Migrants’ and Natives’ Attitudes toward Public Healthcare Provision in Denmark, Germany, and the Netherlands

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Abstract

Public healthcare is still one of the main pillars of European welfare states, despite the increasing number of migrants, we know little about migrants’ attitudes toward healthcare. We used recent data from the MIFARE survey and compared natives with a variety of nine migrant groups living in Denmark, Germany, and the Netherlands, focusing on migrants’ preferred level of governmental involvement and their satisfaction with public healthcare. We found that, compared to natives, migrants held the government less responsible for providing healthcare while expressing a higher level of satisfaction. Whereas health differences among migrants and natives did not explain this ethnic gap, we found that these ethnic gaps are moderated by socialization processes and knowledge of healthcare rights.

Introduction

Public healthcare is one of the core aspects of European welfare states. Studies have emphasized the importance of people’s support for the welfare state as it validates the legitimization of its persistence (Brooks & Manza, 2008) and provide valuable insights for policymakers concerning potential improvements (Schneider & Devitt, 2018). However, existing studies have mostly focused on the native population (e.g., Jæger, 2007; Kohl & Wendt, 2004). This is surprising because within the last few decades, an increasing inflow of migrants challenged European healthcare systems, making studies...
examining migrants’ view on public healthcare all the more urgent. With (first-generation) migrants comprising almost 11% of the total population in the European Union (EU) (Eurostat, 2015), they are a substantial group in Europe whose opinion on the welfare state carries weight within the general discussion on public attitudes (Renema, 2018 Renema & Lubbers, 2019; Schneider & Devitt, 2018; Seibel & Hedegaard, 2017). We therefore contribute to the literature by exploring the degree to which the migrant population (i.e., foreign-born) deviates from the native population and how these divergences can be explained. We are particularly interested in ethnic differences regarding two dimensions of healthcare attitudes: support for governmental involvement in providing healthcare (normative) and satisfaction with the provided healthcare services (evaluative). We thereby ask specifically, “How do migrants differ from the native population in their attitude toward holding the government responsible for providing healthcare and in their satisfaction with the healthcare system, and why?”

For our theoretical framework, we drew on three accounts of welfare state support to explain potential ethnic gaps: personal health, socialization, and knowledge about healthcare rights. First, migrants are on average healthier than natives (healthy immigrant effect, McDonald & Kennedy, 2004), at least within the first years of migration. Since health is crucial factor in how people perceive healthcare (e.g., Missinne, Meuleman, & Bracke, 2013; Schneider & Devitt, 2018), we assume that ethnic health differences also lead to different evaluations of the healthcare system. Second, migrants may differ from the native population in their healthcare perceptions thanks to different socialization processes in various healthcare systems (Reeskens & Van Oorshot, 2015).

We also tested whether such a socialization effect is stable over time or decreases due to acculturation processes (Schmidt-Catran & Careja, 2017). Third, we extended the theoretical framework by investigating how migrants’ knowledge of their access to public healthcare may influence their support for it. Since the three selected receiving countries all provide an unconditional access to public healthcare for migrants, we argued that migrants who were aware of their unconditional access were more prone to demand similar levels of governmental activity as natives would and express higher levels of satisfaction due to a more extended perception of “civic gain” (Morris, 2002).

To answer these questions, we employed unique survey data from the Migrants’ Welfare State Attitude (MIFARE) survey (Bekhuis et al., 2018), studying nine different migrant groups from EU (Spain, UK, Poland, Romania) and non-EU origin (USA, China, Japan, Russia, Turkey) countries in three receiving countries: Denmark, Germany, and the Netherlands, which differ in their healthcare systems with regards to the role of the government, public system financing, and gatekeeping (see Supplementary Table S1). The migrant groups under examination are generally comprised of so-called voluntary and documented migrants, excluding asylum seekers or irregular migrants.

This article begins with a short literature review on the topic, followed by the theoretical framework and hypotheses before describing the methodology and results. We conclude with a discussion of our results.

**Literature Review**

One of the few studies focusing on migrants’ view on the government’s involvement to provide welfare was conducted by Reeskens and Van Oorshot (2015) who showed that
migrants across Europe generally ask for more government involvement than natives. Similar results were obtained by Schmidt-Catran and Careja (2017), who examined migrants’ welfare state support in Germany. However, both works did not study attitudes toward healthcare in particular, but used a general and latent measurement of migrants’ view on the level of governmental involvement to ensure welfare. Hence, these studies do not tell whether migrants show the same level of support toward government involvement in providing healthcare. With regards to healthcare satisfaction, to our knowledge the only study looking at the migrant perspective has been conducted by Schneider and Devitt (2018) who compared migrants from Great Britain and Poland with Irish natives, examining their satisfaction with the healthcare system in Ireland. Schneider and Devitt found that migrants generally view the Irish healthcare system more positively than natives.

However, despite the relevance of the studies mentioned above, they have several limitations which we aim to overcome with this study. First, none of the studies look at personal health as an explanatory variable for differences in attitude between ethnic groups. This is surprising since studies have shown that personal health significantly affects people’s perception of public healthcare (Braunsberger & Gates, 2002; Schneider & Devitt, 2018; Wendt, Kohl, Mischke, & Pfeifer, 2010). In addition, a prominent concept in the health-related literature is the “healthy immigrant effect” (McDonald & Kennedy, 2004), namely, that migrants are generally healthy or often healthier than the native population, at least within the first years after migration. For the European context, studies found that migrants’ health status divergence from the native population is smaller for those who migrated at younger ages or for those who faced less discrimination (Huijts & Kraaykamp, 2012). Hence, there are good reasons to believe that ethnic differences in perceptions of public healthcare might be more related to differences in personal health instead of the often-underlined differences in socio-economic status.

Second, by studying nine different migrant groups in three receiving countries, we were able to study the socialization effect more thoroughly than done in previous research that either looked at a limited number of migrants (Schneider & Devitt, 2018) or at a single receiving country (Schmidt-Catran & Careja, 2017; Schneider & Devitt, 2018); or studies without the specific focus on public healthcare (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017).

Finally, we added to the theoretical framework by looking at migrants’ knowledge about their healthcare rights. We argued that differences between migrants or migrant groups might largely depend on whether migrants are actually aware of their healthcare rights in the receiving country. So far, only a few studies have focused on migrants’ knowledge about their healthcare rights (Renema, 2018; Seibel, 2019) and none have done so with reference to attitudes toward public healthcare.

Theoretical Framework and Hypotheses

Self-Interest Theory

According to the self-interest theory, people are most supportive of social policies if they benefit directly from these measures (Gelissen, 2000). Previous studies on support for governments’ responsibility in providing healthcare have operationalized self-interest in terms of people’s socio-economic position, arguing that people with a lower socio-economic status will be particularly supportive of the idea that the government is
responsible in providing healthcare since they have less of an economic buffer to cover for potential healthcare costs (Kikuzawa, Olafsdottir, & Pescosolido, 2008; Wendt et al., 2010). Although we do not neglect the importance of migrants’ socio-economic status, we argue that personal health is likely to be more relevant to the self-interest explanation. Health is a crucial component of people’s view on public healthcare because it reflects the self-interest people have in the topic of healthcare. People with a poorer health status are apt to demand a high level of governmental involvement in healthcare provision since they are most likely to benefit from this state investment. A strong self-interest can also encourage dissatisfaction since people affected might feel that the government is not doing enough to meet their needs. People of poor health indeed express lower satisfaction with the healthcare system (Schneider & Devitt, 2018; Wendt et al., 2010), because they are more likely to encounter negative experiences with health services. For example, studies showed that sick people are also more likely to rate the communication with their physicians in negative terms, which negatively affects their satisfaction with healthcare (Braunsberger & Gates, 2002). Healthy people often lack such negative experiences and therefore show greater satisfaction with healthcare.

Despite patchy data on migrant health, owing to a positive selection effect research agrees that on average migrants are particularly healthy, particularly upon arrival (healthy immigrant effect) (Lubbers & Gijsberts, 2019; McDonald & Kennedy, 2004). The endeavor of migration is inevitably costly for both emotional and economic reasons and it is argued that only the more resilient people are willing to leave behind their country of birth (Maxwell, 2010). This is also reflected in our data which show that most migrant groups are on average healthier than the native population. Hence, following that argument outlined above and the self-interest argument, we assumed that migrants are less likely to prefer more governmental involvement in public healthcare than natives because it is not risky for them to avoid and hence not have a stake in the system (Blom, Huijts, & Kraaykamp, 2016). Moreover, because migrants are on average healthier than natives, they are less likely to be exposed to negative experiences within the healthcare system, affecting their satisfaction with public healthcare positively. Henceforth, we hypothesized that: Because of their better-off health status, migrants (a) prefer lower levels of government involvement in healthcare and (b) are more satisfied with public healthcare than natives (H1).

Socialization Theory

Next to differences in health, migrants and natives might differ in their views on public healthcare due to different socialization processes (Luttmer & Singhal, 2011; Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017). Comparative welfare research has often suggested that people’s attitudes and values are affected by a regime effect through norm internalization processes (Larsen, 2008); also known as the “socialization hypothesis.” The persistence model by Sears and Levy (2003) predicts that “the residues of pre-adult learning persist throughout life” (Sears & Levy, 2003 p. 78) and that political and social attitudes become “relatively immune to change in later years” (Sears & , 1990 p. 77). Luttmer and Singhal’s (2011) study showed that migrants’ preferences for redistribution indeed seemed to be strongly affected by the preferences in the origin country. Similar results were found by Schneider and Devitt (2018), who find group differences in satisfaction with public healthcare depend on migrants’ origin country.
We therefore proposed that migrants view the public healthcare system differently from natives because of differences in frames of reference (Mamolo, Coppola, & Cesare, 2011). The levels of public healthcare spending in Europe are relatively high (World Bank, 2019), and though some migrants may come from countries with similar healthcare expenditures, most migrants come from countries where little state-provided healthcare was available. Hence, migrants from countries with less extensive public healthcare systems are likely to have lower expectations in terms of the anticipated state’s activity in healthcare provision and are more satisfied with the public healthcare than natives (Schneider & Devitt, 2018). Thus, we expected that: Migrants who have been socialized in countries with fewer public healthcare investments (a) prefer lower levels of government involvement in healthcare and (b) are more satisfied with public healthcare than natives (H2).

However, how stable are such state socialization effects? Different studies have suggested that migrants assimilate in their attitudes and values the longer they stay within the receiving country (Röder & Mühlau, 2012), reflecting acculturation patterns wherein their values and views would gradually align with the general beliefs among the native population. According to the “classical” assimilation theory (Alba & Nee, 1997), we would expect that the “home-country frame” will become less salient over time (Röder & Mühlau, 2012, p. 779) and should therefore lose its impact on migrants’ values and views. Studies indeed showed that the migrant effect on welfare support loses its significance over time (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017; Schneider & Devitt, 2018). Henceforth, we hypothesized the following: The positive socialization effect becomes smaller over time (H3).

Theory of Civic Inclusion and Civic Gain

According to the theory of civic inclusion and civic gain, civic inclusion refers to the formal social rights granted by the government, whereas civic gain depicts the actual realization of these formal rights (Morris, 2002). We argue that migrants’ attitudes toward healthcare depend in particular on their ability to make use of the healthcare system, hence, their civic gain. In all three receiving countries, Denmark, the Netherlands, and Germany, migrants initially have unconditional access to public healthcare once they are registered as residents (Busse & Blümel, 2014; Kroneman et al., 2016; Mossialos, Wenzl, Osborn, & Sarnak, 2015). Hence, all migrant groups enjoy full civic inclusion. However, it might be that not all migrants are aware of this fact; a lack of such knowledge is likely to impact their “civic gain” within the welfare system. Moreover, it might determine whether migrants feel legally included in the overall healthcare system. If migrants perceive themselves as a part of the social policy’s target group, they are more likely to express higher levels of support (Pierson, 1996) and maybe even higher than the native-born for whom civic inclusion is self-evident (policy feedback).

This might be particularly true since the migrants under consideration mostly come from countries with less extensive public healthcare as compared to Germany, the Netherlands, and Denmark. Migrants who are aware of their equal status in healthcare rights might be expected to ask for more government involvement than the native-born do, while migrants who lack this knowledge are presumably under the impression that the provided healthcare services in the destination country are not specifically targeted at them or that they are only provided to them for higher prices (Schneider & Devitt,
A perception of civic inclusion is also likely to lead to higher levels of healthcare satisfaction than natives, although this might be less likely for migrants who are not aware of their inclusive rights within the receiving country.

So far, little research on migrants’ knowledge about healthcare rights has been conducted. Research testing the welfare magnet hypothesis, which argues that generous welfare policies act as migration “pulls,” indirectly assume that most migrants are aware of their welfare rights within the receiving country (Römer, 2017). However, recent empirical research suggests that a significant share of migrants actually lack information about their entitlements (Renema, 2018; Seibel, 2019) and the organization of healthcare services within the receiving country (Migge & Gilmartin, 2011). Hence, we are likely to find a stark variation within migrants about their knowledge about their healthcare rights. Following the theoretical arguments made above, we hypothesized that: If migrants are aware of their immediate access to public healthcare, they (a) prefer higher levels of government involvement in healthcare and (b) are more satisfied with public healthcare than natives (H4).

Methods

Data

The data used in this article are from the MIFARE survey dataset, which was conducted between December 2015 and January 2016. The MIFARE project was particularly interested in first-generation migrants who have been socialized in different welfare states. Migrant groups were therefore sampled according to their country of birth, leading to nine different migrant groups from EU (Spain, UK, Poland, Romania) and non-EU origin (USA, China, Japan, Russia, Turkey). All migrants were born in their country of origin and migrated to the receiving country only at or after the age of 16. In addition, a control sample of the native population was drawn in each receiving country. All respondents were between the ages of 16 and 75 years at the time the survey was conducted (Bekhuis et al., 2018). For validity and reliability reasons, the questionnaire contains mostly items commonly found in other surveys, such as the European Social Survey (ESS) and the International Social Survey Programme (ISSP).

The stratified sampling was conducted by national statistics agencies, using the Civil Registration System in the Netherlands and Denmark, from which national net-samples between 900 and 1100 respondents were randomly drawn for each origin country (depending on earlier presented response rates in other studies). For Germany, the national civil registration system is not accessible, which is why a two-stage probability sample was drawn, which is currently considered best practice in Germany (Häder, 2015). In the first stage, municipalities were sampled. In the second stage, a fixed number of individuals were sampled from the selected municipalities (see Bekhuis et al., 2018, for further information on the sampling strategies). Because German municipalities do not provide information about age at time of migration, the German net sample consisted of slightly higher numbers in order to target sufficient first-generation migrants. Within each receiving country, we aimed to target at least 300 respondents per country of origin (Bekhuis et al., 2018). Respondents were approached with a written invitation letter containing the questionnaire (postal survey) as well as a link to a webpage where the survey could be filled out online (computer-assisted self-interview). To overcome high drop-out rates and validity problems caused by potential
misunderstanding of the survey items, the survey was, with the assistance of professional translators, fielded both in the main language of the receiving country and in the main language of the origin country. Subsequently, respondents chose their preferred language. Furthermore, an incentive in the form of a gift card of 10 Euros (75 DKK movie vouchers in Denmark due to legal constraints) was used, leading to a total response rate (following the American Association for Public Opinion Research Response Rate 4 formula) of 20%, ranging between nearly 35% in Denmark and somewhat over 18% in Germany. In total, the sample includes 5,520 migrants and 875 natives living in private households in Germany, the Netherlands, and Denmark for whom information on all variables was available (see Supplementary Table S2 for distinct sample numbers of each migrant group within each receiving country).

In Denmark, full comparisons could be made with the national population in terms of age, gender, migration history, and socio-economic position. The results were generally positive in terms of representativeness of the sample. Yet, similar to other large-scale public opinion surveys, response rates were higher among the female and younger population (Bekhuis et al., 2018). These small differences nevertheless differed per group (e.g., for some groups unemployment led to higher non-response, while the opposite was found for other groups). For the Netherlands, comparisons with the national populations could be made in terms of sex and social assistance and unemployment benefit reciprocity for every origin country. In Germany, comparisons could be made in terms of sex and age for every origin country. Generally, we saw benign over- or under-representation in terms of benefit reciprocity and a small overrepresentation of females (Bekhuis et al., 2018). We can conclude that although we should keep the slight differences in representativeness in mind when examining, for example, descriptives, all strata were well-represented for each migrant group and likely reflects both the earlier and newer migration inflows (Bekhuis et al., 2018). Therefore (and partly due to a lack of accurate population information for every group), we decided not to weight the data.

Measurement

We analyzed two dimensions of attitudes toward healthcare: preferences for the government’s involvement in providing healthcare and satisfaction with public healthcare. Support for government’s involvement was measured by the question “On the whole, do you think it should or should not be the government’s responsibility to provide healthcare for the sick?” with answer categories ranging from ‘definitely should not be’ (1), ‘should not be’ (2), ‘should be’ (3), and ‘definitely should be’(4). Because the distribution is highly skewed toward strong support for government involvement, we decided to dichotomize the variable into “(definitely) should not be” (0) and “(definitely) should be” (1), in order to get a clearer understanding of support versus non-support. Satisfaction with healthcare was measured by the question “Overall, how satisfied are you with the healthcare services in [receiving country],” with answer categories ranging from “very satisfied” (1) to “very dissatisfied” (5) and a “don’t know” category. We reversed the scale so that a higher value indicates more satisfaction with healthcare. Respondents who indicated that they do not know were dropped from the analyses.

Descriptives of these variables are to be found in the Supplementary Table S2.

We assessed respondents’ migrant status in two steps: We were first interested in the general difference in healthcare attitudes between migrants and natives; hence, for
the first models we created a dichotomous variable with natives as the reference group (0) and migrants as the comparative group (1). In a second step, we further distinguished between different migrant groups depending on their country of origin and knowledge about healthcare rights (see explanation below regarding the measurement of socialization and healthcare knowledge).

Personal health was measured by asking respondents about their general health with answer categories ranging from “very good” (1) to “very bad” (5). Due to a very limited number of cases in the “very bad” category (30 cases), we regrouped the last two categories “very bad” and “bad” into one category and reversed the scale; hence, a higher value on this variable indicates better health.

For measuring the “socialization hypothesis,” we made use of the World Bank data which provides data on public healthcare spending as a proportion of total healthcare spending in the origin and receiving countries for the last 19 years, including the year 2015, the year of data collection (World Bank, 2019). We thereby follow previous research which shows that welfare expenditure is a sturdy proxy for measuring welfare systems (van Ingen & van der Meer, 2011). Since the three receiving countries, Denmark, the Netherlands, and Germany, differ in this regard, we put the expenditure variable in relation with the expenditure measures of the receiving country. In hypothesis 2a, we are interested in the comparison of migrants’ attitudes to those of the native population, and therefore could not treat healthcare expenditures as continuous but had to include it as a categorical variable so that a clear interpretation with reference to the native population is possible. We therefore regrouped the migrant groups depending on the difference of public healthcare spending of their origin countries in relation to the receiving country based on Table 1. Japan and Great Britain (group 1: Very high expenditure), Romania and Turkey (group 2: High expenditure), Spain and Poland (group 3: medium expenditure), China and Russia (group 4: Low expenditure), and USA (group 5: very low) (see Table 1). For testing hypothesis 2b, this step was not necessary since natives are not included in this model. We therefore decided to treat the independent variable as continuous here since according to the theory, a linear effect is expected.

Following previous research (Röder & Mühlau, 2012), we included length of stay in years in the model in order to test whether the socialization effect decreases the longer migrants reside in the receiving country. Length of stay was measured by subtracting the year of migration from the year of the survey and ranges from 0 to 49 years.

Migrants’ knowledge about their healthcare rights was measured by the question “At which point after arrival do migrants from [country of origin] have the same rights as natives in [receiving country] to use the public healthcare system?,” which is adopted from the ESS-item from the survey question on when people think that foreigners should have the same right to welfare access. The answer categories include “after registering as resident in [receiving country]” (1), “after residing in [receiving country] for an extended period of time, whether or not they have worked” (2), “only after they have worked and paid taxes and insurances for an extended period of time” (3), “once they have become a [receiving country] citizen (obtained nationality)” (4), and “they will never get the same rights” (5). Since only documented migrants were surveyed, the correct answer for all three receiving countries is “after registering as resident” (1). The variable is therefore recoded with natives as the reference category (0) (since the question does not apply to their situation and was therefore only asked to migrants),
### Table 1.

*Group Differences in Attitudes toward the Role of Government in Providing Healthcare (Logistic Regressions) and Satisfaction with Healthcare (Linear Probability Estimations)*

|                      | Government responsibility (odds ratio) | Satisfaction (beta–coefficient) |
|----------------------|---------------------------------------|----------------------------------|
|                      | Model A1  | Model B1  | Model C1  | Model D1  | Model E1  | Model A2  | Model B2  | Model C2  | Model D2  | Model E2  |
| Migration background: |           |           |           |           |           |           |           |           |           |           |
| Natives (ref.)       | 0.532*    | 0.533*    |           |           |           | 0.290***  | 0.286***  |           |           |           |
|                      | (0.160)   | (0.161)   |           |           |           | (0.038)   | (0.038)   |           |           |           |
| Healthcare expenditures |           |           |           |           |           |           |           |           |           |           |
| CO/RC: Natives (ref) | Ref.      | Ref.      |           |           |           | Ref.      | Ref.      |           |           |           |
| Very high (JPN, GBR) | 0.806     | 0.903     | 0.232***  | 0.226***  |           | (0.045)   | (0.045)   |           |           |           |
|                      | (0.289)   | (0.328)   |           |           |           | (0.050)   | (0.050)   |           |           |           |
| High (ROU, TUR)      | 0.730     | 0.817     | 0.325***  | 0.319***  |           | (0.050)   | (0.050)   |           |           |           |
|                      | (0.277)   | (0.315)   |           |           |           | (0.050)   | (0.050)   |           |           |           |
| Medium (ESP, POL)    | 0.455*    | 0.540+    | 0.217***  | 0.208***  |           | (0.044)   | (0.045)   |           |           |           |
|                      | (0.151)   | (0.184)   |           |           |           | (0.046)   | (0.046)   |           |           |           |
| Low (CHN, RUS)       | 0.416**   | 0.467     | 0.281***  | 0.275***  |           | (0.046)   | (0.046)   |           |           |           |
|                      | (0.141)   | (0.159)   |           |           |           | (0.046)   | (0.046)   |           |           |           |
| Very low (USA)       | 0.347**   | 0.394     | 0.528***  | 0.521***  |           | (0.053)   | (0.054)   |           |           |           |
|                      | (0.126)   | (0.145)   |           |           |           | (0.053)   | (0.054)   |           |           |           |
| Knowledge healthcare rights: Natives (ref) |           |           |           |           |           | Ref.      | Ref.      |           |           |           |
| No                   | 0.374**   | 0.626*    | 0.366***  | 0.310     |           | (0.117)   | (0.117)   |           |           |           |
|                      | (0.122)   | (0.117)   |           |           |           | (0.046)   | (0.046)   |           |           |           |
| Yes                  | 0.612     | 1.000     | 0.280***  | 0.000     |           | (1.89)    | Omitted   |           |           |           |
|                      | (0.189)   | Omitted   |           |           |           | Omitted   | Omitted   |           |           |           |
| N                    | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     | 6,395     |

*Note:* $p < .10$; $*p < .05$; **$p < .01$; ***$p < .001$. These analyses were controlled for subjective health status, employment status, household income, education, gender, age, age$^2$, receiving country (see Supplementary Table S3).
migrants who did not provide the correct answer (1), and migrants who knew the correct answer (2).

Finally, we control for household income (scale between 1 and 11, resembling the wave 2008 of the ISSP’s family income variable), obtained educational level (ISCED-97 scale), and employment status, since, according to the economic self-interest theory, people hold more positive attitudes toward the welfare state if they are located at the lower end of the social strata (Wendt et al., 2010). Furthermore, we control for age since studies generally point out that the “healthy immigrant effect” wears off when immigrants grow older. Finally, we control for gender since women hold generally more positive attitudes toward the welfare state (Reeskens & Van Oorshot, 2015), are on average healthier, and possess more knowledge about their healthcare rights than men (Seibel, 2019).

Modeling Strategy

Since the variable “government responsibility” is binary, logistic regression analysis was conducted to predict peoples’ attitudes toward the government’s responsibility to provide healthcare, and odds ratio are reported. For satisfaction with healthcare, linear probability estimations were conducted. Because the distribution of the variable “government responsibility” was highly skewed, the results were also estimated with rare events logistic regression (King & Zeng, 2001). The rare event logistic regression results did not differ (not presented here) and confirmed the findings of the regular logistic regression analysis. For testing the “socialization hypothesis,” we ran an interaction between origin country groupings (based on country of origin’s expenditure on healthcare) and length of stay, and additionally presented the average marginal effects of “socialization” on government responsibility and satisfaction for different values of length of stay. Since both variables were only asked to migrants, we excluded the native populations for these model estimations.

Results

The results for migrant and natives’ preferences for government involvement (Models A_1 to E_1) and satisfaction (Models A_2 to E_2) with healthcare are shown in Table 1. For each outcome, government responsibility and satisfaction, the models are structured as follows. The first model (A) shows the main effect of having a migrant background on respondents’ support for government involvement and satisfaction compared with the native population, while controlling for employment status, household income, educational level, gender, age, age-squared, and the receiving country (please see Supplementary Table S_3). In the second model (B), personal health status was added to test hypothesis 1. In the third (C) and fourth model (D), we show further group differences between migrants and natives. In Model C, we test whether attitude differences from the native population were larger if migrants originated from countries with little healthcare expenditure. In Model D, we distinguish between migrants who possessed knowledge about their healthcare rights and migrants who did not possess this knowledge and compared them with the native population. Finally, all variables are presented in Model E.
With regard to government responsibility, we observed in Model A1 that migrants indeed differ significantly from the native population: The odds of supporting the notion that the government is responsible for providing healthcare is significantly lower if respondents are of migrant origin. This result shows the importance of looking at specific welfare services in more detail instead of attitudes toward welfare services in general as has been done in previous research on attitudes toward governments’ responsibility. Whereas previous studies found that migrants on average find the government more responsible for providing welfare services (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017), we show that this is not the case with regards to healthcare. Simultaneously, migrants are found to be significantly more satisfied with the healthcare system in the receiving country than natives, which is in line with previous research (Schneider & Devitt, 2018). Robustness checks (not presented here) where results were analyzed for each receiving country separately showed that these group differences were to a large extent the same across receiving countries. Yet, we do note that with regards to government responsibility, the strongest effects can be found for the Netherlands and Denmark, whereas a higher level of satisfaction with healthcare among migrants is less prevalent in the Netherlands as compared to Denmark and Germany.

We further examined in model C1/C2 and D1/D2 whether these patterns are true for all migrant groups or whether the effect varies depending on the origin country and knowledge about healthcare rights. Before doing that, however, in model B1 and B2, we tested the first hypothesis, namely, that differences between migrants and natives in their healthcare attitudes can be explained by differences in their health status. The results show that the direction of the effect is positive with regards to migrants’ demand for government involvement, though not significant. In terms of healthcare satisfaction, better health is significantly associated with higher levels of satisfaction, supporting findings from previous research (Schneider & Devitt, 2018; Wendt et al., 2010). Nevertheless, personal health did not explain the differences between migrant and native groups found previously. The main effects of being a migrant hardly changed when including personal health in the models and the change observed is not significant. Hence, we have to reject hypothesis 1.

We continue by further looking at certain characteristics of migrants and their relation to attitudes toward healthcare. To test the “socialization hypothesis,” we differentiated between different migrant groups depending on the amount of public expenditure on healthcare in their country of origin in relation to public spending in the receiving country (see Table 1). Model C1 showed that with regards to support for government involvement, the difference from the native population is smaller in size for migrants from countries with similar public expenditures on healthcare as the receiving country, but becomes larger and significant once governmental spending behavior substantially deviates in size. Particularly, migrants from the USA, where expenditures on public healthcare are comparatively low, expressed the lowest demand for government responsibility in providing healthcare relative to natives.

For satisfaction with healthcare (C2), we observed a significant effect in public healthcare expenditure differences among all migrant groups. Again, migrants from the USA stood out with being particularly satisfied with the receiving country’s provided healthcare services. For both outcome variables, government responsibility and satisfaction, the effect of healthcare expenditure of the origin country is not strictly linear.
However, the results do indicate that migrants differ in their attitudes toward healthcare depending on the healthcare context in which they have been socialized which is why we cannot reject hypothesis 2 completely.

We also asked about the stability of such a socialization effect over time. We answered this question by estimating an interaction effect between the healthcare expenditure variable and the length of stay variable. Since both variables are migrant-specific, we estimated the effect for the migrant sample only (see Supplementary Table S4). At first sight, the interaction effect seems not significant. However, rejecting hypothesis 3 based on this non-significant interaction result could lead to understating the results. We therefore additionally estimated average marginal effects of public healthcare expenditure on government responsibility and satisfaction for different values of length of stay. Results are presented in Figure 1 and reveal that for both outcomes—support for government responsibility and satisfaction with healthcare—the socialization effect on migrants’ attitudes toward public healthcare changes over time, although this change is only significant for the first 15 (government responsibility) to 25 (satisfaction) years. Over the years, migrants demand more government involvement in providing healthcare while becoming less satisfied with the healthcare services. Hence, in line with previous research (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017; Schneider & Devitt, 2018), we can conclude that length of stay partly moderates the public healthcare expenditure effect and that, within the first 15–25 years, migrants become similar to the native population, thus, potentially providing us with support for the effect of acculturation.

Finally, we argued that migrants might differ more or less from natives in their attitudes toward healthcare depending on migrants’ knowledge of their healthcare rights. Table 1, model D1, showed that the ethnic difference to the native population in holding the government responsible for providing healthcare is larger for migrants who are not aware of their access rights. This group demands less government involvement in healthcare provision than natives. Hence, knowledge does impact migrants’ expectations...
of the role of the government. Interestingly, we do not find a positive effect of knowledge on satisfaction with healthcare, at least not in the expected direction. Instead, the results show the following unforeseen effect: Migrants who are aware of their rights are slightly less satisfied with healthcare than migrants who are not aware of their rights. Models E1 and E2 combine all estimates for support for government involvement and satisfaction with healthcare. We observe that the knowledge effect became smaller once we controlled for the socialization estimates. This suggests that depending on migrants’ origin they are more or less likely to acquire knowledge about their healthcare rights in the receiving country, which has also been found by previous research (Seibel, 2019).

Regarding the control variables (see Supplementary Table S3), we further observe the following patterns: Employment status did not predict migrants’ and natives’ attitudes toward healthcare. Income did positively affect respondents’ satisfaction with healthcare but did not have any effect on their attitudes toward government responsibility. Education mainly affected people’s satisfaction with healthcare. Interestingly, this relation was found to be negative, meaning that respondents are less satisfied with healthcare the better educated they are. Moreover, women demand more government responsibility than men (though this effect is not significant) and express less satisfaction with healthcare. Finally, age shows a curve-linear effect on both attitudes toward government responsibility and satisfaction.

Finally, and most interestingly, we observe large differences between the receiving countries. People living in the Netherlands and Germany hold the government less responsible for providing healthcare than people living in Denmark. These differences are likely the result of overall differences in state control. The German public healthcare system deviates from the Danish and Dutch cases because the public healthcare institutions are regulated by society-sourced entities controlled outside the government (Crowson et al., 2017). This possibly explains the lesser demand for governmental interference. Moreover, whereas people living in the Netherlands are significantly less satisfied with healthcare than are people living in Denmark, the opposite is true for Germany, where people are significantly more satisfied with healthcare than people in Denmark and the Netherlands. And even though these differences in satisfaction follow our expectations with regards to the countries’ general public healthcare expenditures, both measured as percentage of total healthcare expenditures (World Bank, 2019) as well as the percentage of the national’s Gross Domestic Product (Crowson et al., 2017), other endogenous socialization effects are likely to affect migrants’ satisfaction as well. One reason for Germany’s high levels of satisfaction could be that people have a stronger sense of control over their healthcare provisions, since there is no gatekeeping function (see Supplementary Table S1), General Practitioner geographical restriction, or registration needed (Popic & Schneider, 2018), contrary to the Danish or Dutch case.

Discussion

This study is one of the first studies providing valuable and in-depth insight into migrants’ perspective of public healthcare. While there is recent interest in migrants’ attitudes toward the welfare state (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017; Schneider & Devitt, 2018), far too little attention has been paid to the migrant perspective in terms of public healthcare support in particular (Reeskens & Van Oorshot, 2015; Schmidt-Catran & Careja, 2017). This study contributes to existing
research by studying two dimensions of healthcare attitudes, support for government involvement (normative) and satisfaction (evaluative), by examining ethnic differences between nine different migrant groups (first-generation) and natives in three receiving countries: Denmark, the Netherlands, and Germany.

Using unique data from the MIFARE survey, we showed that migrants differ significantly from the native population in their views on public healthcare. Although migrants are generally in favor of government involvement in providing healthcare, they are so to a lesser extent than natives. At the same time, migrants are significantly more satisfied with public healthcare than natives. We drew on three main theoretical concepts in order to explain this ethnic gap: self-interest in terms of personal health, socialization, and civic gain regarding migrants’ knowledge of their healthcare rights. Our findings show that, whereas migrants are healthier than natives, this health gap does not explain ethnic differences in attitudes toward public healthcare. However, in accordance with the socialization hypothesis, migrants express the lowest demand for government involvement and the highest level of satisfaction when they originate from countries with less emphasis on public healthcare compared to the healthcare systems of the receiving countries. Though this effect is not strictly linear, it shows that the context in which migrants are socialized matters for how they perceive the healthcare system in the receiving country. We also showed that this socialization effect decreases over time, thereby confirming previous research (e.g., Schmidt-Catran & Careja, 2017).

Finally, we argued, with reference to the theory of civic gain and civic inclusion, that migrants’ similarity in attitudes toward healthcare to the native population depends also on their knowledge about their healthcare rights. If immigrants are aware of their right to access healthcare with the same extent as natives, this would lead to more demand for government involvement, as migrants realize their individual benefit of public healthcare, and a higher satisfaction due to a general feeling of inclusion into the receiving country’s healthcare system. Our study shows that, in terms of support for government involvement, the difference compared to the native population exists mainly for migrants who have little knowledge about their access rights. Interestingly, with regards to satisfaction with healthcare, the ethnic gap between migrants and natives is no different if migrants do not possess full knowledge about their healthcare rights. On the contrary, migrants were particularly more satisfied with healthcare than natives if lacking such knowledge about the system.

We also found strong differences across the receiving countries. Migrants and natives living in Germany and the Netherlands demand less government involvement than do Danish people, which might be explained by the strong governmental influence in Danish healthcare. The highest satisfaction, however, can be found in Germany, where people experience less gatekeeping in public healthcare due to the relatively free choice of doctors and easier access to specialists than in the Netherlands and Denmark.

What can we conclude from these findings? It is surprising that the group differences in health status does not explain the ethnic gap in attitudes as we would assume following the self-interest theory. Health is undoubtedly correlated with people’s self-interest in healthcare and accordingly their perception of the healthcare system. However, we doubt that health should be dismissed as an indicator for self-interest. One of the reasons for this non-finding could be the that we did not have access to multi-dimensional measurements of personal health such as indicators of chronic illnesses or behavioral risk factors, which are classic measures of health status.
(McDowell, 2006; WHO, 2001), but had to rely on self-reports. We therefore suggest future research include more precise measurements of health status in order to more clearly understand the impact of health on migrants’ and natives’ perceptions of healthcare and its meaning for explaining ethnic group differences.

In accordance with the socialization theory, our findings show that socialization within different healthcare systems leads to varying healthcare attitudes and point out that migrant groups have to be approached differently depending on their origin country: Migrants who have little experience with public healthcare may be in need of information about both the public healthcare system and their rights within the welfare system, while this is less so for migrants who come from countries with more generous public healthcare systems (Rechel, Mladovsky, Ingleby, Mackenbach, & McKee, 2013).

As derived from theory of civic gain and civic inclusion, migrants’ knowledge about their healthcare rights seem to also impact their civic gain within host societies, thereby shaping their attitudes. It shows that it is not only the de-facto existence of social rights influencing migrants’ healthcare attitudes, but also the extent to which migrants are aware of these rights. However, knowledge does not always seem to lead to positive healthcare attitudes, as this study shows. One explanation could be that migrants in possession of such knowledge might have consciously, or maybe even critically, dealt with the public healthcare system in the receiving country, thereby adapting to the native population. Country specific “flaws” might become more apparent, diminishing the happy migrant effect.

Of course, our study contains some limitations. The country differences mentioned above raise questions about the generalizability of our results to other nations who hold different healthcare policies at place. The mechanisms in, for example, non-western nations might be very different. Moreover, since our data are cross-sectional, there is room to question the causal inference of, for example, usage of healthcare services and attitudes toward the governments’ involvement in providing public healthcare for the sick. One could argue that migrants who hold more negative attitudes toward the governments’ involvement are also more reluctant to make use of these services. However, this would imply that migrants consider their attitudes toward the receiving country’s government as more important than their own health. So far, we could not find research that supports this claim. In addition, our theoretical arguments are mainly measured by single items rather than by multi-item measures, particularly with regards to health.

Also, though we have looked at the effect of time of residency, the cross-sectional nature of our data does not entirely allow us to satisfactorily answer the question on whether changes over time in attitudes are due to socialization in the receiving country, as we argue, or due to differences between individual migration cohorts or periods. Hence, our study should be complemented with panel data in order to adequately address the issue of causality as well as the question of socialization versus cohort or period effects. Finally, we would like to note that migrants differ strongly in their reasons for migration, which is likely to have an impact on their attitudes toward the welfare state. Migrants who migrate under the scheme of family unification might be better informed about the healthcare system than economic migrants who often enter the receiving country without any family ties. Unfortunately, our data does not account for these differences and we recommend further research to look specifically at this relation. Nevertheless, we wish to underline that our contribution is the first to address migrants’
attitudes toward public healthcare to such length, while accounting for a more comprehensive understanding of the general regular migrant population.

Supplementary Data

Supplementary Data are available at IJPOR online.

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