

**Title: Migrants and healthcare: investigating patient mobility among migrants in Ireland**

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## **Migrants and healthcare: investigating patient mobility among migrants in Ireland**

### **Abstract:**

Drawing on detailed interviews with 60 recent migrants to Ireland, we discuss the extent and nature of patient mobility. The paper is framed by the typology of patient mobility outlined by Glinos et al (2010), which highlights patient motivation and funding. We pay particular attention to four key areas: availability of health care for migrants living in Ireland; affordability of care as a push factor for patient mobility; how migrants' perceptions of care affect their decision about where to avail of care; and the impact of familiarity on patient mobility. We provide empirical support for this typology. However, our research also highlights the fact that two factors – availability and familiarity – require further elaboration. Our research demonstrates the need for greater levels of awareness of culture specificity on the part of both migrants and healthcare providers. It also highlights the need to investigate the social and spatial activities of migrants seeking health care, both within and beyond national boundaries.

**Keywords:** Ireland, healthcare, migrants, patient mobility

# **Migrants and healthcare: investigating patient mobility among migrants in Ireland**

## **1. Introduction**

Health care systems are typically territorially organized because rigorously defined units such as nation states are arguably best placed for planning purposes to ensure sustainability of funding, service provision and consumption. While most health care is and is very likely to continue to be provided, accessed and consumed locally and nationally, patient mobility is definitely on the rise world-wide and high on the agenda of international organizations. Patient mobility, the 'deliberate movements across international borders of patients seeking planned health care' (Glinos et al. 2010: 1146), is not a unitary phenomenon but takes a variety of forms ranging from inter-country service agreements, to expatriates returning to their country of origin, to what is often disparagingly termed medical tourism, namely wealthy patients seeking the best care available. In this paper, we focus on one such aspect of patient mobility: migrants seeking health care in their country of origin.

A focus on patient mobility draws on a growing body of work that is loosely characterised as the 'new mobilities paradigm' (Sheller and Urry 2006). Sheller and Urry challenge what they describe as sedentarism within the social sciences – the tendency to reify boundaries and borders, and to take these bounded places as 'the basic units of social research' (Sheller and Urry 2006: 209). They argue for the need to begin 'from the complex patterning of people's varied and changing social activities' (Sheller and Urry 2006: 213). While there is a significant body of work on the relationship between migration and health (Boyle and Norman 2009), this is often place-based in the manner suggested by Sheller and Urry. For example, one body of work highlights the role of migrants in spreading disease. This often leads to the scapegoating of migrant communities in their new homes (see Craddock 2002; Craddock and Brown 2009). A second body of work highlights the relationship between migration and health inequalities (see Bartley and Plewis 1997; Boyle et al 2009), while a third body of work highlights the relationship between migration and subsequent health (see Lara et al 2005). Each of these bodies of work displays, to some extent, the sedentary qualities identified by Sheller and Urry. The focus on migrants as spreaders of disease is on their role within their new (bounded) place of residence. An emphasis on health inequalities often highlights social mobility between areas within national territories. While comparisons between origin and destination are often used to investigate subsequent health, most often the comparisons made are again within national boundaries, between migrants and non-migrants in place, or between different migrant groups. In short, the emphasis is on the state and the migrant community as the basic units of social research.

In contrast, this paper takes migrant social and spatial activities as its starting point. It draws on findings from a broader research project that focused on the experiences of recent migrants to Ireland. The project involved semi-structured interview discussions with 60 migrants from a variety of national and social backgrounds. Interviewees come from 18 different national backgrounds and include people from European countries such as the UK, France, Germany, Finland, Poland and Italy and from outside Europe, including people from North America, Southern Africa and Australasia. Interviewees also differ with respect to age, gender and place of residence in Ireland. A small proportion (around 10 per cent) live in rural areas in Ireland while others live in a variety of urban centres around the country. The main feature shared by interviewees is their time of arrival in Ireland: they first arrived in Ireland in either 2004 or 2007. Interviewees were identified using three methods: snowballing, online recruitment and flyers. We initially used our existing personal and professional contacts and those of colleagues. A number of people self-selected by responding to flyers left in a wide range of public places (for example, libraries) in various parts of the country including Dublin, or by responding to requests for participants on online discussion groups. Interviewees were interviewed twice, with an interval of eight to 12 months between interviews in order to assess changes. Health care was one of a number of issues discussed during the interviews. Most of our interviewees had some form of contact with the Irish health care service either because they or a close family member had to use it; only a handful of interviewees had never accessed any Irish medical services. The services most frequently accessed by our interviewees were general practitioners (GPs) and specialists, usually through local hospitals. Interviewees also talked about contact with other medical services such as emergency care, midwives and dentists. Only very few of our interviewees had to regularly obtain medical help due to chronic health problems.

In Ireland, the relationship between migrants and healthcare has most often been discussed in terms of pressures on service provision (see HSE 2008, 2009; Pillinger 2008), access to healthcare for vulnerable groups such as asylum seekers and undocumented migrants (see, for example, Cárde 2006; Cuadra 2010; Radford 2010; Ryan et al 2007), impacts on disease prevalence (Pringle 2009), and the role of migrant workers in the healthcare system (Humphries et al 2008, 2009). Patient mobility has mostly been discussed in terms of women traveling to Ireland to give birth<sup>1</sup> (White and Gilmartin 2008), or in terms of Irish residents traveling abroad to avail of cheaper health care (Gilmartin and White 2011). Travel from Ireland by recent migrants, for the purposes of health care, rarely features in these discussions. Yet, nearly half of the

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<sup>1</sup> This practice was described as 'citizenship tourism', and was used as a basis for a campaign to change Irish citizenship entitlement from 'birth' to 'blood' in 2004.

people we interviewed stated that they met some, and occasionally most, of their health care needs in their home country, corresponding with our findings in an earlier research project (MCRI 2008). In our examination of the phenomenon of patient mobility, we find the recent work of Glinos et al (2010) particularly useful. They posit two dimensions that affect mobility, **types of patient motivation** and **types of funding**. Patient motivation deals with the reasons for seeking health care outside of one's country of residence and involves four factors, namely availability of care, affordability, familiarity and perceived quality. Two types of funding are identified: so-called out of pocket funding which involves the patient paying their own way, and officially funded treatment supplied either by the country of residence through inter-country agreements or by an insurance company. In what follows, we investigate this typology using data from patient mobility among recent migrants to Ireland. Our study provides much needed empirical data on patient mobility and tests the validity of the typology. Our analysis demonstrates that while Glinos et al.'s (2010) typology goes a long way towards explaining patient mobility among newcomers to Ireland, two factors, availability and familiarity, require further elaboration.

The paper is organized into four key sections. In the first, we discuss issues of availability of health care for migrants. The second part looks at issues of affordability of care as a push factors for patient mobility. Section three examines how migrants' perceptions of care affect their decision to avail of care locally or abroad and section four explores issues of familiarity and their impact on patient mobility. We conclude with reflections on the implications of our research for the typology posited by Glinos et al (2010) and for improving health care provision to migrants in Ireland, and more generally.

## **2. Availability of care: Finding out about the Irish healthcare system**

Glinos et al. (2010) suggest that availability of care involves two dimensions, quantity of services and types of services. Services may be difficult to access because states only make available a limited number of services due to shortages in funding or personnel leading to overcrowding and long waiting periods. In terms of types of services, countries may lack the facilities or have legal or other prohibitions disallowing the provision of certain treatment. Both types of cases are reported for Ireland. For instance, the Republic of Ireland prohibits abortion, and so thousands of women access this procedure annually in the UK and other European countries (Gilmartin and White 2011). The National Treatment Purchase Fund occasionally sends patients abroad for treatment if waiting times are excessive in Ireland. However, none of our interviewees reported traveling abroad to seek care for these or other physically unavailable treatments.

Our interviews, however, strongly suggest that another less tangible issue, namely perceptions of availability, prompt patient mobility. Many of our interviewees reported being confused about the Irish health system, including their entitlements, procedures for obtaining it and the services available:

Interviewer: What about the health service?

Interviewee: I am lost, really I am lost, I just don't know how it works. (2007UK03)

I have some kind of health insurance from work but I am not even sure what it covers. I know if anything goes wrong while I am at work I am covered ok but it is when I am not at work. (2007US03)

The main reason for this confusion appears to be difficulties around information provision. Despite high levels of immigration for many years and the fact that newcomers who work in Ireland are obliged to contribute financially to the Irish health care system through the taxation system, the HSE (Health Service Executive)<sup>2</sup> does not appear particularly effective in explaining to newcomers how the system is structured and what people's entitlements are. As a result of this lack of information, many interviewees report feeling vulnerable, especially in the face of negative stories about the health service in the media and from people they know. Some interviewees deal with the situation by taking out private insurance while others opt for availing of care in their country of origin.

I know when we first came we didn't have any health insurance and then I started getting a bit worried about not having health care insurance because I had heard a story on the radio about this lady who hadn't had any. So we figured that out so we pay this phenomenal amount of money for health insurance, and thank goodness we are all very healthy now and you pay top dollar for that. (2007UK04)

A contributing factor is migrants' manner of obtaining information about health provisions in Ireland. Statutory bodies, such as Citizens Information Centres, provide up-to-date and easily accessible information about the Irish health care system. However, only one of our interviewees accessed this information. Interviewees usually reported seeking information about the health system when they had to deal with acute health problems. At that point, they typically reported accessing a variety of informal sources such as friends and acquaintances, colleagues, office staff, Irish partners and

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<sup>2</sup> The HSE is responsible for the management and operation of all public health services in Ireland. It reports to the Department of Health and Children, but is a separate body.

internet resources. One person also said that she sought help from her general practitioner (GP) when she found herself pregnant (2007GER20B).

Interviewer: And when you needed to go to the GP and the hospital, how did you learn who to go to and what to do?

Interviewee: I asked my husband's Irish colleague and they told me about a good GP here. (2007IT02)

Interviewees also combined several different strategies for obtaining information. As a Dutch interviewee suggested, informal channels of communication provided the most important insights when she was pregnant: 'But I do find out, I make phone calls and I ask my friends' (2004NL01). Some of our interviewees argued that part of the problem may be that the system – including the people working in it – are not aware of its uniqueness and therefore do not realize that it is very difficult to understand<sup>3</sup>. Others argued that it was part of a broader desire to ensure that the system was not fully opened up to newcomers, claiming that 'I think they never thought that anybody but the Irish would use it [health system], I honestly do' (2004UK05).

Most newcomers to Ireland feel that informal sources of information about health care provision and ways of accessing care have generally proven to be very useful, and appear to be more easily accessible than official sources of information. However, the quality of information informal sources provide may be highly variable and may obstruct understanding of the system. This, in turn, may prompt lack of use of the Irish health care system and consequently make patients unnecessarily seek treatment elsewhere, paid for out of their own pocket. Based on findings from our study, we therefore argue that availability of care in Glinos et al.'s (2010) typology of patient mobility must be revised to also take account of more subjective or less tangible factors such as practical information on the health system, as this potentially acts as an important incentive for patient mobility.

### **3. Affordability of Care**

An important reason for patient mobility world-wide is the financial burden associated with health care in many parts of the world. According to Glinos et al. (2010: 1150-1151) people in Western Europe and the USA increasingly travel east and south respectively, to lower income countries to avail of less costly specialized treatment, major dentistry

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<sup>3</sup> The Irish health care system is complex and contradictory, with a nationwide system of public hospitals supplemented by voluntary private health insurance (Burke 2009). Close to 50 per cent of the population has private health insurance (Colombo and Tapay 2005: 8). Anyone resident in Ireland is entitled to free in-patient hospital services, but not to primary health care through the GP network, unless they hold a Medical Card or a GP Visit Card, issued on the basis of income or age.

treatment and cosmetic procedures. Treatment is usually sought elsewhere because it is not covered by private or public schemes and the cost for local services is perceived to be prohibitive. They also report that in some instances insurance companies encourage people to seek cheaper care outside of the local jurisdiction. The first case of patient mobility is well established among Irish citizens who have in recent years increasingly availed of private medical services in Eastern European countries such as Hungary and Poland for non-basic dental care and cosmetic surgery (Gilmartin and White 2011). To our knowledge, private insurance companies do not (yet) openly encourage patients to seek cheaper treatment but many insurance plans allow patients to obtain treatment outside of the Republic subject to prior approval. This suggests that patient mobility is more common than generally assumed.

Our interviews with recently arrived migrants in Ireland confirm that migrants' return to their country of origin for medical treatment is often motivated by issues of affordability. Many of the people we interviewed commented on the high cost of health care in Ireland as they felt that it did not go hand-in-hand with acceptable professional services.

I didn't have that bad experience but I have been once to the doctor and I really wonder if he was a doctor because everything he said to me I could have said myself and I am like, ok you pay €50 for something you already knew. (2007FR01)

Complaints about the high cost of service were not restricted to GP services only. One Italian woman, for instance, was particularly irate about her experience when her partner became very ill during the night, describing how she first called the doctor, and paid €70 to be told to call the ambulance, and pay an additional fee:

I called the ambulance, the ambulance came and said, 'why the doctor didn't do an injection to him?' Because he didn't need to go to the hospital, he just needed an injection. I paid the doctor and he didn't do anything so now they take him to the hospital because he was vomiting more than 10 times, once he fell down and broke his bone because he was really sick. So they take him to [the] hospital, they didn't receive us quickly and ... there was drunk people and the drunk man, he was kicking him. ... So the people from the ambulance said, 'look maybe he has to go before,' he was nice, so then they received him. So we paid another €70 for the hospital. (2007IT03)

Several people admitted that while they had little or no experience with the Irish medical system, frequent talk about the high cost of health care among colleagues and friends and on the media gave them the impression that health care in Ireland is unaffordable:



Interviewee: [...] and you know some people say well if you go into the hospital here then you know you will have to pay for everything that you get. Like if you get

Interviewer: No. If you work here you don't.

Interviewee: No I know you kind of don't but I have heard so many different stories off people you know they are like "get health insurance like because if you don't like you will have to you know pay for kind of everything that you are going to get". (2007UK01)

Based on their own negative experiences and personal and media reports about the financial burden associated with especially non-basic care, migrants who could afford it took out costly private medical insurance while others simply decided to travel back to their country of origin in order to curb the cost of health care provision. Those who preferred the latter option did so not only for specialized procedures such as dentistry and other complicated procedures but also for non-specialized routine checkups and minor treatments: 'Actually, when I would go for summer I would go there and I would check up everything' (2004POL01). In the case of a small number of interviewees of German, Italian and Canadian origin, the decision to seek care 'back home' was facilitated by the fact that they are still covered by the medical system of their home country for various reasons: 'in Canada I get free health care so if there is anything I can put off, when I go home I get it taken care of' (2007CAN02). The majority of interviewees, however, stated that they paid for health care out of their own pocket, usually commenting that they preferred to do so because it was faster and cheaper. Only a handful of people also used private insurance from Ireland to cover the cost of medical services in their countries of origin.

#### **4. Perceived Quality of Health care in Ireland and in country of origin**

Besides the cost of care, quality of care emerged as an important factor that promoted patient mobility among our interviewees. In fact, these two issues often appear to go hand-in-hand for most people: as care is often perceived to be substandard, most patients feel that they are being overcharged, especially because the advice given or the treatment performed initially turns out to be useless forcing them to pay additional fees to sort out the problem either in Ireland or in their country of origin. A case in point is the experience of a young Chinese woman whose gallstones were misdiagnosed as irritable bowel syndrome: 'they gave me totally wrong prescription for 3 years' (2004CH01). She said of Irish health care that 'the standard is quite low' (2004CH01) and now seeks medical treatment when she visits China. Similar concerns about quality of training and care were voiced by European migrants. An Italian woman, for instance, was told by a GP in Ireland to drink a hot whiskey when she presented having lost her

voice. She said, 'next time I go to my doctor in Italy. .... So no I don't really trust, but it's not a cultural thing. It's just that a lot of people experience very bad things' (2004IT01).

Interviewees did not simply complain about the quality of assessments and subsequent treatments received by Irish medical personnel, but also about a number of socio-psychological issues related to care. Several interviewees rated the Irish health care system as bad because they felt that waiting periods for both basic and especially emergency care were unacceptably long: 'the health system is absolutely terrible. ... waiting for hours and hours in the casualty' (2004POL03). This sentiment was also echoed by migrant medical personnel working in Ireland. A medical doctor working in an Irish hospital observed that there is a vicious circle between not seeing patients in a timely fashion and increased pressure on acute services:

...and then another thing I noticed was that patients were presenting as emergencies for things like to have their gall bladder out or a hernia repaired but not because the GPs were sneaking them in but because they were appearing on waiting lists and they just were never getting beds to the hospital because there was so much trauma and overload of a system for various appropriate and inappropriate ways. And the patients were presenting with acute pain because their hernia had blocked off, rather than it being done relatively quickly. (2007UK05)

Some interviewees also expressed surprise about the physical layout of rooms, overcrowding and standards of cleanliness in Irish hospitals. A woman who had recently given birth in an Irish maternity hospital said 'I think it is the difference in cleanliness and the standards are just so different. I was shocked when I went into the hospital for the first time here because in America the hospitals are not like that, they are new and everything is shiny and clean and you have your own room' (2007US04), while a Polish man commented on poor levels of hygiene in comparison to his experiences in Poland (2007POL01).

Finally, in the case of contact with consultants, several people felt that their behaviour toward patients was unacceptable, especially given the high price that had to be paid for such consultations. A woman from the US, who had moved to Ireland from France with her Irish partner, for instance, found consultants in Ireland to be more materialistic than in the US:

Our doctors in the US were concerned about our health and ... the doctors here are concerned about making money. So it was the opposite of what we expected. France was pretty much what we expected for socialised medicine and of course the doctors care about you because they are not making tons of

money in France, they are in it because of medicine and are interested in medicine. (2007US07)

It is these kinds of negative experiences together with unfavourable media reports about the physical state of hospitals and cases of serious misdiagnosis discussed in the media that made many of our interviewees opt for care abroad even for acute cases. The desire to avoid Irish medical professionals may take quite extreme cases as in the case of a young German woman who told us that when she is sick, she prefers to get medical advice over the phone from her doctor 'at home' instead of accessing an Irish GP:

If I have a problem I call him and he will send me over stuff. I needed a prescription recently and I just phoned him and ... then they just send it to me. He sends my mum the prescription and she phones the pharmacy and the pharmacy brings it to her. (2004GER01)

Similarly, a Polish interviewee told us that when she and many of her Polish acquaintances have to access medical professionals, they regularly double-check advice from an Irish doctor with their GP in Poland (2004POL04).

While negative characterizations tended to be frequent, there were also other views that highlighted positive aspects about medical care in Ireland. Such assessments often, but not exclusively, came from people on private insurance or special treatment schemes due to a chronic health problem. For instance, one of our interviewees who had spent several years in Sweden prior to arrival in Ireland felt that Irish doctors were more trustworthy and patient-oriented than Swedish doctors (2007SLO01). Similarly, the small number of people who used dental services in Ireland were happy with the type of care they received. A typical comment among this group was 'the dentists that I have been to have been very good, I have been very impressed with the dentists in their knowledge and the way they explained things to you and treat you' (2007OZ01). However, most of the patients with positive experiences also pointed out that receiving good care often involved a fair amount of personal investment such as getting second opinions, obtaining information independently, and/or paying for some of the medical appointments yourself in order to make a case for certain care options or for more timely treatment. People's evaluations of Irish health care and consequently people's decisions to stay or go elsewhere appear to also heavily depend on the kinds of practices that they were accustomed to from their country of origin or third countries. We will take up the issue of familiarity in the following section.

## **5. Familiarity**

A final push factor for patient mobility is feelings of unease about local care provision due to (perceived) social, cultural, religious and linguistic differences. Such sentiments are compounded in moments of vulnerability and prompt people to seek care in a more

familiar context such as their country of origin in the case of migrants (Glinos et al 2010; Lee et al 2010). Despite much discussion about this topic in the literature, especially in relation to non-European migrants, only a few of our interviewees openly invoked differences in language and health care culture as a major reason for not at all or rarely accessing Irish health care services. For instance, several interviewees complained that medical doctors in Ireland do not spend much time with their patients and that medical personnel in Ireland tend to take a hierarchical approach to doctor-patient interaction. A Polish woman who gave the GP her history, as she would have done in Poland, was told that she was over-sensitive and may be a hypochondriac. As she commented:

Well I think doctors here and in general the medical services people, they don't take into account that when foreign people come they have a different culture and they don't know how to deal with it or they don't want to. Because I can tell you I wasn't the first person and I won't be the last person who had that. (2004POL04)

Similarly, another interviewee described her sense that doctors were unwilling to listen to her concerns. As she said:

But when I had a cold and the doctor don't even look at me, just give me medicine, I wasn't really happy with that, I was trying to make sure what is wrong with me. So that is the only thing that I am really not happy. And next time I will go to the Polish place. (2004FIN01)

In a few cases, patients put lack of understanding on their part down to their own less than perfect knowledge of English and thus try to seek out a medical practitioner from their own country who practices in Ireland.

Even though only a few people raised issues of cultural incompatibility, we suspect that some of the negative characterizations of health provision in Ireland may be due to culturally-based miscommunication or lack of appropriate information about the functioning of the Irish health care provision. We noticed nationally-based differences in complaints about the health system in Ireland. For instance, while many of our European interviewees complained about the high cost of care, we did not receive the same kinds of remarks from US interviewees. On the contrary, several of them positively commented on the low cost of care compared with the US: 'I really really love the fact that [health care] is so much cheaper here than the States, I could never have afforded it in the States' (2007US08). We also found national differences with respect to other issues such as views about waiting periods, standards of cleanliness in hospitals and type of care. For example, while a German interviewee expressed much satisfaction about the Irish pre-natal care system (2007GER02B), a Dutch interviewee had a completely different view. In her view, Irish maternity services are sub-optimally organized, which puts unnecessary pressure on the system. 'I think a huge overhaul is need with regards to maternity care', she told us:

[T]here is no need for me to see an obstetrician, I can see a midwife, midwives are perfectly capable and very good. That they have localised centres for midwives that you can go in your own area rather than having to traipse into town every week, at the end, to go into Dublin to see your obstetrician who pokes your belly for 2 seconds and says, 'are you ok?' and then off you go (2004NL01).

She found that this was not just restricted to maternity care but was also the case with other kinds of minor surgery. Only a handful of interviewees indicated that their preference for medical treatment in the home country was not linked to negative views about the Irish care provisions, but to much more personal issues. One of our Italian interviewees who remarked very positively on her experiences with an Irish GP and Irish hospital services explained to us that she continues to regularly visit the dentist in Italy 'just because I know very well my dentist' (2007IT02).

## 6. Conclusion

The dramatic increase in the size and diversity of the Irish population has put pressure on the capacity of health services and added new challenges<sup>4</sup>. In Ireland, in common with other European countries, '[t]here is evidence that access to and the quality of provisions for minority ethnic groups have been unsatisfactory for a long time' (Jentsch et al. 2007: 131). This has led, in some instances, to people seeking care outside state boundaries. Their reasons for doing so are varied, but include difficulties in accessing healthcare services (because of cost, language, or lack of information), differences in opinions about health and medical care, and lack of social sensitivity among care personnel. Researchers have therefore been strongly advocating for a more holistic approach to healthcare provision (Ivey and Faust 2001; Radford 2010). Providers also need to pay greater attention to differences in culturally-based views about medical conditions, culturally-based ways of accessing healthcare and negotiating care arrangements (Baumann et al. 2003; Steward 2001).

One possible approach to this issue is to focus on patient mobility among migrants: to understand how and why people seek health care in their countries of origin. Drawing on insights from the 'new mobilities paradigm', our focus is on the social and spatial activities of migrants in relation to health care. In addressing this question, we have found the typology of patient mobility devised by Glinos et al (2010) useful, particularly their identification of the importance of patient motivation in the process of decision-making. We have sought to investigate this typology using empirical evidence from a

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<sup>4</sup> The population of Ireland increased from 3.9 million in 2002 to 4.2 million in 2006. The percentage of the population with a nationality other than Irish rose from around 7 percent in 2002 to just over 11 percent in 2006 (CSO 2008)..

study of recent migrants to Ireland. The migrants who participated in our research project came from 18 different countries, with around two thirds from the EU. They are typically considered non-vulnerable migrants because they are educated and skilled and are mostly citizens of other European countries or of English-speaking non-European countries. However, interviews highlighted a number of challenges that they faced in Ireland which often led them to avoid Irish health care provisions in favor of those in their country to origin, if at all possible. Interviewees availed of care in their country of origin because they felt that certain services were locally unavailable. Unlike other studies, our study suggests that this often turned out to be a (mis)-perception on the part of the migrant mostly because they did not have sufficient information about the Irish health system. The two main reasons for cross-border mobility for health care among migrants living in Ireland appear to be issues of affordability and perception of quality of care. They often remarked that the level of care available in terms of both type and nature of treatment and the physical environment and personnel were inadequate given the cost associated with it. Interviewees said little about cultural and linguistic difficulties, but the kinds of complaints received make us suspect that they are related to feelings of alienation.

Our study suggests that Glinos et al's (2010) typology of motivation for patient mobility accurately captures most of the reasons for patient mobility in Ireland. However, it demonstrates that greater attention must be paid to less easily objectifiable factors that only emerge from careful analysis of subjective patient statements. Issues of access are not just a matter of actual availability of treatment options, but also the provision and transmission of information about them. Similarly, issues of unease or lack of familiarity are not always overtly stated or conscious to migrants, but must be inferred through careful analysis of types of assessments provided. This further suggests that an important aspect for attaining greater levels of satisfaction in the area of healthcare provision for diverse populations crucially involves raising levels of awareness about cultural specificity on both sides. Both healthcare providers and patients need to be aware of the cultural and social specificity of their views, understandings and ways of negotiating care. Healthcare systems around the world are not easily compatible and their effective use requires learning just like any other aspect of social life in addition to provision of socially and culturally appropriate materials.

More broadly, our study raises important issues for health care systems that are organized on a territorial basis. Our empirical evidence shows that patient mobility is most evident in the case of planned health care, and that migrants are most likely to access health care in their place of residence at times of emergency or crisis. This places additional strains on nationally-organised health care systems, as it disrupts continuity of care for patients. Our empirical evidence also shows the importance of

understanding the social and spatial activities of migrants in relation to health care, and the complex geographies of health care systems, stretching across national boundaries, that emerge from their activities.

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## References

- Baumann, A., Fardy, H., Harris, P., 2003. Getting it right: Why bother with patient centred care? *Medical Journal of Australia* 179, 253-256.
- Bartley, M., Plewis, I., 1997. Does health-selective mobility account for socioeconomic differences in health? Evidence from England and Wales, 1971-1991? *Journal of Health and Social Behavior* 38, 376-386.
- Boyle, P., Norman, P., 2009. Migration and Health. In: Brown, T., McLafferty, S., Moon, G. (Eds), *A Companion to Health and Medical Geography*. Oxford, Wiley-Blackwell, pp. 346-374.
- Boyle, P., Norman, P., Popham, F., 2009. Social mobility: evidence that it can widen health inequalities. *Social Science and Medicine* 68, 1835-1842.
- Burke, S., 2009. *Irish Apartheid: Healthcare Inequality in Ireland*. New Island, Dublin.
- Cáirde, 2006. *Assessing the health and related needs of minority ethnic groups in Dublin's north inner city: a case study of a community development approach to health needs assessment*. Dublin: Cáirde. Available online at <http://www.cairde.ie/research-policy/reports/>. Accessed October 2010.
- Central Statistics Office (CSO) (2008) *Census 2006: Non-Irish Nationals living in Ireland*. Dublin: Stationary Office. Available online at <http://www.cso.ie/census/Non-Irish%20Nationals.htm>. Accessed October 2008.
- Colombo, F., Tapay, N., 2005. *Private Health Insurance in Ireland: A Case Study*. OECD Health Working Paper No 10. Available online at [http://www.oecd.org/document/25/0,3343,en\\_2649\\_33929\\_2380441\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/25/0,3343,en_2649_33929_2380441_1_1_1_1,00.html), accessed October 2010.
- Craddock, S., 2002. City of plagues: disease, poverty and deviance in San Francisco. *Bulletin of the History of Medicine* 76: 390-391.
- Craddock, S., Brown, T., 2009. Representing the un/healthy body. In: Brown, T., McLafferty, S., Moon, G. (Eds), *A Companion to Health and Medical Geography*. Oxford, Wiley-Blackwell, pp.301-321.

Cuadra, C.B., 2010. Policies on Health Care for Undocumented Migrants in EU27. Country Report Ireland. Malmö, Sweden: Malmö University. Available online at <http://files.nowhereland.info/652.pdf>. Accessed October 2010.

Gilmartin, M., White, A., 2011. Interrogating Medical Tourism: Ireland, abortion and mobility rights. *Signs: Journal of Women in Culture and Society* 36(2), 275-280.

Glinos, I. A., Baeten, R., Helbe, M., Maarse, H. 2010. A typology of cross-border patient mobility. *Health & Place* 16, 1145-1155.

HSE 2008. *National Intercultural Health Strategy 2007-2012*. Dublin: HSE. Available online at <http://hse.openrepository.com/hse/handle/10147/45774>. Accessed October 2010.

HSE, 2009. *Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings*. Dublin: HSE. Available online at <http://hse.openrepository.com/hse/handle/10147/86553>. Accessed October 2010.

Humphries, N., Brugha, R., McGee, H., 2008. Overseas nurse recruitment : Ireland as an illustration of the dynamic nature of nurse migration. *Health Policy* 87(2), 264-72.

Humphries, N., Brugha, R., McGee, H., 2009. 'I won't be staying here for long': a qualitative study on the retention of migrant nurses in Ireland. *Human Resources for Health* 7: 68.

Ivey, S., Faust, S., 2001. Immigrant women's health: initial clinical assessment. *Western Journal of Medicine* 174, 433-437.

Jentsch, B., Durham, R., Hundly, V., Hussein, J., 2007. Creating consumer satisfaction in maternity care: The neglected needs of migrants, asylum seekers and refugees. *International Journal of Consumer Studies* 31, 128-134.

Lara, M., Gamboa, C., Kahramanian, M.I., Morales, L.S., Bautista, D.E.H. 2005. Acculturation and Latino health in the United States: a review of the literature and its sociopolitical context. *Annual Review of Public Health* 26, 367-397.

Lee, J.Y., Kearns, R.A., Friesen, W., 2010. Seeking affective health care: Korean immigrants' use of homeland medical services. *Health & Place* 16(1), 108-115.

MCRI (Migration and Citizenship Research Initiative), 2008. *Getting On: From Migration to Integration*. Dublin, Immigrant Council of Ireland.

Pillinger, J., 2008. *Consultation Report: HSE National Intercultural Health Strategy*. Dublin: HSE. Available online at <http://hse.openrepository.com/hse/handle/10147/45775>. Accessed October 2010.

Pringle, D., 2009. The resurgence of tuberculosis in the Republic of Ireland: Perceptions and reality. *Social Science & Medicine* 68(4), 620-624.

Radford, K., 2010. 'Unkind cuts': Health Policy and Practice versus the Health and Emotional Well-Being of Asylum Seekers and Refugees in Ireland. *Journal of Ethnic and Migration Studies* 36(6), 899-915.

Ryan, D., Benson, C., Dooley, B., 2007. Forced migration and psychological stress. In: Fanning, B. (Ed), *Immigration and social change in the Republic of Ireland*. Manchester University Press, Manchester, pp.113-128.

Sheller, M., Urry, J., 2006. The new mobilities paradigm. *Environment and Planning A*, 38, 207-226.

Steward, M. 2001. Towards a global definition of patient-centred care. *British Medical Journal* 322, 444-445.

White, A., Gilmartin, M., 2008. Critical geographies of citizenship and belonging in Ireland. *Women's Studies International Forum* 31(5), 390-399.