

IRISH CATHOLIC HEALTH DISADVANTAGE IN THE WEST OF SCOTLAND

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THE IRISH AS AN ETHNIC MINORITY

The Irish have been described as an 'invisible minority' in Britain (Pearson et al 1991). With the same skin-colour and language, they are usually assumed to be well assimilated in the general population. The lack of monitoring in official statistics has meant that scant attention could be paid to their equality of opportunity or particular service needs. Until recently, they were not treated as a distinct group – coming within the ubiquitous 'white' category. Following pressure from researchers (Walls 2001), this changed at the Census of 2001, in the light of evidence demonstrating their health and socio-economic disadvantage. 'Irish' was included as a category in the ethnicity question in Scotland and England and Wales, and Catholic was included as a separate category in Scotland for two questions on religion covering both current belonging and upbringing. This paper reviews the evidence which prompted the inclusion of these categories, and sets it in the context of Irish Diaspora health, by comparing mental and physical health outcomes and mortality of Irish migrants, and their British-born descendants.

The Irish are Britain's largest ethnic minority. Establishing the size of this group is difficult given that the bulk of immigration from Ireland occurred in the mid-nineteenth century. It is further hampered by the inability to disaggregate Northern Irish from other UK origins, and patterns of geographical settlement in different time periods. However, an attempt has been made to enumerate those born in Ireland or who had at least one parent

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or grandparent born in Ireland using data from the 1971 Census (which collected parental birthplace data) and the Longitudinal Study of England and Wales. This estimates the combined first, second and third generation Irish in Britain as six million or 11% of the population (Hickman et al 2001). The inclusion of those of more distant Irish ancestry, such as the long-settled Irish community in the West of Scotland, would further inflate this estimate.

CATHOLIC RELIGION AND IRISH ETHNICITY IN THE WEST OF SCOTLAND

In Glasgow, persons brought up in the Catholic faith comprise about a third of the population. Ethnically, they are mainly of Irish descent, the remainder being made up of a small Scottish Catholic component, and a number of people who convert to Catholicism on marriage, as well as a few immigrant Catholics from other European countries such as Italy and Poland. Irish immigration was substantial from the 1840s, peaked in the 1850s, when around 22% of the West of Scotland population was born in Ireland, and tailed off in the 1930s. It was a response both to push-factors of hardship and famine in Ireland, and the pull-factor of a labour shortage due to the expansion of heavy industry in the West of Scotland. Unlike the South East of England, which experienced a more recent influx around the time of the second world war, there was no 'second wave' of migration to Scotland. So its Irish population is longstanding, mainly fourth and fifth generation, and there are very few recent migrants. The 1991 census recorded only 1.6% of Glasgow's population as born in Ireland.

Of the immigrants from Ireland, probably about three quarters were Catholic. Despite the effects of outmarriage and lapsation over four or five generations, about three-quarters of their descendants in the West of Scotland are likely to be still identifiable as Catholic (Williams 1993). Irish Protestants also migrated to Scotland during the nineteenth century, making up about a quarter of the total number. But often these Protestants were of Scottish ancestry whose forebears had moved to Ireland during its colonisation. The Protestants intermarried with the Scots to a much greater extent than the Catholics, such that their Irishness became so diluted over the generations that they are no longer distinguishable as a group.

METHODS

Identifying Irish Catholics for research in Glasgow presents some difficulty. A question on ethnic origin asked in the first wave (1987) of the West of Scotland Twenty-07 Study (Macintyre et al 1989) only obtained 1% 'Southern Irish' among 55 year olds (author's unpublished tabulation). As this figure approximates the percentage born in Ireland, the implication is that the second and later generations do not think of themselves as Irish. Thus ethnic origin is not a usable indicator for an Irish population which is mainly upwards of the fourth generation. As an alternative, a question on birthplace of parents and grandparents would identify a greater proportion, but still miss the bulk of the group. Name analysis is another method which can be used to classify surnames as Irish or other. This is possible because Irish surnames or spellings are generally quite distinctive, but again the method becomes less useful with every passing generation because of mixed marriages. The most enduring identifier of this group appears to be Catholic religion of background. This is usable for cohorts born before 1970 (when mixed marriages began to increase), and it was asked in the Scottish Census of 2001. Catholic identification remains high even among the non-practising, and is the primary marker used for social labelling in Glasgow. Because of the substantial overlap between the two categorisations, Irish and Catholic, in the West of Scotland, research using either identifier in this area will necessarily yield information on the other (Williams 1993). This is not to say that Catholicism is taken as an unproblematic proxy for Irishness, but given the difficulty of identifying the descendants of the Catholic Irish in the West of Scotland, it represents the best attempt to identify a hidden population group about which there are health concerns. Such health concerns ought to be investigated despite this group's lack of a sense of Irish identity. It should be noted that using Catholicism as a proxy for Irishness would not hold in other parts of Britain, where the Catholic community comprises a larger proportion of non-Irish ethnic groups. Insofar as there is misclassification, its consequence will be to underestimate the magnitude of any inequality in health. A similar argument applies for the use of Irish surnames as a proxy for Irish Catholic origins in the West of Scotland.

THE HEALTH OF PEOPLE OF IRISH ORIGIN IN THE WEST OF SCOTLAND AND OTHER PARTS OF BRITAIN

Like some more visible ethnic minority groups in Britain, the Irish experience elevated death rates and excess illness. I now summarise the evidence relating to the West of Scotland, and set it in context of findings from other parts of Britain. Readers should note the very limited comparability between the long-standing Irish Catholic population of the West of Scotland with more recently arrived Protestants and Catholics from both parts of Ireland in England and Wales, to which the cited studies refer. Evidence relating to first and second generation Irish in Britain is included in the absence of data on more long-established Irish communities outside the West of Scotland. The purpose of their inclusion is to compare the nature of Irish health disadvantage between the West of Scotland and other parts of Britain, and to investigate commonalities and differences in the explanation of inequalities. Mortality results are presented first, then studies relating to child, working age and elderly populations respectively, following a life-course approach.

Mortality

A high rate of deaths has been found among men with Irish surnames in the West of Scotland, particularly from cardiovascular disease (Abbotts et al 1998), using data from the Midspan Study. In this study, 5,700 male employees aged between 35 and 64 were examined in 27 workplace settings in Glasgow, Grangemouth and Clydebank between 1970 and 1973. Twenty-one years' mortality follow-up was analysed from a survey involving a health questionnaire and medical examination, using name analysis to identify those of patrilineal Irish descent. Fitting Cox's proportional hazards model to date of death, using date of birth and Irish name as covariates, resulted in the Irish showing elevated mortality from all causes¹ and coronary heart disease². Mortality risk for men with an Irish surname was also elevated for cerebrovascular disease³, respiratory disease⁴ and injury or poisoning⁵,

¹ relative risk 1.22; 95% confidence interval [1.08, 1.38].

² relative risk 1.53; 95% confidence interval [1.27, 1.83].

³ relative risk 1.30; 95% confidence interval [0.86, 1.95].

⁴ relative risk 1.17; 95% confidence interval [0.73, 1.86].

⁵ relative risk 1.42; 95% confidence interval [0.78, 2.61].

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although the low numbers of men dying from these causes meant that differences did not reach statistical significance at the 5% level. No differences were observed for cancer or other causes.

These findings are consistent with results from the Longitudinal Study (Fox and Goldblatt 1982) of excess all-cause mortality among third generation Irish living in England and Wales aged under 55 in 1971⁶ (Harding and Balarajan 2001). This pattern is continued from the second generation, which had excess all-cause mortality among men and women of working age (Harding and Balarajan 1996), although only for all cancers and lung cancer did specific causes demonstrate statistical significance. Comparable levels of excess mortality were seen regardless of which part of Ireland parents originated from or whether mother only, father only or both parents were Irish (Raftery et al 1990).

More data are available for the Irish-born, demonstrating excess mortality of migrants to Britain compared both with those who remained in Ireland and with the England and Wales born population. Considering deaths occurring between 1989-1992 of those aged 20-69, standardised mortality ratios (death rates compared to a reference population with rate 100) were elevated to 139 for Irish men and 120 for Irish women, compared to the total population (Wild and McKeigue 1997). Excesses were particularly noted for ischaemic heart disease, cerebrovascular disease and lung cancer. Deaths from ischaemic heart disease in people aged 20-69 in England and Wales between 1979 and 1983 showed standardised mortality ratios of 114⁷ for Irish-born men and 120⁸ for Irish-born women (Balarajan 1991). This study also found an excess of cerebrovascular deaths among men⁹ and women¹⁰. Analysis of a greater number of causes of deaths between 1970 and 1972 found high standardised mortality ratios among the Irish-born for tuberculosis (men and women), cancers of the buccal cavity and pharynx (men), oesophagus (men and women), liver and intrahepatic bile ducts (men), gall bladder and bile

⁶ relative risk 1.31; 95% confidence interval [1.06, 1.63] for men and 1.55; 95% confidence interval [1.17, 2.05] for women.

⁷ 95% confidence interval [111, 117].

⁸ 95% confidence interval [115, 125].

⁹ standardised mortality ratio 123; 95% confidence interval [116, 130].

¹⁰ standardised mortality ratio 117; 95% confidence interval [110, 125].

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ducts (men), trachea, bronchus and lung (especially women), skin (men), hypertensive disease (men), bronchitis, emphysema and asthma (men and women), peptic ulcer (men and women), cirrhosis of the liver (men and women), 'other' nephritis (men and women), motor vehicle accidents (men and women), accidental poisoning (men and women), accidental falls (men), suicide (especially women), homicide (especially men) and undetermined whether accidental or purposeful injury (men and women) (Marmot et al 1984).

In an analysis based on electoral wards, a higher rate of stroke mortality among middle-aged men in London between 1986 and 1992 was partly explained by the proportion born in Ireland (Maheswaran et al 1997). Analysis of suicides in men and women aged 20-69 in England and Wales by country of birth revealed elevated standardised mortality ratios for the Irish of 126 for men¹¹, and 130 for women¹², compared to the host population (Raleigh and Balarajan 1992). These rates were also significantly greater than those found in Ireland. The situation was most extreme for Irish immigrants in their twenties with standardised mortality ratios of 174 for men¹³ and 267 for women¹⁴. Confirmatory results were reported from a London study which imputed suicide to open, unnatural and drug-dependence verdicts in cases where a suicide note had been found and unambiguously indicated suicide or suicidal intent (Neeleman et al 1997).

While indicating cause for concern in terms of current health inequality, mortality statistics mainly tell us about deaths over a specified period of people who may have been born in the earlier part of the twentieth century. There is necessarily a considerable time lag in terms of a population's experience between mortality studies and current health surveys. Such a time lag may mean that inferences about health status from mortality statistics are outdated by the time the statistics are published. They also work less well for younger groups, which have fewer deaths, and tell us nothing about people's health immediately preceding death – whether death was sudden with no prior symptoms or whether it followed a period of ill-health. However,

¹¹ 95% confidence interval [112, 140].

¹² 95% confidence interval [113, 149].

¹³ 95% confidence interval [126, 234].

¹⁴ 95% confidence interval [171, 397].

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mortality statistics are useful for generating hypotheses testable in health surveys.

Health of children

Data from the West of Scotland 11-16 Study (West and Sweeting 1996) were used to compare Catholic and non-Catholic eleven-year-olds on a range of indicators of general health, recent acute symptoms, chronic conditions, mental health and physical measures (Abbotts et al 2001b). No evidence was found of any systematic health inequality. A few indicators did show statistically significant differences at the 5% level, but these were not in any consistent direction. In the Health Survey for England 1999, Irish children and adolescents (aged 2-20) had elevated rates of acute illness¹⁵ compared to the general population (Saxena et al 2002). Birth prevalence of neural tube defects was found to be significantly elevated in babies of two Irish parents compared to the offspring of British or mixed British and Irish parentage, in a study of births in Birmingham between 1963 and 1978 (Leck and Lancashire 1995). The authors note that these findings could not have been due to ethnic differences in antenatal testing for neural tube defects and related termination of pregnancies, as the impact of these practices was 'imperceptible' before 1979 (although it had become very marked by 1984).

Health of adults

Research on the Catholic population in the West of Scotland using the West of Scotland Twenty-07 Study found pervasive, although generally not large, disadvantage throughout a wide range of measures encompassing general and physical health, psychological distress, impairments, disabilities, and physical measures (Abbotts et al 1997). After controlling for the effects of sex and social class, statistically significant Catholic disadvantage was found for poor self-assessed health (at age 58), poor self-assessed health for age (at age 18), having experienced four or more symptoms in the previous month (38, 58), sadness or depression in the previous year (38, 58), having experienced four or more psychosomatic symptoms in the previous month (18), not seeing well enough to recognise someone across the road (18), and self-assessed disability (58). Results for limiting longstanding illness showed no evidence of inequality in the cohorts aged 18 and 58; and an apparent 35% Catholic excess at age 38 failed to reach statistical significance.

¹⁵ odds ratio 1.45; 95% confidence interval [1.10, 1.98].

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Analysis of General Household Survey pooled data from 1991 to 1996 found similar levels of limiting longstanding illness at working ages for first and second generation Irish as for the remaining 'white' group in Britain (Evandrou 2000). This contrasts with evidence from the Census 1991 in Britain that those born in the Republic of Ireland or Northern Ireland had an excess of limiting longstanding illness, standardised for age (Owen 1995).

Remarkably high rates of psychiatric admissions have been recorded for Irish-born men and women in England (Cochrane and Bal 1989). Age-standardised data collected in 1971 showed a similarly large excess of admissions regardless of which part of Ireland a person was born in, whereas data collected in 1981 showed that admission rates for the Northern Irish born had decreased dramatically over the decade, although were still substantially higher than the English-born. Rates for those born in the Republic of Ireland remained very high between 1971 and 1981, and were spread over all diagnostic categories, although particularly noted for alcohol abuse. Contrary to the pattern shown by mental hospital admission statistics, a community study found less psychological disturbance among Irish immigrants than the native English (Cochrane and Stopes-Roe 1979). Furthermore, the Irish in Ireland had no more symptoms than the English in England. They concluded that the high rate of mental hospital admissions among the Irish (in Ireland or England) was due to a small group of disturbed individuals, mainly itinerant or living in hostels, not readily accessible to sample surveys. This is confirmed by a finding of Irish over-representation in hostels for alcoholics (Otto and Orford 1978).

The Health Survey for England 1999 found an excess of limiting longstanding illness for Irish men, and acute sickness among the Irish of both sexes (Erens et al 2001). Among first generation Irish women in England and Wales, excess incidence of lung cancer and lower incidence of ovarian cancer have been recorded (Harding 1998). The same report showed for first generation Irish men, that bladder cancer incidence was lower than in the remaining population. Cancer incidence among the second generation Irish was found to be elevated overall, and specifically for lung, ovarian and cervical cancer among women, and prostate cancer among men (Harding 1998). This could not be explained by socio-economic position. No explanation was offered for the reversal of risk for ovarian cancer between generations.

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Health of elderly people

Analysis of General Household Survey pooled data from 1991 to 1996 of people over 75 appeared to show an excess of limiting longstanding illness and acute illness or injury for (first and second generation) Irish men, and an excess of reporting 'not good' general health for Irish men and women compared to the remaining 'white' group in Britain (although significance levels were not available for these specific comparisons) (Evandrou 2000). For people aged between 60 and 74 in this study, there was no obvious inequality in health, except perhaps an excess of reporting 'not good' health among Irish women.

A study of the mental health of migrant elders in London, found a lower prevalence of dementia among the Irish-born¹⁶ (Livingston et al 2001).

EXPLANATIONS FOR IRISH HEALTH DISADVANTAGE

In the search for explanations of Irish disadvantage in health and mortality, various risk factors have been examined. Considering first the mortality of men with Irish names in the West of Scotland, the 51% excess in deaths from cardiovascular disease was reduced to 35% by adjusting for established medical, behavioural and socio-economic risk factors (Abbotts et al 1999a). Thus, known risk factors were able to partially explain the high mortality, but there remained a substantial excess unexplained by such factors.

Lifestyle factors

Lifestyle behaviour is implicated in a number of causes of death for which an Irish excess has been found. Consider first alcohol use. Increased levels of consumption among men with Irish names were noted in the West of Scotland in the Midspan Study (Abbotts et al 1999a), but not for those of Catholic background in the West of Scotland Twenty-07 Study (Mullen et al 1996; Abbotts et al 1999b). There is evidence of excess alcohol consumption among first generation Irish in England (Harrison and Carr-Hill 1992), associated with being a migrant, rather than Irish ethnicity. A 1971 study showed that the extent of drinking, its social meaning and function were different among English and first and second generation Irish young people,

¹⁶ relative risk 0.36, 95% confidence interval [0.17, 0.87].

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and while ethnic status did not have a direct effect on drinking behaviour, it did have a very strong influence on father's attitude and peer support for drinking (O'Connor 1978). Second generation Irish in this study were found to have the greatest number of heavier drinkers, which was hypothesised to be due to exposure to two cultures in relation to drinking without assimilating the constraints of either culture. A study of alcohol-use-related mortality between 1989 and 1991 in England and Wales, which included alcohol psychosis, alcohol dependence syndrome, alcoholic polyneuropathy, alcoholic cardiomyopathy, alcohol gastritis, nondependent abuse of alcohol, alcohol poisoning and 80% (alcohol attributable fraction) of chronic liver disease and cirrhosis, calculated a standardised mortality ratio of 252¹⁷ for the Irish-born (Harrison et al 1997). There is also evidence of increased likelihood of relapse for Irish alcoholics after detoxification (Foster et al 1998).

Smoking was found to be a minor factor in the excess of deaths among Irish men in the West of Scotland (Abbotts et al 1999a). Similarly, it was not able to explain very much of the Catholic health disadvantage found in the West of Scotland Twenty-07 Study, except for lung power in the 58 year old cohort (Abbotts et al 1999b). Indeed a Catholic excess of smoking was only statistically significant in the 58 year old cohort, and not for the 18 or 38 year olds. Data from the General Household Survey showed that more first and second generation Irish were current smokers, compared to the remaining white population, among those over 60 in 1992, 1994 and 1996, and there appeared to be an excess of heavy drinking by Irish men aged 60-74 (Evandrou 2000).

Walsh and McGrath explored the relationship between identity and health-related behaviour among Irish immigrants in England (Walsh and McGrath 2000). They found that those who positively evaluated their ethnic origins reported engaging in healthier behaviour and adopting more beneficial coping strategies. Those who reported their ethnic origin as more central to their overall identity were also more likely to adopt beneficial coping strategies. However, they had fewer than desired opportunities for expressing their ethnic identity, which was in turn associated with less beneficial coping and health behaviour. Encouragement to feel more positive about Irish identity

¹⁷ 95% confidence interval [223, 286].

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might result in greater usage of behavioural approach coping, and improved health-related behaviour.

Socio-economic factors

Relative poverty during childhood and adulthood (as measured by father's social class and own current social class) were the main influences on high Irish mortality in the West of Scotland (Abbotts et al 1999a). Unlike in Scotland, the excess mortality of second (Raftery et al 1990; Harding and Balarajan 1996) and third (Harding and Balarajan 2001) generation Irish in England and Wales was not explained by socio-economic position, as measured by housing tenure and car access.

A higher proportion of Catholics in the West of Scotland were in households headed by someone of manual social class (Abbotts et al 1997; Abbotts et al 2001b). This was seen in all age cohorts (11, 18, 38, 58) and mirrored other socio-economic indicators. By controlling for social class, school leaving age, housing tenure and car ownership, part of the Catholic health disadvantage was explained (Abbotts et al 2001a). By focusing on the eldest cohort, where inequality was most pronounced, and examining longitudinally a number of key health measures, the direction of causality was established in favour of socio-economic disadvantage preceding ill-health.

There appeared to be lower incomes and excess deprivation among first and second generation Irish people over 60 in the General Household Survey 1991-1996, although statistical significance levels for these specific comparisons were not available (Evandrou 2000). In the multivariate analyses of these data, income and deprivation were able to explain ethnic differences in limiting longstanding illness among men over 60. They were not able to explain the excess of reporting 'not good' general health among first and second generation Irish women over 60. There is evidence of socio-economic disadvantage among first generation Irish migrants to England, by a range of measures in the 1991 Census (Model 1999), assumed to be partly associated with negative selectivity: that is, unlike the situation in populations where the costs of migration are much higher, among the Irish it tends to be the less well off who come to Britain. In contrast, a slightly better head of household social class profile was tabulated for (mainly second generation) Irish children in the Health Survey for England 1999 than the general population (Saxena et al 2002).

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Diet

The West of Scotland diet is notoriously deficient. To properly investigate whether the Irish Catholic diet is any worse than the general population's would require a weighed food intake study, which has not been done. However, for the middle cohort of the West of Scotland Twenty-07 Study, self-reported frequency of eating certain foods was examined by religion and compared with contemporaneous health promotion guidelines (Mullen et al 1996). Catholic diets appeared to be less healthy overall, with lower consumption of fruit, yoghurt and vegetables, and an excess of snacks and processed foods. This was explained to some extent by social class. Education explained the remainder of the Catholic difference.

Other factors

So what of the remaining excess of deaths and ill-health unaccounted for by established risk factors? It may be that socio-economic position is being inadequately measured. Broad categories such as a manual/non-manual social class classification (as has been used in the two West of Scotland studies) will have concealed the extent to which Irish Catholics are in the worst jobs within each stratum (Williams and Ecob 1999).

Looking to the country of origin for (genetic) explanations for the high mortality and morbidity of Irish migrants and the subsequent British-born generations has been done by a number of authors. Considering migrant mortality generally, there is a health selection effect, with those who emigrate being healthier. Migrants tend to have lower mortality than in their home country and the host population. After one or two generations, however, the influence of lifestyle and environmental factors results in a mortality profile similar to the host country. Unlike immigrants to Britain from the new Commonwealth or the Indian subcontinent, for whom there are many barriers to immigration, such as distance, expense and border controls, the Irish have much freer access to Britain. It is possible that this ease of access diminishes the health selection effect, and leads to the less healthy Irish migrating to Britain. Evidence for this is suggested by mortality figures. Whilst immigrants to England and Wales from the Caribbean commonwealth and Italy have lower mortality than their home countries, Irish male migrants have raised mortality and Irish female migrants have a similar mortality profile to the population of Ireland (Republic and Northern Ireland) (Adelstein et al 1986). Immigrant mortality in both sexes is generally highest relative to Ireland in conditions whose causes are largely behavioural responses to

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stress. Thus factors associated with the country of origin are unlikely to be responsible for the excess mortality of the Irish in Britain, and problems related to migration stress and assimilation difficulties need to be examined.

Religious bigotry is commonplace in the West of Scotland, in particular anti-Catholic prejudice. Discrimination has been suggested as a factor in the lower socio-economic position of the Irish in Britain (Hickman and Walter 1997). Experience of religious discrimination was asked in the latest sweep of the West of Scotland Twenty-07 Study. Analysis of these data will enable us to quantify discrimination in all cohorts for the first time. Anti-Catholic discrimination may be operating as people apply for jobs initially, and as they seek promotions. Complementary data from a qualitative project which examined experience of discrimination throughout people's careers found widespread anti-Catholic discrimination reported by both Catholics and Protestants (Walls and Williams 2003). Qualitative and quantitative data collected from second generation Irish adolescents in Birmingham and London illustrated problems with prejudice and issues of identity (Ullah 1985). Some of these adolescents took pride in their Irish origins, but felt the strain of negative stereotypes, anti-Irish jokes and the troubles in Northern Ireland; for others, these were reasons to hide their ethnic origins and attempt to 'pass' as English. Those rejecting the stigma of their Irish origins recreated positive group characteristics of 'friendly' and 'fun-loving' to replace the negative ones of 'drunkenness' and 'stupidity'. A study of a clinical population with severe mental illness found the Irish more likely to perceive discrimination as a factor in life events in the legal category than white British patients, but no significant difference for life events related to assault, finance, health or housing (Gilvarry et al 1999).

AGE AND COHORT EFFECTS IN IRISH CATHOLIC DISADVANTAGE

The inequalities in health in the West of Scotland were most extreme in the eldest cohort (age 58), and hardly apparent in the youngest (age 18). The inequalities in smoking followed the same pattern. The inequalities in social class were very large in all cohorts of the West of Scotland studies. Social class results from the Scottish Social Attitudes Survey collected between 1999-2000 showed that Catholics were less likely than Protestants to occupy non-manual jobs (Bruce and Glendinning 2003). This was most extreme among respondents aged 55 or over and those living in the South West of

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Scotland, but still apparent for younger age groups and other regions. There are two ways in which this patterning by age can be interpreted, and scholarly support is found for both hypotheses. Is inequality emerging with age? Do the effects of ageing, such as increased illness, happen faster for Catholics than others? Alternatively, is the inequality a feature of one particular cohort throughout their lifespan, which is not seen in younger cohorts? An age effect would describe the former situation of Irish Catholic disadvantage emerging in all cohorts as they get older. In this case we would expect inequality to emerge convincingly in the youngest cohort as it moves towards mid-life. Alternatively, the pattern could be a cohort effect, such that particular historical circumstances resulted in Irish Catholic disadvantage for the oldest group, and to a lesser extent the middle group, who grew up in the aftermath of the second world war. But later born cohorts might go through life without disadvantage.

In their chapter of a book whose contributors mainly argued that Catholic disadvantage was a thing of the past, Williams and Walls showed that it had diminished but was still apparent, and showed that younger Catholics who had achieved socio-economic equality may be 'stalling' in this process by early mid-life (Williams and Walls 2000). Continuing social disadvantage is likely to be replicated by health disadvantage in (later) adult life, despite it not being apparent during adolescence (Abbotts et al 2001b). Further data to address the question of whether the socio-economic gap between Catholics and non-Catholics in the West of Scotland is diminishing between generations or over time continues to be collected. At present we cannot be optimistic about health equality enduring for people born in the 1970s and 1980s, because this will depend on the effects of different influences on health over the life course, and Catholic social mobility.

CONCLUSION

In conclusion, health disadvantage persists among Catholics in the West of Scotland, who are mainly of Irish descent, as it does for more recently arrived Irish immigrants in England. From the research that has been done on men with Irish surnames, and those of Catholic background in the West of Scotland, we have shown how historical health disadvantage has passed through the generations when there has been nothing in place to reverse fortunes. There is evidence that this is partly related to long term socio-economic disadvantage, and to a lesser extent to lifestyle. In contrast, in

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England and Wales, where comparisons are limited by most of the data relating to migrants or their children, the balance of explanations is reversed, with evidence implicating behavioural responses to stress in the migrant generation, such as smoking and heavy drinking, but not socio-economic position in the longer term. In response to pressure from the research community (Walls 2001), the Scottish Census of 2001 included 'Irish' as an ethnic category and 'Catholic' as a religious group. Research on Irish Catholic health in the West of Scotland will now be much enhanced. Current public health and social surveys are using the Census questions, and the issue of Catholic disadvantage and whether, over time, there is progress towards equality, will be further illuminated.

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March 2003