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# Concepts of illness causation and attitudes to health care among older people in the Republic of Ireland

Anne MacFarlane<sup>a</sup>, Cecily Kelleher<sup>b,\*</sup>

<sup>a</sup>Department of Primary Care and Population Sciences, Royal Free Hospital and UL Medical School, Rowland Hill St., London, NW32PF, UK

<sup>b</sup>Department of Health Promotion, Clinical Science Institute, National University of Ireland, Galway, Ireland

## Abstract

Fifty-one older people (26 of them women) in the Republic of Ireland were interviewed using a semi-structured schedule on their health and illness experiences at three different time points in their lives; as children, as young adults and presently. Of particular interest were their views about the causes of heart disease, cancer and tuberculosis and their experiences of the prevailing health care system during their lifetime. Participants were recruited by letter from a database of respondents to a previous national quantitative survey of older people. Of 247 people originally contacted 127 (51%) responded by letter and 51 of these took part in the interview study. Data were analysed according to principles of content analysis using NUD.IST software. Reported ideas about causes of illnesses were multicausal. These were categorised as behavioural, biological, psychosocial or other explanations. While respondents placed most emphasis on behavioural explanations, this was accompanied by more complex views and critical questioning of formal health education messages. There was a strong allegiance to current biomedical concepts and practices. This appeared to be explained in part by reported negative experiences of health care treatments during childhood, particularly in hospitals, now perceived to be much improved. Advances in biomedicine were discussed with accounts of benefits received or observed by participants. An analysis of the history of health services in Ireland suggests that some of the attitudes reported reflect the experiences of the respondents as a generation rather than as older people per se and hence highlights the impact of public policy on people's experiences of and attitudes toward health and health care systems. © 2002 Elsevier Science Ltd. All rights reserved.

*Keywords:* Lay concepts; Attitudes to health services; Older people; Health policy; Ireland

## Introduction

Attitudes of individuals to health maintenance and health care arguably influence demand for health service delivery, in that public opinion will influence what policy decisions are made by politicians and other service providers. This may be particularly important in the case of older people, since they are significant users of health care. In recent years policy-makers have placed increasing emphasis on health promotion programmes

using the rationale that some illness at least may be avoidable if lifestyle modifications are made successfully (Kelleher, 1993). However, we do not know enough about the attitudes of ordinary individuals to these developments and it is likely that such attitudes vary considerably between countries, across generations and according to chronological age. In Ireland there has been little work to date on these issues. There are therefore three relevant issues to be addressed; first, are there demographic variations in attitudes to health and illness? Second, to what extent are these generational as opposed to age related? Third, how important is cultural context, including the nature and provision of health care, in forming and interpreting these attitudes?

\*Corresponding author. Tel.: +353-91-750-319; fax: +353-91-750-547.

E-mail addresses: a.macfarlane@pcps.ucl.ac.uk (A. MacFarlane), cecily.kelleher@nuigalway.ie (C. Kelleher).

What of the health profile of Irish people over the last 50 years? Tuberculosis (TB) continued to be a major public health problem until well into the second half of the last century. A major programme of sanitarium provision was introduced in the 1950s, associated with the charismatic but controversial health minister Dr Noel Browne (Browne, 1986). Rates have been declining significantly since that period though still higher in high-risk groups such as the travelling community. TB was therefore a widespread and feared disease which challenged the resources of the health care system as it became more formalised. In common with other developed countries cardiovascular diseases accounted for about half of all deaths during the latter part of the last century; rates of coronary heart disease are approximately double the European Union average and continue to pose a huge public health problem. A major cardiovascular strategy was launched to tackle the issue two years ago and significant new funding injected into the health care system (Cardiovascular Health Strategy Group, 1999). Cancers account for about a quarter of all deaths, though rates for cancer of the colon and breast are relatively higher than other countries.

The Irish health care system evolved in the Victorian period along very similar lines to that in the United Kingdom (Barrington, 1987). Even after Ireland gained independence in 1922 there were significant similarities in structures and exchange of medical and nursing personnel was feasible because professional training was comparable in the two jurisdictions. However, post second world war a major difference compared to the United Kingdom emerged in that the comprehensive National Health Service, free at point of access to all, was introduced in the United Kingdom, whereas in Ireland a two-tiered health care system emerged which continues today.

In 1947 a National Department of Health was established and in 1970, new enabling legislation introduced a regional health board structure. The old dispensary system for general practitioner care was replaced by a means tested general medical services scheme for the least affluent in the primary care setting and hospital services were made available free for all, though private care could be purchased through the voluntary health insurance scheme. This latter is a statutory body established to cater for those above the means threshold for comprehensive state-provided services (Barrington, 1987). In effect there are therefore two tiers to the service. In general, more older people are eligible for comprehensive care, in part because of their fall in income with ageing. The recently published National survey of Lifestyle, Attitudes and Nutrition, SLAN, indicated that 29.6% of males and 23.0% of females under 55 held a medical card, compared with 48.8% of males over 55 years and 57.6% of females

(Friel, NicGabhainn, & Kelleher, 1999). In addition, the survey indicated that more older people were likely to receive health education advice from their general practitioner than from any other source. While through the 1970s there was now a comprehensive health care structure, in the 1980s due to escalating costs, cutbacks were made and since then, as in other developed countries there has been constant pressure on the acute hospital health care structure in particular, especially during the winter months. Both the health care provisions and the major patterns of illness have altered considerably over the last 50 years, therefore.

While much more work on attitudes to health and illness has been published in recent years, there is a dearth of information about the attitudes of older people (Kelleher, 1993; Edmondson, 2000). Further, there are few in depth qualitative studies on the attitudes of this group and some writers at least are sceptical about the theoretical constructs underpinning such research and the methodological drawbacks to its conduct (Edmondson, 2000). Relevant research does indicate that views of health determinants by lay-people without a health professional background tend to be both broad-ranging and multicausal and are influenced by demographic considerations. Stainton-Rogers (1991) has argued that people's ideas about health and illness are best understood from a postmodern perspective because they comprise of multiple, co-existing and, sometimes, contradictory views and realities.

Conceptualisations of health and illness have been found to vary according to social class (Pill & Stott, 1982) and gender (Blaxter, 1990). Evidence that age has an impact has also been recorded. A well-known study of health beliefs among three generations of working class women in Aberdeen, Scotland by Blaxter and Paterson (1982) revealed that older women, more so than younger participants, emphasised environmental agents as causes of disease. This was explained by perceptions of improvements in broad social and material circumstances among the younger generation. Elsewhere Blaxter has indicated that heart disease has been seen to be multicausal (Blaxter, 1990) and has emphasised that those in the lower social classes are more likely to use behavioural explanations (Blaxter, 1993). One reason for the lack of a focus on social rather than individual level explanations is the sense that it devalues the individual to perceive him or herself as unequal to others (Blaxter, 1997). Conflicts between medical advice about health promotion behaviours and people's experiences have however been highlighted. Cornwell's (1984) study in the East End of London demonstrated that people did not believe that smoking causes lung cancer, citing examples of smokers who had not got cancer and non-smokers who had. She distinguished between public accounts (which are consistent with medical advice and information) and private

accounts (which emphasised personal experiences and life stories) and were more likely to emerge later in interviews after a sense of trust had developed between the interviewer and the interviewee. Older people have been found to emphasise health as a functional concept more so than young people. This finding is consistent over time and in different countries, for instance, England (Sidell, 1995), Scotland (Blaxter & Paterson, 1982; Williams, 1983) and France (Pierret, 1993). There is also evidence that older people are sceptical about lifestyle advice for healthy living (Backett & Davidson, 1992). Similar findings were reported by Blaxter and Paterson (1982) and Herlizch (1973). Comparative assessments between personal anecdotes and formal health messages have since been well-documented both in the UK (Davison, Frankel, & Davey Smith, 1992) and in Ireland (Sixsmith & Kelleher, 1996) and are evident across socio-economic groups in Ireland (NicGabhainn et al., 1999).

Views among older people that certain illnesses are inexplicable have also been documented. Murray and McMillan (1993) reported that older people are more likely to attribute the cause of cancer to factors such as luck and chance. Sontag (1989) suggests that medicine's central promise in this era, that all disease can be cured, is not consistent with people's experiences. This emphasises the inter-relationship between lay concepts of disease causation and attitudes to health care systems. While some quantitative studies about health beliefs and behaviours among Irish older people had been conducted (Fahey & Murray, 1993) no systematic qualitative research has been undertaken. Both the study in the Eastern part of the Republic by McCluskey (1989) and a small scale qualitative study as part of the Kilkenny Health Project (Conroy & Shelley, 1986) revealed that cancer was a more feared condition than heart disease and the Kilkenny participants were fatalistic about its inevitability, considering it to be a disease of ageing. A more recent Irish study on attitudes to cardiovascular disease among adults generally confirmed the findings of the two earlier studies (NicGabhainn et al., 1999). The recently published national health and lifestyle surveys in Ireland (Friel et al., 1999) demonstrate major socio-demographic differences in lifestyle behaviours, including smoking, alcohol consumption and diet. In general, older study participants were less likely to report smoking, there were a higher proportion of abstainers from alcohol, at nearly 1/3 of older women and 1/5 of older men. However, older people tended to have a lower calorie intake overall and of specific food items like fruit and vegetables.

There is evidence that older people show strong admiration for health care systems operated according to a predominantly biomedical paradigm. Cornwell (1984) reported that older participants were complimentary of, and respectful toward, doctors. Doctors were

perceived to be highly trained and scientific medical knowledge was regarded as superior to the knowledge of ordinary people in respect of treatment regimens. Views were also expressed that the medical profession should not be bothered with trivial complaints. Similarly, Blaxter and Paterson (1982) documented admiration for medical science among older women, even though participants rarely gave the impression that biomedical advances had had a direct impact on their own health. Beliefs that younger people visited GPs too frequently and unnecessarily were recorded by both Blaxter and Paterson (1982) and Cornwell (1984). In this way, interpretation of symptomatology, as described by Field (1997) is relevant to health-seeking behaviour. Distinctions between effective treatment services and factors important for health maintenance are apparently made by older people. Kelleher (1993) reviewed the general literature on attitudes of older people to ageing and to various social activities and found these to be generally positive. However, it is difficult to generalise from research carried out in the UK or elsewhere because of our knowledge that culture is an important dimension of health (Airhihenbuwa, 1996).

The aims of the present study were to explore attitudes to illness determinants held by older people in Ireland and to elicit their views of the health care system. We wished to address what their concepts of illness were, particularly in relation to important conditions like heart disease, cancer and TB and to explore how well they felt the health care system had addressed their needs over the period of their life time to date.

## Methods

As part of a larger project, we wished to identify older people who were born in the early 1920s in the Republic of Ireland and who therefore might have participated as schoolchildren in a National folklore study of interest to the researchers. It is not within the scope of the present paper to expand on this aspect of the project. The database developed for a large-scale quantitative study by the Economic and Social Research Institute (ESRI) of health and autonomy among older Irish people was identified as a convenient means of identifying participants for the present study (Fahey & Murray, 1993). The ESRI database comprised a randomly selected national probability sample of persons aged 65 years and over, resident in private households in Ireland. It was estimated that some members of this cohort, born in the late 1920s, would be aged between 69 and 72 years at the time of sampling and data collection (1994/1996). Clearly, using a representative sample in qualitative work raises methodological and epistemological issues. However, Silverman (1985) has considered the benefits

of mixing principles from competing positivist and anti-positivist paradigms and Patton (1987) has written about the benefits of and credibility from, random sampling in qualitative studies. For this study, we wanted, as far as possible to identify people in diverse geographical settings on a national basis, to focus on their experiences of health and health care as a particular generation of older people.

The Economic and Social Research Institute and the National Council for Ageing and Older People, who commissioned the original study, granted permission for us to conduct the project. There were 247 people in the relevant age range and each of these received a short postal questionnaire outlining the purpose of the study and asking if they would be willing to be interviewed. Fifty-one per cent ( $n = 127$ ) responded and 62 per cent of these ( $n = 79$ ) indicated their availability for interview. Participants from a total of 18 of the 26 counties within the Republic of Ireland were represented in the interview study sample. Seven regional field trips were organised. Contact was made with participants by letter and telephone to provide details of interview dates. Overall, 51 interviews were conducted between October 1995 and June 1996. Reasons for non-participation related mainly to the logistics of conducting a national interview study; call backs were rarely possible because of the distances involved. Also, ill-health prevented participation in a small number of cases.

Interviews were conducted in participants' homes. In keeping with Moser and Kalton's (1992) guidelines for interviewing, participants were given a short briefing about the research prior to interview. It was stated that the present research was concerned with ideas older people had about health and illness, the kind of illnesses they had experienced during their lives and ways in which they had dealt with these illnesses. Participants were assured of confidentiality and anonymity and their permission to tape record the interview was sought. Only one person refused. On average, interviews were between 50 and 60 min in length.

The interviews were exploratory in nature as described by Oppenheim (1992). The interview schedule was semi-structured and construct driven, developed around a small number of concepts previously identified as relevant to lay representations of health and illness: definitions of health (McCluskey, 1989), value of health (Wallston, 1991), health behaviour (Kasl & Cobb, 1966), illness behaviour (Mechanic, 1989) and sick-role behaviour (Parsons, 1951). A life stage approach was used in the development of the interview schedule. Participants were asked to reflect on their experiences for three distinct life stages—childhood (0–20 years of age), young adulthood (20–45 years of age) and present years (45–present). Each was asked to identify both a serious or non-serious illness he or she experienced during each life stage and to discuss that illness experience in terms

of the perceived cause (*What do you think caused that illness?*) and subsequent treatment utilisation (*Did that illness improve? How? Can you describe the treatment you received?*). In this paper, reported causes of heart disease, cancer and TB are presented only.

Completed interviews were analysed according to the principles of content analysis. Drawing on the work of Holsti (1969) efforts were made to ensure that analytic categories were independent, exhaustive and mutually exclusive. There were four main stages of category development:

- familiarisation with collected data,
- development of category system and coding,
- analysis of category contents,
- drawing conclusions.

The process by which the category system was developed was documented carefully as advocated by Bromley (1977) and, more recently, Morse (1994). The identification of themes and clusters of themes was recorded. A unit of analysis was identified for each category. Category definitions were also developed. This process was an iterative one, whereby the researcher moved between theory and data to develop a category system that reflected the ideas of the older people who had been interviewed. QSR. NUDIST (Richards & Richards, 1994) was used in the development of a category system and for data coding.

An independent observer conducted an inter-rater reliability analysis of the category system. The independent observer was a social science researcher with experience in qualitative analysis but, in keeping with Krippendorff's (1980) recommendations, someone with no previous involvement in the present study. The overall rate of consensus agreement was 96%. Details of the category system relevant to the present paper are shown below as results.

## Results

The results are divided into three parts. First, a demographic description of participants is provided. Second, participants' ideas about causes of heart disease, cancer and TB are presented. The final section describes participants' attitudes toward, and experiences of, the Irish health care system over time.

Interviews were completed with 25 men and 26 women. Thirty-six participants were married and the remainder were widowed. Participants came from a range of socio-economic backgrounds, according to the Irish ordinal social class scale (O'Hare, 1982). Sixteen were from social class 1 to 2, 20 from social class 3 to 4 and 15 from social class 5 to 6. The profile of participants was compared with those aged between 69 and 72 years of

age within the main ESRI database (Fahey & Murray, 1993) and it was found that there were no differences, apart from the fact that those interviewed had slightly higher levels of formal education ( $\chi^2 = 15.25$ ,  $p < 0.05$ ).

#### *Causes of illness: heart disease, cancer and tuberculosis*

Participants were asked to describe illnesses experienced by them during their life time and to consider the causes of those illnesses. In total, 256 different diseases were discussed. Participants' beliefs about disease causation were categorised as Determinants of Health under fifteen different conceptual categories which, in turn, were broadly classified under the following headings: behavioural, psychological, social, environmental, biological and 'other'. Heart disease, cancer and TB featured strongly in the interviews. Accounts about these illnesses were particularly rich and occurred with some frequency and are described in detail under the sub categories below. Table 1 shows that participants considered a wide range of causes for each disease.

#### *Behavioural explanations*

Ideas that the current pace of life was a fast one and that people were over worked were very common in these data. These were categorised as "Activity" and were frequently found in reported concepts of causation

for heart disease. Diet was discussed by a majority of those interviewed. A "poor diet" was, for instance, cited as a cause of TB (Participant 21 M). It was explained that, in the past, people who were undernourished were more likely to get TB than others. Notions that too much of the "wrong food", such as fats, fries, sugar, sweet things, red meats and starchy food, could lead to high cholesterol and heart disease were also reported (Participant 47 F). Associations between diet and cancer were recorded, although these were generally cited less frequently and with less certainty.

Smoking behaviour and alcohol consumption featured very strongly as perceived causes of heart disease and cancer. The only exception to this was one participant who discussed smoking specifically in relation to chest problems. Answers to direct questions about the cause of cancer and heart disease referred to smoking as a causative agent. Comments that the medical profession blamed cancer and heart disease on cigarettes and drinking were common. Personal observations and experiences were also referred to. The following quote is from a woman living in a council estate in a major Irish city. She had been recently bereaved and talked with much emotion about her husband and his health. Here she remembers her son's concern for their father:

He (husband) was an awful heavy smoker...he'd nearly smoke in his sleep, so it was the fags (cigarettes) they said. The boys like said to me, "Do you see what's happening with the fags", and he just fell down dead one day... (Participant 18 F)

Expressions of doubt and uncertainty about smoking behaviour and alcohol consumption as causes of disease were also evident. Specifically, while the medical profession highlighted these behaviours as risk factors for disease, this did not always correspond accurately with participants' own experiences. One woman commented:

I'm not sure what causes heart disease, but of course they'll tell you it's smoking... Like, I don't think my dad smoked and it was his heart that... But my brother than was another kettle of fish. He drank and smoked and he went off... I suppose it has a bearing on your heart... I don't know, I really don't know (Participant 6 F).

Stories about people with cancer who had never smoked, or conversely, smokers who had lived to an old age were provided. Tensions between medical advice and personal experiences were most evident in relation to alcohol as a cause of heart disease and in relation to smoking as a cause of cancer. The view that alcohol or smoking was detrimental to one's health was often

Table 1  
Frequency of mention by respondents of various categories of risk factors in relation to heart disease, cancers and tuberculosis

<i>Behavioural</i>	
Diet	Heart disease (14), Cancer (10), Tuberculosis (6)
Activity	Heart disease (9), Cancer (2), Tuberculosis (1)
Smoking	Cancer (15), Heart disease (14)
Alcohol	Heart disease (11), Cancer (3)
<i>Psychosocial</i>	
Psychological	Heart disease (12), Cancer (2), Tuberculosis (5)
Social	
<i>Biological</i>	
Medical/Physiological	
Explanations	Heart disease (10), Cancer, Tuberculosis (1)
Hereditary/Family Tendencies	Heart disease (10), Cancer (7), Tuberculosis (6)
Developmental	Heart disease (2)
Infectious	Tuberculosis (7)
Environmental	Cancer (7), Tuberculosis (4), Heart disease (3)
<i>Other</i>	
No explanation	Cancer (9)

qualified in terms of the effects of *excessive* consumption.

#### *Psychological and social explanations*

Psychological factors, particularly stress, were cited as a cause of cancer but more particularly, heart disease. Stress was perceived as something which could “*ruin your health*” (Participant 12 F) and is the “*worst thing you could have*” (Participant 1 F).

The negative health effects of poverty and poor housing were cited as factors relevant to the onset of TB. Specifically, links between overcrowded accommodation, poor sanitation and a lack of money for food were made. However, overall, with the exception of TB, there was a conspicuous lack of specific links between social conditions and disease.

#### *Biological explanations*

Physiological or medical explanations for disease were discussed, such as references to high cholesterol and blood pressure levels as risk factors for heart disease. Queries or doubts about these associations were raised. The effect of cholesterol on one’s heart was questioned cautiously by several participants.

The infectious nature of TB was discussed frequently. It was explained that TB used to kill whole families and that people were afraid to visit the homes of TB patients, because the disease was understood to be so highly contagious. Some explanations referred to TB as a germ that got in the lungs and which family members “*took*” from one and another (Participant 44 M). Heredity was also mentioned as a cause of TB. Similarly, the idea that some families are “*inclined*” to get cancer was noted (Participant 47 F). The perceived association between hereditary factors and disease was most striking for heart disease. Seventeen people, or one-third of those interviewed, considered hereditary factors as of greater importance than other risk-factors. One woman explained that she thought heart disease was hereditary and, therefore, lifestyle was not an important factor. Similarly, another woman commented that hereditary factors were more influential than diet. A man, who was living in a large housing estate on the outskirts of the capital with his wife, reflected on his three brothers who had died from heart disease. He concluded that heart disease was not preventable:

Is it possible to prevent heart disease?

No. I think it is bred in you. I think it is hereditary. It must be, to see the way our family went...(Participant 39 M)

Heart disease was associated with older adulthood by some participants. They explained that people their age experienced heart attacks and strokes. One woman felt

that “*naturally*” as one gets older one would get a stroke (Participant 17 F).

#### *‘Other’ explanations*

While several possible causes of cancer were considered by participants, it was also the only disease for which some participants felt there was no explanation. A number of participants suggested this.

#### *Irish health care: attitudes and experiences*

Participants were asked to describe their use of the prevailing health services over time, what factors influenced their health service use and their opinions about the services received. Participants’ attitudes to biomedicine were categorised under several conceptual categories. These were entitled conditions, availability, utilisation patterns, treatment delivery, treatment description and treatment outcome.

Analysis revealed that the collected data referred to experiences of primary health care and secondary health care, predominately to GP and hospital services, respectively. Also, participants talked predominately about their childhood years and their older adulthood. Less consideration was given to experiences of health services during their younger adulthood. Therefore, the results shown here refer to childhood years and older adulthood.

#### *Childhood years*

When participants considered illness experiences from childhood they reported consistently and repeatedly that, in the past, people did not contact doctors very often. It was emphasised that doctors were only seen when it was very necessary. One man, living with his wife in a rural area to the north of Ireland, explained that doctors were not called unless the symptoms of illness were very serious or unless someone was near death:

Years and years back. I’m talking now back in the ‘30s and ‘40s. You’d want to be almost dead before you’d have a doctor (Participant 2 M).

Descriptions of serious symptoms included symptoms that worsened, persisted, involved broken limbs or bones or internal problems. It was also evident that for older people and children medical attention was more likely. This point was explained most clearly by one older woman who lived with her daughter and family outside a small town in the far south:

I mean with the old people anyways, the doctor was called straight away...

*Why would that be?*

Well, I mean they would be more of an age and more at risk.

*Is that right?*

Well, I mean with the children we called him straight away anyway too (Participant 13 F).

When participants talked about contact with hospitals during their childhood years, they also emphasised symptom severity: *I was really very sick, I had no idea* (Participant 20 M) or *well I had no choice, I was just operated on* (Participant 15 M).

Other reasons participants gave for lack of contact with health services as children related to issues of service availability and accessibility. It was reported that there were fewer doctors in the past, perhaps just one in each town. Access to hospitals was limited because transport was problematic. Also, doctors' fees and hospital care was expensive relative to the amount of money people had at that time. One man commented that if people could have afforded the price of medicine, they would have had more contact with the doctor.

Participants described the contact that they had had with doctors and hospitals during their childhood years. There was a strong perception that medical practitioners were less effective in the past than currently. Furthermore, the kind of treatments recommended by doctors in the past, such as advice to keep warm, drink buttermilk, use breadsoda and camomile lotion among other things, were not regarded by participants as treatment per se (11 F). Instead, such practices were considered to be common sense.

...it might have been camomile lotion or maybe breadsoda baths. No treatment as such. The doctor came in and probably said "stay in bed for so long", you know. But I don't think there was any exact treatment like there would be nowadays (Participant 11 F).

Very negative accounts of hospital experiences from childhood were recorded. Hospitals were described as drab and dreary institutions. The most vivid accounts of hospitals in the past discussed the implications of receiving treatments without an anaesthetic:

They took out my adenoids...they asked me to open my mouth. I opened my mouth and they put a thing like the barbers have for shaving the back of the neck down my throat without an anaesthetic or anything. It was like cutting gristle when you're doing a piece of meat. I can hear it to this day....(Participant 37 F)

#### *Older adulthood*

Participants' views about present day use of health services, once again, focused a lot on the amount of contact people have with services. The majority of

participants reported that they had fairly regular contact with their GPs at present. It was also evident that there was an increase in levels of contact with hospitals. Only 14% reported contact with hospitals as children, one-third had experience of hospitals during their younger adulthood and 42% reported contact in more recent years.

However, participants were keen to impress upon the interviewer that they did not use services, particularly GP services, unnecessarily. As one woman explained that she would not "trot off (to the doctor) with every little ache and pain" (Participant 12 F). Nearly all participants felt that doctors' services were currently used excessively and unnecessarily. They cited many symptoms and conditions, such as children's ailments (chicken pox, mumps, measles), which would not have received medical attention when they were children but which were treated by GPs nowadays.

Invariably, views about contemporary patterns of treatment utilisation were expressed in strong critical tones and directed toward the younger generations.

I don't know, it's run to the doctor with everything today. Things that aren't in much need of going....(Participant 42 M).

Nowadays, when anyone is sick at all, with any ache or pain at all, they go to the doctor....(Participant 20 M).

These quotes are from two male participants living in rural areas. However, while these views were expressed by both male and female interviewees, it seemed that the older women were particularly critical of their daughters and daughters-in-law about the amount of contact their grandchildren had with GPs.

In relation to secondary health care services, there were some views that people tended to "rush" to outpatient clinics and "waste" the staff's time (Participant 31 F; Participant 33 F). Overall, however, perceived differences in utilisation patterns between generations referred to contact with GP services.

Participants considered various reasons for these perceived changes. On the one hand, participants felt that services were more available now than they were 30 years ago. Also, they felt that people had more money nowadays and that they were better able to afford doctors' fees. The impact of state general medical services scheme introduced in 1970, was also considered relevant. The overall view was that because people had medical cards and did not have to pay the doctor, they were using the services more frequently and unnecessarily. One woman, who was living alone in a small housing estate said:

I mean, if you can go into a doctor with your medical card whether you have a pain in your big toe, you're

going to go aren't you? But if you have to go into a doctor and pay £15, begod, you're going to look at it three or four times, you know. There is a difference if you know what I mean? (Participant 6 F).

Finally, some participants felt that medicine was "coming in" (Participant 33 F; Participant 32 M). The quote below is taken from an interview with a man who lived with his wife. He considered this issue thoughtfully:

I think they are more conscious now, if you can imagine we turn on the radio or television and we're told you should look after yourself, that time we had no way of knowing (Participant 44 M).

Data were also collected about the contemporary experiences participants had of health services. Some negative experiences were described and these tended to relate to difficult encounters with medical staff rather than the nature of treatments received. One man expressed extreme dissatisfaction with the treatment he received from a specialist to whom he was referred:

...of all the ignorant people I ever met there was a young lady doctor—she was so uncivil. I am not angered by a lot of people, but Lord God she was the most cruel person...that doctor won't do her profession any good..."you're in the way" she said, "push this finger, you're not doing what I'm telling you"...I never met anybody like her in my life....! (Participant 43 M).

However, overall, participants expressed positive attitudes toward primary and secondary health care practitioners. It was very common for participants to say that their doctor had been very good and that they could not say enough in favour of biomedical practitioners they had encountered. Helpfulness and the willingness to spend time talking with patients, both emerged as important to participants. The skills and experience of medical practitioners were also commented on. Generally, it was believed that the medical profession knew *best* about health and illness presently:

...what we're advised to do by the doctor, we do it and that's that (Participant 29 F).

When participants did discuss medical treatments received by them as adults surgical procedures featured strongly. While accounts of mistakes and errors in hospital treatment did feature, again, overall, perceptions of treatment were positive. Reported outcomes following treatments were predominately positive with an emphasis on the benefits of antibiotics, the speed with which medication worked and, also, the life-saving benefits of operations. A dominant recurring view was that medical science and surgery had advanced considerably in recent years. There was little evidence of differing views by men and women on these issues.

## Discussion

This paper describes the concepts of causes of illness and attitudes to the prevailing health care system of a group of older people in Ireland born in the late 1920s. The demographic profile of the interviewees was consistent with the nationally representative sample of a larger quantitative survey undertaken by the ESRI for the National Council of Older People by the Economic and Social Research Institute (Fahey & Murray, 1993), apart from the interviewees' length of time at school.

The use of a representative sample in qualitative work does introduce certain methodological tensions because, clearly, principles from competing paradigms are mixed. However, proponents of methodological pluralism argue that rigid demarcations between paradigms are unhelpful and discourage movement between research approaches (e.g. Silverman, 1985; Henwood & Nicolson, 1995; Pope & Mays, 1995) and Patton (1987) writes explicitly about the usefulness of representative samples in qualitative work. From the perspective of methodological pluralism, movement between paradigms takes place on the basis of the topic of interest. In the present study, we had an interest in a generation of older Irish people in a national setting. Analyses at a lower level, as for instance, urban/rural, or education and class were not part of the study design. We were interested in a particular national social and health service history and this is why this age-group was chosen and why a representative sample was sought. The interview data provide a rich and detailed portrait of their life experience of health matters; in some ways it is consistent with other accounts in the literature, though some of our findings suggest that their experience as a generation of people may be at least as important as their chronological age or even their individual attitudes.

In this analysis of perceived causes of illness, particular attention was paid to TB, heart disease and cancer. TB was widely prevalent during the childhood of these interviewees and so was likely to figure recurrently in discussion of serious illnesses. Both cancer and heart disease are common in western societies and previous research has indicated that a certain degree of fatalism is exhibited by people in considering their likely cause. Previous Irish data reporting on adults generally from the Eastern Health Board area (McCluskey, 1989), the Kilkenny Health Project (Conroy & Shelley, 1986) and a west of Ireland based study on attitudes to cardiovascular disease across social classes (NicGabhainn et al., 1999) all confirm that cancer is considerably more feared as an illness and many people believe that heart disease is strongly heritable and, therefore, inevitable. This finding is confirmed among the older cohort of people as well.

In keeping with other research from other countries (e.g. Cornwell, 1984; Stainton-Rogers, 1991) the

reported determinants of health and illness by our respondents were multicausal. Behavioural, psychosocial, biological and to a lesser degree other explanations all emerged in this analysis. The frequency and strength with which individual behavioural explanations of disease were cited was notable. Much consideration was given by respondents to the impact of activity levels, dietary habits, smoking behaviour and alcohol consumption on health status. Occasionally, social factors were acknowledged but this was mostly in relation to an illness associated with the past, like TB, rather than in relation to presently more prevalent diseases, such as heart disease and cancer. This may be explained by a perception on the part of older people that improvements in social and material circumstances have occurred since their childhood as discussed by Blaxter and Paterson (1982) or reflect, in Ireland at least, the lack of explicit focus in public health education campaigns on social variation in health status as an explanation for ill-health (Department of Health, 1994). The emphasis on individual responsibility is also compatible with a reductionist biomedical conception of health. It further suggests some assimilation of lifestyle messages of health promotion campaigns which are topic specific and focused in the main on the individual. The inadequacy of such strategies in health promotion has been highlighted (e.g. Tones, 1986) and has been linked with the potential for victim-blaming (Thorogood, 1992; Blaxter, 1993) but this may not have been conceptualised in this way as yet by the general public. The results from the quantitative National survey on lifestyles, attitudes and nutrition SLAN would lend some support to this assertion (Friel et al., 1999) in that less stress was the top ranked requirement for better health irrespective of age and social class and more willpower was the second most frequently cited option by all but the over 55 year olds, who opted instead for a change in weight as a beneficial factor.

Notwithstanding the emphasis placed on behavioural factors by participants in the present study, doubts were expressed about the certainty of these associations. Views that heredity played a part were also recorded. The idea that cancer was a disease for which there is no known cause was noted as well. These findings concur with the previous Irish studies, and highlight the complex and contradictory nature of lay health beliefs. A recent study on Irish people's ideas about cause of heart disease also highlighted tensions between personal anecdotes about the experiences of friends and family, and equivocal messages received from health professionals and considered the possible role of media coverage and debate of health issues in this regard (NicGabhainn et al., 1999). Evidence of critical questioning of formal health messages by people is highly relevant to health care workers, because it shows the interplay between the so-called lay and expert domains.

Health professionals need to comprehend the ways in which people critically assess, modify, reject or accept formal messages about health. In theoretical terms, these findings illustrate the dynamic nature of relationships between human agency and social structures.

A strong sense of faith in, and allegiance to, the biomedical health care system was recorded in the present analysis. Perceptions that contemporary treatments, particularly tablets and antibiotics, were "real" treatment as opposed to procedures and practices used by doctors in the past are also noteworthy. A high regard for the knowledge and expertise of present day practitioners was recorded. Annoyance at unnecessary utilisation of doctor's time and knowledge by younger people was expressed strongly. These findings are consistent with previous studies (Cornwell, 1984; Blaxter & Paterson, 1982). Interestingly, while Blaxter and Paterson (1982) reported that few of their participants had benefited directly from advances in medical science, there were numerous accounts of actual benefits from those in the present study. Blaxter and Paterson's (1982) sample was made up exclusively of women from lower-income backgrounds while the present sample was older, of mixed gender and included people from lower, middle and higher income groups and both urban and rural areas. This may account for the observed differences although there was no evidence in this study that benefits of biomedicine were exclusive to those from higher-income backgrounds. There were stories of people receiving surgery and other treatment through the state medical aid system for example.

Admiration for medicine was not devoid of negative experiences with individual practitioners or references to unpleasant aspects of treatments used. Nonetheless, the overall view reported by participants was that the health care system was a good one. Of course, the way in which people assess and weigh up the positive and negative aspects of health services lies at the heart of much health-seeking behaviour research. There is some evidence that among older people at least the need for treatment will over-ride other beliefs and attitudes (Strain, 1991). This may be because of feelings of susceptibility to ill-health in later years. Certainly, the view that some illnesses are inevitable when one is older, because one is older, was evident in these data. The allegiance to the health care system may be explained also by perceived susceptibility linked with older age. Heart disease for instance was associated with ageing. However, old age is not in itself a satisfactory explanation for ill-health (Peto & Doll, 1997).

Another possible explanation is the unique historical context of this generation of people. These participants were children at the foundation of the new Irish Free State, established in 1922. TB constituted one of the greatest health problems in Ireland during the 1930s and this laid down the priorities for the Department of

Health, which was established in 1948 (Devlin, 1977). Significant and effective proposals put in place during the 1940s and 1950s improved the delivery of health services in Ireland: the Tuberculosis Act, 1945, the Health Act, 1947 and the Health Act 1953 improved the accessibility of health services. The Health Acts of 1947 and 1953 improved the standard of hospital services and also preventive services. This coincided with one of the largest increases in life expectancy ever seen in recent times (Devlin, 1997).

The more recent 1970 Health Act, introduced when these participants were reaching middle-age and indeed when epidemic patterns of coronary heart disease reached their peak, marks another significant point of Irish health service development. Primary health care services which had, to that point, been geographically based and offered no choice of practitioners under a dispensary system were replaced with a General Medical Service (GMS). This saw increased availability of services as well as a choice of doctor scheme. This represents a relatively recent improvement and benefit for participants in the present study. Administrative changes also resulted from the 1970 Health Act, whereby eight regional health boards and several specialist bodies, including the Health Education Bureau, were established. Kelleher (1997) has argued that this led to the increasing recognition for health promotion in Ireland culminating in the Department of Health's (1994) *Shaping a Healthier Future* policy document and subsequent healthy ageing document (e.g. Ruddle et al's review of "The Years Ahead" policy document, Ruddle, Donoghue, & Mulvihill, 1997).

These changes in Irish health services reflect very closely the changing health needs of the cohort of people interviewed at each life stage. Participants recounted the reduction of TB, and other potentially fatal infectious diseases, during their childhood years and younger adulthood. Initiatives to improve services for mothers, infants and schoolchildren were put in place during their childbearing and parenting years. Furthermore, they experienced greater access to doctors and hospitals during their older adulthood. In the space of one lifetime, the health and medical services of Ireland were transformed (Barrington, 1987) and, clearly, it was within the space of participants' "one lifetime" that these major improvements took place. These experiences of health policy shifts would have undoubtedly encouraged and fostered allegiance to the health care system and could have contributed to their belief systems about causes of ill-health. It is perhaps surprising that there was not more explicit criticism of health care services given the history of service shortages and cutbacks during the mid 1980s and the discussion that continues on the priority to be given to health care, though it may in part be explained by the comparative nature of the assessment we asked participants to undertake over

time. In relative terms, things have improved, in their view. These findings therefore merit further attention to cohort or generational differences in attitudes to health care, taking public policy initiatives into account. It is also probable that some attitudes are culturally highly specific and this too should be taken into consideration. The cohort or secular effects implied in these findings highlight the cultural and demographic particularity of such qualitative work. This is of course in keeping with other studies of lay health beliefs (e.g. Cornwell, 192) and that specifically with older people (e.g. Blaxter & Paterson, 1984). It is indeed unwise to generalise from one setting to another, in part a rationale for this study in the first place. These findings serve as an endorsement of the social constructionist perspective which argues that health and illness experiences are located in a broad social, cultural and political context and suggest that future research should attend to specific national and social histories in order to fully appreciate the nature and origins of health related views. In conclusion, this qualitative study of a sample of older Irish people demonstrates expected attitudes to risk factors for major illnesses in keeping with other countries of comparable age but also quite particular views on the prevailing health care system suggesting the importance of taking this factor into account when assessing effectiveness of services.

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