The Economic and Social Review, Vol. 49, No. 1, Spring 2018, pp. 45-71

How do the Foreign-Born Rate Host Country Health Systems? Evidence from Ireland

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Abstract: This article evaluates how foreign-born residents perceive the Irish health system compared to the Irish-born. Using data from the European Social Survey (2002-2012), the article finds that the foreign-born are more positive than the native-born regarding the Irish health system. This positive attitude is most pronounced in the first years after their arrival and decreases with time spent in Ireland. However, perceptions vary according to the country of origin: Polish migrants are much more positive about the Irish health system than the Irish, while British-born residents rate the system just slightly more positively than Irish natives.

I INTRODUCTION

To adequately address the health needs of the wider public, scholars and health policy advisers point to the relevance of public opinion on healthcare (Busse 2013; Busse *et al*., 2012; Roberts *et al*., 2004; Smith *et al*., 2009; World Health Organisation, 2000). Public ratings of healthcare services provide policymakers with relevant information on the functioning of healthcare systems and also serve

Acknowledgements: This research is part of the NORFACE Welfare State Futures funded research project 'The Paradox of Health State Futures' (HEALTHDOX) (EC ERA-Net Plus funding, grant agreement number 618106, File Number 462-14-070). We sincerely thank Peter Mühlau, Richard Layte and the anonymous reviewers for their valuable comments on earlier drafts of this article. For all statements of fact, data analyses and interpretation of results, the authors alone bear responsibility.

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as an important indicator of approval of healthcare reforms (Blendon and Benson, 2001; Mossialos, 1997). Moreover, research suggests that perceptions of healthcare services influence the utilisation of those services and consequently health outcomes (Fitzpatrick, 1991; Hudak and Wright, 2000).

Despite the growing interest in public opinion on healthcare services, scholars have rarely addressed the views of specific sub-populations, such as migrants. This is surprising, given that migrants represent a growing share of European populations and are of both economic and political relevance. Due to falling birth rates and ageing societies, most European countries are in need of additional economically active and healthy workers. However, migrants form a very diverse population vulnerable to particular health problems (Rechel *et al*., 2013). They have to adjust to the particular practices and healthcare arrangements in the host society and often face very specific barriers in accessing healthcare services (Mladovsky *et al*., 2012; Rechel *et al*., 2013; Suphanchaimat *et al*., 2015). To adequately address the health needs of migrants from diverse backgrounds and to ensure that migrants remain healthy and economically active, more information is needed on healthcare services from the perspective of migrants.

Migrants' perceptions of healthcare services are also of broader political relevance and can influence the development of welfare states. As migrants settle and gain more political rights, they can influence election results (Dancygier, 2010; Fanning, 2011) and thereby shape the future of welfare states and the development of healthcare systems (Schmidt-Catran and Careja, 2017). If significant sections of the migrant population are negative regarding the healthcare system in their country of residence, it is conceivable that they could contribute to exerting change on that system over time. Equally, if significant numbers of migrants are positive about the health system of the country of residence, they would be unlikely to constitute a force for reform of that health system.

Studying differences in perceptions of public institutions between natives and migrants also provides valuable information on processes of acculturation and integration of migrants in host societies. Social integration theory suggests that if migrants are fully integrated into the receiving society, they will adapt to the opinions of the majority (Reeskens and van Oorschot, 2015). Differences in perceptions between migrants and natives indicate that migrants may not be well integrated into the host society, especially if these differences persist over time.

Further, migrants form an interesting study population that informs health policymakers about the performance of healthcare services *relative* to other healthcare systems. Migrants have experienced different healthcare systems and are likely to judge the services in the host country on the basis of prior experiences in the country of origin (Dinesen, 2013; van Tubergen *et al.,* 2004). At the same time, migrants who have recently arrived provide a fresh perspective on healthcare systems as "outsiders" who have not (yet) been socialised into that particular system, taking its rules, regulations and practices for granted.

In summary, to promote the health of an increasingly diverse, economically active and politically relevant population, it is in the best interests of European countries to adequately address migrants' concerns about healthcare and to react to the particular challenges that they face in accessing health services in their countries of residence (Rechel *et al*., 2013). In this context, more research is needed on migrants' views of health services in their countries of residence and on the extent to which their perspectives are shaped by prior experiences in their country of origin.

Curiously, prior research provides different expectations regarding migrants' perceptions of health services, in particular in comparison with native-born residents. The literature on migrants and healthcare emphasises the various challenges that migrants face in accessing healthcare, as well as their concerns about the affordability and quality of care (Mladovsky *et al*., 2012; Rechel *et al*., 2013; Suphanchaimat *et al*., 2015), suggesting that migrants should be more negative regarding the health services in their country of residence than the native-born. On the other hand, research on migrants' attitudes towards their host society and its public institutions suggests the opposite: migrants' initial optimism and excitement makes them more positive about host country institutions than the native-born, at least in the first few years following their arrival. Indeed, in a process of social integration, it has been shown that their attitudes adapt over time to those of the native-born. Accounting for group specific differences among migrant groups, the literature also suggests that migrants vary in their perceptions of the host society due to prior experiences in their country of origin (Dinesen, 2013; Maxwell, 2010; Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012).

This study aims to empirically test different hypotheses derived from these two areas of scholarship by investigating foreign-born residents' perceptions of health services in Ireland. Using Irish data of the European Social Survey (2002-2012), this study explores: how the foreign-born in Ireland rate Irish health services in comparison to Irish natives and in comparison to the ratings of health services in their country of origin; if foreign-born residents' attitudes change over time and adapt to the native majority; and whether attitudes vary between groups, in particular between the foreign-born from Great Britain and Poland, who currently form the two largest foreign national groups in Ireland (CSO, 2012).

We expect our study to inform research on migrants' assessments of Irish social services. Moreover, our study provides new evidence on the effects of knowledge and experience of other health systems on ratings of Irish health services, contributing to the international literature on migrant attitudes to host country institutions, which until now has not focused on health systems.

II THE IRISH CASE

Ireland is an interesting test case for the study of foreign-born residents' perceptions of health services. Like other EU Member States, the Irish health system has faced new challenges since immigration levels became significant from the late 1990s. Migration to Ireland rose from 20,000 entries a year in 1987 to just under 110,000 in 2007 in the context of strong employment growth (O'Connell *et al*., 2012). Indeed, in little more than a decade, the foreign-born population grew to a higher proportion of population than many other European states (Devitt, 2014; Rechel *et al*., 2013). According to the last Census in 2011, 17 per cent of those usually resident and present in Ireland were born outside the State, with over 12 per cent born in other EU states (CSO, 2012).

Furthermore, and unlike other national healthcare systems (NHS), the Irish system is a mixture of a tax-financed public health service and a fee based private system and has never provided universal access to healthcare (Barrington, 1987; Wren, 2003). Residents are obliged to pay for GP services, unless they are eligible for "medical cards"[1] or "GP visit cards," which are largely means-tested. Residents are entitled to public hospital care, however those without medical cards must pay user charges, which are set per day and capped per annum. About half of the population are signed up for private health insurance, which provides faster access to hospital care. Private patients can be treated in private or public hospitals and pay higher charges as well as specialist fees, a proportion of which is reimbursed by private health insurance companies (Nolan *et al*., 2014; Turner, 2015).

In response to concerns about efficiency and equity, the Irish health system has been the object of reform and reform proposals since the turn of the millennium (Burke, 2009; Wren, 2003). Healthcare costs are comparatively high, due to hospital charges, outpatient fees and doctor and dentist fees (Thomson *et al.*, 2014), which can deter people from seeking medical assistance (O'Reilly *et al*., 2007). A growing and ageing population has led to further pressure on the public health system over the past decade, illustrated, for example, by long waiting times for treatment for those without private insurance (Burke *et al*., 2014). In this context, it is no surprise that the Irish health system is not highly rated by its residents. Past research reports low levels of satisfaction with the system and a strong demand for fundamental healthcare reforms (Mossialos, 1997; OECD, 2013; 2015; Wendt *et al*., 2010). According to Eurobarometer data on public satisfaction with health services from 2002, Ireland ranked third last, just before Greece and Portugal, out of 14 Western European countries (Wendt *et al*., 2010). In the latest OECD reports, Ireland ranked 25 out of 34 countries in 2012 and 24 out of 34 countries in 2014, based on Gallup World Poll data (OECD, 2013; 2015). While health services are not highly rated

[1] Those with largely means-tested "medical cards" – approximately a third of the population – are entitled to General Practitioner (GP) and hospital care free of charge, as well as support towards the cost of pharmaceutical drugs.

by the Irish public, foreign-born residents' perceptions of health services have – to the best of our knowledge – not yet been studied in depth.

III THEORETICAL BACKGROUND

3.1 Migration and Healthcare

While migrants are often healthier than the native-born, at least initially, they can be more vulnerable to particular health problems, including maternal and child health problems, occupational health hazards, injuries and poor mental health, some of which can be explained by living and working conditions in host countries as well as the psychological stresses associated with migration (Rechel *et al.*, 2013). The most significant barriers to access to health services for migrants are restricted legal entitlements to healthcare (a particular problem for asylum seekers and undocumented migrants), inadequate information regarding entitlements, user fees, language barriers, inadequate health literacy, social exclusion, discrimination and health service resource constraints (Mladovsky *et al*., 2012; Rechel *et al*., 2013; Suphanchaimat *et al*., 2015). It is, however, important to emphasise that migrants are not a homogenous population and their experiences with the health system vary considerably, according to, for example, their country of origin and socio-economic status in the destination country (Rechel *et al*., 2013; Stan, 2015).

The Irish National Intercultural Health Strategy 2007-2012 of 2007 is based on an acknowledgement that people from minority ethnic groups are at increased risk of poverty and social exclusion, which, along with language and cultural barriers, can compromise their health and well-being. Amongst other objectives, it aims to facilitate access to services by, for example, improving information on entitlements and services and providing culturally competent services (HSE, 2008). However, while the Irish policy was lauded for its balanced and detailed approach in a recent comparative analysis of migrant health policies in Europe, little evidence is available on the implementation of this and other national strategies (Mladovsky *et al*., 2012; Rechel *et al*., 2013). Existing research on migrants and the Irish health services shows that a larger proportion of non-Irish nationals have to pay for health services out-of-pocket than amongst those with Irish citizenship; for example, in 2010, 42 per cent had neither medical cards nor private insurance cover compared to 20 per cent of Irish nationals (CSO, 2011). Non-Irish nationals are less likely to have private insurance than Irish nationals; in 2010, only 24 per cent of non-Irish nationals were insured compared to 51 per cent of Irish nationals. This means that 76 per cent of non-Irish nationals are vulnerable to public hospital waiting times. In 2010, 34 per cent of non-Irish nationals had a medical card, compared to 29 per cent of Irish nationals, reflecting the fact that a larger proportion of non-Irish nationals are employed in low income occupations (Barrett and Kelly, 2012). Furthermore, 40 per cent of non-Irish nationals did not attend a GP in the previous

year, compared to 24 per cent of Irish nationals; however, this may be partly due to a higher proportion of non-Irish citizens perceiving their health to be very good compared to Irish citizens (54 per cent versus 44 per cent in 2010) (CSO, 2011), as well as the common practice of seeking medical assistance in countries of origin (Migge and Gilmartin, 2011; Stan, 2015). Those with undocumented status and those engaged in informal work face barriers in accessing services due to difficulties proving 'ordinary residence' (Stan, 2015). As regards undocumented migrants, a recent study placed Ireland in the group of EU Member States where undocumented migrants have less than minimum rights of access to healthcare. In 2009, undocumented migrants could access emergency care for an unclear cost in Ireland, while in a majority of EU states they could access emergency care or healthcare free of charge (Cuadra, 2011).

Qualitative research into the transnational healthcare practices of migrants in Ireland highlights how migrants often lack information about entitlements and the organisation of Irish healthcare services (Migge and Gilmartin, 2011; Stan, 2015). Concerns about affordability and the quality of care – including medical assessment and treatment quality, waiting times, the physical layout of rooms, overcrowding and standards of cleanliness in Irish hospitals – were reported as the two main reasons for cross-border mobility for healthcare among a group of 60 migrants in Ireland from 18 different national backgrounds, a majority coming from EU or English speaking countries. Nearly half of these migrants met at least some of their health needs in their country of origin (Migge and Gilmartin, 2011). This literature on migrants and healthcare systems emphasises the challenges that migrants face in accessing healthcare, as well as their concerns about the affordability and quality of care. It thus provides the expectation that *the foreign-born in Ireland are more negative than the native-born regarding Irish health services (H1)*.

3.2 Migrant Attitudes Towards Host Country Institutions

However, despite these challenges with regards to accessing healthcare and evidence of migrant concerns regarding the affordability and quality of healthcare in Ireland, research on migrants' attitudes towards the public institutions of their host societies finds that they tend to be more positive than natives (Maxwell, 2010; Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012). Cross-comparative studies have found that migrants show stronger support for state intervention (Reeskens and van Oorschot, 2015), higher levels of political trust (Röder and Mühlau, 2012) and satisfaction with public institutions (Maxwell, 2010; 2013) compared to native populations. This positive attitude of first generation migrants is often attributed to their general optimism and excitement paired with lower expectations towards their host society. As Maxwell (2010) reasons:

> *Many first-generation migrants have undergone conscious sacrifices and may be prepared to accept difficult circumstances as the price for moving to*

> *their chosen host society. (...) migrants' dissatisfaction with the homeland prompted the move, so even difficult circumstances in the host society are likely to be viewed in a more positive light* (p.30).

Therefore, and contrary to our first hypothesis, research on migrants' attitudes towards their host society and its public institutions in general leads us to expect that *foreign-born residents in Ireland are more positive than the native-born regarding Irish health services (H2)*.

Acculturation and integration processes can affect migrants' perceptions of the host society. First generation migrants' attitudes gradually adapt over time to the majority attitude in the host society (Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012). Röder and Mühlau (2012) concluded that

> *migrants give credit to the host countries, but this credit fades away the more migrants are exposed to the working of these institutions and as the memories of the country of origin become more distant* (p.790).

The study of second generation migrants further supports this assumption, finding no or only minor differences between the attitudes of second generation migrants and their host society (Dinesen and Hooghe, 2010; Maxwell, 2010; Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012). These findings lead us to expect that the attitudes of foreign-born residents in Ireland adapt over time. *The longer the foreign-born have resided in Ireland, the more similar they perceive Irish health services to Irish natives (H3)*.

As migrants are not a homogenous population, we can expect to find group specific differences in their attitudes to host country institutions due to prior experiences in their country of origin. Indeed, it has been argued that migrants form an interesting study population as they apply a "dual frame of reference" when they evaluate institutions in their destination country. Experiences in the host society are evaluated against previous experiences in and perceptions of their country of origin, which function as an important referential standard. Röder and Mühlau (2012), for example, found differences in political trust between first generation migrants and natives to be fully explained by "relative" institutional performance: the better the institutional performance in the host country compared to the country of origin, the higher the institutional trust of first generation migrants. With regards to health systems, Migge and Gilmartin (2011) maintain that migrants' assessments of the Irish system appear to depend on the practices they were used to in their countries of origin or third countries. Similarly, Macfarlane and de Brun (2010) found that refugees and asylum seekers from the former Soviet bloc compared the Irish health system in a negative light to those of their countries of origin. The study of migrants' attitudes towards health services provides, therefore, an interesting starting point to study group specific differences in migrants' attitudes and to

analyse the functioning and public support for healthcare systems of both the country of origin and the destination country. For example, taking the two largest foreign-born groups in Ireland, we expect differences in the rating of Irish health services between the British-born and the Polish-born. The British National Healthcare System (NHS) provides the most universal access to healthcare of the three countries (Boyle 2011; van Doorslaer *et al.,* 2006). With a strong public health system, a marginal private health sector, comparatively low out-of-pocket payments and shorter waiting times (Huber *et al.*, 2008; Schoen *et al.,* 2010; Siciliani *et al.,* 2014), the British system is also more positively perceived by the public than the Polish and Irish health systems (Wendt *et al.,* 2011). Indeed, the Polish system scores the lowest of the three countries, despite the implementation of a compulsory health insurance system in the 1990s that covers more than 98 per cent of the population (Sagan et al. 2011). With long waiting times and high out-of-pocket payments due to financial constraints, unclear regulations, and high rates of reported unmet health needs (Huber *et al.,* 2008; Sagan *et al.,* 2011), the Polish health system is generally not well received by the Polish public. Consequently, *we could expect the British-born to be more critical of the Irish system than the Irish-born (H4a) and the Polish-born to be more positive towards it (H4b).* Respectively, comparing British- and Polish-born residents' attitudes to the Irish health system with their co-nationals' ratings of health systems in their countries of origin, we expect the *British-born to be more critical of the Irish system than their co-nationals are with the British system (H5a), and the Polish-born to be more positive about the Irish system than their co-nationals are with the Polish system (H5b).*

IV METHODS

4.1 Data

The empirical analyses are based on European Social Survey (ESS) data. The ESS is a high quality, cross-comparative dataset that provides biannual information representative of the resident national population living in private households aged 15 and above. The ESS follows a repeated cross-sectional design and respondents were selected using strict probability sampling. Data were collected via face-to-face interviews.

This study uses the first six waves of the ESS on the Republic of Ireland and covers a timespan of ten years (2002-2012). Response rates varied and ranged from 51.6 per cent in 2009/2010 to 67.9 per cent in 2012/2013.[2] In total, the Irish sample includes 12,296 individuals living in private households in Ireland for whom

[2] Response rates of the Irish ESS sample for each round: Round 1 (2002/2003): 64.5 per cent; Round 2 (2005): 62.5 per cent; Round 3 (2006/2007): 56.8 per cent; Round 4 (2009/2010): 51.6 per cent; Round 5 (2011/2012): 65.2 per cent; Round 6 (2012/2013): 67.9 per cent.

information on all variables was available. For comparisons of migrants with their co-nationals in their country of origin we also include the information of 11,785 individuals of the British ESS sample and 10,374 of the Polish ESS sample (excluding respondents who were not born in either of the two countries).

Although the ESS does not apply a specific sampling scheme with regard to migrants, it seeks to interview residents regardless of their nationality, citizenship or language. Questionnaires are prepared for each language used by at least 5 per cent of the population. Since British nationals are the only migrant group in Ireland that meets this requirement, interviews in Ireland were conducted in English only. Thus, a sufficient level of language proficiency by the foreign-born was required and certain migrant groups may be underrepresented. Moreover, no information about the experiences of undocumented migrants is available.

4.2 Variables

The perception of health services forms the main dependent variable of our analysis. Respondents were asked what they "think overall about the state of health services in Ireland nowadays" on an 11-point scale ranging from 0, extremely bad, to 10, extremely good. In comparison to other indicators on attitudes towards the health system (e.g. state responsibility), this indicator was found to be more responsive to institutional differences (Missinne *et al.,* 2013; Wendt *et al.,* 2010). We also assume it to be sufficiently sensitive for observing intergroup differences in healthcare experiences.

The perception of the state of education: We test the sensitivity of our findings on health services by comparing them to results on the perception of the state of education. This indicator has also been included in all six rounds of the ESS and has been measured on a similar response scale. Respondents were asked what they "think overall about the state of education in Ireland nowadays?" on an 11-point scale ranging from 0, extremely bad, to 10, extremely good.

The Foreign-Born: Our study focuses on the perceptions of individuals born outside of the Republic of Ireland and currently residing in the Republic of Ireland.[3] Table A1 in the Appendix reports the descriptive statistics on foreign-born by their country of origin using the pooled Irish sample of the ESS (2002-2012).[4] The ESS counts 1,445 respondents with valid information born outside of Ireland. In accordance with the national statistics (CSO, 2012), the largest foreign-born groups

[3] We chose this definition over a more restrictive one as we assume all individuals born outside the country (including those whose parents were born in Ireland) to have experienced another healthcare system and to apply different frames of reference when judging the Irish health system. We re-ran the analysis with a more restrictive definition of migrants (excluding individuals whose parents were born in Ireland). The results are fairly similar but the sample size decreased dramatically.

[4] To extend the number of observations on foreign-born, we used the pooled ESS sample of all rounds. Separate analyses for the specific years/rounds are similar to those reported in this paper. Significance levels can vary and are likely to be due to the reduced sample size and number of foreign-born.

in Ireland are from Great Britain (N=656) and Poland (N=183). Further, we controlled for respondents born in Ireland, having two parents born outside of Ireland.

Length of Stay: To test for acculturation effects, we use information on the respondents' length of stay in Ireland. Different answer categories across years in the ESS paired with the low number of individuals who recently migrated to Ireland (less than one year) required a re-coding of the variable into four categories: migrants living in Ireland for less than six years; six to ten years; 11 to 20 years; and more than 20 years.

Individual Control Variables: We control for additional demographic and socio-economic characteristics of the individual that influence the perception of Irish health services (Missinne *et al.,* 2013; Wendt *et al.,* 2010). The respondent's sex and age function as standard control variables. To control for health needs, we included two health variables: the respondent's self-reported health status measured on a 5-point scale, ranging from very good to good, fair, bad, and very bad; and health related limitations in daily lives and routines re-coded into a dummy variable (no limitations and a lot/to some extent). We introduced socio-economic characteristics, such as household income (quintiles), years of education, and the current status of employment (paid work, unemployed, retired, other employment status). We created a dummy variable including individuals without income information. To control for other household characteristics, we included the household size and whether children are living in the household.

Table 1 shows the means/proportions of all variables of this study. Samples of natives and foreign-born vary with regard to demographic and socio-economic characteristics, which are important for the analysis of healthcare ratings. A larger percentage of the foreign-born residing in Ireland is between 21 and 49 years of age (75 per cent) compared to the Irish-born (50 per cent). They often enjoyed a longer education (15 years compared to the average of 13 years of the Irish-born), but are also more often unemployed (14 per cent compared to 8 per cent of the Irish-born). The Polish-born are particularly healthy, but often work in low income jobs (indicated by a high percentage of Polish-born in paid work (62 per cent) and the lowest income group (22 per cent)). While the Polish-born often recently migrated to Ireland (63 per cent within the past six years), the British-born have resided in Ireland for a longer timespan (50 per cent migrated more than 20 years ago). Given these systematic differences between native and foreign-born samples, the inclusion of demographic and socio-economic characteristics in the empirical analysis is necessary.

4.3 Analysis

We apply ordinary least square (OLS) regression analysis with robust standard errors using the Huber-White-sandwich estimator. At all stages, we control for individual characteristics, i.e. demographic and socio-economic characteristics of

Table 1: Variables, Means/Proportions by ESS sample

	Irish Sample Total	*Irish Sample Native*	*Irish Sample Born outside of Ireland*			*British Sample Native*	*Polish Sample Native*
			Total	*GB*	*PL*		
Perception of health services (11-point scale)	4.08	3.99	4.72	4.07	5.73	5.62	3.65
Perception of education (11-point scale)	6.33	6.33	6.34	6.24	6.51	5.60	5.33
Foreign-born (1 = foreign-born, 0 = native)	0.12	0.00	1.00	1.00	1.00	0.00	0.00
Length of stay (1 = < 6 years, 0 = other)	n/a	n/a	0.30	0.11	0.63	n/a	n/a
Length of stay (1 = 6-10 years, 0 = other)	n/a	n/a	0.24	0.14	0.33	n/a	n/a
Length of stay (1 = 11-20 years, 0 = other)	n/a	n/a	0.18	0.26	0.03	n/a	n/a
Length of stay (1 = > 20 years, 0 = other)	n/a	n/a	0.27	0.50	0.01	n/a	n/a
Parents: foreign-born (0 = natives)	0.00	0.00	0.00	0.00	0.00	0.04	0.01
Gender (1 = female, 0 = male)	0.51	0.51	0.50	0.52	0.46	0.52	0.52
Age (1 = 15–20 years, 0 = others)	0.10	0.11	0.07	0.08	0.08	0.10	0.11
Age (1 = 21–35 years, 0 = others)	0.29	0.27	0.42	0.22	0.76	0.22	0.26
Age (1 = 36–49 years, 0 = others)	0.24	0.23	0.33	0.39	0.14	0.24	0.23
Age (1 = 50–64 years, 0 = others)	0.22	0.24	0.13	0.22	0.02	0.24	0.24
Age (1 = 65 years or more, 0 = others)	0.14	0.15	0.05	0.09	0.00	0.20	0.15
Health Status (1 = very good, 0 = others)	0.44	0.43	0.45	0.43	0.57	0.31	0.15
Health Status (1 = good, 0 = others)	0.41	0.41	0.41	0.40	0.35	0.42	0.43
Health Status (1 = fair, 0 = others)	0.13	0.13	0.12	0.14	0.05	0.21	0.30
Health Status (1 = bad, 0 = others)	0.02	0.02	0.02	0.02	0.02	0.06	0.09
Health Status (1 = very bad, 0 = others)	0.00	0.00	0.00	0.00	0.01	0.01	0.02
Limitations (health caused) (1 = a lot/some, 0 = none)	0.15	0.15	0.12	0.18	0.06	0.25	0.27
Education in years	13.57	13.40	14.86	14.35	15.06	12.99	11.80
Employment (1 = paid work, 0 = other)	0.47	0.46	0.50	0.46	0.62	0.52	0.46
Employment (1 = unemployed, 0 = other)	0.09	0.08	0.14	0.12	0.20	0.05	0.07

Table 1: Variables, Means/Proportions by ESS sample (Contd.)

	Irish Sample Total	*Irish Sample Native*	*Irish Sample Born outside of Ireland*			*British Sample Native*	*Polish Sample Native*
			Total	*GB*	*PL*		
Employment (1 = retired, 0 = other)	0.12	0.13	0.05	0.09	0.01	0.22	0.26
Employment (1 = other empl. status, 0 = other)	0.33	0.33	0.31	0.32	0.17	0.21	0.21
Household income (1 = 1st quintile, 0 = other)	0.16	0.16	0.21	0.16	0.22	0.15	0.44
Household income (1 = 2nd quintile, 0 = other)	0.18	0.18	0.19	0.17	0.23	0.16	0.13
Household income (1 = 3rd quintile, 0 = other)	0.16	0.16	0.16	0.18	0.19	0.14	0.09
Household income (1 = 4th quintile, 0 = other)	0.17	0.17	0.13	0.16	0.07	0.23	0.08
Household income (1 = 5th quintile, 0 = other)	0.07	0.07	0.06	0.09	0.02	0.11	0.07
Household income (1 = no information, 0 = other)	0.26	0.26	0.25	0.24	0.26	0.21	0.19
Number of persons in household	3.47	3.47	3.47	3.49	3.26	2.74	3.52
Children in household (1 = yes, 0 = no)	0.45	0.44	0.49	0.53	0.39	0.36	0.50
Number of observations	12,296	10,851	1,445	656	183	11,785	10,374

Source: ESS, Irish Sample, Rounds 1-6, standard weights applied.

the individual including health needs. Standard weights are applied following the recommendations of the ESS.

4.4 Research Strategy

After reporting a first snapshot of the general public rating of health services in Ireland, we evaluate how foreign-born residents' ratings differ from those of Irish natives and how the length of time spent in Ireland influences their perception of health services. Second, we focus on the foreign-born from Great Britain and Poland, and investigate how people with experience of specific institutional settings differ in their perception of Irish health services from Irish natives. We also compare British- and Polish-born residents' attitudes to the Irish health system with co-nationals' ratings of health systems in their countries of origin in order to investigate whether source country health systems are rated more or less highly than host country systems. To validate our findings and to test for their sensitivity (i.e. capturing perceptions towards the health system rather than attitudes towards public institutions in general), we compare our findings on health services with results on perceptions of the state of education. If quality ratings on education vary from those on healthcare, we receive additional support that our results are sufficiently sensitive to the Irish health system and cannot be generalised as culturally or structurally rooted attitudes towards public institutions in general. Results are expected to provide a deeper understanding of the functioning of Irish health services from a foreign perspective – in particular people from Great Britain and Poland who have experienced different health services in their country of origin and therefore apply different frames of reference.

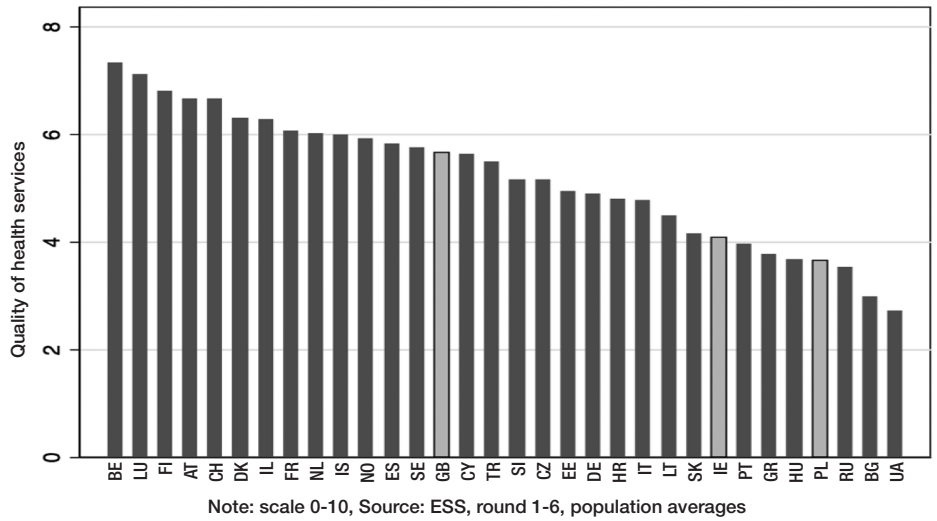
V RESULTS

5.1 The Public Perception of Irish Health Services

Figure 1 shows the average rating of health services for all European countries included in the ESS study for which information on this variable was available. In line with previous research (OECD, 2013; 2015; Wendt *et al.,* 2010), Irish residents are on average comparatively critical regarding their health services. With a mean of 4.07 (SD = 2.49) measured on an 11-point scale, Ireland belongs to the group of European countries with the least positive perception of health services. Lower ratings are only reported for Portugal, Greece, Hungary, Poland, Russia, Bulgaria and Ukraine – countries known for their comparatively poor performance in the health sector.

Table 2 reports the results of the linear regression models for quality ratings of health services in Ireland. Overall, and in line with previous research (Missinne *et al.,* 2013; Wendt *et al.,* 2010), perceptions vary according to the person's gender, age and health status. Women are in general less positive about Irish health services

Figure 1: Perception of Health Services (Mean) across European Countries



Source: ESS, round 1-6, population averages.
Note: averages are calculated on available years; several countries have not participated in all rounds of the ESS, which are: BG (Round 4-6), HR (Round 4 and 5), CY (Round 4-6), CZ (Round 1, 2, 4-6), EE (Round 2-6), GR (Round 1,2, 4,5), IS (Round 2, 6), IL (Round 1, 4-6), IT (Round 1, 2, 6), LT (4-6), LU (Round 1, 2), RO (Round 3, 4), RU (Round 3-6), SK (2-6), TR (Round 2, 4), UA (Round 2-6).

than men, as are the middle aged compared to younger and older age groups. A positive and linear effect is reported for health status: the better the health – and thus the less dependent and often less experienced individuals are with Irish health services – the more positive the perception. No significant differences are observed for daily limitations due to health issues, nor do the years of education influence a person's rating. However, coefficients go in the predicted direction, showing that the higher educated tend to be more critical regarding the health system than the lower educated. Middle income groups rate health services less positively than the lowest income groups, who often hold a medical card and enjoy health services free of charge (while also being more dependent on the public system, thus facing longer waiting times). The results further show a significant effect for household composition: the higher the number of people living in the household, the more positive the perception of health services. Interestingly, despite the massive cuts in public spending on healthcare over recent years and the ongoing debate on healthcare reforms that can be expected to have raised awareness about problems in the health system (even amongst those not directly affected by the malfunctioning of the system), the perception of health services in Ireland has not significantly changed over the past decade. None of the year dummies included in the analysis showed any significant deviation.

Table 2: Perception of Irish Health Services

	Model 1		*Model 2*		*Model 3*	
	β	*se*	*β*	*se*	*β*	*se*
Foreign-born Characteristics						
Foreign-born (0 = natives)	0.85***	(0.08)	1.66***	(0.12)		
Length of stay in IE (metric, 0 = 0–5 years)			–0.55***	(0.06)		
Foreign-born by length of stay: (0 = natives)						
Foreign-born: 0–5 years in IE					1.71***	(0.14)
Foreign-born: 6–10 years in IE					1.04***	(0.16)
Foreign-born: 11–20 years in IE					0.49**	(0.16)
Foreign-born: > 20 years in IE					0.05	(0.12)
Parents: foreign-born (0 = natives)	0.51	(0.50)	0.53	(0.50)	0.53	(0.50)
Demographic Characteristics						
Female (Ref. male)	–0.41***	(0.05)	–0.41***	(0.05)	–0.41***	(0.05)
Age (0 = 36–49 years)						
15–20 years	0.79***	(0.13)	0.75***	(0.13)	0.75***	(0.13)
21–35 years	0.21**	(0.07)	0.12	(0.07)	0.12	(0.07)
50–64 years	0.23**	(0.07)	0.23**	(0.07)	0.23**	(0.07)
65 years or more	1.06***	(0.11)	1.07***	(0.11)	1.07***	(0.11)
Health Status (0 = very good)						
Good	–0.16**	(0.06)	–0.17**	(0.06)	–0.17**	(0.06)
Fair	–0.55***	(0.09)	–0.54***	(0.09)	–0.54***	(0.09)
Bad	–0.58**	(0.21)	–0.60**	(0.21)	–0.59**	(0.21)
Very bad	–1.38**	(0.45)	–1.33**	(0.44)	–1.34**	(0.44)
Health Limitations (0 = no limitations)	0.12	(0.08)	0.13	(0.08)	0.13	(0.08)
Socio-Economic Status						
Education in years	–0.00	(0.01)	–0.00	(0.01)	–0.00	(0.01)
Employment status (0 = paid employment)						
Unemployed	0.04	(0.10)	0.03	(0.10)	0.03	(0.10)
Retired	0.13	(0.10)	0.12	(0.10)	0.12	(0.10)
Other empl. status	–0.02	(0.07)	–0.01	(0.07)	–0.01	(0.07)
HH-Income (0 = 1st Quintile)						
2nd Income Quintile	–0.12	(0.08)	–0.12	(0.08)	–0.12	(0.08)
3rd Income Quintile	–0.20*	(0.09)	–0.18*	(0.09)	–0.18*	(0.09)
4th Income Quintile	–0.11	(0.10)	–0.09	(0.10)	–0.09	(0.10)
5th Income Quintile	–0.06	(0.12)	–0.01	(0.12)	–0.01	(0.12)
No Income Information	–0.08	(0.08)	–0.07	(0.08)	–0.07	(0.08)

Table 2: Perception of Irish Health Services (Contd.)

	Model 1		*Model 2*		*Model 3*	
	β	*se*	*β*	*se*	*β*	*se*
Household Characteristics						
HH-Size (metric)	0.06**	(0.02)	0.07**	(0.02)	0.07**	(0.02)
Children in HH (0 = no children)	–0.09	(0.07)	–0.09	(0.07)	–0.09	(0.07)
Year of survey (0 = 2002/2003)						
2004/2005	0.00	(0.09)	0.00	(0.09)	0.00	(0.09)
2006/2007	–0.11	(0.10)	–0.13	(0.10)	–0.13	(0.10)
2008/2009	0.06	(0.09)	0.02	(0.09)	0.02	(0.09)
2010/2011	0.00	(0.09)	–0.04	(0.09)	–0.03	(0.09)
2012/2013	0.01	(0.09)	0.00	(0.09)	0.01	(0.09)
Constant	*3.90***	*(0.13)*	*3.91***	*(0.13)*	*3.91***	*(0.13)*
R^2	0.05		0.05		0.05	
N	12,296		12,296		12,296	

Source: ESS, Irish Sample, Rounds 1-6, standard errors in parentheses, standard weights applied.
Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

5.2 Exploring Differences in the Perception of Health Services between the Foreign-Born and Natives in Ireland

Table 2, Model 1 presents results on differences in the health services ratings of the foreign-born and natives in Ireland. Contrary to the hypothesis that migrants experience more difficulties in accessing Irish health services and are more critical towards them than Irish natives (H1), we observe a significant and positive effect which indicates that the foreign-born in Ireland view Irish health services on average almost one scale-point (β = .85, se = .08) more positively than Irish natives. Our results therefore support previous research on migrants' attitudes towards their host society and our hypothesis (H2) that the foreign-born view Irish health services more positively than Irish natives.

Results in Model 2 indicate a linear decline of this difference with the length of time the foreign-born reside in Ireland (β = –.55, se = .06) and support our hypothesis on adaptation effects (H3). Those who recently arrived in Ireland (0-5 years ago) rate Irish health services on average 1.7 points higher than those born in Ireland (β = 1.71, se = .14), while those who have lived longer than 20 years in Ireland show no significant attitudinal difference compared to Irish natives (β = .05, se = .12) (Model 3). The results are robust to demographic and socio-economic characteristics. In total, and similar to previous studies, individual characteristics explain close to 5 per cent of variation in the perception of Irish health services.

Results in Table 3 reveal interesting differences for the British and Polish-born residing in Ireland and support our assumption that quality ratings of Irish health services vary by country of origin. Contrary to our hypothesis (H4a), our results show that the British-born are slightly more positive about Irish health services than Irish natives (β = .20, se = .10). Further, no significant trends are observed with the length of time they have resided in Ireland. Results on the Polish-born are in line with our hypothesis (H4b) and show that the Polish-born rate Irish health services on average 1.9 scale points higher than Irish natives (β = 1.88, se = .22). Polish migrants who recently arrived in Ireland are the most positive with close to two scale-points above Irish natives (β = 2.01, se = .26). No significant adaptation effects are observed for Polish migrants according to the length of time spent in Ireland, but these results require careful interpretation as most of the Polish-born in Ireland arrived less than ten years ago.

Table 3: Perception of Irish Health Services: the British- and Polish-born in Ireland

	Model 1		*Model 2*	
	β	*se*	β	*se*
Foreign-born Characteristics				
Foreign-born: from UK (0 = natives)	0.20*	(0.10)	0.34	(0.22)
Length of stay in IE (metric, 0 = 0–5 years)			–0.07	(0.09)
Foreign-born: from Poland (0 = natives)	1.88***	(0.22)	2.01***	(0.26)
Length of stay in IE (metric, 0 = 0–5 years)			–0.25	(0.32)
Foreign-born: from other country (0 = natives)	1.21***	(0.12)	1.95***	(0.16)
Length of stay in IE (metric, 0 = 0–5 years)			–0.70***	(0.10)
R^2	0.05		0.06	
N	12,296		12,296	

Source: ESS, Irish Sample, Rounds 1-6, standard errors in parentheses, standard weights applied, controls for other demographic and socio-economic characteristics, HH-characteristics, and years of survey (see Table 2).
Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

5.3 Exploring Differences in the Perception of Health Services between the British- and Polish-born in Ireland and their Co-nationals living in Great Britain and Poland

Table 4 reports the regression results for ratings of health services in Great Britain and Poland and contrasts them with co-nationals' ratings of the Irish health system. In line with our hypothesis (H5a), the results reveal that, although the British-born in Ireland are slightly more positive in their perception of Irish health services than

Irish natives (see earlier findings in Table 3), they are significantly less positive about Irish health services (β = -1.58, se = .10) than the British residing in Great Britain are of the British health services. In comparison, and in accordance with our next hypothesis (H5b), the Polish-born in Ireland rate the Irish health services two scale-points higher than their co-nationals in Poland rate the Polish system (β = 2.08, se = .21). For those having recently migrated to Ireland, perceptions are even slightly more positive (β = 2.16, se = .25). Again, due to the low number of Polish-born who have stayed longer than ten years in Ireland, adaptation effects are hard to pinpoint on the basis of the available data.

Table 4: Perceptions of Health Services in Great Britain and Poland

	British Sample				*Polish Sample*			
	β	*se*	β	*se*	β	*se*	β	*se*
Foreign-born characteristics								
Resident in IE from UK/Poland	–1.58***	(0.10)	–1.43***	(0.21)	2.08***	(0.21)	2.16***	(0.25)
Length of stay in IE (metric, 0 = 0−5 years)			–0.07	(0.09)			–0.17	(0.32)
R^2	0.12		0.12		0.07		0.07	
N	12,441		12,441		10,557		10,557	

Source: ESS, British and Polish sample, Rounds 1-6, standard errors in parentheses, standard weights applied, controls for other demographic and socio-economic characteristics, HH-characteristics, and years of survey (see Table 2).
Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

5.4 Exploring Differences between Perceptions of Public Institutions: Health vs. Education

Comparing our results on health services with attitudes towards the Irish education system, we find respondents' evaluations to be distinct and institution specific (see Table 5). Compared to Irish natives, we find the foreign-born to be slightly more positive regarding the state of education in Ireland (β = .25, se = .07). This attitude towards the education system is, however, less positive than their perceptions of health services (β = .82, se = .08).[5] Furthermore, group-specific analysis reveals that the British-born do not differ significantly in their perception of educational services to Irish natives (β = .05, se = .10), but, and as stated above, are slightly more positive with regard to Irish health services. Polish migrants are slightly more positive regarding the state of education compared to Irish natives (β = .59, se = .19), but, like the British, are more positive regarding Irish health services.

[5] We adjusted the sample size and only include observations if they were available for both outcome measures, i.e. perceptions of health services and educational services, and all independent variables.

Table 5: The Perception of Public Institutions (Health Services vs. Education) of Foreign-Born in Ireland

		Irish Sample (Ref. Irish natives)			*British Sample (Ref. British natives)*		*Polish Sample (Ref. Polish natives)*	
	Health	*Health*	*Education*	*Education*	*Health*	*Education*	*Health*	*Education*
Foreign-born Characteristics								
Foreign-born in IE (0 = natives)	0.82***		0.25***		–1.57***	0.53***	2.03***	0.68***
	(0.08)		(0.07)		(0.10)	(0.10)	(0.23)	(0.18)
Foreign-born in IE (0 = natives)								
from UK		0.20*		0.05				
		(0.10)		(0.10)				
from Poland		1.82***		0.59**				
		(0.23)		(0.19)				
from other country		1.20***		0.38***				
		(0.13)		(0.11)				
R^2	0.05	0.05	0.05	0.05	0.12	0.12	0.07	0.07
N	11,952	11,952	11,952	11,952	11,993	11,993	10,029	10,029

Source: ESS, Irish, British and Polish Sample, Rounds 1-6, adjusted sample size, standard weights applied, standard errors in parentheses, controls for other demographic and socio-economic characteristics, HH-characteristics, and years of survey (see Table 2).
Note: * $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$.

Comparing the attitudes of the British- and Polish-born in Ireland with their co-nationals residing in their home countries, we find the following: In contrast to perceptions of health services, the British-born in Ireland are more positive about the Irish education system than their co-nationals in Great Britain are regarding the British education system (β = .53, se = .10). In contrast, the Polish-born evaluate the Irish health and education system in general more positively than their co-nationals rate institutions back home. However, comparing the education system with the health system, we find that the Polish-born ratings of the Irish education system are only slightly more positive than Polish ratings of the Polish education system (β = .68, se = .18).

In summary, the results reveal that the perceptions of the foreign-born in Ireland differ across public institutions. Different ratings for health and educational services strengthen the argument that attitudes are distinct and institution specific and provide additional support to our previous findings, proving our measurement to be sufficiently sensitive.

VI DISCUSSION AND CONCLUSION

This study examines the ratings of Irish health services of the foreign-born in Ireland compared to those of Irish natives, as well as the ratings of co-nationals living in the country of origin of their national health services. We expect our results to inform research on migrant assessments of the Irish health system and to contribute to scholarship on migrant perspectives of host country institutions, which until now have not focused on foreign-born attitudes to health systems.

6.1 Summary

In general, and in line with past research on migrants' attitudes towards the public institutions of their host society (Maxwell, 2010; Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012), we find the foreign-born in Ireland to be more positive about Irish health services than Irish natives. These differences cannot be explained by standard demographic and socio-economic characteristics, which we controlled for in the analysis, but point to the general optimism of newly arrived immigrants. However, since Irish health services are in general not well perceived by the Irish public and score among the lowest ratings in Europe, this more positive view among the foreign-born should not be overstated and our results do not therefore contradict the findings of qualitative studies on migrant perceptions of Irish health services, which highlight migrants' concerns regarding the affordability and quality of services (Migge and Gilmartin, 2011; Stan, 2015).

Our results further reveal that foreign-born residents' perceptions adapt to the view of Irish natives over time. No significant differences in perceptions are observed between Irish natives and the foreign-born who have lived more than 20

years in Ireland. This result suggests a general acculturation tendency in foreign-born residents' perceptions of health services in Ireland that has been pointed out in previous research on migrants' attitudes towards other public institutions (Maxwell, 2010; Reeskens and van Oorschot, 2015; Röder and Mühlau, 2012). Research using longitudinal data is, however, necessary to confirm this effect, and to test for changes in attitudes before and after the time of migration.

The separate analysis for the two major foreign-born groups in Ireland, the British and the Polish, reveals interesting differences between groups and highlights the importance of prior experiences with health services in their home country, and the application of a dual frame of reference among the foreign-born. Contrary to the hypothesis that the British-born will be particularly critical regarding the Irish health system, they are slightly more positive than Irish natives. The difference in the quality rating is, however, small, and indicates a rather critical view of Irish health services among the British-born, comparable to Irish natives. Indeed, and in line with our prediction, British-born are significantly less positive about Irish health services than their co-nationals are with British health services. No significant differences are observed amongst the British-born according to the length of time spent in Ireland. The Polish-born, on the other hand, are not only more positive compared to Irish natives but are also more positive than their co-nationals in Poland are with Polish health services, which is in line with our expectation. Due to the recent migration of Poles to Ireland, current results are hard to interpret with regards to adaptation effects. More research in the following years will reveal whether Polish migrants will adapt to the attitude of the Irish majority.

Comparing our findings on health services with perceptions of another social institution, the education system, further indicates that quality ratings are distinct and institution specific. Results on the British-born in Ireland compared to their co-nationals in Great Britain demonstrate these differences well. While the British-born rate health services in Ireland less highly than their co-nationals rate British health services, they are more positive towards educational services in Ireland than their co-nationals are regarding British educational services.

6.2 Limitations

Due to the unavailability of data, we were not able to control for the utilisation of and experience with Irish health services in our analysis. Our results are therefore limited and do not allow any conclusions on the particular challenges the foreign-born face, and how they affect their general perception of health services.

We were also not able to control for the insurance status of respondents which may have important implications for their perception of health services. The mix of public and private healthcare in Ireland creates a class system in accessing healthcare that is likely to influence the experience and perception of health services. In our study, we were only able to control for socio-economic

characteristics that often serve as a rough proxy for the type of healthcare received by the respondent and the amount of co-payments to be made.

The analysis is also based on cross-sectional data. Therefore, any assumptions on causality remain speculative and would require the inclusion of relevant indicators in longitudinal survey studies. We were therefore unable to include information on prior experiences of migrants with other institutional systems other than those of the country of birth. No information is available in the ESS on when the respondent emigrated from his country of birth or whether the respondent lived in different institutional settings before arriving in Ireland. Migrants may have gathered experiences in other healthcare systems before their time of arrival in Ireland.

Further, we cannot rule out that some migrants may have migrated to Ireland in order to receive healthcare. Although healthcare services are generally not the main motivation for migration (Pedersen *et al.,* 2006), it is possible that family members from countries with low quality healthcare services follow their relatives in the destination country to receive better healthcare services and other social services. More research in this area is warranted.

Other biases may arise from the population sample. Our findings are based on respondents with sufficient command of the English language. Foreign-born residents with insufficient language skills or undocumented migrants may therefore be under-represented in this survey. Further, interviewer biases cannot be ruled out, nor can the possibility that the foreign-born adjust their healthcare ratings and are, for example, more positive if the interviewer is of Irish nationality.

6.3 Conclusion

In summary, our results are in line with migration studies that find high levels of optimism amongst migrants, especially those who have recently entered a country. The foreign-born adapt to the views of Irish natives regarding healthcare services, which implies a socialising effect of the Irish healthcare system. At the same time, attitudes differ between foreign-born groups, which suggests that perspectives are shaped by prior experiences in the country of origin.

In general, our results can be perceived as good news for integration scholars as we find that migrants fully adapt to the majority perspective over time. However, health policymakers should be concerned. In comparison with other healthcare systems in Europe the Irish system is perceived negatively by residents. The fact that migrants' views of the Irish healthcare system become more negative over time may not only be a case of adaptation to the majority opinion, but also the result of first-hand experiences with Irish health services, which, over time, make the foreign-born as negative regarding those services as Irish natives. This paper thus provides further evidence that the Irish health system requires significant reform in order to respond to the needs of its users.

While this study investigated ratings of the health system in general, research comparing foreign-born and native perspectives on specific aspects of the health system including affordability and quality are warranted in order to gain a more in-depth understanding of differences amongst these groups. Our results also encourage further research to dig deeper into the institutional roots of attitudes towards welfare states and healthcare systems in particular. Cross-country comparative research is needed to test whether it is the quality of healthcare systems or simply the change of system combined with a general optimism towards the host society that results in migrants' positive perceptions of healthcare services, at least during the initial stages of residence in their destination country.

REFERENCES

Barrett, A. and E. Kelly, 2012. "The Impact of Ireland's Recession on the Labour Market Outcomes of its Immigrants", *European Journal of Population,* Vol. 28, No. 1, pp. 91-111.

Barrington, Ruth, 1987. *Health, Medicine and Politics in Ireland 1900-1970*, Dublin: Institute of Public Administration.

Blendon, Robert J. and John M. Benson, 2001. "Americans' Views on Health Policy: A Fifty-Year Historical Perspective", *Health Affairs*, Vol. 20, No. 2, pp. 33-46.

Boyle, Sean, 2011. "United Kingdom (England). Health System Review", *Health Systems in Transition*, Vol. 13, No. 1.

Burke, Sara, 2009. *Irish Apartheid. Healthcare Inequality in Ireland*, Dublin: New Island.

Burke, Sara, Steve Thomas, Sarah Barry and Conor Keegan, 2014. "Indicators of Health System Coverage and Activity in Ireland during the Economic Crisis 2008-2014 – From 'More with Less' to 'Less with Less.'" *Health Policy*, Vol. 117, No. 3, pp. 275-278.

Busse, Reinhard, 2013. "Understanding Satisfaction, Responsiveness and Experience with the Health System" in Irene Papanicolas and Peter C. Smith, (eds.), *Health System Performance Comparison. An Agenda for Policy, Information and Research*, pp. 255-279, New York: Open University Press.

Busse, Reinhard, Nicole Valentine, Suszy Lessof, Amit Prasad and Ewout van Ginneken, 2012. "Being Responsive to Citizens' Expectations: The Role of Health Services in Responsiveness and Satisfaction" in Josep Figueras and Martin McKee, (eds.), *Health Systems, Health, Wealth and Societal Well-Being. Assessing the Case for Investigating Health Systems*, pp. 175-208 New York: Open University Press.

CSO, 2011. *Health Status and Health Service Utilisation, Quarterly National Household Survey*, Dublin.

CSO, 2012. *Migration and Diversity*, Dublin: Central Statistics Office.

Cuadra, Carin Björngren, 2011. "Right of Access to Health Care for Undocumented Migrants in EU: A Comparative Study of National Policies", *European Journal of Public Health*, Vol. 22, No. 2, pp. 267-271.

Dancygier, Rafaela, 2010. *Immigration and Conflict in Europe*, New York: Cambridge University Press.

Devitt, Camilla, 2014. "Ireland" in Ruby Gropas and Anna Triandafyllidou, (eds.), *European Immigration. A Sourcebook*, Adershot: Ashgate.

Dinesen, Peter Thisted, 2013. "Where You Come from or Where You Live? Examining the Cultural and Institutional Explanation of Generalized Trust Using Migration as a Natural Experiment", *European Sociological Review*, Vol. 29, No. 1, pp. 114-128.

Dinesen, Peter Thisted and Marc Hooghe, 2010. "When in Rome, Do as the Romans Do: The Acculturation of Generalized Trust among Immigrants in Western Europe", *International Migration Review*, Vol. 44, No. 3, pp. 697-727.

Fanning, Bryan, 2011. *Immigration and Social Cohesion in the Republic of Ireland*, Manchester: Manchester University Press.

Fitzpatrick R., 1991. "Surveys of Patient Satisfaction: Important General Considerations", *British Medical Journal*, Vol. 302, No. 6781, pp. 887-889.

HSE, 2008. *National Intercultural Health Strategy 2007-2012*, Dublin: Health Service Executive.

Huber, A. Stanciole, K. Wahlbeck, N. Tamsma, F. Torres and E. Jelfs, 2008. *Quality in and Equality of Access to Healthcare Services*, European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities, Luxembourg.

Hudak, Pamela L. and James G. Wright, 2000. "The Characteristics of Patient Satisfaction Measures", *Spine*, Vol. 25, No. 24, pp. 3167-3177.

Macfarlane, A. and Th. de Brun, 2010. "Medical Pluralism in the Republic of Ireland: Biomedicines as Ethnomedicines", in *Folk Healing and Health Care Practices in Britain and Ireland. Stethoscopes, Wands and Crystals,* pp. 181-200, Berghahn, Oxford, UK.

Maxwell, Rahsaan, 2010. "Evaluating Migrant Integration: Political Attitudes across Generations in Europe", *International Migration Review* , Vol. 44, No. 1, pp. 25-52.

Maxwell, Rahsaan, 2013. "Assimilation and Political Attitude Trade-Offs" in Jennifer Hochschild, Jacqueline Chattopadhyay, Claudine Gay, and Michael Jones-Correa, (eds.), *Outsiders No More? Models of Immigrant Political Integration*, pp. 270-287, Oxford: Oxford University Press.

Migge, Bettina and Mary Gilmartin, 2011. "Migrants and Healthcare: Investigating Patient Mobility among Migrants in Ireland", *Health and Place* , Vol. 17, No. 5, pp. 1144-1149. Retrieved (http://dx.doi.org/10.1016/j.healthplace.2011.05.002).

Missinne, Sarah, Bart Meuleman and Piet Bracke, 2013. "The Popular Legitimacy of European Healthcare Systems: A Multilevel Analysis of 24 Countries", *Journal of European Social Policy*, Vol. 23, No. 3, pp. 231-247.

Mladovsky, Philipa, Bernd Rechel, David Ingleby and Martin McKee, 2012. "Responding to Diversity: An Exploratory Study of Migrant Health Policies in Europe", *Health Policy*, Vol. 1, pp. 1-9.

Mossialos, Elias, 1997. "Citizens' Views on Health Care Systems in the 15 Member States of the European Union", *Health Economics,* 1166, pp. 109-116.

Nolan, Anne, Sarah Barry, Sara Burke and Steve Thomas, 2014. *The Impact of the Financial Crisis on the Health System and Health in Ireland*, Copenhagen: World Health Organisation.

O'Connell, Philip J., Corona Joyce and Mairead Finn, 2012. *International Migration in Ireland*, Dublin: The Economic and Social Research Institute.

O'Reilly, D., T. O'Dowd, K. J. Galway, A. W. Murphy, C. O'Neill, E. Shryane, K. Steele, G. Bury, A. Gilliland and A. Kelly (2007). "Consultation Charges in Ireland Deter a Large Proportion of Patients from Seeing the GP: Results of a Cross-Sectional Survey", *European Journal of General Practice*, Vol. 13, No. 4, pp. 231-236.

OECD, 2013. *Government at a Glance 2013*, Paris: OECD Publishing.

OECD, 2015. *Government at a Glance 2015*, Paris: OECD Publishing.

Pedersen, Peder J., Mariola Pytlikova and Nina Smith, 2006. "Migration Into OECD Countries 1990-2000" in Craig Parson and Timothy Smeeding, (eds.), *Immigration and the Transformation of Europe*, pp. 43-84, Cambridge: Cambridge University Press.

Rechel, Bernd, Philipa Mladovsky, David Ingleby, Johan P. Mackenbach and Martin McKee, 2013. "Migration and Health in an Increasingly Diverse Europe", *The Lancet* , Vol. 381, No. 9873, pp. 1235-1245.

Reeskens, T. and W. van Oorschot, 2015. "Immigrants' Attitudes towards Welfare Redistribution. An Exploration of Role of Government Preferences among Immigrants and Natives across 18

European Welfare States", *European Sociological Review*, pp. 1-13. Retrieved (http://esr.oxfordjournals.org/cgi/doi/10.1093/esr/jcv003).

Roberts, Marc J., William Hsiao, Peter Berman and Michael R. Reich, 2004. *Getting Health Reform Right. A Guide to Improving Performance and Equity*, New York: Oxford University Press.

Röder, Antje and Peter Mühlau, 2012. "Low Expectations or Different Evaluations: What Explains Immigrants' High Levels of Trust in Host-Country Institutions?" *Journal of Ethnic and Migration Studies*, Vol. 38, No. 5, pp. 777-792.

Sagan A., D. Panteli, W. Borkowski, M. Dmowski, F. Domański, M. Czyżewski, P. Goryński, D. Karpacka, E. Kiersztyn, I. Kowalska, M. Księżak, K. Kuszewski, A. Leśniewska, I. Lipska, R. Maciąg, J. Madowicz, A. Mądra, M. Marek, A. Mokrzycka, D. Poznański, A. Sobczak, C. Sowada, M. Świderek, A. Terka, P. Trzeciak, K. Wiktorzak, C. Włodarczyk, B. Wojtyniak, I. Wrześniewska-Wal, D. Zelwiańska, R. Busse, 2011. "Poland: Health system review", *Health Systems in Transition*, Vol. 13, No. 8, pp. 1-193.

Schmidt-Catran, Alexander W. and Romana Careja, 2017. "Institutions, Culture and Migrants' Preference for State-Provided Welfare. Longitudinal Evidence from Germany", *Journal of European Social Policy*, Vol. 27, No. 2, pp. 197-212.

Schoen, C., R. Osborn, D. Squires, M. M. Doty, R. Pierson and S. Applebaum, 2010. "How Health Insurance Design Affects Access to Care and Costs, by Income, in Eleven Countries", *Health Affairs*, Vol. 29, No. 12, pp. 2323-2334.

Siciliani, Luigi, Valerie Moran and Michael Borowitz, 2014. "Measuring and Comparing Health Care Waiting Times in OECD Countries", *Health Policy*, Vol. 118, pp. 292-303.

Smith, Peter C., Elias Mossialos, Irene Papanicolas and Sheila Leatherman, 2009. *Performance Measurement for Health System Improvement: Experiences, Challenges and Prospects*, Cambridge: Cambridge University Press.

Stan, Sabina, 2015. "Transnational Healthcare Practices of Romanian Migrants in Ireland: Inequalities of Access and the Privatisation of Healthcare Services in Europe", *Social Science & Medicine*, Vol. 124, pp. 346-355.

Suphanchaimat, Rapeepong, Kanang Kantamaturapoj, Weerasak Putthasri, and Phusit Prakongsai, 2015. "Challenges in the Provision of Healthcare Services for Migrants : A Systematic Review through Providers ' Lens", *BMC Health Services Research*, Vol. 15, pp. 1-14.

Thomson, Sarah, Matthew Jowett and Philipa Mladovsky, 2014. *Health System Responses to Financial Pressures in Ireland. Policy Options in an International Context*, Copenhagen.

Turner, Brian, 2015. "Unwinding the State Subsidisation of Private Health Insurance in Ireland", *Health Policy*, Vol. 119, No. 10, pp. 1349-1357.

van Doorslaer, Eddy, Cristina Masseria and Xander Koolman, 2006. "Inequalities in Access to Medical Care by Income in Developed Countries", *Canadian Medical Association Journal*, Vol. 174, No. 2, pp. 177-183.

van Tubergen, F., Ineke Maas and Henk Flap, 2004. "The Economic Incorporation of Immigrants in 18 Western Societies: Origin, Destination, and Community Effects", *American Sociological Review*, Vol. 69, No. 5, pp. 704-727.

Wendt, Claus, Jürgen Kohl, Monika Mischke and Michaela Pfeifer, 2010. "How Do Europeans Perceive Their Healthcare System Patterns of Satisfaction and Preference for State Involvement in the Field of Healthcare", *European Sociological Review*, Vol. 26, No. 2, pp. 177-192.

Wendt, Claus, Monika Mischke, Michaela Pfeifer and Nadine Reibling, 2011. "Confidence in Receiving Medical Care When Seriously Ill: A Seven-Country Comparison of the Impact of Cost Barriers", *Health Expectations*, Vol. 15, No. 2, pp. 212-224.

World Health Organization, 2000. *The World Health Report 2000*. Geneva: WHO. Retrieved (http://www.who.int/whr/2000/en/whr00_en.pdf).

Wren, Maev-Ann, 2003. *Unhealthy State Anatomy of a Sick Society*, Dublin: New Island.

APPENDIX

Table A1: Foreign-born residing in Ireland by their Country of Origin

Country of Origin	*N*	*% Irish Pop.*	*% Migrants*	*Country of Origin*	*N*	*% Irish Pop.*	*% Migrants*
AE	2	0.02	0.14	JP	3	0.02	0.21
AF	1	0.01	0.07	KE	2	0.02	0.14
AO	1	0.01	0.07	KR	1	0.01	0.07
AR	1	0.01	0.07	KZ	1	0.01	0.07
AU	12	0.10	0.83	LK	1	0.01	0.07
BD	8	0.07	0.55	LT	41	0.33	2.84
BE	2	0.02	0.14	LV	23	0.19	1.59
BG	4	0.03	0.28	LY	2	0.02	0.14
BO	3	0.02	0.21	MA	2	0.02	0.14
BR	17	0.14	1.18	MD	2	0.02	0.14
BY	1	0.01	0.07	MT	2	0.02	0.14
CA	12	0.10	0.83	MU	3	0.02	0.21
CG	5	0.04	0.35	MW	1	0.01	0.07
CH	1	0.01	0.07	MY	10	0.08	0.69
CL	2	0.02	0.14	NG	52	0.42	3.60
CM	1	0.01	0.07	NL	10	0.08	0.69
CN	10	0.08	0.69	NO	1	0.01	0.07
CO	2	0.02	0.14	NZ	2	0.02	0.14
CY	2	0.02	0.14	PH	23	0.19	1.59
CZ	10	0.08	0.69	PK	14	0.11	0.97
DE	27	0.22	1.87	PL	183	1.49	12.66
DK	4	0.03	0.28	PS	1	0.01	0.07
DZ	2	0.02	0.14	PT	2	0.02	0.14
EE	8	0.07	0.55	RO	25	0.20	1.73
EG	2	0.02	0.14	RS	1	0.01	0.07
ES	14	0.11	0.97	RU	5	0.04	0.35
FI	1	0.01	0.07	SD	5	0.04	0.35
FR	26	0.21	1.80	SE	1	0.01	0.07
GB	656	5.34	45.40	SI	1	0.01	0.07
GH	8	0.07	0.55	SK	5	0.04	0.35
GI	1	0.01	0.07	SO	2	0.02	0.14
GQ	1	0.01	0.07	SY	1	0.01	0.07
GR	1	0.01	0.07	TG	1	0.01	0.07
HK	4	0.03	0.28	TH	3	0.02	0.21
HU	9	0.07	0.62	TR	2	0.02	0.14
ID	3	0.02	0.21	TZ	1	0.01	0.07
IN	32	0.26	2.21	UA	3	0.02	0.21
IQ	5	0.04	0.35	US	49	0.40	3.39
IR	4	0.03	0.28	VE	3	0.02	0.21

Table A1: Foreign-born residing in Ireland by their Country of Origin (Contd.)

Country of Origin	*N*	*% Irish Pop.*	*% Migrants*	*Country of Origin*	*N*	*% Irish Pop.*	*% Migrant*
IS	1	0.01	0.07	VN	1	0.01	0.07
IT	13	0.11	0.90	ZA	19	0.15	1.31
JE	1	0.01	0.07	ZM	2	0.02	0.14
JM	1	0.01	0.07	ZW	7	0.06	0.48

Source: ESS, Irish Sample, Rounds 1−6, foreign-born respondents residing in Ireland with no information on the country of origin: N = 5.