'The very pests of society': the Irish and 150 years of public health in England

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After all, emigration is not just a chronicle of sorrow and regret. It is also a powerful story of contribution and adaptation.

(President Mary Robinson, 2 February 1995)

ABSTRACT – In the context of efforts to reduce health inequalities, the health status of the Irish in England should be a major subject for concern. As England's longest standing and most numerous ethnic minority, the Irish have at times been regarded as a public health threat and have repeatedly been stereotyped in literature and image. There has also been a failure to recognise and celebrate the contributions to the improvement of public health made by members of the irish community such as Kitty Wilkinson. In recent years alarming evidence has emerged that the mortality of Irish people living in England appears to have worsened in successive generations. Comparison of available data on some of the key determinants of ill health shows that the Irish in England have a worse profile than the Irish living in Ireland. A concerted programme of action is needed to investigate why the irish should have such poor health status and to develop a programme to address it.

KEY WORDS: determinants, ethnic minorities, health inequalities, Irish, lifestyle, public health

The fortunes of the islands of Ireland and Britain have been linked, for good and ill, since time immemorial. Evidence of the exchange of people and goods across the Irish Sea predates history, but the most profound effects occurred in the last two centuries of Irish migration. It is a common belief that mass Irish migration to England only took place following the Irish famine of the late 1840s. Some modern historians have challenged this and argued cogently that it was the coming of peace at the end of the Napoleonic Wars in the second decade of the nineteenth century that was of prime importance. The peace gave rise to profound economic effects, and these in turn created mass migration of the rural Irish population. As the historian Eric Hobsbawm has remarked, 'the 19th century was a gigantic machine for uprooting countrymen'.[1] In the virtual absence of urban-based industrial development in Ireland, the numbers of Irish people moving to England grew substantially.

The growth of the population in the major cities of England at this time was without precedent. Birmingham, for example, an epicentre of the industrial revolution, saw its population swell from 71,000 in 1801 to 233,000 by 1851. This uncontrolled growth of the cities not only sucked in the English rural population but also acted as a magnet for the Irish. The trail to England had been well blazed. Movement of Irish labour across the Irish Sea had been going on for many decades and every year upwards of 100,000 seasonal agricultural workers, known in Irish as 'spalpeen', made the return journey to England.

In the nineteenth century, however, the migration became a permanent one and the destination was urban rather than rural. The introduction of steam vessels on Irish Sea routes both speeded the journey and reduced its cost, but the transport of these economic migrants was unregulated and the poorest passengers endured truly terrible conditions as 'deck passengers'.

A new beginning?

In the early nineteenth century typhus and relapsing fever (both of which were associated with the human louse), as well as smallpox and dysentery, were endemic in Ireland. But despite this burden of communicable disease, the statistics gathered at the time suggest that life expectancy in rural Ireland was greater than in the urban centres of England.[2]

Into the teaming cities of England poured the poor of Ireland. For many of the Irish who arrived in England it was merely a stopping-off place while they waited for a passage to Canada or the USA. Fares to the USA were cheaper from England than from Ireland and many stayed only a short time in the lodging houses and cellars of the cities on the Western seaboard of Britain. For others who could not afford the passage to the New World, or who needed to earn the money for their passage, Liverpool and the other major centres of the north of England were to become their homes.

The new migrants found themselves in difficult

This article is based on the Milroy Lecture given at the Royal College of Physicians on 17 September 2002 by **Gabriel Scally** MFCM, Regional Director of Public Health, Government Office for the South West, Bristol

Clin Med JRCPL 2004;**4**:77–81

economic and social circumstances that worsened over time. As a result, in 1836, a Royal Commission was established on the Irish poor. Although it dealt mainly with Ireland, the appendix by Lewis on the Irish poor in Britain is a most thorough exposition of the conditions under which the Irish in England were living and their attitudes to health and disease.[3]

The overcrowding, lack of light and ventilation, dampness, and in particular the lack of sanitation and means of waste disposal, were graphically described. However, it was not always the social conditions in the cities that were blamed by doctors for the outbreaks of disease. Giving evidence to the Royal Commission, Mr John Mouchet Baynham, who was surgeon of the General Dispensary and of the Town Infirmary of Birmingham, declared,

> *The Irish in Birmingham are the very pests of society. They generate contagion. More and worse cases of fever, and other infectious diseases of a spontaneous origin, occur among them, and the acute diseases of which they become the subjects are fatal in a much larger proportion than among the English; they are chiefly liable to fever.*

Given the conflicting theories about the causation of epidemic disease, it is perhaps not surprising that the Irish should be accused of generating contagion. Nor indeed, given the prevalence of typhus amongst the Irish community, that one of the most common synonyms for typhus should have been 'Irish fever'.

A *Punch* cartoon (Fig 1) from the mid-nineteenth century graphically depicts the social conditions of the poor in the English cities. Entitled 'A Court for King Cholera' this street scene contains a dung heap, washing drying above the street, a coffin, lodging houses and, prominent amongst its characters, a stereotypical Irishman. Such a depiction with hat and pipe was common in political cartoons of the time.[4] The lodging houses which form the backdrop to the cartoon were closely identified with disease and in his landmark *Report on the Sanitary Condition of the labouring Population of Great Britain*, published in 1842, Edwin Chadwick identified them as foci of contagious disease.[5] The Committee of Physicians and Surgeons in Birmingham, reporting to Chadwick on local conditions, identified three kinds of lodging house: 'mendicants' lodging houses, lodging houses where Irish resort, and houses in which prostitutes live, or which they frequent'.

Witnesses to the Royal Commission on the Irish Poor also uncovered evidence of a different health belief system amongst the Irish. Three separate witnesses reported that during illness, pain around the heart was a common complaint even if the heart was not directly involved in the disease process (Box 1).

Box 1. Evidence to the Royal Commission on the Irish Poor, 1836.

'The Irish often complain of pain about the heart in an indefinite manner, without sufficient ground.' (Thomas Osborn Dobson, House Surgeon of the South Dispensary, Liverpool)

'Whatever may be their disease they always complain of oppression about the heart.' (James Kenworthy House, Surgeon of the Wigan Dispensary)

'However they frequently complain of oppression about the heart when the heart is not affected.' (William Moncrieff MD, Physician of the Royal Dispensary, Edinburgh)

Fig 1. 'A court for King Cholera.' *Punch*, 25 September 1825. © Punch, Ltd.

The heart makes frequent appearances in Irish literature and song as the focus of the emotions and it is not surprising that somatisation, the expression of psychological distress as a physical symptom, should appear in this fashion.

An Irish public health hero

Despite having such a huge burden of ill health, few Irish people are remembered for their contribution to the sanitary revolution. Someone who did have a profound effect on public health in England, and deserves to be better recognised as an outstanding figure in public health, is Kitty Wilkinson.[6] Kitty, born in Derry in 1775, set sail for Liverpool in February 1794 as a deck passenger, along with her family. There she scraped a living doing a variety of menial jobs including working in a nail factory and collecting manure from the streets to sell to farmers. In the spring of 1832 cholera reached Liverpool. Kitty's unofficial role as unqualified nurse and leader in her community grew with the epidemic. Acting on instinct and humanity, Kitty placed great store on cleanliness and fresh air in combating cholera. As well as nursing the sick, at a time when others would not go near them, Kitty washed their bedding and clothing. A large copper boiler was installed in her kitchen and her husband set up clothes lines in the yard of their house.

Although Kitty nursed, cared for, adopted and educated many of the poor who lived around her, it was for establishing the first public washhouse that she was to become well known. In the years that followed, her example inspired others. The Association for the Establishment of Baths and Washhouses for the Labouring Poor was created, and, aided by permissive legislation, the development of municipal wash and bathhouses spread across the country and abroad.

In 1846, during a visit to Liverpool by Queen Victoria, Kitty was invited to meet the Queen in person and was presented with a silver tea service which was engraved with the words:

> *Thou shalt love thy neighbour as thyself*
> *Presented by the Queen, the Queen Dowager, and the ladies of Liverpool to Catherine Wilkinson 1846.*

Other Irish women also showed courage in the face of cholera. Giving evidence to the 1836 Commission, James Reed MD of the Kilmarnock Dispensary said:

> *When the cholera prevailed here with some severity, the only people who would act as nurses were some old Irish women: they behaved very ill, but at first no-one else would undertake the office.*

The Irish in contemporary England

The second major wave of Irish immigration came in the decades following the Second World War. The current first generation Irish community in England is much more akin to the general population in age structure and, importantly, in socio-economic structure than other immigrant communities. The Irish population in England does, however, contain a slightly higher proportion of people in social class IV and V.

It was in the mid-1980s that significant attention began to be paid to the differential health experience of migrant groups in England. Marmot and Adelsteen demonstrated in their work on mortality patterns around the time of the 1971 census that Irish men had the highest all-cause standardised mortality ratio (SMR) of any immigrant group.[7] For Irish women, although the SMR was markedly higher than that of the general population it was less than that for women from the Caribbean and African Commonwealth. Most immigrants had lower SMRs than the population of their home countries. For male and female Irish immigrants of virtually every social class grouping the SMR exceeded, and sometimes considerably exceeded, that of the English population as a whole.

Adelstein, Marmot and colleagues[8] proposed that in the case of Ireland, proximity and consequent ease of movement might mean that ill health, rather than being an obstacle, might act as a positive spur to migration and explain a subsequent higher mortality. Should the selective migration explanation be appropriate, then one would expect the selection effect to recede rapidly with subsequent English born generations. Routine mortality data, since they record only place of birth of the individual, not that of the parents, are of no assistance to us in exploring this matter.

The Longitudinal Study, initiated by the Office of Population Censuses and Surveys, now subsumed into National Statistics, has, however, proven to be of immense value. This unique cohort study consists of an anonymised data set comprising linked event records for a 1% sample of the 1971 census of England and Wales. The ability to follow the cohort has meant that it has been possible to describe the health experience of second generation Irish immigrants based on the information provided in their 1971 census returns. Harding and Balarajan have analysed these data and showed that second generation Irish have a significantly worse mortality even when social class and other important variables are controlled for.[9,10]

Unfortunately, the data collected at the 1971 census do not provide a complete picture, as only those who entered for their parents' and grandparents' place of birth as 'Republic of Ireland' or 'Ireland (part unspecified)' can be identified. The definition of second generation Irish used in these data includes those with one or both parents born in Ireland.

Mortality varied considerably depending on whether one or both parents were Irish and in the case of those with one Irish parent varied with the gender of that parent. Although the wide confidence limits add a note of caution, it is fascinating that for a second-generation Irish man it is better to have an Irish born father and for a second-generation Irish woman it is better to have an Irish mother. This must surely warrant further exploration.

Again using the Longitudinal Study, Harding and Balarajan have gone on to explore the mortality experience of third generation Irish men and women.[11] Taking as their cohort those under the age of 55 years at the time of the census in 1971, they have demonstrated that rather than a regression to the norm for England and Wales the very high mortality for Irish men not only continues and if anything worsens. For Irish women the

gradient of worsening mortality experience is even steeper (Table 1).

Disease causation

Smoking, obesity and alcohol should not be regarded as the underlying reasons for the poor health record of the Irish. They are not issues of untrammelled individual choice. They occur under the influences of environment, commerce, family, culture, workplace and education. The risk factors are therefore products of the situation within which the Irish in England live.

Smoking

Smoking remains the single biggest public health problem in England and more Irish men and women smoke than any other ethnic minority except Bangladeshi men.

The proportion of smokers who smoke over 20 per day is, however, far higher than in any other ethnic group and higher than the general population (Table 2).

Using data from lifestyle surveys in England and Ireland, it is notable that for men, in every age group, smoking rates are markedly higher amongst the Irish in England. For women, with the exception of the 16 to 34 group, the Irish in England have the highest rates.[13–15]

Obesity

Using comparative data from these three surveys, it can be seen that Irish men and Irish women in England display levels of obesity higher than their counterparts in Ireland, North or South (Table 3).

Alcohol

Despite the temptation to avoid the subject because of the association with ethnic stereotyping, one cannot ignore the issue of alcohol.

Using data from the General Household Survey in 1978, 1980 and 1988, Balarajan and Yeun[12] and Harrison and his colleagues[16] constructed a Standardised Drinking Ratio, which confirmed that Irish men, living in England or Ireland, drink alcohol in amounts likely to cause physical damage.

Data from the 1988 General Household Survey display similar results.[16] The results this time take into account the drinking of both men and women, break the Irish down into first and second generation and also differentiate between the Republic of Ireland and Northern Ireland. Not for the first time in the exploration of data concerning the Irish in England, there appear to be interesting differences between people with Northern Irish and Republic of Ireland origins.

Table 1. Hazard ratios for all cause morality 1971–97 for first, second and third generation Irish men and women (aged under 55 in 1971) living in England and Wales.

	Adjusted for age		Adjusted for age, housing and access to car	
	Men	Women	Men	Women
Other	1.00	1.00	1.00	1.00
First generation (NI)	1.27 (1.11–1.47)*	1.25 (1.04–1.49)*	1.17 (1.02–1.35)*	1.19 (0.99–1.41)
First generation (RoI)	1.13 (1.04–1.23)*	1.14 (1.03–1.26)*	1.02 (0.93–1.11)	1.05 (0.95–1.16)
Second generation	1.29 (1.18–1.41)*	1.21 (1.09–1.36)*	1.23 (1.13–1.34)*	1.17 (1.05–1.31)*
Third generation	1.31 (1.06–1.63)*	1.55 (1.17–2.05)*	1.26 (1.02–1.56)*	1.49 (1.13–1.97)*

*p <0.05. NI = Northern Ireland; RoI = Republic of Ireland.
Source: Ref 11.

Table 2. Percentages of current self-reported smoking amongst Irish men and women in England, and men and women in the Republic of Ireland and Northern Ireland.

	16–34 (%)		35–54 (%)		55+ (%)		All ages (%)	
	Men	Women	Men	Women	Men	Women	Men	Women
Irish in England	50	36	42	36	25	25	39	33
RoI	35*	38*	30	29	17	18	27	31
NI	38	35	32	35	22	17	31	30

*18–34 years.
Sources: *Health Survey for England,* 1999; *Survey of Lifestyles, Attitudes and Nutrition* (Republic of Ireland), 1999; Northern Ireland *Health and Social Well-being Survey,* 1997.

Table 3. Levels of Body Mass Index amongst men and women in England, Republic of Ireland and Northern Ireland.

	Normal (<25) (%)		Overweight (%)		Obese (>30) (%)	
	Men	Women	Men	Women	Men	Women
Irish in England	37	45	43	34	20	21
RoI	48	66	40	25	12	9
NI	37	50	46	30	17	20

Sources: *Health Survey for England*, 1999; *Survey of Lifestyles, Attitudes and Nutrition* (Republic of Ireland), 1999; Northern Ireland *Health and Social Well-being Survey*, 1997.

Conclusion

The picture is clear. The Irish in England, the largest ethnic minority, have a substantially worse death rate than the general English population. This cannot be explained by social class differences. Most worryingly, for each successive generation of Irish people born in England, the position appears to be worse. Across a range of risk factors associated with serious illness, the position of the Irish in England is poor compared with other ethnic groups, the general population of England, and the Irish still in their native country.

There are many possible explanations for this, including selective migration theories, genetic deficiencies, and alienation from society. It is not possible to say conclusively what the correct explanation is and indeed the explanation is almost certainly multifactorial. We need to develop a consensus around a structured, nationally coordinated research programme that can help further to identify the causative factors of the appalling health record of the Irish in England and which can also provide evidence on how Irish health can be improved.

The inclusion of a separate 'Irish' category in the 2001 census is greatly to be welcomed and the census data, as it becomes available, must be exploited to the full. The nature of Irish ethnicity is complex, however, and cannot be reduced to a simple matter of place of birth. It is a rich mixture of influences, which include religion, gender, generation and political beliefs. The personal and community boundaries are fuzzy and may be defined in different ways at different times. This is at times positive and is part of the richness of being Irish in England. It is for these reasons that there also needs to be a process of meaningful engagement with the Irish community on public health issues.

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