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Title: Welfare Attitudes in Crisis: The Role of Ideology in Healthcare Satisfaction in Portugal and Ireland

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Abstract

Previous studies have documented that crisis trends are associated with negative changes in healthcare satisfaction. Yet, most research has focused on the role of self-interest and little is known about the ideological dimension of these changes. The article investigates this underexplored topic by examining the ideological divide in satisfaction with healthcare in two countries strongly hit by the recent economic crisis, Portugal and Ireland. The results of the empirical analysis based on the European Social Survey data from 2008 to 2015 show that ideology played a role in shaping healthcare satisfaction in both countries. In Portugal, healthcare satisfaction declined more for the left- than for the right-oriented, while in Ireland the right-oriented demonstrated a stronger decline in satisfaction than the left-oriented. In addition, the results identify an interaction between ideology and self-interest, showing that ideology trumps self-interest among the low income, but the opposite is true among the high income groups. Overall, these findings suggest that there is a substantive ideology-driven dimension in public satisfaction with health systems and point to the need for theoretical integration of different approaches in the analysis of healthcare attitudes in the crisis context.

Within research on welfare attitudes in the context of the recent economic crisis, significant attention has been paid to the role of individuals' socio-economic positions in attitude formation. Multiple studies have shown that how much one earns, how healthy one is, or where one stands in the labour market are predictors of how one views welfare state and its services in the crisis context (AlSaud et al. 2018; Brito Vieira et al. 2017; Popic et al. 2018; Roots et al. 2019). This emphasis on self-interest has been questioned through a growing body of literature that considers other factors, such as individuals' political orientations, beliefs or deep-rooted ideological views, and the relationship of these factors to self-interests, in shaping welfare attitudes in economically hard times (Brooks and Manza 2013; Margalit 2013; Naumann et al. 2016; Gonthier 2017).

We contribute to this debate by examining the relationship between self-interest, ideology and satisfaction with healthcare in the context of crisis. The 2007-2008 financial crisis lends itself particularly well for the analysis of this relationship because the crisis prompted a series of austerity-driven reforms of health policy across Europe. Most of these reforms involved cuts of public healthcare spending and a related increase in private out-of-pocket payments for medical services, which in turn affected accessibility of care (Thomson et al. 2014; Pavollini and Guillén 2013). The two countries analysed in this article, Portugal and Ireland, were among the hardest hit by the crisis, and also implemented significant retrenchments in their healthcare sectors (Kentikelenis 2015; Thomas et al. 2014; Burke et al. 2016). Effects of these measures have already been documented in the form of deteriorating access to healthcare services and increasing unmet healthcare needs (Legido-Quigley et al. 2016; Burke et al. 2016). Previous studies have found that these crisis trends in the two countries had been associated with negative changes in healthcare satisfaction and have explained these changes with reference to self-interest (AlSaud et al 2018; Popic et al. 2018). However, the ideological dimension of these changes has not yet been explored.

The ideological dimension of healthcare satisfaction has also been a particularly underexplored topic within the broader literature on attitudes toward healthcare. Most research that focused on the individual level factors has analysed the relationship between ideology and self-interest in the context of normative attitudes, such as those focused on the responsibility of the state in providing healthcare (e.g. Gevers et al. 2000; van Oorschot et al. 2012; Naumann 2014). To the best of our knowledge, the study by Missinne and her colleagues (Missinne et al. 2013) is the only relevant comparative study that analyses the ideological divide in healthcare satisfaction, including its interaction with socioeconomic positions, and there is no study to date that analyses these two factors and their relationship to healthcare satisfaction in the context of the crisis (see also Tavares and Ferreira 2020).

The scarcity of research on this topic stands in stark contrast with its theoretical, political and policy relevance. Theoretically, general satisfaction with healthcare is considered to be one of the two dimensions of the popular legitimacy of the healthcare systems and policies (Rothstein 2001).[1] Healthcare satisfaction also has broader political relevance in modern democracies, as research shows that higher satisfaction with healthcare system performance is associated with stronger trust in government (He and Ma 2021). Whether healthcare satisfaction is ideologically divided is highly relevant for the politics of health. As an ideological divide in citizens' views over health system can turn healthcare into a positional as opposed to valence issue (see Jensen and Petersen 2017), this can lead to different health policy preferences of political parties and be pivotal in explaining directions

[1] In this article, we consider only general satisfaction with the healthcare system, rather than patients' satisfaction or satisfaction with more specific aspects of healthcare provision (e.g. satisfaction with specific medical specialties). The general satisfaction is more adapt for the study of the public's general attitude towards the health system as it reflects the views of both users and non-users of healthcare services, and therefore provides a composite assessment of the healthcare system more broadly (see Hudak and Wright 2000).

of health policy reform. From a policy point of view, satisfaction attitudes are relevant as they focus on the actual rather than ideal state of affairs and are therefore considered more 'realistic' indicators of the public view of the welfare state and its sectors (Kohl and Wendt 2004). Understanding these attitudes and their possible divide along ideological lines is therefore essential if we wish to understand the sustainability and legitimacy of the welfare state, issues highly relevant in the context of crisis (see Taylor-Gooby et al. 2017).

2. Individual determinants of healthcare satisfaction

Literature on individual level factors shaping attitudes on satisfaction with welfare services can be divided into three broad views (see de Block et al. 2020: 204). One view argues that these types of attitudes depend on individual characteristics such as gender, income, education level or ideological orientation. Another view holds that satisfaction attitudes are cognitive in nature (see Schneider and Popic 2018), affected by service performance trends and information individuals are exposed to. The last approach argues that it is personal experiences with the welfare services that matters for satisfaction, implying satisfaction depends on individual's encounters with the welfare services or on information about experiences of others (see Wendt and Naumann 2018: 131).

Research on healthcare satisfaction shows that these three views are not necessarily exclusive. While personal experiences with healthcare services might be important for satisfaction with the health system, these are affected by one's socio-economic characteristics such as income, education or gender and can also generate specific types of expectations. Low income individuals, for example, tend to receive low standards of care and therefore also show reduced satisfaction with the system (Hall and Dornan 1990). Individuals with lower education have lower expectations regarding healthcare, and for this reason are more

satisfied even if they receive services of lower quality (Wendt et al. 2010; Wendt and Naumann 2018). Similarly, direct or indirect information about the state of health services or health reform proposals can also affect satisfaction and are 'filtered' through individual's characteristics, including their normative beliefs (see Missinne et al. 2013). Especially during the period of the economic crisis, when healthcare systems are affected by austerity-driven reforms, we assume that healthcare satisfaction will be influenced by experiences and expectations, shaped by individual's socio-economic characteristics and ideological beliefs.

2.1. Self-interest

The view that socio-economic position plays an important role in shaping healthcare attitudes is grounded in the self-interest approach. This approach assumes that individuals' behaviour is driven by instrumental rationality and the pursuit of personal gain (Svallfors 1991; Kangas 1997; van Oorschot 1999; Gevers et al. 2000). As indicated by individuals' labour market position or income, their socio-economic positions are associated with certain health risks and resources they use to protect themselves against. This in turn determines the extent to which individuals benefit from the health system and shapes their views of its performance. As such, elements of one's socio-economic position, such as income, are seen as one of the key factor shaping attitudes toward healthcare (Missinne et al. 2013; see also Svallfors 1991).

Individuals with better income are able to meet their health needs by using alternatives to publicly provided healthcare not accessible to low income groups. The possibility to make use of alternative solutions and more easily gain access to care leads to higher satisfaction with the health system (Wendt et al. 2010). Those with lower income, instead, face greater financial barriers in healthcare access and are also been less confident than their counterparts that they will receive good medical care (Wendt et al. 2012). Studies

of patients' satisfaction also show that those with low income receive lower standards of care (Hall and Dornan 1990). Several other studies align with these findings, showing that individuals in lower socio-economic positions are less satisfied with the healthcare system than those in higher positions (Wendt et al. 2010; Footman et al. 2013; Tavares and Ferreira 2020). However, these findings contrast other studies that do not find links between income and healthcare satisfaction (Hall and Dornan 1990; Kotzian 2009).

While evidence on the relationship between income and satisfaction in 'normal' times is inconclusive, a few recent studies demonstrate that one's income can be a good predictor of his or her healthcare satisfaction in the crisis context (AlSaud et al. 2018; Popic et al. 2018; Roots et al. 2019). A country study of healthcare satisfaction in crisis-hit Portugal finds that satisfaction of individuals with lower income dropped particularly strongly compared to satisfaction of those with higher income, whose satisfaction levels show minor and insignificant changes (Popic et al. 2018). Another study, on all Baltic countries, found that individuals' economic situation, as measured though difficulties in paying bills, was related to healthcare satisfaction, such that those who more often experienced these difficulties were less satisfied (Roots et al. 2019). The analysis in question also revealed country variation in the association between the economic differences and satisfaction, with this association being the strongest in Latvia, country whose healthcare system was hit the hardest by the crisis.

Countries most strongly affected by the economic crisis have undergone significant retrenchment of public health spending, which had particularly adverse effects on healthcare access of those with lower financial means (see Stuckler et al. 2009; Thomson et al. 2014). Those with low income experience access barriers and face longer waiting times, while those with better economic standing have alternative ways of accessing the needed care. Therefore, in accordance with the self-interest approach, we expect that *during the crisis, those with*

lower income would become less satisfied with the healthcare system than those with higher income (*Hypothesis 1*).

2.2. Ideology

In contrast to the self-interest approach which focuses on individual gains or losses, the approach to attitudes formation based on ideology concentrates on values and beliefs. This approach rests on the assumption that individuals' behaviour and perceptions of the world around them are formed according to a set of beliefs and cognitive frameworks that provide individuals with rationales in everyday life (d'Anjou et al. 1995; Gevers et al. 2000; Lau and Heldman 2009). These cognitive frameworks can be understood more broadly as values, but also in a narrower sense as socio-political beliefs such as an individuals' ideological positions, which shape their worldviews and hence also perceptions on more specific and concrete phenomena of daily life (d'Anjou et al. 1995).

Compared to studies on self-interest, studies on the relationship between ideology and healthcare satisfaction are scarce. Most studies focus on the ideological divide in normative attitudes regarding the role of the state in healthcare, showing that the left-oriented express stronger support for the state's role than those on the right (e.g. Naumann 2014). The few studies of healthcare satisfaction, however, provide some cues about the relationship between values or beliefs and satisfaction. Missinne and her colleagues find that those holding egalitarian values, and who therefore have a stronger preference for state involvement in healthcare, are less satisfied than those endorsing non-egalitarian values (Missinne et al. 2013). Similarly, a more recent study by Tavares and Ferreira which looks at left–right self-placement, shows that the individuals who position themselves more on the left are less

satisfied with the health system coverage than those leaning to the right (Tavares and Ferreira 2020).

The above studies focus on the ideological divide in healthcare satisfaction in 'normal' times. In times of economic crisis, we expect that this ideological divide would broaden. The austerity measures retrenched public health spending which in turn reduced the role of the state in healthcare (see Thomson et al. 2014). Given this austerity-driven character of health reforms, we expect individual's ideological orientations to be particularly relevant for satisfaction, especially for those on the left side of the ideological spectrum, who have stronger expectations of the state's role in healthcare (see Naumann 2014). Therefore, we expect that *during the crisis, those with left-oriented ideological position become less satisfied with the healthcare system than those with right-oriented position* (*Hypothesis 2*).

2.3. Self-interest and ideology

A third approach suggests that the effects of self-interests and ideology do not have to be mutually exclusive, but that they are both important factors shaping attitudes. Study by Missinne and her colleagues on the interaction between the two found that in 'normal times' the ideological divide tends to be higher among some socio-economic groups than others. It also showed that that the effect of egalitarianism on healthcare satisfaction is stronger for low earners than for high earners, explaining this by the low confidence about receiving healthcare among the low income groups (Missinne et al. 2013).

While studies on the interactions and their effects on health attitudes in crisis times are lacking, analyses of broader welfare attitudes in crisis provide some useful insights. A study by Margalit (2013), for example, showed that the ideological divide differs across socio-economic groups also in crisis times. Another study by Brooks and Manza (2014)

found a crisis-generated tendency of a considerable ideological divergence, with the left-wing moving toward stronger support for state's role in public provision and the right-wing individuals moving in the opposite direction. In terms of the interaction between self-interest and ideology, this finding suggests that the ideology moderates the ways in which individuals perceive and react to changes in the material circumstance (see also Naumann et al. 2016).

Building on these findings, we expect the ideological divide to increase in the crisis context also when it comes to healthcare satisfaction. As previously assumed, the crisis effects would be particularly pronounced for those on low income as they could face higher barriers to healthcare access compared to those on higher income. Therefore, we expect the ideological divide among those on low income to play out more strongly than the ideological divide among the higher income groups. More specifically, as the self-interest of the low earners oriented to the left aligns with their anti-austerity and egalitarian position, these individuals will become the most dissatisfied during the crisis. The right-oriented low income earners will also become dissatisfied because of their self-interest, but not as dissatisfied as the left-oriented in the group, as they support the austerity approach. In contrast, the satisfaction of the right-oriented high income earners can be expected to be the least affected, as their resources and pro-austerity position dampen the consequences of austerity measures. The left-oriented high income earners, instead, are expected to experience a drop in satisfaction during the crisis due to their ideological position. However, this drop is expected to be smaller than that of ideological like-minded low income earners, due to the high earners superior economic sources and thus lower barriers in healthcare access. Therefore, we expect that *during the crisis, the ideological divide in satisfaction with healthcare system will increase more among the low income groups than among the high income groups* (*Hypothesis 3*).

3. Research Design

3.1. Case selection

We test our hypotheses by focusing on healthcare attitudes in two countries: Portugal and Ireland. The two countries were hit strongly by the economic crisis and sought external help, agreeing to austerity measures in exchange for financial assistance. The effects of crisis and austerity on the Portuguese and Irish health systems were significant, with public spending on healthcare cut by approximately 9% on an annual basis (OECD 2019). The crisis also affected equality of healthcare provision in the two countries, particularly due to their two-tier health systems in which access to services depends on the ability to pay (Devitt 2021; Asensio and Popic 2018).[2] The high retrenchment and reduced access to healthcare, especially for lower income groups (Popic et al. 2018; Nolan et al. 2014), make these two countries the most likely cases to test for self-interest vs. ideology-driven changes in healthcare satisfaction during the crisis.

Data

Data come from the European Social Survey (ESS), a well-established, cross-comparative survey study of representative European country samples run biannually since 2002. Respondents from Portugal and Ireland were interviewed face-to-face in each of the seven ESS waves. Response rates vary for the different waves, falling between 51% and 68% in

[2] In the two-tier healthcare systems those with private health insurance have better access to care compared to those who have only coverage of the public healthcare system as they are, for example, able to avoid the waiting lists for public healthcare services or gain access to private hospital beds (see Devitt 2021). Apart from inequalities in healthcare access, two-tier health systems have also been associated with social inequalities in health (see Campos-Matos et al. 2016).

Ireland and 43% and 77% in Portugal.[3] After eliminating respondents with missing or invalid responses to the variables of interest, the samples used in regression analysis include a total of 5,466 respondents from Portugal and 7,637 respondents from Ireland.

Variables

The dependent variable is *healthcare satisfaction*, asking respondents what they 'think overall about the state of health services in their country nowadays' on an 11-point scale, ranging from 0, extremely bad, to 10, extremely good (used also by Wendt et al. 2009; Missinne et al. 2013).

One key independent variable is respondents' *income*, measured using respondents' subjective evaluation of their household income. Respondents are asked whether they live comfortably on their present income, cope on their present income, find it difficult to live on their present income, or find it very difficult to live on their present income. We use the subjective instead of the objective measure of income because the objective income is missing from the 2010 wave dataset in Portugal. Subjective measures of income, however, have been found to explain subjective worries and to be better self-interest predictors of welfare state attitudes than objective income (Hacker et al. 2013). Furthermore, previous studies of healthcare satisfaction have found a self-interest effect when subjective income (Wendt et al. 2010) rather than objective income (Missinne et al 2013) was used. After 2009, the share of those who found it difficult or very difficult to live on their income increased by 10% in Ireland but did not change significantly in Portugal. Instead, in Portugal the proportion of those who live comfortably doubled between 2012 and 2015.[4]

[3] See Table 1 in Online Appendix for the exact dates of the fieldwork of all four waves, response rates, and number of total respondents, as well as observations with valid data.

[4] See Figure 3 in Online Appendix for further information.

Another key independent variable is *political ideology*, measured using respondents' self-placement on a 0-10 ideological scale where 0 is left and 10 right. The item is identical to the item of political ideology used in the study by Tavares and Ferreira (2020) that found that the right-leaning respondents were on average more satisfied with health system coverage. We follow Jaeger's (2008) argument that the left-right orientation is formed by political socialization prior to welfare attitudes, and as such it is unlikely that changes in healthcare satisfaction will significantly shift individuals' ideological position. During the period under analysis, there are no substantive ideological shifts in Ireland, while in Portugal there is an increased polarization between 2012 and 2015, with around 8% of respondents placing themselves on both extremes (0 and 10 on the scale) compared to less than 3% in 2012.[5]

In our analysis, we distinguish respondents' ideological position from their partisanship by including respondents' government support, i.e. whether they are partisans of or voted for the party in power, as a control variable.[6] Government supporters are, on average, less critical of public services (Tilley and Hobolt 2011) and we wanted to ensure that any association found between ideology and healthcare satisfaction would not be an artefact of pro-government groups' more positive views of health systems.

We control for age, gender, education, employment status, subjective health status, work limitations due to illness, migration, marriage status and children, all of which have been associated with healthcare satisfaction (Popic and Schneider 2018). By including these variables, we account for the compositional differences of survey waves.

[5] See Figure 4 in Online Appendix for further information.

[6] The variable is coded 1 if respondents say they feel close to the party in power at the time of the interview and 0 otherwise (mention another party, are non-partisans or do not answer at all) to limit the number of missing values.

Austerity measures in healthcare were introduced simultaneously with several other economic and social austerity policies that could have affected citizens' satisfaction with both the economy and the health system. To account for any spill-over effects of economic changes and reforms in other social policies into healthcare satisfaction, we control for respondents' satisfaction with the economy and their redistributive preferences (see also Gonthier 2017).

4. Results

We estimate separate OLS models of healthcare satisfaction in Portugal and Ireland using the pooled 2008-2015 ESS wave samples, with post-stratification and design weights to ensure representative estimates for the two populations. To test our hypotheses *H1* & *H2* and determine how satisfaction changes among different social and ideological groups during the economic crisis, we include interaction terms between subjective income and ideological position on the one hand and survey years on the other.[7] In a second step, we test *H3* by including three-way interactions between the two main independent variables – subjective income and ideological position – and the survey years to test whether political ideology moderates the overtime change in satisfaction of different socio-economic groups. All models include the same set of control variables specified above. The coefficients of the survey years and their interactions with ideology and subjective income thus capture differences in healthcare satisfaction of different social and ideological groups between two (consecutive) survey waves that are not due to changes in support for the government or redistribution, evaluations of the economy or imbalances between waves.

[7] As in most modules, interviews were conducted in two consecutive years, we refer to the year when the fieldwork started. For example, module 4 in Ireland was conducted between October 2009 and March 2010; we refer to it as 2009.

Based on the regression estimates, we calculate the predicted levels of satisfaction in each survey wave as well as changes in healthcare satisfaction between two consecutive survey waves and their corresponding standard errors (Figure 1 & 3). We present the results separately for different levels of political ideology and subjective income in Figure 1 (Portugal) and Figure 3 (Ireland).[8] For ease of presentation, we show the results for a few discrete values on a 0-10 political ideology scale, generically called left (2), centre-left (4), centre-right (6), right (8).[9] The objective is to see whether left and right-wing groups diverge over time and thus understand the ideological divide in views of the health system during the crisis. For the income groups, we present the marginal changes of satisfaction in all groups: living comfortably on current income, coping or finding it difficult or very difficult to live on one's current income. As for ideology, the aim is to see whether the gap in satisfaction between those with low and those with high income in the two countries increases or decreases during the crisis. The results should be seen as reflecting group-level changes; the cross-sectional nature of the data does not allow us to observe within-individual changes in economic status, ideology, or satisfaction. In Figure 2, we plot the income and ideological divide in different waves for both countries, calculated as the variables' marginal effects.

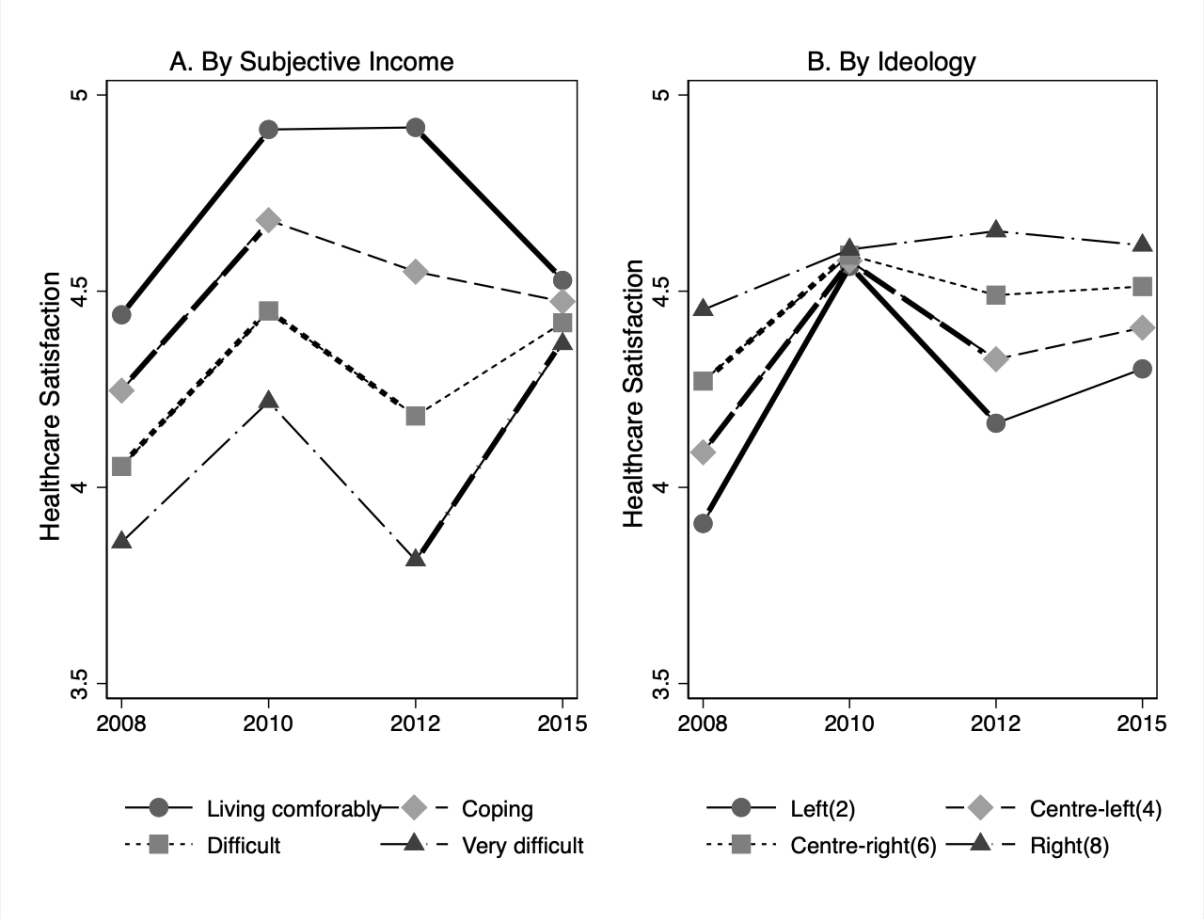
The results in Figure 1 show that in Portugal healthcare satisfaction increases between 2008 and 2010, i.e. before the introduction of austerity measures. All income groups seem to experience similar increases in satisfaction before 2010, but the change among those who find it very difficult to live on current income is not statistically significant (Panel A). The left-leaning individuals experience the strongest improvement while the changes among

[8] All estimated regression coefficients are presented in the Appendix.

[9] Based only on the survey data available, we cannot determine whether those who place themselves at 0 or 10 do indeed hold extreme political values.

right-leaning groups (between 7 and 10 on the 0-10 scale) are of smaller magnitude and not statistically significant (Panel B).

Figure 1. Predicted levels and changes in healthcare satisfaction in Portugal, by income and ideology



Note: Predicted probabilities and marginal changes calculated based on regression results from Model 2 in Table 2 in Online Appendix. Thick lines correspond to statistically significant marginal difference in satisfaction between two consecutive survey waves.

In 2010, public opinion on healthcare in Portugal is divided based on subjective income, but not ideology (Panel A, Figure 2). Yet, by 2012, the divide among income groups increased because those who found it hard or very hard to live with their level of income became even more dissatisfied, while the satisfaction of those who were living comfortably

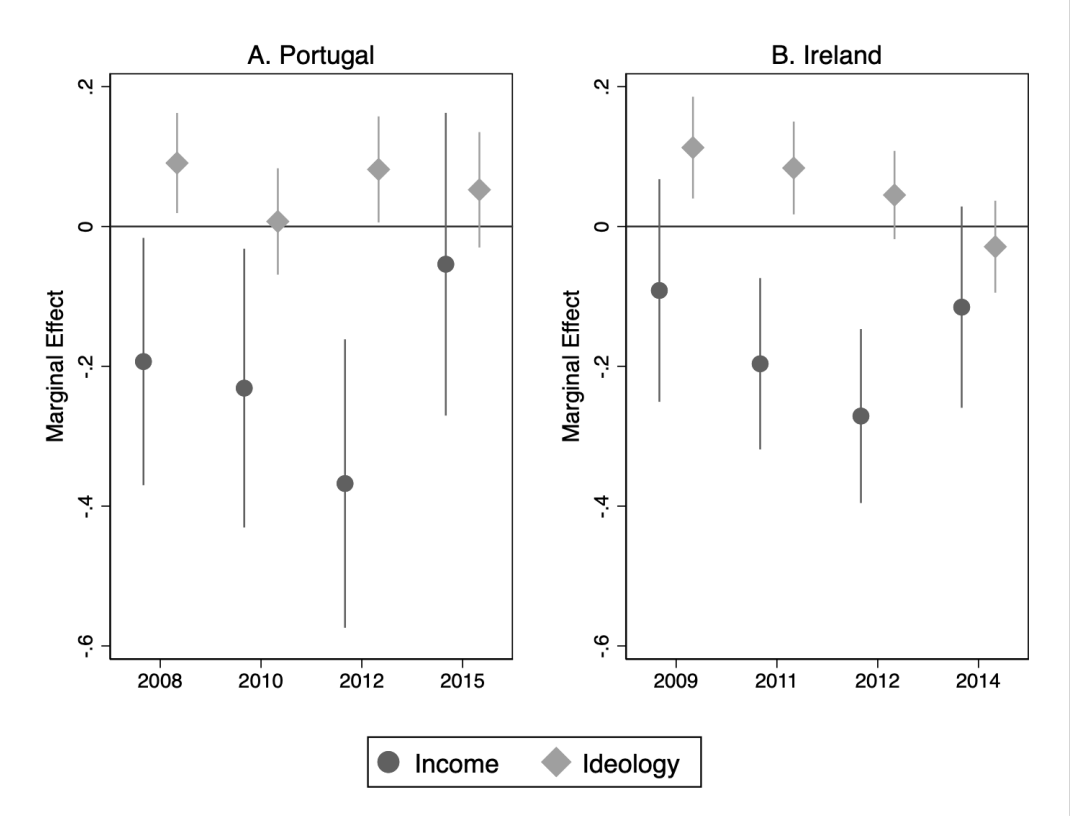
or are coping barely changed. Among the ideological groups, the healthcare satisfaction of the left-oriented group declined substantially: 0.23 for the centre-left vs. 0.57 points for the extreme-left (Panel B, Figure 1). The ideological divide in satisfaction was similar in 2008 and 2012, with the right-leaning more satisfied with the health system than the left-leaning (Panel A, Figure 2).

From 2012 to 2015 there are no changes in satisfaction among the ideological groups (small size and statistically insignificant differences between the two years). In contrast, the income groups show different patterns: the satisfaction of high earners declined sharply from 4.92 to 4.53 while satisfaction among low earners increased from 3.81 in 2012 to 4.37 in 2015 (Panel B, Figure 1). As result, there no substantive ideological and economic differences in satisfaction are found in 2015 (Panel A, Figure 2).

Overall, in Portugal, we find support for *H1* and *H2* that the lower income and the left-oriented are less satisfied compared to other income or ideological groups after austerity measures are introduced.[10] By 2015, the harshest austerity measures had already been implemented and the new measures affected the privileged social groups more significantly (Popic et al. 2018). This could be a possible explanation for the increase in satisfaction among those with lower incomes and the drop among those with higher incomes.

[10] The data however does not allow us to say with certainty that the austerity measures had a causal effect on these changes.

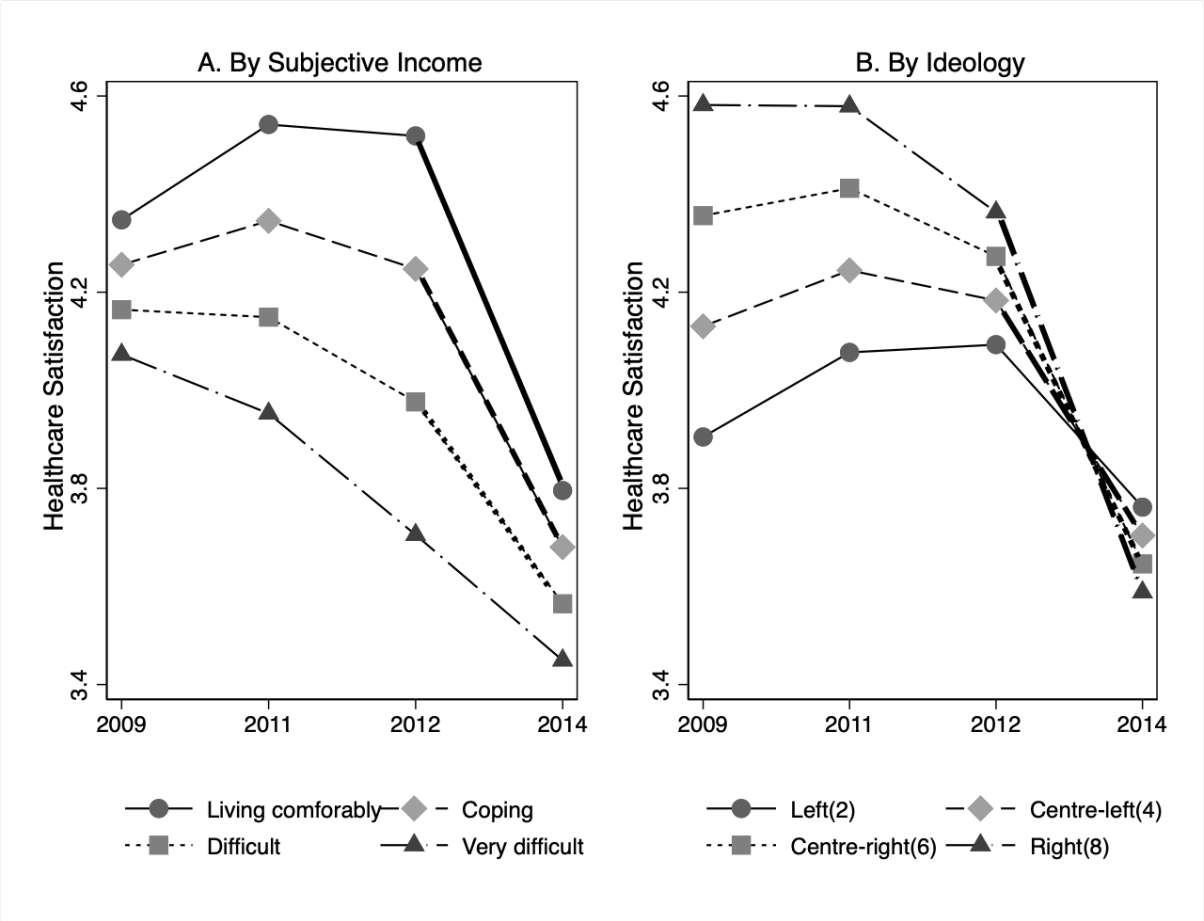
Figure 2. Marginal effects of income and ideology in Portugal and Ireland (2008-2015)



Note: Marginal effects calculated based on regression results from Models 2 & 5 in Table 2 in Online Appendix.

In Ireland, healthcare satisfaction in various income and ideological groups does not change significantly between 2009 and 2012 (the differences in satisfaction between two consecutive waves are not statistically different from 0) (Figure 3). In all three waves, the divide in satisfaction between the different economic groups is present and increases across the three waves (Panel B, Figure 2). Among the ideological groups, the right-oriented in Ireland are also more satisfied with the health system than the left-oriented between 2009 and 2012.

Figure 3. Predicted levels and changes in healthcare satisfaction in Ireland, by income and ideology



Note: Predicted probabilities and marginal changes calculated based on regression results from Model 5 in Table 2 in Online Appendix. Thick lines correspond to statistically significant marginal difference in satisfaction between two consecutive survey waves.

Satisfaction declines between 2012 and 2014 among all income groups in Ireland (Panel A, Figure 3). Compared to the other three groups, the change in satisfaction between 2012 and 2014 for those finding it difficult to live on current income is not statistically significantly different from 0. If we look, however, at the change between 2011 and 2014, we observe that this is statistically significant, and this group's satisfaction starts declining at a steeper pace earlier on. If we compare the size of the change among different groups between 2011 and 2014 or 2012 and 2014, the differences are not statistically different from 0, so we

conclude that none of the income groups in Ireland have experienced a stronger change in satisfaction. Therefore, we do not find empirical support in Ireland for the expectation that the healthcare satisfaction of those with lower income will decrease more strongly than that of those belonging to high income group (*H1*).

Between 2012 and 2014, satisfaction dropped for most ideological groups too (Panel B, Figure 3). Contrary to hypothesis *H2*, the decline in satisfaction is higher and statistically significant for those on the right (interaction term significant at 0.1 level): e.g. 0.35 for the left-oriented group and 0.80 for the right-oriented group. The change in satisfaction, especially for the right-leaning groups, starts already in 2011. By 2014, the ideological gap in satisfaction disappears, with the left- and right-oriented having similar levels of satisfaction. Compared to Portugal, in Ireland the right-leaning groups have become more dissatisfied than the left-leaning groups. This confirms that ideology shapes healthcare satisfaction but contradicts the more specific expectations of our second hypothesis (*H2),* according to which the left-leaning are expected to become more dissatisfied.

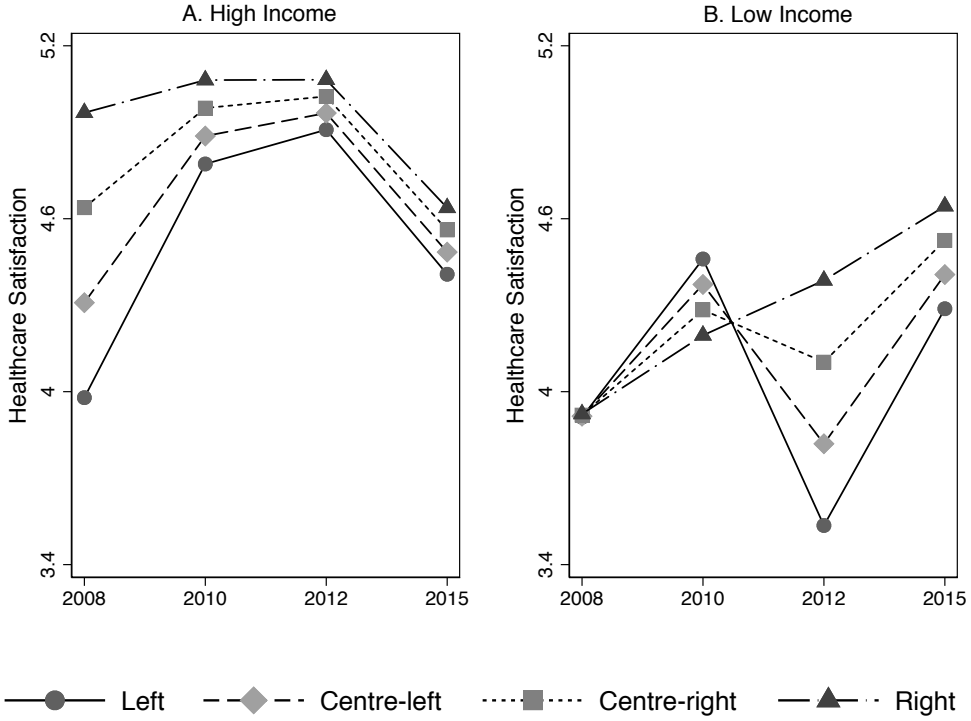
The interaction between ideology and self-interest

We turn now to testing *H3* regarding the stronger effect of ideology in healthcare satisfaction among the individuals with low as to compared to those with high income. Figure 4 (Portugal) and Figure 6 (Ireland) present the predicted levels of satisfaction of the low and high income individuals with different ideological positions. These have been calculated based on the three-way interaction between subjective income, ideology and the survey waves. As the number of observations in some groups is significantly small, e.g. the left-oriented among the high income and the right-oriented among the low income individuals and can inflate the standard errors, we have not calculated the statistical significance of changes in satisfaction between-waves for each subgroup. Instead, we look at the size of the

change and separately estimate the ideological divide within income groups in every wave in Figure 5, based on the marginal effects of ideology.

In 2008 in Portugal, the high earners, those living comfortably on current income, are strongly divided: the right-leaning are by more than 1 point (on a 0-10 scale) more satisfied than the left-leaning in the group (Figure 4, Panel A). Among the low earners, those finding it very difficult to live on current income, there are no ideological differences (Panel A, Figure 6). Over time, the ideological gap in satisfaction increases among the latter group but declines for the former, so by 2012 there are no statistically significant differences in satisfaction among the high earners. In contrast, among low earners the ideological differences are the highest and statistically significant in 2012. Those on the left among the low earners are the most dissatisfied: their satisfaction level is by more than 1 point lower than of those on the right. The ideological divide seems to be the result of a higher drop in satisfaction between 2010 and 2012 among the left-leaning in the group.

Figure 4. Predicted healthcare satisfaction for the high and low income groups in Portugal, by ideological position

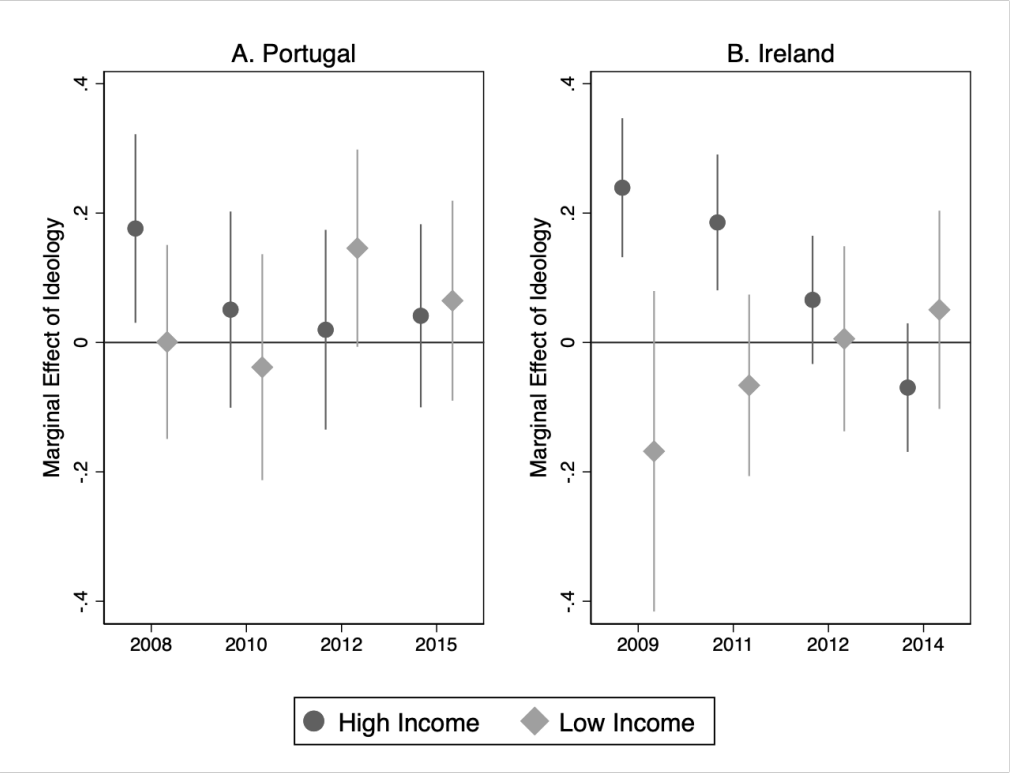


Note: Predicted values calculated based on regression results from Model 3 in Table 2 in Online Appendix. Low income groups are those who said that they find it very difficult to live on current income. High income groups are those who said that they live comfortably on current income.

The results found in the entire Portuguese sample (Figure 1), i.e. that the left-wing become more dissatisfied between 2010 and 2012, hold only for the low earners groups. Among the high earners (Panel A, Figure 4) satisfaction does not change much for any of the ideological groups. Between 2012 and 2015, the individuals belonging to this group experience a drop in satisfaction of similar sizes for all ideological subgroups. Instead, all ideological subgroups among the low earners experience an increase in satisfaction by 2015. What is particularly interesting is that the satisfaction of the right-wing (those who place themselves on 7 or higher on a 0-10 left-right ideological scale) shows a positive trend for the

entire period under analysis (Figure 4, Panel B). Overall, these results for Portugal provide support for hypothesis *H3*, showing that during the crisis the ideological divide among the low income earners has increased compared to the ideological divide among those on high income.

Figure 5. Marginal effects of ideology among the low and high income groups in Portugal and Ireland (2008-2015)



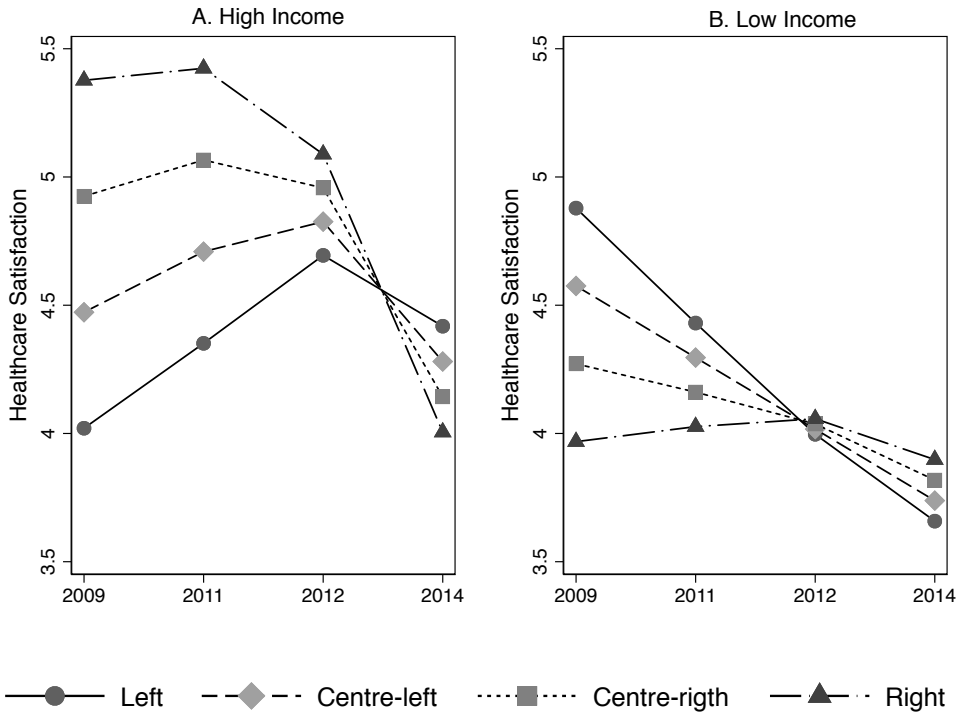
Marginal effects of ideology calculated based on regression results from Models 3 & 6 in Table 2 in Online Appendix.

Low income groups are those who said that they find it very difficult to live on current income. High income groups are those who said that they live comfortably on current income.

In Ireland, we observe in 2008 the highest ideological divide within both groups – the low and the high earners (Figure 5, Panel B). In accordance with Missinne and her colleagues (2013), the right-wing among the high earners are the most satisfied (Figure 4, Panel A).

Contrary to the same study, among those with low income, the left-wing are instead more satisfied (Figure 6, Panel B). During the crisis, both subgroups experience the highest drop in satisfaction. For those with high income, the decline in satisfaction starts in 2012 and affects especially the right-oriented. By contrast, for those with low income, satisfaction drops already in 2010 for the left-oriented in the group but does not change for the right-oriented (Figure 6, Panel B). In 2012 we observe instead the lowest divide among both income groups (Figure 5, Panel B). Overall, in Ireland we observe an interaction between ideology and self-interest that goes against hypothesis *H3*, that during the economic crisis, the ideological divide in satisfaction increases more among the low income groups than among the high income groups.

Figure 6. Predicted healthcare satisfaction for the high and the low income groups in Ireland, by ideological position



Note: Predicted values calculated based on regression results from Model 6 in Table 2 in Online Appendix.

Robustness checks and limitations

Our results remain robust when we use objective income instead of subjective income evaluations[11] and when missing values of ideology are included in the analysis coded as a separate category. The results, however, are sensitive to the inclusion/exclusion of evaluations of the economy. While in Portugal, their inclusion makes some of the changes among the low earners statistically insignificant, in Ireland, excluding evaluations of the economy reduces some of the ideological differences. Additional analysis indicates that in stark contrast to the results found in models of healthcare satisfaction, satisfaction with the economy drops more for the left-oriented than the right-oriented in Ireland. These findings provide additional leverage to our finding that the ideological divide in healthcare attitudes during the economic crisis reflects changes in the health system and not only the economy. The results are robust when other control variables, e.g. employment status, redistribution preferences, partisanship, age or marital status are excluded.

We focused on income as core driver of self-interest because austerity measures increase the vulnerability of the economically worse off, who are more likely to experience problems in healthcare access in a two-tier system like the one in Portugal and Ireland. Additional analysis using subjective health status as the driver of self-interest, however, supports our main findings.[12] First, similar to our findings on income, we find that those with poorer health status, experience the highest drop in satisfaction in Portugal but not in Ireland. Assumption of the *H3*, that the ideological divide is more likely among the worse off, is

[11] For Ireland, objective income is available in all survey waves.

[12] Subjective health status is only a proxy of individuals' experience with the health system, which may vary depending on their material resources and access to private insurance/services. Unfortunately, we are unable to test how individual's actual contacts with the healthcare system affect satisfaction due to the lack of this type of data in the ESS.

supported in both countries but again the results point in different directions. While in Portugal, the satisfaction of the left oriented among those with poor health drops the most, it is the right oriented among those with bad health who are more dissatisfied in Ireland (See Figures 5-7 in Online Appendix). This suggests that our findings of the ideological divide could be applied not only to the economically more vulnerable, but also to the other types of disadvantaged groups.

Nevertheless, our findings are not without limitations. As our analysis reports within-group changes, we should refrain from seeing these as individual level changes. Unlike longitudinal analyses with repeated observations of the same individual, where the estimates are averages of changes over time for each respondent, our estimates are calculated as differences over time in group averages. Furthermore, we base our expectation on the assumption that different social groups are affected by austerity, and this is reflected in their healthcare satisfaction. Nevertheless, the results should not be interpreted as causal effects of austerity on healthcare satisfaction. There may be other unobserved macro factors and events influencing satisfaction during the observed period, e.g. government's discourse.

5. Discussion and conclusions

In this article, we examined the links between self-interest, ideology and healthcare satisfaction in the context of economic crisis in Ireland and Portugal. As the healthcare systems in the two countries were similarly affected by austerity-driven measures, we expected changes in the individuals' satisfaction with the system and tested how these varied between different income and ideological groups.[13]

[13] For cross validation, we ran the analysis on ESS data from Germany, one of the least likely cases to observe a self-interest or/and ideology-driven attitudinal change due to austerity measures. Since 2008, Germany's health reforms were focused on improving patient's access to care (Immergut and Wendt 2021), a valence-issue which

While we find only partial support for the self-interest hypothesis, as income shapes healthcare satisfaction in Portugal and not in Ireland, our results provide convincing support for the ideology hypothesis - showing that ideology plays a role in shaping healthcare satisfaction in both countries. However, we also find that the role of ideology plays out differently in the two countries. In Portugal, healthcare satisfaction declined more for the left- than for the right-oriented, while in Ireland the right-oriented demonstrated a stronger decline in satisfaction than the left-oriented. In addition, our results also identify an interaction between ideology and self-interest. In Portugal, we find an ideological divide among those with low income - satisfaction dropped for the left-oriented but increased for the right-oriented. There is no ideological divide among those with high income during the crisis. In contrast, in Ireland, the satisfaction of the right-oriented in the high income group dropped substantively, while that of the left-oriented increased. For the low earners in Ireland, satisfaction dropped for the left-oriented – as in Portugal, but has not changed for the right-leaning. Therefore, the expectation that the ideological divide in satisfaction increases more among the low income groups than among the high income groups is supported by the data from Portugal, but not from Ireland.

The reasons why the link between ideology and satisfaction played out differently in the two countries could be contextual. It may be that the institutional characteristics, such as share of public or private spending for healthcare, influence individual experiences and thus explain the country differences (see Popic and Schneider 2018). Yet, the explanations based on institutional factors in accounting for the links ideology and satisfaction may be limited, as institutions may be simply 'filtered' through individuals' characteristics. For example, what

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is expected to improve satisfaction, regardless of groups' income and ideology. Contrary to the results from Ireland and Portugal, the findings from Germany show parallel trends in satisfaction improvement across ideology and income (see Figures 1 and 2 in the Online Appendix).

matters for satisfaction may not be whether there is a high share of out-of-pocket payments for healthcare services, but rather whether individuals think that these payments are legitimate in the first place, which in turn depends on their ideology and associated expectations regarding the state's role in healthcare provision.

Alternatively, it may be that the different political discourse surrounding austerity measures in the two countries explains the country differences (see Barnes and Hicks 2018). In Portugal, the major austerity-oriented health reforms during crisis were coupled with the discourse that stressed there is 'no alternative' to austerity (see Fonseca and Ferreira 2015). In contrast, in Ireland, besides the austerity measures after 2012, the government presented a plan to shift to a more egalitarian health system (see Burke et al. 2016). We also find that with respect to satisfaction with the healthcare system, ideology interacts with self-interest more for the low income than for the high income groups. Among the individuals with low income, when self-interest and ideological orientation align, the left-oriented low income earners become more dissatisfied with the healthcare system after their rights and access to healthcare are reduced. The cross-pressured group, the right-oriented low earners, instead seem to follow their ideology in both countries, as their satisfaction either does not change or increases. Among the high income earners, instead, self-interest seems to trump ideology in Portugal - there is no ideological difference in satisfaction during the crisis. In Ireland, instead, the right-oriented high income earners become less satisfied than the cross-pressured group, the left-oriented high earners. This suggests that government discourse about future healthcare regime changes may condition how individuals react to current measures, a hypothesis that should be tested in the future.

The above differences could also reflect differences in the ideological composition of the governments, as in 2011 both countries elected new governments: a center-right coalition in Portugal and a center-left coalition in Ireland. While we acknowledge that government

supporters and groups holding a similar ideology would be more likely to overlook the effects of austerity, and anti-government supporters would be likely to be more dissatisfied, it is unlikely that our results are driven by partisan behavior. In all models of healthcare satisfaction, we control for whether respondents are supporters of the government, and in models of satisfaction with the economy we find that in both countries the left-oriented groups became more dissatisfied with the economy during the same period, indicating that ideological groups, especially in Ireland but also in Portugal, do not just respond to government ideology.

An important implication of our findings concerns the politics of the welfare state. Contrary to the existing claims that ideology plays little or no role in shaping attitudes toward healthcare (see Jensen and Petersen 2017), we show there are substantive ideology-driven changes in attitudes when it comes to satisfaction with health systems. This suggests that healthcare, or at least some of its aspects, such as health system performance, may be a positional rather than a valence issue. Both left- and right-oriented voters may support well-functioning healthcare systems and ask for better health services, but their views on the appropriate way to achieve these goals might be different. Using a dynamic approach that made it possible to examine changes over time has allowed us to identify differences between ideological groups and their healthcare attitudes in the context of significant policy changes, differences that would not have been observable using data from one time point. In short, we believe refined analyses that distinguish between different types of healthcare attitudes and take a dynamic approach in examining the role of ideology in shaping these attitudes over time would provide promising avenues for further research.

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