<table>
<thead>
<tr>
<th><strong>Title</strong></th>
<th>Hurling Alone? How social capital failed to save the Irish from cardiovascular disease in the United States</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Author(s)</strong></td>
<td>Kelleher, Cecily; Nolan, Geraldine; Tay, Joseph</td>
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</tr>
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<td><strong>Item record</strong></td>
<td><a href="http://hdl.handle.net/10379/2317">http://hdl.handle.net/10379/2317</a></td>
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</tbody>
</table>

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Increasing evidence indicates that a full etiological explanation for major adult chronic diseases must include consideration of influences across the life course. Current rates of coronary heart disease in Ireland and parts of Scotland with high rates of Irish immigration rank among the highest in the developed world, and rates are twice the European Union average in the Republic of Ireland. In addition, Irish immigrants to the United Kingdom retain an overall increased risk of ill health for at least 2 subsequent generations, which can be partly accounted for by lifestyle and social conditions.

In this article we examine how the early- and later-life conditions of the Irish, one of the major ethnic groups to immigrate to the United States in the 19th and early 20th centuries, contributed to their overall patterns of cardiovascular mortality. Some 4.5 million Irish immigrated to the United States over a period of 80 years, particularly after the great Irish famine of 1847. This famine was the most devastating example in modern European history of the acute effects of a crop failure, resulting directly and indirectly in a halving of Ireland’s population. The cultural story of these Irish immigrants has been documented in remarkable detail. The Irish settled throughout the United States, and particularly in large East Coast cities. When a general ancestry question was reintroduced into the United States Census in 1980, 40.2 million people, or 20.64% of the White/European population, declared themselves to be of Irish ancestry. Despite criticisms of the reliability of this measure, demographic analysis indicates that this number is likely to be reasonably accurate.

**METHODS**

**Ethnic Origin and Mortality in US Census Vital Statistics Records**

In a 1933 report, considerable and unexplained variation in infant mortality rates across Boston’s census tracts was found. In 1985, findings from the Ireland–Boston Diet Heart Study were published. These 2 reports constitute the tip of the iceberg of what is a largely neglected story. Both used a unique and extensive US vital statistics database to examine ethnic variations in disease risk. For this analysis we reviewed all hard-copy census reports and undertook a literature search for related publications, with a particular focus on the City of Boston. From 1850, country of nativity was recorded routinely as part of the US Census, and from 1870 to 1970, nativity of parents was recorded as well. (The exact terminology varies from census to census, as we will present, but respondents may be categorized according to [a] whether they were native born vs foreign born, [b] whether they were of native-born vs foreign-born parentage, or [c] their country of origin.) Furthermore, both all-cause and disease-specific mortality were recorded, first retrospectively through census enumeration and then through state-level registration processes that achieved national coverage by the 1930s. It is possible, therefore, to document the variation in disease patterns related to country of origin for immigrants and their first-generation American children. Because country-of-nativity questions deal specifically with the experiences of respondents or their parents, they are more precise than the recently employed general ancestry question. An examination of each of these original census records revealed that the Irish had excess mortality throughout the 1850–1970 period, particularly from diseases of the heart and circulatory system. Readers should note that processes of classification of circulatory diseases were not standardized at the end of the 19th and the beginning of the 20th centuries—diagnostic criteria developed over this period. Thus, it is unavoidable that we refer to several classifications of circulatory diseases (“circulatory disease,” “cerebrovascular disease,” etc.) as they were used in the different historical reports.

**RESULTS**

The extensive US vital statistics database is summarized in Table 1. The first census report, in 1850, clearly documented that the Irish were at increased risk. The 1860 census report concerned itself only with the health differences between Blacks and Whites.
and 1920, rates were elevated among various citizens of Irish extraction. In 1910 the latter half of the 19th century continued to ever, the subsequent 4 census reports across the latter half of the 19th century continued to indicate excess cardiovascular mortality risk among citizens of Irish extraction. In 1910 and 1920, rates were elevated among various foreign-born groups, but particularly among the Irish. For instance, in all the urban areas with the highest age-specific death rates for stroke (another condition that may have early-life origins in 1920, men and women of Irish parentage were at demonstrably increased risk, whether US-born or not.

From the period of the 1910 census onward, a number of monographs and reports examined the effect of migration on health with Socioeconomic Circumstances and Cardiovascular Disease, 1850–1980

### TABLE 1—The Irish Transition in the United States: Summary of US Census-Related Data on Socioeconomic Circumstances and Cardiovascular Disease, 1850–1980

<table>
<thead>
<tr>
<th>Census Data Year</th>
<th>Observations and Analysis of the Health of Ethnic Irish Groups in the US and Comparisons With Other Immigrant and Nonimmigrant Groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1850</td>
<td>Irish born constituted 4.81% of the total population in the US but made up 6.23% of deaths from circulatory disease, 7.12% of deaths from respiratory disease, and 6.33% of deaths from tuberculosis. All-cause death rates were 16.41 per 1000 deaths, comparable with the US average (16.16 per 1000 deaths).</td>
</tr>
<tr>
<td>1870</td>
<td>Crude death rates from circulatory disease for Irish-born Americans were 85.9 per 100 000 deaths, comparable with rates among Americans born in England and Wales (90.1 per 100 000) but higher than for all foreign-born immigrants to the US (55.7 per 100 000) and for US-born White Americans (41.4 per 100 000).</td>
</tr>
<tr>
<td>1880</td>
<td>Health status of Americans of Irish and German extraction is contrasted. Deaths from heart disease and dropsy stood at 62.3 per 1000 deaths among Americans of Irish-born parentage, 60.9 per 1000 deaths among Americans of German-born parentage, 64.5 per 1000 deaths among Black Americans, and 56.1 per 1000 deaths among White Americans generally. Tenement conditions were implicated in high death rates of poor White Americans. Rates of tuberculosis infection were excessive among immigrants to the US of Irish-born parentage.</td>
</tr>
<tr>
<td>1890</td>
<td>Heart disease and dropy death rates were higher overall among foreign-born Americans than among US-born Americans. Irish rates of heart disease and dropsy are the highest of any immigrant group in the United States—Americans with mothers born in Ireland at 15–45 years of age: 96.86 per 100 000 (compared to 66.32 per 100 000 for native-born White Americans); at 45–65 years: 401.94 per 100 000 (compared to 305.68 per 100 000 for native-born White Americans); and at 65 years and older: 1199.33 per 100 000 (compared to 1129.01 per 100 000 for native-born White Americans).</td>
</tr>
<tr>
<td>1900</td>
<td>Irish-born immigrants represented 2.12% of the US population, but Americans of Irish-born parentage number 4981 047, or 6.53% of the total population. However, this Irish group (both Irish-born and of Irish-born parentage) contributes 10.54% of total deaths from circulatory disease in the US.</td>
</tr>
<tr>
<td>1910</td>
<td>Death rates from organic heart disease were 5.63 per 1000 among Americans born in Ireland compared to 0.82 per 1000 of Americans born in Italy. Death rates for other circulatory disease were 1.90 per 1000 for Americans born in Ireland and 0.23 per 1000 in Americans born in Italy. Americans of Irish origin accounted for 10.11% of organic heart disease cases and 11.24% of circulatory disease cases in the US, though immigrants born in Ireland made up only 1.47% of the total US population.</td>
</tr>
<tr>
<td>1920</td>
<td>Age-adjusted death rates from cerebral hemorrhage per 100 000 population were reported according mother’s country of birth—New York City: 99.9 Ireland vs 81.9 US, Pennsylvania: 95.7 Ireland vs 86.1 US, New York State: 85.6 Ireland vs 67.2 US, and Chicago: 82.4 Ireland vs 60.4 US. Americans with mothers born in Ireland had higher rates of cerebral hemorrhage than any other group, including Americans with US-born mothers. The highest rate of heart disease was in New York (389.3 per 100 000) for those with mothers born in Ireland and the lowest, in Pennsylvania, for those with mothers born in Italy. In a detailed monograph, Carpenter reported the health status of immigrants and their children, including socioeconomic circumstances; he singled out the Irish for special mention as being at particularly excessive risk of poor health.</td>
</tr>
<tr>
<td>1930</td>
<td>The total foreign-born population from Ireland was 1 037 234 in the US. National mortality data were not published, but a Boston-based census tract-level study found that the highest rates of infant mortality were in Charlestown and South Boston (neighborhoods in Boston, Mass.), through the Irish were integrated across the city. A strong inverse relationship was also found between 1930s socioeconomic indicators and present-day health status. The correlation between infant mortality rates during the 1930s and the coronary heart disease rate in the 2001 Health of Boston report was 0.564 (P &lt; 0.5), with the highest rates being in Charlestown and South Boston.</td>
</tr>
<tr>
<td>1950</td>
<td>Two area-based studies showed excess mortality among those of Irish extraction in the US. Trulson et al. showed that first-generation Irish have higher death rates than US-born Bostonians with US-born parents and Stamler et al. showed considerably excessive risk at 45–64 years for the Irish in America compared with other immigrant groups, US-born Americans, and the Irish in Ireland.</td>
</tr>
<tr>
<td>1980</td>
<td>Rosenwaike and Hempstead, analyzing data through the 1980 US census, concluded that the SMR (Standardized Mortality Ratio) for heart disease is 0.95 for those male immigrants to the US born in Ireland compared with US-born males, but with a ratio of 1.16 to the rate for Italian American males and that an excess of cerebrovascular disease cases and 11.24% of circulatory disease cases in the US, though immigrants born in Ireland made up only 1.47% of the total US population. Dublin and Baker reviewed in more detail the available data for Pennsylvania and New York, confirming excessive mortality for those of foreign and mixed (one parent not from US) parentage and those who were foreign born—this excessive mortality was especially true for the Irish of all categories, being about double the rate for second-generation Americans. Heart disease for males born in the US aged 45–64 years was 232.5 per 100 000 in Pennsylvania and 316.3 per 100 000 in New York, compared to 529.3 per 100 000 for Irish-born males in Pennsylvania and 580.2 per 100 000 in New York. Rates of heart disease were also much higher among similar groups of Irish women when compared with overall rates for women in Pennsylvania and New York.</td>
</tr>
</tbody>
</table>

Note. We refer to several classifications of circulatory diseases (“circulatory disease,” “cerebrovascular disease,” etc.) as they were used in the different historical reports. The terminology regarding race/ethnicity also varies from census to census—respondents may be categorized according to (a) whether they were native born vs foreign born, (b) whether they were of native-born vs foreign-born parentage, or (c) their country of origin. All data were taken from US Census Bureau reports unless otherwise cited.
careful, age-standardized approaches.\textsuperscript{32–38,41–44} During this period, the overwhelming majority of immigrants were Whites of European origin. In examining the documents, we found a general consensus among them that immigrants, and indeed their first-generation children, were at excess risk of circulatory diseases compared with US Whites of native parents, and that the Irish were consistently at higher risk than other immigrant groups. This phenomenon of Irish immigrants being at particularly high risk for cardiovascular disease persisted over a period of 150 years.\textsuperscript{36,38–44} The important question is, why?\textsuperscript{45–47}

Although early demographers considered the effects of ethnicity and adverse social conditions on longevity and health,\textsuperscript{45,46} newer generations of epidemiologists were more inclined to attribute these effects to a so-called process of Americanization mainly related to individual-level adult lifestyle.\textsuperscript{36–38,44} However, no one adequately explained why the Irish were consistently at higher risk. Was their excess risk related to constitutional or genetic factors, adverse lifestyle practices, processes of material disadvantage, or psychosocial processes operating at the individual or community level? As suggested in the title of this article, one way of re-stating this question is to paraphrase it in terms of Robert D. Putnam’s most influential work, \textit{Bowling Alone: The Collapse and Revival of American Community}, in which he describes—beginning with the example of the rise in popularity of bowling but the decline of bowling leagues—Americans’ increasing disconnectedness with each other.\textsuperscript{47} Putnam maintains that this “bowling alone”—a marker of the decline in social capital—is partly responsible for the apparent collapse of community in America and it may have far-reaching health impacts.\textsuperscript{45–47}

The Boston Health League in the early 1930s\textsuperscript{17} investigated the predisposition of certain areas to higher infant mortality with 2 detailed reports that incorporated social and health statistics.\textsuperscript{33,34} There were then 14 census tract areas in Boston (Table 2). For each of these areas, the following data were collected: (1) ethnicity (percentage of all foreign-born, US-born of foreign parents, US-born of native parents, Negro [sic], and foreign-born from several countries, notably Ireland, Italy, and Canada), (2) citizenship status (percentage naturalized citizens, aliens, and those with “first papers” [those in the process of naturalization]), (3) health indicators (infant mortality, tuberculosis incidence, and adult mortality), and (4) economic status (unemployment; criminal delinquency; numbers receiving unemployment aid, dependent aid, mother’s aid, and old-age assistance; and housing type and median monthly rental [$$]).

A variation in infant mortality was found; the highest proportion of Irish-born was found for the 2 areas with highest mortality, Charlestown and South Boston (Table 2). When the interrelationship between variables is explored using Pearson’s correlation method, these data present a convincing pattern of each ethnic group in social transition. The Irish, as the longest-established immigrant group, were distributed across the city and were likely to live in areas with high numbers of US-born people of foreign-born parentage ($r=0.719$, $P=.004$) and high numbers of naturalized citizens ($r=0.716$, $P=0.004$) but were unlikely to be living in areas with high numbers of aliens ($r=–0.759$, $P=0.002$). The Canadians, by contrast, were more affluent and were most likely to be living in communities with high numbers of US-born people of native-born parentage ($r=0.902$, $P<.0001$) and were highly unlikely to live in communities with high proportions of foreign-born people ($r=–0.950$, $P<.0001$), unemployment ($r=–0.622$, $P=.018$), or criminal delinquency ($r=–0.741$, $P<.560$). The Italians, more recently arrived, were unlikely to live in areas with high numbers of either Irish or Canadians or high numbers of native-born people of native-born parentage ($r=–0.620$, $P<.018$), and they were also more likely to reside in areas with high rates of dependent support, various forms of relief, and juvenile criminal delinquency. Table 3 indicates strong, consistent interrelationships between health and social indicators, with median rental income inversely associated with infant mortality rate and with incidence and mortality rates of tuberculosis.

In line with the hypothesis of early-life influences on adult health,\textsuperscript{1–4} the question arises as to whether these previous patterns of association between social and health indicators can be related to present-day health profiles. The net effect of social mobility over time and between areas of any large city is complex—so interpretation of such long-term, complex changes must be done cautiously. However, 13 of the 14 original census areas still exist, though subdivisions and changes make them only indirectly comparable. For instance, the West End is now part of Back Bay and the Beacon Hill neighborhood, and Mattapan and Roslindale are now considered separately.

In a special study of these changing community profiles, Gamm used sociodemographic data by census tract (ethnicity continued to be recorded to some degree between 1940 and 1970) to examine patterns of migration of Jewish and Catholic groups in Boston—he complemented this census data with church and synagogue records.\textsuperscript{38} He also took account of major policy initiatives around affordable housing, including the Boston Banks Urban Renewal Group scheme. Gamm found that there was surprisingly little shift in the Catholic populations, largely owing to strong affiliation to religious parishes. Because these populations are predominantly of Irish extraction, we can therefore be somewhat confident of a continuing pattern of people remaining in their areas of birth, particularly among the older generations. Table 2 shows present-day rates of age-standardized coronary heart disease and stroke, which are still reported by neighborhood in Boston.\textsuperscript{15} Overall, there is a significant correlation between infant mortality rates in 1930–1934 and coronary heart disease rates averaged for 1994–1998 ($r=0.564$, $P=.04$). Present-day rates of coronary heart disease are clearly highest in Charlestown and South Boston (Table 2). Although the relationship between overall infant mortality rate in the 30s and present-day Irish-born percentage is not quite as strong ($r=0.46$, $P=.09$), both coronary heart disease rates for the 1994–1998 ($r=0.608$, $P=.027$) and stroke rates for 1994–1998 ($r=0.591$, $P=.033$) are signifi-
TABLE 2—Characteristics of 14 Census Tract Areas in 1930s Boston (Boston Neighborhood Study\textsuperscript{33,34}) and Corresponding 1990s Stroke and Coronary Heart Disease Rates (Health of Boston 2001\textsuperscript{35})

<table>
<thead>
<tr>
<th>Back Bay</th>
<th>Brighton</th>
<th>Dorchester North</th>
<th>Dorchester South</th>
<th>East Boston</th>
<th>Hyde Park</th>
<th>Jamaica Plain</th>
<th>North End</th>
<th>Roxbury</th>
<th>South Boston</th>
<th>South End</th>
<th>West End</th>
<th>West Roxbury</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nativity, %</td>
<td></td>
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</tr>
<tr>
<td>All Foreign-born</td>
<td>26.00</td>
<td>35.8</td>
<td>44.9</td>
<td>52.9</td>
<td>55.5</td>
<td>68.7</td>
<td>47.10</td>
<td>43.00</td>
<td>68.70</td>
<td>43.00</td>
<td>68.70</td>
<td>43.00</td>
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<tr>
<td>US-born to foreign parents</td>
<td>24.00</td>
<td>31.00</td>
<td>34.00</td>
<td>30.00</td>
<td>26.00</td>
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<td>34.00</td>
<td>0.00</td>
<td>22.00</td>
<td>30.00</td>
<td>34.00</td>
</tr>
<tr>
<td>US-born to US-born parents</td>
<td>48.00</td>
<td>32.00</td>
<td>20.00</td>
<td>17.00</td>
<td>18.00</td>
<td>9.00</td>
<td>23.00</td>
<td>23.00</td>
<td>3.00</td>
<td>14.00</td>
<td>14.00</td>
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<td>5.20</td>
<td>13.20</td>
<td>28.20</td>
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<td>13.20</td>
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<td>0.70</td>
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<td>Italian-born</td>
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<td>9.20</td>
<td>0.00</td>
<td>63.70</td>
<td>22.80</td>
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<td>0.00</td>
<td>10.50</td>
<td>15.80</td>
<td>26.70</td>
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<td>Canadian-born</td>
<td>37.00</td>
<td>26.40</td>
<td>18.80</td>
<td>16.90</td>
<td>12.30</td>
<td>14.00</td>
<td>19.00</td>
<td>20.40</td>
<td>0.70</td>
<td>17.60</td>
<td>10.10</td>
<td>17.70</td>
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<td>Citizenship status, %</td>
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<td>Naturalized citizen</td>
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<td>65.00</td>
<td>64.00</td>
<td>66.00</td>
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<td>66.00</td>
<td>30.90</td>
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<td>59.10</td>
<td>30.00</td>
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<td>9.00</td>
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<td>9.90</td>
<td>7.50</td>
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<td>14.10</td>
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<tr>
<td>7–16 y</td>
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<td>31.00</td>
<td>14.00</td>
<td>9.30</td>
<td>34.10</td>
<td>11.70</td>
<td>12.80</td>
<td>30.80</td>
<td>18.40</td>
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<td>66.20</td>
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<td>77.00</td>
<td>75.40</td>
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<td>102.00</td>
<td>94.00</td>
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<tr>
<td>Unemployment</td>
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<td>2.50</td>
<td>12.60</td>
<td>6.30</td>
<td>3.80</td>
<td>17.20</td>
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<td>6.30</td>
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<td>1.80</td>
<td>6.00</td>
<td>8.80</td>
<td>2.10</td>
<td>11.20</td>
<td>6.60</td>
<td>5.60</td>
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<td>5.80</td>
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<tr>
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<td>28.80</td>
<td>46.90</td>
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<td>7.10</td>
<td>17.80</td>
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<td>73.70</td>
<td>72.00</td>
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<td>71.20</td>
<td>53.10</td>
<td>65.80</td>
<td>92.90</td>
<td>82.20</td>
<td>73.10</td>
<td>83.90</td>
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<tr>
<td>In lodgings\textsuperscript{a}</td>
<td>9.20</td>
<td>0.30</td>
<td>0.30</td>
<td>0.30</td>
<td>0.30</td>
<td>0.30</td>
<td>0.30</td>
<td>0.30</td>
<td>5.90</td>
<td>0.30</td>
<td>0.30</td>
<td>18.30</td>
</tr>
<tr>
<td>Median monthly income, $</td>
<td>54.60</td>
<td>52.90</td>
<td>21.70</td>
<td>39.80</td>
<td>42.30</td>
<td>25.50</td>
<td>35.90</td>
<td>40.90</td>
<td>24.10</td>
<td>33.30</td>
<td>24.20</td>
<td>27.60</td>
</tr>
<tr>
<td>Mortality</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infant mortality rate\textsuperscript{b}</td>
<td>64.50</td>
<td>50.50</td>
<td>85.70</td>
<td>59.60</td>
<td>49.00</td>
<td>66.80</td>
<td>47.50</td>
<td>48.20</td>
<td>62.70</td>
<td>64.40</td>
<td>74.40</td>
<td>73.10</td>
</tr>
<tr>
<td>Tuberculosis incidence\textsuperscript{c}</td>
<td>125.00</td>
<td>104.60</td>
<td>172.00</td>
<td>112.60</td>
<td>87.60</td>
<td>133.80</td>
<td>90.60</td>
<td>101.80</td>
<td>160.10</td>
<td>171.50</td>
<td>168.60</td>
<td>359.40</td>
</tr>
<tr>
<td>Tuberculosis mortality\textsuperscript{c}</td>
<td>34.50</td>
<td>35.90</td>
<td>76.90</td>
<td>43.40</td>
<td>31.60</td>
<td>45.60</td>
<td>33.00</td>
<td>47.70</td>
<td>55.50</td>
<td>73.30</td>
<td>85.40</td>
<td>154.60</td>
</tr>
<tr>
<td>Health of Boston</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke\textsuperscript{d}</td>
<td>12.80</td>
<td>25.10</td>
<td>28.90</td>
<td>29.00</td>
<td>20.20</td>
<td>16.00</td>
<td>19.90</td>
<td>14.10</td>
<td>16.30</td>
<td>28.10</td>
<td>23.30</td>
<td>19.10</td>
</tr>
<tr>
<td>Coronary heart disease\textsuperscript{d}</td>
<td>79.80</td>
<td>112.50</td>
<td>151.20</td>
<td>136.90</td>
<td>109.70</td>
<td>125.80</td>
<td>108.90</td>
<td>92.30</td>
<td>76.30</td>
<td>149.10</td>
<td>172.80</td>
<td>133.80</td>
</tr>
</tbody>
</table>

Note. The terminology used is that of the historical reports.
\textsuperscript{a}“In lodging” refers to renting a room within the landlord’s home, whereas “renting” indicates separate accommodations.
\textsuperscript{b}Average infant mortality rates 1930–1933 per 1000 live births.
\textsuperscript{c}Average tuberculosis incidence and mortality rates 1930–34 per 100 000 population.
\textsuperscript{d}Age-standardized stroke and coronary heart disease rates per 100 000 1994–1998.

cantly related to proportion Irish born in Charlestown and South Boston at the 1930 census. No relationship with present-day rates is seen for Italians, although Italians were more concentrated in fewer census tract areas.

Taken together, these findings indicate that socioeconomic circumstances in early life are likely to have played a role in the etiology of cardiovascular disease regardless of ethnic origin, in keeping with previous findings.\textsuperscript{1–4} However, a contrast between the health and socioeconomic circumstances of the Irish and Italians indicates some residual factors as well. This detailed social portrait in 1 city corroborates findings at the national level mentioned previously (Table 1)—that some ethnic groups are more at risk of cardiovascular diseases than others. To the extent that the Irish were disadvantaged, a relationship between childhood material deprivation and later health outcomes existed. However, this association between being a member of an Irish American community and cardiovascular disease within a single city echoes the pattern of high rates seen in other regions with significant Irish populations.\textsuperscript{7,8} In Ireland itself,\textsuperscript{49} infant mortality rates during the 1930s were only weakly related to

TABLE 3—Pearson Correlations and \( P \) Values for Association Between (a) Measures of Socioeconomic Status and Rates of Infant Mortality in 1930–1933 and Tuberculosis Incidence and Tuberculosis Mortality in 1930–1934\(^{33,34} \) and (b) Rates of Stroke and Coronary Heart Disease in 1994–1998\(^{35} \): Boston

<table>
<thead>
<tr>
<th>Measure of Socioeconomic Status</th>
<th>(a) 1930–1934</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Infant Mortality</td>
</tr>
<tr>
<td>Own home</td>
<td>(-.486 .078 )</td>
</tr>
<tr>
<td>Rent home</td>
<td>(-.486 .078 )</td>
</tr>
<tr>
<td>In lodgings*</td>
<td>(.204 .485 )</td>
</tr>
<tr>
<td>Median monthly rent</td>
<td>(-.587* .027 )</td>
</tr>
<tr>
<td>Unemployed</td>
<td>(.552* .041 )</td>
</tr>
<tr>
<td>Criminal delinquency, 7–16 y</td>
<td>(.538* .047 )</td>
</tr>
<tr>
<td>Criminal delinquency, 17–20 y</td>
<td>(.644* .013 )</td>
</tr>
<tr>
<td>Receiving unemployment assistance</td>
<td>(.341 .233 )</td>
</tr>
<tr>
<td>Receiving old-age assistance</td>
<td>(.498 .070 )</td>
</tr>
<tr>
<td>Receiving dependant aid</td>
<td>(.295 .306 )</td>
</tr>
<tr>
<td>Receiving mothers’ aid</td>
<td>(.337 .239 )</td>
</tr>
</tbody>
</table>

Note. The terminology used is that of the historical reports.
*In lodging* refers to renting a room within the landlord’s home, whereas “renting” indicates separate accommodations.
\*\( P < 0.01 \); **\( P < 0.001 \).

TABLE 4—Estimates of Infant Mortality per 1000 Live Births, by Area: Boston Neighborhood Study\(^{33,34} \) and Irish Free State Vital Statistics Report\(^{56} \): 1930–1933

<table>
<thead>
<tr>
<th>Estimated Infant Mortality</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish Free State (urban)(^a)</td>
<td>1930 90</td>
</tr>
<tr>
<td>Liverpool, England(^b)</td>
<td>1930 82</td>
</tr>
<tr>
<td>Edinburgh, Scotland(^c)</td>
<td>1931 82</td>
</tr>
<tr>
<td>Charlestown, Boston(^d)</td>
<td>1930–1933 86</td>
</tr>
<tr>
<td>Belfast, Northern Ireland(^e)</td>
<td>1930 70</td>
</tr>
<tr>
<td>All Boston(^f)</td>
<td>1930–1933 61</td>
</tr>
<tr>
<td>London, England(^g)</td>
<td>1930–1933 59</td>
</tr>
<tr>
<td>Irish Free State (rural)(^h)</td>
<td>1931 56</td>
</tr>
<tr>
<td>West Roxbury, Boston(^i)</td>
<td>1930–33 46</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Irish Free State report.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(^*)Boston Neighbourhood study.</td>
</tr>
</tbody>
</table>

present-day adult coronary heart disease rates (\(r = 0.26 \) for men and 0.29 for women). Nevertheless, when infant mortality rates for selected urban and rural areas of Ireland\(^50\) and countries to which Irish people migrated are ranked, a strong influence of urban deprivation on these patterns is clearly apparent (Table 4). In the 1930s, infant mortality rates were lowest in rural Ireland and highest in urban Dublin, with intermediate rates in the American cities to which the Irish immigrated in large numbers: Boston, as discussed in the section on community networks and health, presents a wide variation. Two processes must be understood before interpreting the relationship between (a) infant mortality rate, ethnicity, and urban deprivation and (b) later-life health: the effect of disadvantage on the health of Irish immigrants and also the possibility that something particular about the Irish as an ethnic group causes them to continue to incur excessive risk even as they become more affluent.

DISCUSSION

Social Capital and the Irish

The recent focus on social capital as a potentially important explanatory pathway between relative disadvantage and ill health is particularly apposite in this situation, because the cardiovascular health experiences of the Irish and the Italians contrasts so sharply during the period of their assimilation into the American way of life. Concepts of trust, reciprocity, net-
a vestige of an ancient Celtic culture that was 
“hostile to literacy”53 and that Ireland was the 
only Western country that did not build a uni-
versity during the Middle Ages. In fact, the 
historical record clearly shows that the manu-
scripts of Irish monastic scholars almost 
certainly saved the remnants of Greco-Roman 
culture for posterity.54 The Irish preserved 
their cultural identity through religious belief 
and the Gaelic language. The strongly religious 
Irish immigrants in early-twentieth-century US 
cities, therefore, favored denominational 
schools but were not necessarily as interested 
in leaving blue-collar work situations and com-
munities as other immigrants were,52 in part 
perhaps because of their strong social and 
community identity.

Many of the values prominent among Irish 
people are highly consistent with notions of so-
cial support and social capital. The Irish fleeing 
the famine came from a country in which the 
first mass movement of modern history, an 
almost classic example of social capital in practice, 
originated—the Catholic Emancipation move-
ment of Daniel O’Connell,12,14 which helped 
achieve the right to full social and political par-
ticipation by Catholics in Ireland in 1829. This 
emancipation movement exemplifies a phenom-
enon of cross-class support for centrist, charis-
matic leaders that still continues today but that 
also has concealed serious economic inequality. 
Emancipation itself perpetuated a class distinc-
tion among rural tenant farmers by raising the 
land-value threshold of those entitled to vote.14 
Nor could this mass populism stem the horror 
of the famine itself, which in very large measure 
was directly attributable to British economic 
policy at the time. Contemporary interpretations 
by Putnam and others45–47,51 of the importance 
of social networks and support in promoting 
and maintaining health therefore present the 
case of the Irish as a paradox.

Although initially despised as an ethnic 
group, the Irish became one of the most highly 
successful social networking groups in the 
United States,15 contributing constructively to 
the political and cultural life of their adopted 
country from the period of the American Revo-
lution onward.19 In cities such as Boston, Chi-
cago, and New York, the Irish have formed the 
backbone of local politics and municipal ser-

### RESEARCH AND PRACTICE

Knights of Columbus, and, as Gamm pointed 
out, their parish networks were so strong in 
many areas that they were more reluctant than 
other immigrant groups to join the urban exo-
dus of the 1950s and later.18 Coogan represents 
just one of many commentators and social histo-
rians to have chronicled these developments, 
and, as he noted, “in South Boston the Irish 
look after their own.”15 It is instructive that John 
F. Kennedy’s Pulitzer prize-winning book was 
calculatedly devoted to aspects of heroic citizen-
ship.55 However, as is well documented, this 
community solidarity possessed a dark side. 
More recently, Ignatiev12 described numerous 
examples of how the Irish, in the course of their 
social ascent, ruthlessly forged an identity sepa-
rate from African Americans (who were also in 
extremely adverse social circumstances)—often, 
Ignatiev asserted, this resulted in racial preju-
dice and hostility. Also, political influence can 
be open to corruption on occasion.15

Nonetheless, the Irish are characterized by 
strong family and community support, church-
going, and extensive civic participation. How-
ever, the Irish do not appear to have benefited 
from these stocks of social capital in health sta-
tus terms. A present-day analysis of the rela-
tionships among deprivation, lifestyle, and vot-
ing patterns in Ireland shows the continuing 
importance of material indicators of depriva-
tion.56 The immigrant group with whom the 
Irish are most often compared in the United 
States, the Italians, has qualitatively similar 
families and networks. The Italians do indeed 
experience much less coronary heart dis-
 ease,37,38,43,44 but the assumption that this is a 
consequence of community social capital17,51 is 
confounded by a number of other important 
factors.57 For instance, it is quite clear from 
the historical data we review here that the 
case of the community of Roseto, Pa—given such focus in the 
social capital literature as an apparent excep-
tion to the epidemic patterns of coronary heart 
disease at the time—was just one of many pre-
dominantly Italian communities with lower 
risks of heart disease compared to surrounding 
communities.57 Must we therefore look to 
more traditional risk factors than social capital 
to explain the differences?

### The Ireland–Boston Diet Heart Study

The objective of the prospective Ireland-
Boston Diet Heart Study was to recruit siblings 
in Ireland and in the Boston area18,37 to study 
diet and lifestyle in relation to cardiovascular 
disease. Initially, as a report using 1950 US 
census data on Boston ethnicities described, 
both Irish-born immigrants to the US and first-
generation Irish Americans had much higher 
rates of cardiovascular disease and all-cause 
mortality than either US-born Bostonians or 
their counterparts in Ireland.50 However, in 
1985 there was no significant difference in car-
diovascular disease events between recruited 
groups of Irish-born brothers, who either immi-
gated to Boston or stayed in Ireland, and US-
born men of Irish parentage; but, the sample 
numbers were small.38 The Ireland-dwelling 
brothers had higher calorie and carbohydrate 
takes than did the US-dwelling brothers, who, 
nevertheless, were heavier, less physically ac-
tive, and more likely to be smokers and drink-
ers. Saturated fat intake was not different be-
tween the 2 groups. It seems that secular factors 
may have confounded the original investigators’ 
intentions. Recruitment to the study occurred at 
the peak of the cardiovascular disease epidemic 
in the United States, but in the interval between 
recruitment and follow-up, rates had begun to 
fall dramatically. Conversely, rates began to rise 
in Ireland, so that by 1985, a crossover had oc-
curred,58 and rates of cardiovascular disease in 
Ireland have continued to be considerably 
higher among middle-aged people.56 This 
crossover was observed in other contemporary 
cohort studies of Northern European immi-
grants as well, illustrating the critical importance 
of accounting for conditions in both country of 
origin and country of destination.59

### Lifestyle Influences on 
Cardiovascular Disease

The National Nutrition Surveillance Centre 
in Ireland has examined dietary patterns that 
emerged over the period since the Irish 
Famine.60–63 The contemporary Irish diet now 
shows major social variation, reflected in both 
nutrient and food intake, consistent with 
emerging inequalities in rates of chronic dis-
ease.62 The estimates of diet composition from 
a series of studies of dietary intake from 1863 
to 1998 are summarized in Table 5. Fat intake 
rose consistently, in keeping with the upward 
trend in cardiovascular disease rates, from a 
strikingly low baseline. Unlike the Italians, the 
Irish were not consumers of monounsaturated
fats, fruits, and other vegetables. The Irish population thrived on a peculiarly (by European standards) high-carbohydrate diet primarily because of their dependence on the potato (Table 5). It has been documented by Diner, in an authoritative historical review of the eating patterns of Italian, Irish, and Jewish immigrants to the United States, that the Irish were more likely than other immigrant groups to adopt the prevailing diet and to adopt it more rapidly and completely. Immigrant groups for whom cuisine was culturally central, such as the Italians and the Jews, did eat differently from the Anglo-German mainstream, with its heavy reliance on meat and a relatively high salt and fat intake. Diner singled out isolated communities like Roseto, Pa, that consumed more cardioprotective products such as olive oil. In some instances, the Irish (for whom the memories of the famine were vivid) even established dining clubs at which to eat anything but their traditional fare. Conceivably, they may have been especially unprepared, in genetic terms, for the high-saturated fat diet they encountered and embraced so enthusiastically in the United States. Celiac disease is extraordinarily common in Ireland, and, arguably, gluten intolerance would have persisted in a population with relatively low exposure to grains and cereals, especially if the predisposing human leukocyte antigen phenotype carried other selective advantages. A major selection effect therefore may have occurred in famine survivors on this high-carbohydrate diet, both before and after the famine in Ireland. These lines of evidence related to diet are consistent with a particular genetic predisposition to heart disease persisting across generations.

**CONCLUSIONS**

This study has synthesized information from the historical record and across several past and current epidemiological studies. There is convincing evidence that Irish immigrants to the United States had inordinate risk of cardiovascular disease for at least 2 generations. This risk appears to have been mainly related to material deprivation in both early and later life and aggravated by an adverse diet encountered on arrival to the United States. Additionally, the social deprivation of the Irish had an important psychosocial component, characterized by the often intense hostility, prejudice, and discrimination toward them. Nevertheless, the Irish had the support of strong religious ties, community networks, and families. Contrasting the different cardiovascular health profiles of two immigrant groups—the similar social circumstances (high material deprivation and high social capital) but the different dietary patterns of Irish and Italian Americans—suggests that in the face of powerful behavioral factors, enhanced social capital may be relatively less important to population health than previously proposed.

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**Contributors**

C. Kelleher contributed to the collection, analysis, and interpretation of data. J. Lynch contributed to data analysis and interpretation of findings. S. Harper contributed to the collection of US Census archival documents and to their interpretation and analysis. J. Tay contributed to the analysis and interpretation of the Boston-area data. G. Nolan contributed to the interpretation of historical dietary data.

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**Human Participant Protection**

No protocol approval was needed for this study.

**References**


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**TABLE 5—Estimates of Dietary Composition Among Irish People Since 1863: National Nutrition Surveillance Centre**

<table>
<thead>
<tr>
<th>Year and Source of Data</th>
<th>% Protein</th>
<th>% Fat</th>
<th>% Carbohydrate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1863 UK Dietary Survey</td>
<td>11</td>
<td>9</td>
<td>79</td>
</tr>
<tr>
<td>1905 UK survey on consumption and cost of food in workmen’s families</td>
<td>11</td>
<td>24</td>
<td>66</td>
</tr>
<tr>
<td>1936 Food Consumption Survey</td>
<td>12</td>
<td>29</td>
<td>59</td>
</tr>
<tr>
<td>1948 National Nutrition Survey</td>
<td>13</td>
<td>30</td>
<td>57</td>
</tr>
<tr>
<td>1961 Irish Statistical Bulletin</td>
<td>17</td>
<td>29</td>
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</tr>
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<td>1971 Irish Statistical Bulletin</td>
<td>19</td>
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<td>1990 National Nutrition Survey</td>
<td>15</td>
<td>36</td>
<td>47</td>
</tr>
<tr>
<td>1998 Survey of Lifestyles, Attitudes and Nutrition National Survey</td>
<td>17</td>
<td>34.5</td>
<td>46.5</td>
</tr>
</tbody>
</table>

Note. Data cited to other organizations within the table was collated in the National Nutrition Surveillance Centre reports.