, abandonment, or light-hearted mischief; often in the context of drinking or music' (OED).

3.2.4 There was a tendency on the part of some Irish people interviewed, particularly the first generation, to report not needing much and being content with their financial situation. Some people linked this belief or way of thinking to growing up in poverty in Ireland. This was so for Christopher, for instance, who is now retired but worked in several manual jobs throughout his life and had drunk heavily in the past:

The money, the money is nothing...[...] no, no, money uh money uh it's not, it's, as long as I've always what I maintain, as long as you have food, enough food on the table [...] a nice bed to lie in [...] you know, a clean bed to lie in, a nice bed and you've, you don't owe anybody any money [...] you paid your bills [...] and that's all you need [...] that's all you need...that's how, that's how I always looked at it... back at home, in Ireland, when we [unclear] that's all we ever had (Christopher, 1st generation Irish man).

Moreover, several Irish people interviewed, particularly from the second generation, believed it was important to have a positive outlook and attitude on life, which research has shown to have a 'salutogenic' (health promoting) effect (Bartley 2006; Bartley et al, forthcoming). Some Irish people interviewed themselves thought that being content with one's financial situation may counteract some of the negative effects on health of relative deprivation by changing one's perception of one's financial situation. While having a positive outlook on life can help people cope with difficult life events and circumstances, this does not mean of course that it wholly counteracts negative 'material' effects.

- 3.2.4 Thus a single view of culture as either positive or problematic for health needs to shift to a more differentiated approach. Thus while being 'content' can have protective effects, this can also lead, as was evident in some of our interviews, to a stoicism about illness that was associated with a reluctance to seek medical help, particularly by first generation Irish men. Some of the interviewees saw such stoicism as an Irish trait, although we would be cautious about this, seeing it also linked to age, class position and education. Nevertheless, it is an issue that it is significant for policy makers and practitioners in accessing Irish people, especially given that significant numbers of Coventry Irish people are in the older age brackets (FIS, 2007b).

3.3 The Complex Effects of Community Support on Health

- 3.3.1 This indicates a more differentiated approach than is indicated in the 'social capital' (social support) health literature which arguably over-romanticizes the positive effects of community networks, obscuring the power relations that generate social disadvantages and the fact that any compensatory effects often arise from struggle against them (Navarro, 2002). It can also feed into anti-statist reliance on community as a panacea justifying a withdrawal or denial of public provision (Schuurman, 2003). In reality the evidence is that those with greatest access to family and community capital, also possess the most economic capital (Bourdieu, 1986). Our interview results suggest that there may be some compensatory features but that strong cultural ties can also give rise to problems. The positive impact on health of having supportive social networks has been documented (Stansfeld, 1999). Moreover, Halpern (1993) found ethnic group clustering to have a protective effect on health by reducing exposure to direct prejudice.

3.3.2 Many of those interviewed, across the two generations of Irish men and women, obtained significant social support from membership of the Coventry Irish community. Others, however, did not feel so embedded within the Irish community and felt deprived of the social support they needed. Katie, a second generation Irish woman who is a teacher in a Catholic school, talked of the positive effects of Irish community support:

She [mother] was 57 and she suffered a stroke in [...] just amazing anyone you know, 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 you know, for family, when they are bereaved [...] it's incredible really you know [...] oh just that support that you need [...] the network that you really rely on, you know (Katie, 2nd generation Irish woman)

In contrast, Sheila, a first generation Irish woman working part-time as a counselor, talked of the negative effects of lack of Irish community support on health,

The postnatal depression was...I always felt that it was the lack of support in the background, that there was nobody here, around me, there was nobody that could have... [...] I think that, that I was going through alone and I was, I was struggling [...] because I was very isolated...there was, 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 wasn't uh, it was very isolating (Sheila, 1st generation Irish woman)

Some Irish people interviewed, from both generations, both men and women, experienced difficulties in accessing support from Irish community because they were not going to Irish pubs/clubs or Church, or had a non-Irish spouse. The danger is that policy makers and practitioners, sometimes influenced by 'naive' social capital/social support theory, can make unwarranted assumptions about the degree of support available through ethnic minority family and community networks, an issue well documented in relation to South Asian people (e.g. Katbamna et al, 2004). In this respect, Irish organizations like the CIS have a vital community development role to play in providing a venue for first and second generation Irish people, including a place to meet and get various forms of support, cementing or reconnecting with an Irish identity.

3.3.3 Another aspect of ethnicity as cultural identity is religion. Several studies have documented the beneficial effects of religion, and more specifically of Church attendance, prayer, and intrinsic religiosity, on health (e.g. Koenig, 1992). However, some studies have also suggested that religion may negatively impact psychological health by creating anxiety and fear due to beliefs in punishment (e.g. hell) for wrongdoing and by fostering low self-esteem through generating unhealthy levels of guilt (Schumaker, 1992). Religion appeared to have a positive impact on the health of the interviewees with strong religious beliefs, most often first generation Irish women:

My religion makes me feel very happy [...] I don't know really, er, I believe it so much, and I pray a lot, and I think that helps me (Molly, 1st generation Irish woman)

I couldn't without my religion, I don't know how people do but I couldn't (Lily, 1st generation Irish woman)

However religion appeared to have a negative impact on the psychosocial health of those interviewees in the study who felt 'Catholic guilt' or had a negative relationship with the Church. This was more often the experience of the second generation Irish interviewees, especially though not exclusively men. Some stated that they experienced religious 'indoctrination' when growing up and even as adults did not feel in full control of their emotions. Brendan, a second generation Irish man, talked of the negative effects of religion on mental health and self-esteem,

I: Did you feel any, any guilt due to religion?

Brendan: yeah total, yeah, that's why I, carried with me I'm responsible for everything, I think we grew up in an era of, you grew up in era of hell and damnation

I: would you say that had a, an impact on health, physical and mental health?

Brendan: [pause] I think it's all to do with that, the devils of self-esteem and things.

3.4 Culture Conditioned by Disadvantage: 'Irish drinking', and help seeking behaviour

- 3.4.1 'Irish drinking' is a complicated issue and an unhelpful label. To begin to understand why some Irish people in Britain drink heavily, requires an investigation of both structural disadvantage and cultural identity dimensions of Irish ethnicity. There was evidence from the narrative interviews that excess drinking may result from both structural factors, that is, from the migration experience of first generation Irish men and work experiences of first and second generation Irish men in England, and perhaps in part 'Irish drinking culture' brought over to England, though overall there does not appear to be much general difference between Irish and English consumptions levels. For the second and third generations Irish people drinking patterns may be shaped by English 'binge drinking', with some research (in London rather than Coventry) suggesting that an 'Irish' emphasis on quantity, combined with an 'English' tendency to frequency, can increase health risks (McCambridge, *et al* 2004).
- 3.4.2 These findings are consistent with other studies of excess drinking as originally a product of the pressures of male migration, reinforced by Irish cultural attitudes which may sanction heavy drinking at home or view heavy drinking in the pub as acceptable? (Greenslade *et al*, 1995, Leavey *et al*, 2004; Tilki, 2006). Both Sheila and Owen linked Irish drinking to the migration experience of first generation Irish men,

Many people have a perception of the Irish as being drunks, that was one of the things that they used to think, is, there's a good reason for that if you analyse it because the simple reason that an awful lot of them [Irish migrant men] wouldn't have a place to go to and where would they meet up to socially meet them? They'd meet in the pub [...] and of course in, in the pub, who goes needs, needs to drink, full stop. I can say that, that's the reason (Sheila, 1st generation Irish woman):

When you finished your day's work, it wasn't like you were gonna go home you were just, you were in there [digs] because you were paying them and that's it, and they, they let you know that they wanted you out, so of course, the main port of call became the Pub (Owen, 1st generation Irish man)

In contrast, James, a second generation Irish man who is currently unemployed and suffers intermittently from back trouble, linked Irish drinking to both an 'Irish drinking culture' and to difficult work experiences:

I think [...] there's an emphasis on drink in the Irish people in the UK, drink culture [...] yeah yeah absolutely yeah [Coventry as well], er, the drink culture, yeah a lot, I know a lot of people, Irish second generation who've got drink problems, if not myself so erm, a lot of people yeah [...] they [Irish friends] do get in to a little bit of trouble erm, but mainly you know, they've, they've just had, if they've had problems with dr..., erm, alcohol and some sort of instability that they can't identify so [...] 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, erm, I think it seems to be a way of letting off steam and [...] I think, I think it's just a way of releasing you know, erm, cause they're hard workers so they [...] (James, 2nd generation Irish man).

- 3.4.3** A number of the interviewees indicated that they were reluctant to seek medical help. As with excess drinking, there was evidence from the narratives that this resulted from structural factors. This included a combination of alienation from and dissatisfaction with the (NHS), experiences of discrimination by health professionals, social isolation and exclusion, and a tendency to 'stoicism' involving an unwillingness to complain about one's health or visit the GP. Tara, a second generation Irish woman who is a housewife and smokes, was one of a number who expressed dissatisfaction with health professionals:

I find them [health professionals] very abrupt, they don't seem to...they just want to kind of deal with you and that's it, you know [...] you, I've got to move on to the next one [...] I do [feel that if they were Irish I could talk to them better], yeah, yeah... (Tara, 2nd generation Irish woman).

James believed Irish migrants were reluctant to seek medical care because they felt cut-off from mainstream society,

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, erm so that could be so [...] (James, 2nd generation Irish man).

Liam believed that Irish people were stoical and reluctant to complain about their health and to go to the doctor:

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 (Liam, 1st generation Irish man)

3.4.4 Thus ethnicity as structural disadvantage and cultural identity can interact in problematic ways. To give a few examples, there was evidence in the accounts that being embedded within the Irish community protected some against discrimination experiences. However such strong bonds formed in response to discrimination could reinforce social exclusion and a sense of alienation from mainstream services: 'You're not English [...] that's for sure [...] you can be made to feel that way as well at times' (James, 2nd generation Irish man). Reflecting on these and other issues, a number of people interviewed spontaneously suggested that there was a need for Irish specialist services in Coventry. Those who attended the Coventry Irish Society praised it for the services it provided, including the practical assistance they received from the CIS with respect to passports, housing issues, use of the internet and the purchase of flights to Ireland. A number stated they looked forward to the regular luncheons and social events it organized. According to Orla, a second generation Irish woman, there was a lack of investment in Irish centres, and she felt they were especially needed for older Irish people to combat isolation and connect with the Irish culture:

There could be more support for the older Irish today which obviously the Irish society and places like that, but it would be nice to see more investment because, especially in Coventry now over the last couple of years a lot of Irish Centres have closed down due to lack of investment [...] it would be nice to see another Irish Centre or few Centres be set up in Coventry because there is a great Irish Community here [...] when I was growing up there was two or three Irish clubs that the Irish people could go to, now there's only one [...] so I think the Irish community needs that to bring them all together again because they're going their own way in some way and going over to other cities, like to Birmingham, to the Irish Centre there, instead of mixing in their own City (Orla, 2nd generation Irish woman).

She also believed that the establishment of more Irish centres and clubs in Coventry would also benefit the second generation Irish people there by helping them reconnect with their Irish roots, culture, beliefs and values and mix with the first generation:

It would help the second generation to reconnect with their roots, the next generation as well and I think because there isn't a focal point that people can go to, to these Irish Centres there isn't that opportunity to mix with the first generation and to keep those values and those cultures and beliefs going, you know, that's kind of lost in some ways because the second generation are moving on, you know to other Cities whether it's London or Birmingham or Manchester, so that in a way is lost, it's been lost by not having these like Communities and these Clubs and so forth that people can socialize in, that's my own opinion" (Orla, 2nd generation Irish woman)

4 Conclusions and Policy Implications

- 4.1 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 penalty’. Most importantly, however, it has dug beneath the statistics to reveal the lived health experiences of a range of first and second generation ‘settled’ Coventry Irish men and women. It has shown how ‘ethnicity’, as a form of structural disadvantage from above and a community constructed identity from below, can be both a cause of health problems and a protection against them. It has shown how these effects may sometimes occur separately, but also often in combination. We do wish to point out however that there is still research needed into the third generation, and also Irish travelling people, which this report does not address.
- 4.2 The evidence of our report points in a clear and imperative direction: there is substantial evidence of unmet need and considerable potential for both mainstream services to respond more effectively, and for more support to be given to specialist culturally sensitive services. While many of the factors producing a persistent ‘Irish health penalty’ are due to wider political and economic influences, this is compounded by neglect and lack of action by mainstream agencies, who have over the years taken a complacent attitude to the problems we have identified in this report. What is particularly alarming is the fact that the stoicism of significant number of interviewees is combined with a feeling that statutory services are often unsympathetic to their plight. Addressing this is vital context of on the one hand, and ageing Irish population with considerable health needs, and on the other of a second generation that often feels adrift from both Irish and British culture and experiencing psychosocial dislocation. This report is also being produced at a time of economic downturn, which will certainly impact most heavily on those already experiencing substantial disadvantages. The findings might also give some food for thought for the Irish community to combat potentially problematic identity issues and health behaviours.

4.3 In dealing with these issues we believe that the Coventry Irish Society is exceptionally placed as an intermediary between different generations, the Coventry Irish community and statutory agencies, organisations representing people from other ethnic minority groups, and with the white British people of Coventry. It is carrying out an impressively wide range of work directly relevant to improving the health and wellbeing of Coventry Irish people, including day to day support and wider community development work, as documented by its website (www.coventryirishsociety.co.uk). It is staffed by skilled professionals, who are however hard-pressed and currently operating on something of a shoestring. The CIS has only received very limited support from Coventry based funded sources, and is heavily reliant on support from the Irish government. This low level of funding contrasts with the high levels of need identified in this report. Coventry NHS is a Spearhead PCT which is charged to make special efforts to target health inequalities, and the evidence in this report indicates that this should be an area of need that should be much more centrally in its sights. As we have seen the CIS enjoys the considerable confidence of the Irish community and in celebrating the positives it does not shy away from tackling difficult and problematic issues associated with Irish 'culture'.

4.4 The research evidence presented in this report provides strong support for:

- A much stronger Irish health dimension to health inequalities work, including upstream health promotion, efforts to improve access to mainstream health services and provision culturally sensitive and respectful services. While this will require extra public investment, it will in the long run be cost-effective in securing improved public health.
- The need for training materials which address positive and problematic aspects of being Irish in England, and facilitate appropriate responses, as this is largely missing from the current 'ethnicity' literature. This should be combined with Cultural Awareness Training, which the staff of the Coventry Irish Society are well placed to deliver.
- Efforts by organisations like CIS to promote community pride and social capital. This includes plans to develop further specialist services acceptable to Irish people in collaboration with statutory agencies. It also broadly supports the idea that a proposed Coventry Irish Heritage Centre would help to solidify community pride and educate Coventry people as a whole on the immeasurable contribution made to the city's life, often at considerable personal cost.

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