

## Research paper

# ‘You doctor yourself’: health beliefs, resilience and well-being among the Irish in Yorkshire

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### What is known on this subject

- The health of the Irish in the UK is exceptionally and persistently poor relative to that of the white majority.
- Health inequalities continue across the generations, and relate to both physical and mental health.
- There are significant gaps in knowledge relating to health beliefs, health-seeking behaviours and use of health services.

### What this paper adds

- Resilience is a key coping mechanism in illness and health.
- The social dimensions of health have particular resonance for Irish people.
- Irish people use a wide range of strategies and resources to maintain health and cope with illness.
- Community intermediaries have a key role to play in public health initiatives aimed at Irish people.

## ABSTRACT

There is a growing body of evidence that points to the poor health of the Irish in the UK. Based upon two focus groups, a total of 15 in-depth interviews and a self-completion survey of Irish people in a medium-sized town in Yorkshire, this paper uses a socio-ecological framework to explore the effect of social and cultural factors on Irish people’s health. First, the article argues that the explanatory theory of *resilience* is central to Irish people’s attitudes towards health. Resilience is manifested in the related concept of *reliance* (on the self and on others), which informs health-seeking behaviours and health service

use strategies at both an individual and a community level. Secondly, the *social context* is a crucial yet hitherto underdeveloped component of Irish people’s conceptions of health and health-seeking behaviours. Thirdly, the construction of *well-being* is also firmly rooted in a social conception of healthy living which has yet to be adequately recognised by health researchers and health policy makers.

**Keywords:** beliefs, Irish, resilience, social, well-being

## Introduction

One dimension of inequality between social groups, as defined by socio-economic status, age, gender and increasingly ethnicity, is the experience of ill health and access to health services (Ahmad and Bradby, 2008). There is a burgeoning interest in the health inequalities that are prevalent among minority ethnic groups in both the UK and the USA (see Box 1)

(Kelleher and Hillier, 1996; Nazroo, 1998; Hseuh-Fen *et al*, 2004). Understandings and experiences of health and illness vary through time and across cultures (Kleinman, 1981). Religion and spirituality among minority ethnic groups may also have a bearing on health outcomes (Larson and Larson, 2003; Walls and Williams, 2004). Despite a growing focus on cultural

### Box 1 Health inequalities and health behaviours

**Health inequalities** may be defined as differences in health status or in the distribution of health determinants between different population groups (World Health Organization, 2010).

**Health behaviours** are defined as activities followed in relation to the maintenance of health (Kasl and Cobb, 1966).

explanations for health inequalities, there has been a tendency to treat culture in relation to health as a solely individual trait that is directly responsible for individual behaviour (Hseuh-Fen *et al.*, 2004), rather than treating culture as dynamic and shared on a social level, as well as on an individual and familial level. This position lends itself to a further tendency to pathologise individuals' culturally informed health behaviours (Walls, 2006). Influenced by their cultural experiences and diverse backgrounds, individuals actively interact with their environment to structure their health behaviours (see Box 1; Hseuh-Fen *et al.*, 2004). However, a shared culture is viewed as just one factor among many that influence health outcomes. Diversity among the Irish in terms of age, socio-economic factors and migration experiences (Casey and Flint, 2008) may also impinge on health and well-being. Thus cultural factors pertaining to health can only have meaning within a given context, and it is imperative to place culture *in situ*.

This paper aims to contribute to an understanding of ethnicity, culture and health among Irish people by utilising their narratives to examine how their *resilience*, in the form of *reliance* on the self and others, shapes their health experiences. The desire to cope with the minimum recourse to formal healthcare is explored as a key aspect of health behaviours and experiences. This is complemented by an examination of the influence of familial and social support and community networks in order to obtain a more nuanced perspective on ethnicity and health. Health is viewed as an embedded social practice that is mediated by family and community structures, concerning which, with some notable exceptions (Malone, 2001; Ryan *et al.*, 2006), there has been a paucity of research.

## The nature of resilience

Resilience as a concept has emerged in recent years in an effort to ascertain how individuals and families cope in the face of multiple and overlapping challenges, such as poverty and ill health (Canvin *et al.*,

2009). Resilience theory is concerned with the factors that enable individuals to overcome such adversities, and signals a clear shift away from the deficits approach to social issues. In brief, resilience focuses on strengths and assets rather than on pathology and problems. Such assets might be cultural or social, and contribute to resilience at the individual and community level (Friedli, 2009, p. 23). Resilience is not only a trait of the individual, but is also conceptualised as a process and a response to the social environment. The health literature suggests the importance of understanding resilience in its wider context as a product of close collaboration and mutual co-construction between the individual and the collective (McCubbin *et al.*, 1998). This theorisation of resilience is of particular relevance to the health of the Irish in the UK, as will be evidenced throughout this paper.

## The health of the Irish in the UK

Studies on the health of the Irish in the UK focused initially on addressing the health risk factors, linked mainly to lifestyles and health-damaging behaviours thought to engender health inequalities (Adelstein *et al.*, 1986). Mental health was identified as being of particular concern for Irish people (Bracken *et al.*, 1991; Leavey, 1999). These studies were groundbreaking in their focus on the Irish as a distinct ethnic group and on the health inequalities experienced by Irish people. However, although they provided a much needed evidence base, they also had the unintended and unavoidable consequence of individualising health problems rather than locating these inequalities in their wider context. The emphasis has been broadened somewhat in recent years to take into consideration wider socio-economic and structural factors (Tilki, 2003), such as discrimination (Hickman and Walter, 1997; Tilki, 2003), religion (Walls and Williams, 2004), culture (Kelleher and Hillier, 1996), the migration experience (Leavey, 1999), and how Irish identity is a factor in health outcomes (Kelleher and Hillier, 1996; Kelleher and Leavey, 2004). Clucas (2009) found a persistent health disadvantage for first-generation and UK-born Irish people living in England, and suggests that aspects of ethnicity relating to structure and identity may be relevant factors.

There is a growing body of evidence that the Irish in the UK do experience health inequalities which continue across generations, and relate to both physical and mental health disadvantages (Tilki, 1998; Horn *et al.*, 2008), as well as related discrimination and socio-economic disadvantage (Hickman and Walter, 1997; Walls, 2006). The comparatively high levels of health problems within the Irish population are compounded by the lack of ethnic monitoring, and hence

the invisibility of the Irish community to public health authorities and service providers more generally (Mac An Ghaill, 2000; Casey and Flint, 2008).

However, although there is a growing interest in the health needs of the Irish, there are significant gaps in knowledge. In particular, very little is known about health beliefs, health-seeking behaviours and the use of health services. With some notable exceptions (McGee *et al*, 2008; Mulligan and Daly, 2009), there is a distinct lack of empirical analysis which links Irish health experiences at the local micro-level of health service provision. The need to situate the health profile and experiences of the Irish within a social context is clear, and it provided the rationale for the socio-ecological theoretical approach that was used in this study (Sword, 1999; Sallis and Owen, 2002). Consistent with the objective of adopting an approach that would privilege the voices of the research participants, grounded theory was used to investigate how individuals made sense of health and well-being within the context of their everyday lives. The next section outlines the background to the study and research methods, the grounded theory approach and the socio-ecological analytical framework used in the study.

## Conduct of the study

### Background and methods

Calderdale in West Yorkshire has a small but ageing Irish population of 2082, and constitutes the second largest minority ethnic group in the town (1.1% of the population, compared with 4.9% who are Pakistani) (Office for National Statistics, 2001 Census). This qualitative study was commissioned as a result of engagement between the primary care trust, NHS Calderdale and local Irish residents who were advocating the health needs of the local Irish population. The research focused on Irish people aged 50 years or over.

The aim of the research was to present a qualitative account of the health needs of the Irish population in Calderdale. The following research questions were included in the study:

- What are the life experiences and health beliefs that inform the health behaviours of older Irish individuals?
- What are the expressed health needs of the Irish population?
- What resources do Irish people draw upon to meet their stated health needs?

The research methodology was informed by three guiding principles. First, the working definition of 'Irish' referred to individuals of Irish origin, whether they were born in the republic of Ireland, Northern

Ireland or other parts of the UK, or elsewhere. Secondly, a broad definition of 'health' was used to include aspects of participants' physical, emotional and social health and well-being. Thirdly, there was recognition of the diversity of the Irish population in Calderdale (e.g. with regard to age, gender, religion, country of birth, housing tenure and occupation) and the varying degrees of individuals' involvement in Irish community activities.

A number of approaches were used to advertise the study and to recruit participants, with the aim of minimising any possible bias caused by disproportionate representation from any one source of recruitment (Scanlon *et al*, 2006). The study was publicised both nationally and at local level. Respondents were recruited from an article in the *Irish Post* and the *Irish World* newspapers (the weekly newspapers for the Irish in the UK) and from a local Irish radio programme. Information about the study was placed on the Federation of Irish Societies website. Finally, a briefing about the study was given at the monthly Luncheon Club for Irish Elders at the local Irish Centre, and surveys were distributed among attendees. The project was reviewed by Sheffield Hallam University's ethics committee and a favourable opinion was obtained.

### Data collection

Data were collected over a five-month period between November 2008 and March 2009. A postal survey was undertaken which sought information on a broad range of health issues, including the health status of respondents, their views on health and well-being, and their experiences of health services. In total, 113 out of 600 questionnaires were returned.

Two focus groups, each consisting of 10 participants (six women and four men), explored in detail the views, attitudes and experiences of the participants. Although the focus group discussions were guided by a number of broad themes relating to health and well-being, the emphasis was on what the participants themselves thought was important and relevant about these issues.

After the focus groups, a series of 15 one-to-one interviews (with seven women and eight men) were conducted (see Box 2; nine of the interviewees had taken part in the focus groups). These interviews gave participants the opportunity to raise issues relating to their own health and well-being that did not arise in the group discussions. Interviews lasted between one and two hours and took place in individuals' own homes. Care was taken to preserve the participants' anonymity and confidentiality, and inclusion of biographical details was kept to a minimum. In total, there were 119 participants in the study.

## Box 2 Interview topic guide

### General background and circumstances

- Can you tell me a little bit about your migration story? (length of time in England, circumstances when arrived in England, alone or with family, etc.) *or*
- Can you tell me about your Irish background/heritage?
- Where have you lived since you arrived here? *or*
- Where did you grow up?
- Can you tell me about your family/marriage or relationship/children/extended family?
- Can you tell me about your employment history?

### Health profile and beliefs

- Are you in good health? What about your partner/children/extended family?
- Do you have any health concerns? What about the rest of your family?
- What about the health of Irish people in Calderdale generally?
- What do you mean by 'being in good health'?
- What do you understand by the term 'well-being'? What does that mean for Irish people?

### Health interactions and services

- Are you registered with a GP?
- Do you go to the doctor regularly/at all?
- What has your experience of doctors/hospitals/healthcare staff been like?
- Have you had any negative experiences?
- Have you had any positive experiences?
- Do you think there are any barriers for you in accessing healthcare?
- Do you think there are any barriers to accessing healthcare for Irish people in general?
- Do you have any other health concerns?
- Do you have any other comments about health issues?

## Analytical framework

### Grounded theory

Grounded theory (GT) is a research approach that has its origins in the interpretive tradition of symbolic interactionism (Glaser and Strauss, 1967). Attridge-Stirling (2001, p. 385) indicates that an inductive approach begins with researchers immersing themselves in the data in order to identify themes. The development of inductive categories allows the researcher to link or *ground* these categories to the data from which they derive (Berg, 1989, Ononeze *et al.*, 2009). It is also reasonable to assume that general insights and questions about what was being studied would be partially drawn from the literature. It was this interplay of experience and inductive and deductive reasoning that led to a decision to deploy a grounded theory approach to the analysis.

Three interrelated and unifying categories of resilience were identified, namely beliefs and knowledge about health, experiences of reliance on self and others, and the strategies involved in managing health and well-being in day-to-day life. The first category (beliefs and knowledge) relates to lay conceptions and understandings of health and well-being in the context of daily life. Health beliefs are closely linked to views

about the appropriate resources and support that can be called upon in times of illness, hence the second category, a key feature of which is reliance on family, friends and other social support. The third category reflected the strategies deployed in times of illness. These are closely related to the social context and interactions between participants and health service providers and professionals at a local level. In order to explore the relationship between these lay health beliefs and behaviours, a socio-ecological framework was used that was adapted from the model of Sallis and Owen (2002).

### Socio-ecological approach

Although there have been advances in understanding how some determinants of health, such as socio-economic circumstances (Nettleton, 1995) and gender (Roberts, 1985), may affect health, more embedded or implicit determinants such as cultural expectations and beliefs may be overlooked, and the limitations of focusing solely on individual behaviour are now recognised. The focus has moved towards approaches that situate the individual within their social and cultural milieu. This allows the identification of a range of domains of influence on health behaviours. These include beliefs, knowledge, attitudes and skills

of individuals, the proximal social environment, social norms, organisational and community social structures, and the relevant attributes of physical environments (Owen *et al*, 2004). The ecological approach recognises that human behaviour is a consequence of transactions at multiple levels of influence, including intrapersonal, interpersonal, organisational or environmental, community and policy arenas. The theory of resilience was analysed within a socio-cultural framework in order to identify how multiple domains of influence affected health behaviours, experiences and interactions with health services. This showed the importance of considering how health beliefs and behaviours operate beyond the level of the individual and how different factors will come into play to influence health behaviours (see Figure 1). The remainder of this paper sets out how health beliefs, well-being and interactions with health services are influenced by the social context of being Irish in a particular time and place. It is important to analyse how those elements are shaped within personal histories played out within social and cultural settings.

## Findings

### Health beliefs: resilience and identity

The majority of the participants had arrived in Yorkshire during the 1950s and 1960s to seek work in the mills and foundries or the two local hospitals, which employed a large number of Irish nurses who were mainly, although not exclusively, women. It quickly became clear that attitudes towards health and illness are intimately connected with past experiences of earning a living and getting by on a day-to-day basis (Cornwell, 1984, p. 129). It was apparent from personal biographies that participants' health and illness were bound up with their self-image and identity as

hard workers who were able to look after themselves. Coping with adversity was a necessity and a harsh reality of life for those with limited resources to draw on beyond themselves, their close families and the Church:

'You just got on with it and hoped for the best ... that you weren't struck down with anything. If you did get sick God help you.'

(Male participant, Interview 14)

One of the reasons given was that they were a small community dispersed throughout Calderdale, who at the time of the Troubles in Northern Ireland were regarded with suspicion by some local residents. This contributed to the widely held view among participants that one could only look to 'one of your own' to help out in times of need. Irish people tended to socialise among themselves, and relied on the Irish Centre as a place of refuge from the stresses of the Irish migrant experience. It was also a respite from the lodgings where many of the men lived in severely overcrowded conditions.

The participants used contacts within the Irish social network for everything from housing to employment, so when things went wrong, solutions were sought mainly within the community itself rather than from the local authority or social services:

'It's not like it is now with a lot of support for different ethnic groups. When we came over we were on our own. You got no help, only from the Church.'

(Male participant, Focus group 1)

Taking pride in the collective identity of being physically resilient was a key theme. Many of the participants were keen to point out how physically robust Irish people were by comparison with other minority ethnic groups:

'The Irish had to be healthy, didn't they ... working in the foundries was hard, dirty work. When the Irish were gone

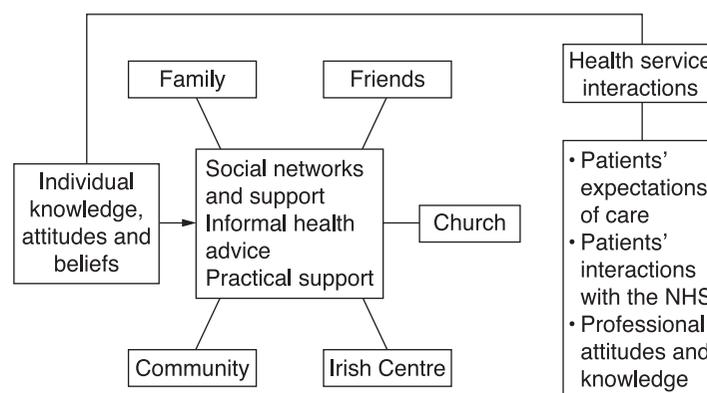


Figure 1 The factors that influence health behaviours

from those jobs they were replaced by Pakistani men and they found that they couldn't do it ... weren't strong enough.'

(Male participant, Focus group 1)

Conversely, being ill was seen as having negative associations and as contributing in some way to the spoiled identity of Irish people. Several studies have reported similar attitudes towards ill health among the white working class in the UK (Calnan, 1987; Blaxter, 1990), but in this study the participants' approach to health seemed to be imbued with a much greater sense of the shared collective reasons for ill health, such as the environment and work-related risk factors, rather than the individualised accounts that have been found in other studies (see, for example, Blaxter, 1990). The past was seen in the embodied present in the physical form of a wide range of complaints, such as arthritis and back problems, all linked directly to working on the roads and building sites and labouring more generally:

'They're bent, they're crippled and they're knackered.'

(Male participant, Focus group 1)

Despite the onset of poor health, there was a general tendency to delay any contact with a GP or hospital, a theme which is explored further below.

## Health and well-being

Both men and women in the study attached great importance to the social and community aspects of health and well-being. When asked to describe a healthy person, the participants articulated a conception of health that was much broader than the absence of illness, and that encompassed some of the key definitions of a social model of health (Marmot and Wilkinson, 2006). Describing their own well-being, the participants broadened their interpretation to include aspects of the community and their social networks:

'energetic, sociable and interested in life ... healthy as in a social person, not just a physical person.'

(Female participant, Interview 2)

When describing the factors necessary for a healthy life, the participants emphasised the importance to their well-being of being able to meet Irish friends on a regular basis, and of 'socialising with other people' at the Irish Centre:

'You need to be able to get out and meet people. I always think that if you can do that you'll stay young and healthy for longer.'

(Male participant, Interview 9)

In contrast to the study by Blaxter (1990), both men and women in this study included social relationships in their definitions of health. Spending time with other Irish people with whom they shared a history and culture had a significant positive impact on their quality of life and well-being. It also meant that friendships, which had been a source of solace when they had first arrived in Calderdale, in some cases alone and without any family support, could be maintained over the years.

The mental distress and anxiety associated with being a suspect community (Hillyard, 1993), and the possible effects on long-term health many years after such events have taken place, albeit difficult to quantify, cannot be discounted without further investigation. Although the political situation in Northern Ireland has changed considerably, there was still a legacy of sticking together in the face of adversity among the older generation, which meant that Irish community activities continued to play a significant role in participants' health and well-being.

The Catholic Church and their Catholic faith was a key aspect of some participants' sense of well-being. In total, just under half (46%) of the survey respondents cited religion and church activities as one means of preventing illness:

'Catholicism stays with you for the rest of your life ... wherever you go it's something you always have ... whatever life throws at ya.'

(Female participant, Interview 11)

Being able to attend mass, or to watch mass on the television, despite ill health, was an integral part of people's faith. Simple gestures such as making sure that they had their rosary beads and holy water by their side on the bedside locker became even more significant when Irish people were ill. The participants spoke of the comfort they derived from being visited by a priest, and receiving Holy Communion while they were in hospital.

It is evident that the study participants had a holistic view of health which incorporated not only physical and mental aspects, but also social well-being. Religious beliefs and the Catholic Church also played a significant role in participants' sense of well-being.

## Family, social and community networks

Self-reliance was clearly a key mechanism for coping with ill health, but self-oriented ways of coping (Tilki, 2003) were complemented by reliance on others during times of ill health. The most commonly used strategy was to confide in family or close friends. For some

older women, daughters provided a steady source of reassurance and guidance about medical matters. In a couple of instances, family members were themselves nurses, which made them ideally placed to give health advice to relatives.

However, it was also common to rely on advice from friends whom they met socially in the Irish Centre, which was itself a key source of practical as well as social support. Individuals at the Centre, who were known to provide help and advice on matters relating to housing and employment, for example, were also consulted about health problems. One participant had acquired a reputation for being able to provide help with a wide variety of issues. The following was a typical case:

‘They’d ask someone else rather than ask the expert [the GP], and it was usually when it turned out to be too late. One fella was quizzing me about his aches and pains and I said “Why don’t you ask the doctor, I can only give you an opinion”. His reply was “If it’s bad news I’d prefer not to know.”’

(Male participant, Interview 7)

The community also provided financial support in the event of accident or illness. When accidents occurred, the first line of action was not to seek state welfare benefits, but to obtain help from the close-knit social network at the Irish Centre and local Catholic Church. The following account was by no means uncommon, and was just one example of this type of support:

‘A 40 ton metal box fell from a crane, sunk him into the sand and paralysed him. He was 35 with a young family to support and he ended up in a wheelchair. My father and uncle used to support him. The community networked.’

(Male participant, Focus group 2)

Another man, who was in his 70s, recounted how he visited Irish people in hospital, including those who were living alone and did not have any immediate family in Calderdale. Every patient whom he visited, including second-generation Irish people, would be given £1 from the Irish Club fund:

‘I’d get people at the [Irish] club to let me know who was in hospital and I’d go and visit them ... I went to eight different people in one night. Every one of them got the princely sum of a £1 just because they were in hospital, regardless of their circumstances.’

(Male participant, Interview 13)

Community intermediaries, who helped other Irish friends or acquaintances to access social care and healthcare, were a key feature of the Irish social network in Calderdale. More recently, a couple of individuals had decided to take a lead on health issues of particular relevance to Irish people, and to encourage them to have vaccinations and go for health checks. One member of the Irish Centre had also become

involved in a local black and minority ethnic (BME) health forum, in order to ensure that Irish health needs were not forgotten.

In summary, the family, social support and the Catholic Church were key resources that influenced individuals’ health behaviours and strategies. In times of ill health, and at the end of life, emotional support and financial help from within Irish social networks were significant factors in coping, and there was a reluctance to use more formal sources of help. However, and perhaps not surprisingly given the age profile of the respondents, individuals also used health services. This topic is addressed below.

## Health experiences and interactions

The attitude of Irish people towards their own health encompassed a large degree of resilience, self-help and fortitude in the face of real or potential health problems. This self-reliance also influenced their use of health services. Reluctance of Irish individuals to engage with health services as a result of previous negative experiences has been noted in other studies (Tilki, 1998; Walls, 2006), and was borne out in Calderdale. Although the majority of the Irish people in the study were registered with a GP, they were inclined to wait as long as they could before consulting with a doctor:

‘If it’s not an emergency I’m happy to wait my turn. That’s the kind of thing an Irish person would say to you.’

(Female participant, Interview 8)

Many older, first-generation Irish people were still influenced by childhood experiences of delaying seeking medical care because of the financial implications of doing so, as has been suggested in other studies (Scanlon *et al*, 2006). The lack of a national health service in Ireland and the resultant high costs of going to consult a doctor meant that Irish people grew up with the culture of going to see a GP only when it was absolutely necessary:

‘There was never the money to go to the doctor when we were growing up ... so it never crossed your mind to go unless you were very, very sick.’

(Male participant, Focus group 1)

Attitudes towards the medical profession were passed on to second- and third-generation Irish people, who were also thought to have a healthy disrespect for health professionals. The following account from a second-generation Irish woman highlights how health beliefs are transmitted from Irish parents to their English-born children:

'My mother was terrified of doctors. She had a brother who died of TB and that put her off doctors. ... She was afraid of hospitals ... I'm the same about doctors, etc., very sceptical. I have to be nearly dead before I go to one. It must have come from my mother that.'

(Female participant, Interview 11)

Although the majority of the survey respondents expressed great satisfaction with the NHS generally, 18% of them felt that there was a lack of cultural awareness on the part of health professionals in understanding Irish people. Although the participants had not experienced any deliberate discrimination, they did encounter a lack of understanding of their cultural needs and background. Cultural beliefs with regard to religious practices, language and the family were identified as areas where Irish people were distinguished from the general population, and which had a bearing on their interactions with the health service:

'They [nursing staff] had no idea about the rosary beads – one of them said 'he kept looking for these beads' as if they were nothing.'

(Female participant, Focus group 2)

Several other participants reported difficulties in communicating with their GP practice due to their accent and use of Irish phrases:

'Jim's [Mayo] accent was as strong as the day he landed in England. He was talking so fast the doctor couldn't understand him at all. I had to repeat what he was saying.'

(Female participant, Interview 3)

There was a lack of understanding of elderly Irish people's reluctance to attend a GP practice or hospital, and the anxiety that they felt about being in the unfamiliar environment of a hospital. These negative experiences led to feelings of lack of control for some participants, which were manifested in their low take-up of health services. This indicated that stoicism and resignation were not necessarily inherent, but rather were borne out of previous experiences with the health service, among other factors.

Whereas some of the men and women in the study were passively receiving healthcare, or being self-reliant by avoiding the NHS, others were adopting a more pro-active approach to coping with illness, which involved seeking help both within and outside the NHS. Age emerged as a significant factor in this regard. Older people (aged over 65 years) were inclined to defer to the expertise of health professionals and not question the treatment that they were given. In contrast, younger participants (aged 50–64 years) were far more likely to be active in managing their own health problems. Being pro-active about health matters manifested itself in an apparent willingness to pay for

private medical care in the face of long waiting lists or unsatisfactory treatment options. Perhaps also reflecting the system of private healthcare in Ireland, of which many participants had first-hand experience, a small number of younger Irish people in the study were prepared to fund their own consultations and treatments. One middle-class professional woman went to some lengths to ensure that she could see the same dentist even after she had moved some distance away from the dental practice:

'I travel 60 miles to see the same dentist – and he's a private dentist, not the NHS. I do pay for the dentist because I'm willing to do that for the sake of my teeth.'

(Female participant, Interview 11)

Paying for private healthcare was not the preserve of Irish professionals. In one instance, a man who had been in the army for a number of years, and who was not financially well off, borrowed a significant sum of money to fund his heart surgery:

'I had to have a triple by-pass ... I had to borrow eight and a half thousand pounds for the operation. There was a 20-month waiting list at the time on the NHS so I went private. I have paid back the eight and a half grand with no help from the council or anybody else.'

(Male participant, Interview 14)

Another strategy for dealing with illness was to seek healthcare from complementary medical practitioners. This achieved the dual goals of avoiding getting treatment from the NHS while also taking control by exploring alternative options. A minority of participants expressed positive views about a range of complementary medical treatments, such as reflexology and iridology:

'I think alternative medicine is good. My husband is also going to a chiropractor ... alternative medicine has a place.'

(Female participant, Interview 8)

A small number of participants (mainly those who were relatively young) were also using the Internet to obtain health advice.

This indicates that there are diverse health behaviours among the Irish population, and it challenges the notion that Irish people are, in the main, passive or unwilling consumers of healthcare. Some Irish people are asserting a degree of control over their own healthcare and have a variety of reasons for doing so. In some instances they are motivated by previous negative experiences of the NHS, or the desire to be seen privately or more quickly, or to ensure continuity of care. In other cases, motivation stems from wanting to opt out of the NHS altogether by accessing alternative health advice and health professionals.

## Conclusion

This paper has addressed its stated aims of understanding how resilience, social networks and well-being affect the health of Irish people. Drawing in particular on the work of Nettleton (1995) and Kelleher and Leavey (2004), it contributes to studies of cultural diversity in health in three ways.

First, among Irish people, resilience is a key coping mechanism in illness and health. Many of the findings concur with the results of previous studies on the self-reliance of Irish people (Tilki, 2003). However, this study develops this concept further by presenting a more nuanced understanding of self-reliance and coping mechanisms within Irish social networks that affect health. The importance of the community in providing practical and emotional support in times of ill health is highlighted. Furthermore, it points to the role of community-minded individuals in providing lay expertise and advocacy, key assets that could be used as a bridge between Irish people and their access to health services.

Secondly, this study engages with and seeks to elaborate the conceptualisation of well-being among Irish people, a subject about which there has been a dearth of research to date. The importance of social interactions both with other Irish people, and more generally, engenders a sense of well-being. Health and well-being are closely related to social dimensions of health (Saltonstall, 1993), which have particular resonance for Irish people. This points to the importance of moving beyond the biomedical model to a broader understanding of the complex ways in which Irish people view their own state of well-being. It suggests that religiosity is a key factor in understanding some Irish's people's conceptualisation of having a healthy mind and body, a factor that does not feature widely in the literature on the sociology of health.

Thirdly, this study highlights the wide range of strategies and resources that Irish people employ in order to cope with health problems and deal with illness. Although Irish people share a cultural heritage that has some influence on their health beliefs, this study demonstrates that differences are just as important. These differences are most clearly manifested in knowledge about health issues, the way that people access health services and the variety of services used. Indeed, the diversity of Irish people's approaches to healthcare, some of which appear to be age related, is a key issue that would benefit from further research.

From a public health policy perspective, focusing on resilience rather than a deficit approach offers the possibility of a more balanced discourse when considering outcomes for the Irish population. Acknowledging that the Irish in the UK have resources at their disposal and long experience of community self-help,

while also addressing relevant health inequalities, is a first step towards sensitising health programmes aimed at this ethnic group. There is also a pressing need to acknowledge the diversity of the Irish population in terms of socio-economic, generational and migration experiences, and to take this into account in public health initiatives. Finally, giving due regard to the value of lay expertise and knowledge and the vital role of community activists presents an opportunity for Irish people themselves to play an active part in the health of their own communities.

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#### CONFLICTS OF INTEREST

None.

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