COUNTRY REPORT

SWEDEN

MIPEX HEALTH STRAND

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MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Sweden

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	9.644.864	●●●○○
GDP per capita (2014) [EU mean = 100]	124	●●●●○
Accession to the European Union	1995	

Geography: Bordering the Baltic Sea and sandwiched between Norway and Finland, Sweden is the third largest EU country. The terrain is mostly flat or gently rolling lowlands, with mountains predominating in the west. It is the most populous of the Nordic countries with a density of 22/km2, most of the population living in the south. Eighty-six percent of the population live in urban settings, the largest city being the capital Stockholm (1.486.000 inhabitants). The most densely populated regions are the counties of Stockholm and Skåne, the latter being connected to Denmark by the spectacular Öresund road and rail bridge (8km), which was completed in 2000.

Historical background: Sweden was a regional military power until two centuries ago, but since then the country has not participated in any war. A state of armed neutrality was maintained in both World Wars.

Government: The country is a constitutional monarchy divided into 21 counties. It joined the EU in 1995 and membership of the Schengen Zone was implemented in 2001. Sweden is not part of the Euro zone.

Economy: Sweden combines a high-tech capitalist system with a well-developed welfare state. The so-called 'Swedish model' of labour relations aims to reduce conflict between labour and capital by collective bargaining agreements based on mutual interest (Fulcher, 1991). This model has helped Sweden achieve one of the world's highest standards of living, with high levels of social mobility, equality and social cohesion. However, the model was not achieved painlessly. Sweden was hard hit by the Great Depression during the 1930s: even before then, the country had a history of bitter confrontations between its robust union movement and equally well-organised employers' federations. In 1932, at the lowest point of the depression, the Social Democratic Party was elected to power: it applied Keynesian economic remedies and laid the foundations for a collective bargaining model, implemented in 1938, which still characterises Swedish labour relations. Currently, the most important sectors of Sweden's economy are public administration, defence, education, human health and social work activities (24%), industry (20%), and wholesale/retail trade, transport, accommodation and food services (17%).

Sweden has an open economy, strongly integrated into global markets and therefore vulnerable to external events. Economic growth slowed in 2013 as a result of continued economic weakness in the EU, Sweden's main export market. Unemployment was particularly high in 2012 and 2013. Economic growth since then has varied between 2-4% per annum.

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	15,9	●●●●●
Percentage non-EU/EFTA migrants among foreign-born population	63	●●●○○
Foreigners as percentage of total population	7,1	●●●○○
Non-EU/EFTA citizens as percentage of non-national population	50	●●●○○
Inhabitants per asylum applicant (more = lower ranking)	119	●●●●●
Percentage of positive asylum decisions at first instance	77	●●●●●
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	66	●●●●●
Average MIPEX Score for other strands (MIPEX, 2015)	80	●●●●●

In the 1930s, Sweden changed from being a country of emigration to a country of immigration, although most immigrants were returning Swedes who had previously moved to North America. The immigration trend accelerated in the 1940s due to refugees arriving from the Baltic and Nordic countries (Bengtsson et al. 2005). Sweden's modern immigration era can be divided into four distinct stages, each stage representing different types of immigrants and immigration (Westin 2006):

1) Refugees from neighbouring countries (1938 to 1948)
2) Labour immigration from Finland and Southern Europe (1949 to 1971)
3) Family reunification and refugees from developing countries (1972 to 1989)
4) Asylum seekers from South-eastern and Eastern Europe and other regions (1990 to present) and the free movement of EU citizens within the European Union.

Concerning current immigration policies, regulations generally aim to facilitate immigrants seeking work, and are broadly based on the demand for labour within a framework of controlled immigration, while upholding the rights to asylum and family reunion (SOU 2011:28). The primacy given to labour migration is further strengthened not only by the introduction of the construct 'circular migration',[2] but also by the fact that since 2008 asylum seekers have been able to 'change track' and apply for a work permit without having to leave the country to apply (Government Proposition 2007/08:147). This policy can be understood as a measure to counteract irregular migration (Björngren Cuadra, 2014).

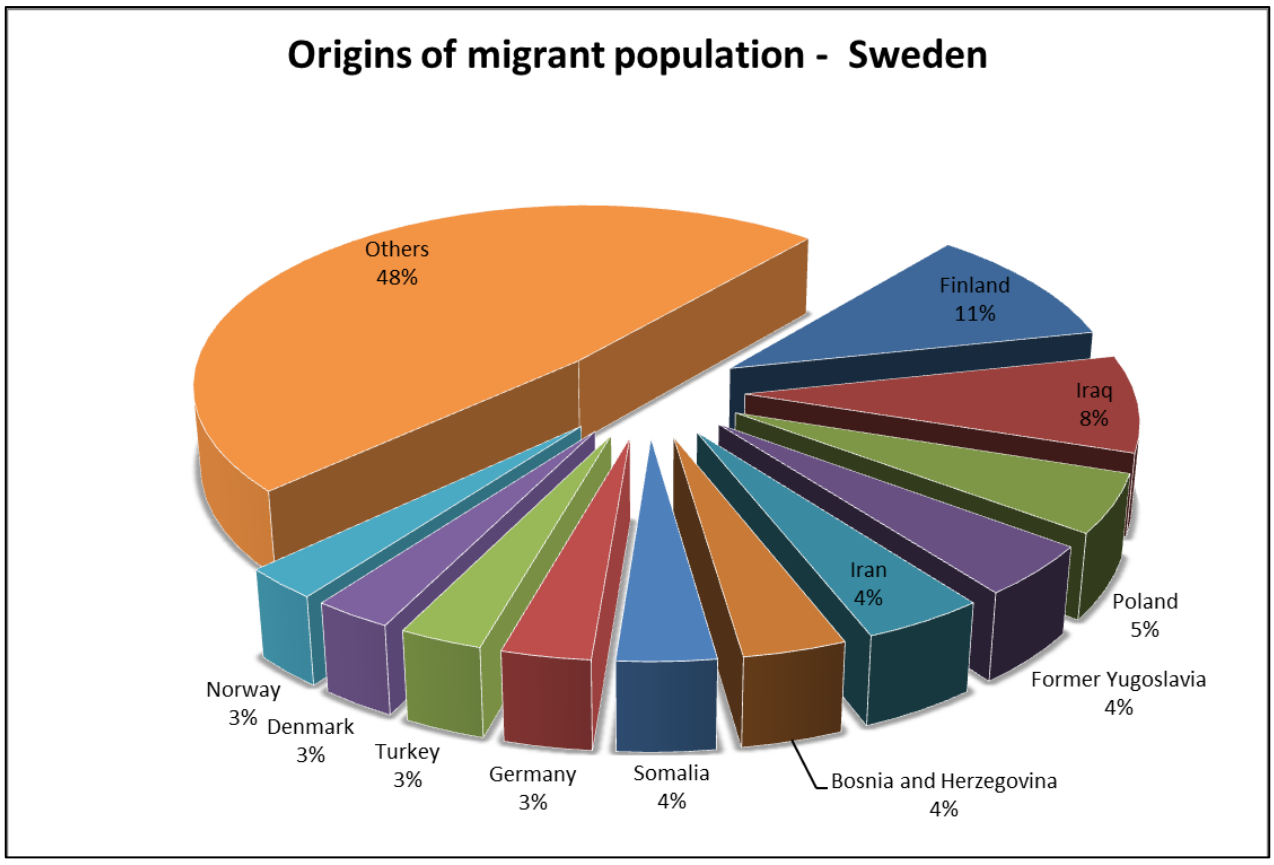
[2] Circular migration aims at migration to and from the country, implying "crossing the border twice". From this perspective all migrants in Sweden are seen as potential circular migrants. The construct is to be understood as a way to interconnect migration policy and policies of global development (see SOU 2011: 28).

The only options currently available for migration to Sweden for non-EU citizens are asylum seeking, family reunion, education and controlled labour migration. In the latter case, work permits are required prior to entry into the country.

In 2014 Sweden received 74.980 first-time asylum applications, but this number more than doubled in 2015 to reach nearly 163.000. In that year the ratio of inhabitants to new asylum applicants became 61 to 1, the highest concentration in the EU. The main countries of origin in 2015 were Syria (50.890), Afghanistan (41.190), Iraq (20.190), stateless (7.445) and Eritrea (6.515). In the same year, 44.695 first-instance decisions were issued and the rate of asylum recognition was 72%, down slightly from 77% in 2014. Sweden adopted more restrictive policies on asylum in November 2015 as well as 2016;[3,4] by mid-December 2016, the total of asylum seekers arriving in that year had fallen to a mere 28.000,[5] due to a combination of these policies and external factors.

In 2015, 110.623 first residence permits were issued (fewer than the number of first-time applications for asylum). Reasons for the permits were family reunion (42%), employment (19%) education (8%) and others (31%, including asylum).[6] The majority of work permits issued were short-term – a trend which is on the rise, fuelled by the increase in applications from Thai, Indian, and Chinese nationals.[7] Figure 1 shows the countries of origin of migrants in Sweden in 2014.

Figure 1 Foreign-born population in 2014 by country of origin (Eurostat)



[3] https://www.theguardian.com/world/2015/nov/24/sweden-asylum-seekers-refugees-policy-reversal
[4] http://www.migrationsverket.se/English/About-the-Migration-Agency/New-laws-in-2016.html
[5] http://www.thelocal.se/20161226/number-of-asylum-seekers-to-sweden-dropped-sharply-in-2016
[6] http://bit.ly/2iQPxba
[7] http://bit.ly/2iW8Hgh

Sweden has consistently obtained the highest scores on the Migrant Integration Policy Index (MIPEX). Its government adopted a multicultural policy in 1975 (the Immigrant and Minority Policy)[8] and Swedes tend to have favourable attitudes to migration and migrants, although this consensus came under strain following the unprecedented influx in 2015.

Estimates of the number of undocumented migrants (UDMs) in Sweden in 2010 were in the range 10.000–35.000 (Socialstyrelsen, 2010). According to police data at the time, 13.072 persons were wanted by the police (for expulsion), while the 35.000 figure is largely based on "guesstimates" made by nongovernmental organisations. This number equals approximately 0,4% of the population and represents a comparatively modest level within the European context (Baldwin-Edwards & Kraler 2009:41). In terms of pathways into irregularity, failed asylum seekers probably make a larger contribution to the total than 'overstayers' or unauthorised entrants.

[8] See http://www.queensu.ca/mcp/immigrant-minorities/evidence/sweden

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	3.012	●●●●○
Health expenditure as percentage of GDP	12,0	●●●●●
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	84	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	14	●●●●○
Score on Euro Health Consumer Index (ECHI, 2014)	761	●●●●○
Overall score on MIPEX Health strand (2015)	62	●●●●●

Health care in Sweden is considered a public responsibility and is circumscribed by a welfare model (Anell et al. 2012) that in comparative work has been characterized as 'universal' (Björngren Cuadra 2014). In a Titmussian tradition (see for example Titmuss, 1967), the model opposes targeted and/or means-tested services, as they are understood to be stigmatizing.

However, and in line with that same tradition, selective services are used as a complement, in particular when targeting especially vulnerable groups. There is also a need to consider the longstanding integration policy which grants migrants (i.e. 'regular migrants') equal rights as citizens. Since the mid-1960s, when immigrants were first identified as a welfare target group, there has been a tendency to apply general welfare solutions. Back then, responsibility was placed on the general authorities and institutions within the welfare system rather than invoking special provisions. The general understanding was conceptualized in socio-economic terms as immigrants "receiving satisfactory social and cultural services" and "equal living conditions to those of the majority" (Borevi 2002). Also, according to the 'multicultural' strategy launched in 1975, the prevailing focus was on equality. As far as health and related services were concerned, these were seen as a provision that should be organised within the framework of general welfare solutions.

This paradigm was confirmed by Government Proposition 1997/98:16 and further reaffirmed in Proposition 2008/09:01. It is geared towards general services, implying that universally oriented mainstream institutions should, in addition to a general orientation, also have the competence to meet particular needs rather than launching parallel particularistic approaches. Consequently, the universal approach focuses on individual needs as opposed to immigrant status. Specific immigration-related needs are only targeted during the first two years of residence (Government Proposition 1997/98:16), which can be understood as compensatory measures strengthening a vulnerable group's rights.

Since December 2010, selective measures have been aimed at people granted residence, called 'newly arrived' (under the Act on the Establishment of Certain Newly Arrived Immigrants [*Lag (2010:197) om etableringsinsatser för vissa nyanlända invandrare*]. These measures focus on the first period (generally

2-3 years) of legal residence in the country, defined as the period of establishment (Swedish: *etablering*). Initiatives are currently under way to implement a health-promoting approach (see section 6 below).

In terms of legislation, Sweden's health care system is regulated by the 1982 Health and Medical Services Act (*Hälso- och sjukvårdslagen*). In keeping with the universal approach, the health care services framework has a publicly operated health service and is organized on three levels: national, regional, and local (Anell et al. 2012). Health care is predominantly financed through national and local general taxation (84%); total expenditure constituted 12% of GDP in 2014. Private health insurance plays a supplementary role, providing faster access to care, but covers only 2,5% of the population (Thomson et al. 2009). County councils, which form the basis of the system, are responsible for financing primary care, hospital care, and mental health care. Municipalities are responsible for financing home care and nursing home care. Most primary health care centres and hospitals are owned and operated by county councils, although the number of privately contracted primary care providers is growing (up to 60% in some urban counties). Residents are increasingly able to choose their primary care providers. Primary care has no formal gatekeeping function, but financial incentives (higher co-payments) encourage patients to visit primary care providers before visiting specialists (Thomson et al. 2009).

At a national level, the overall responsibility for health care development rests with the Ministry of Health and Social Affairs (*Socialdepartementet*). The National Board of Health and Welfare (*Socialstyrelsen*) is the government's central advisory and supervisory agency, responsible for providing follow-ups, evaluations and guidelines (Anell et al. 2012).

Under the 1982 Health and Medical Services Act, all legal residents are covered for a comprehensive range of health services. The goal is to provide "the entire population good health and care on equal terms", which is granted on the basis of need. There is no defined list of benefits, but guidelines have been put in place by the Board of Health and Welfare to establish health care priorities. Co-payments exist for most health services, but children are exempt. The co-payment for health care services ranges from €10 to €30, depending on the county council and the type of treatment. For hospital stays the fee is €8 per day. Annual out-of-pocket payments are capped at €190 for health care services and €200 for prescription medications. Medical care for children and young people up to the age of 19 is free of charge (Anell et al. 2012). Dental care is covered by the national dental insurance system; for adults, care is partly subsidised. The pricing of dental care has been deregulated, which means that providers set their own fees for each form of treatment and subsidies are more limited. Dental care for children and young people up to the age of 20 is free.

The health care delivery system, managed by the county councils, involves primary care, hospital care, public health and preventive care. County councils are organised into health care districts with responsibility for the health of the population in their areas. The health care facilities are organised as regional hospitals and district county hospitals. Primary care is provided in health care centres (vårdcentraler). County councils regulate the private health care market. A private health care provider must have a contract in order to obtain reimbursements from the social security insurance. Accordingly, private health care, with few exceptions, is publicly funded via insurance (Anell et al. 2012). In April 2009, a change (called *Care Choice)* in the Health Care Act was implemented, strengthening the position of private providers and de-coupling the geographical affiliation of patients seeking primary care (Government Proposition 2008/09:74).

4. USE OF DETENTION

In its study on alternatives to detention and best practices in detention, the Refugee Council of Australia (2000) cited the "the Swedish model of detention" as an exemplary system of immigration detention. However, in the wake of increased numbers of asylum seekers and migrants, the Swedish government has adopted more stringent measures - introducing additional border controls, reinforcing police forces, and plans to deport up to 80.000 non-citizens who failed to qualify for refugee status.

Immigration policy – including conditions for detaining migrants – is regulated by the Aliens Act of 2005 which incorporates the EU Returns Directive. The Act designates the Government, the Migration Court, the Migration Court of Appeals and the Swedish Migration Agency as the competent authorities with decision-making powers and enforcement duties. More precisely, the Swedish Migration Agency (SMA) is responsible for all aspects of immigration in Sweden, from receiving asylum applications to enforcing detention and deportation orders. According to the Aliens Act, non-citizens may be detained 1) when their identities cannot be clearly established, 2) when it is necessary to investigate the migrant's right to remain in Sweden, 3) when there is no proof of the right to enter or stay in the country.

Depending on the legal grounds for detention, the maximum **duration of detention** varies - from 48 hours when a migrant is detained for the purpose of investigating his/her right to remain in Sweden, to two weeks in case of detention during the verification of his/her right to enter or stay in the country, and 12 months for people detained while awaiting deportation.

Swedish law allows the **detention of minors for immigration-related reasons** in cases where a deportation order has been issued against the child, where it is probable that he/she will be refused entry, or where he/she presents a flight risk. Detention of children is also carried out when the supervision is not sufficient to enforce a refusal of entry or expulsion order. Minors may be detained, together with their parents or family members, for a maximum of 72 hours. Unaccompanied minors may be held in detention only under exceptional circumstances.

Detention facilities

Sweden has five detention centres, run by the Swedish Migration Agency, which is responsible for the custody of migrants and for the provision of services in the centres.

Management of the centres was assigned to the government agency in order to tackle the dramatic cases of violence reported by Swedish media and human rights groups in the 1990s. Until 1997, detention facilities were under the responsibility of the Federal Police, who contracted private security companies for the daily management of the centres. After alarming practices were uncovered by an inquiry ordered by the government into detention and deportation practices, important reforms were undertaken - including transferring the management of the centres to the Migration Board and mandating the availability of qualified health personnel.

The structures of the immigration detention buildings in Sweden bear almost no resemblance to prisons. Indeed, under the Aliens Act, migrant detainees may not be accommodated in prisons, or remanded to prisons or police stations, except in cases where they are awaiting expulsion for having committed a

criminal offence, or being held in isolation in a dedicated detention centre and cannot be held there any longer for security reasons.

Conditions of Detention

The Swedish system places particular emphasis on the rights of detained migrants. According to the Aliens Act, "detention facilities are to be organized in such a way to cause the least amount of infringement of detainees' integrity and rights".

In its 2014 annual report, the Migration Agency gave a detailed description of its facilities. All detention centres have separate sections for women and families (normally housed in four-person rooms). Migrants can move freely within the centres and have access to the courtyard for at least three hours per day. If they have no access money of their own, they receive a daily subsistence allowance; they are also provided with food and hygiene products, have free access to internet and mobile phones, and can receive visitors (Swedish Migration Board 2016).

Health care is provided by the country councils in which the detention centres are located. Detainees have the same rights to medical care as asylum seekers. Detainees therefore have access to hospital care, preventive child and maternity care, and care and treatment of diseases and injuries.

However, research by Soorej Puthoopparambil (2016) on health in the Swedish immigration detention centres shows that the healthcare services are viewed as inadequate by the detainees and the staff, especially with regard to the mental health problems faced by migrants. Indeed, none of the centres have arranged for regular visits by mental health professionals. The study also highlighted the challenges faced by staff who both provide social services to detainees and at the same time assist in executing deportation decisions.

5. ENTITLEMENT TO HEALTH SERVICES

Score 78 **Ranking** ●●●●●

A. Legal migrants

Inclusion in health system and services covered

For legal migrants, inclusion in the system of health care coverage is unconditional: in line with the policy approach to integration outlined in Government Proposition 1997/98:16, it is the same as for nationals. Consequently, all persons with a residence permit (temporary or permanent) enjoy the same rights under the Health and Medical Services Act [*Hälso- och sjukvårdslag,* 1982:763] as Swedish citizens. This act outlines the county councils' responsibility to provide health care services to what the law refers to as 'the entire population,' which in practice is interpreted as 'all legal residents.' Administrative discretion and documentation involving residence permits rests with the Migration Board. When an individual is granted a residence permit, he or she is assigned a unique personal number by the tax authorities (the Swedish Tax Agency). This number is required for accessing health care; it is a prerequisite for being signed up as a patient at health care facilities, as well as for insurance administration purposes.

Special exemptions

As migrants with a residence permit are included in the mainstream system, there are no restrictions on entitlements and therefore no need for exemptions from restrictions.

Barriers to obtaining entitlement

None

B. Asylum seekers

Inclusion in health system and services covered

The inclusion of asylum seekers in into the system of health care coverage is unconditional insofar as it applies to all asylum seekers. However, when seeking care they have to bring an identification card issued by the migration authority to prove their legal status. Furthermore, they are not covered for the same services as nationals.

Entitlements for asylum seekers are outlined in the Act on Healthcare for Asylum Seekers and Others [*Lag om Hälso- och sjukvård åt asylsökande m.fl., 2008:344*]. Under this law, children (under 18 years of age) are entitled to the same level of care as legal residents/nationals with no fee for service. Co-payments for asylum seekers are outlined in an ordinance (*Förordning om vårdavgifter m m för vissa utlänningar*, SFS1994:362); for adults the fee is 50 SEK (approximately 5 EUR), i.e. 25% of the amount paid by persons with full access to health care (200 SEK).

Coverage extends to 'care that cannot be postponed´, as determined by the physician. The law states that maternity care, reproductive counselling, abortion and one health examination are included in this concept. As stated, asylum seekers of minor age enjoy full health care coverage.

Special exemptions

Infectious diseases (e.g. TB, HIV/Aids testing and treatments) are included in the law covering asylum seekers. Victims of trafficking are covered in a special track (see section above on legal migrants).

Barriers to obtaining entitlement

None as long as the person has his or her identity card (which functions as a health card).

C. Undocumented migrants

Inclusion in health system and services covered

Previously, UDMs were completely excluded from the health care system, but following extensive campaigns a new law was introduced in July 2013 laying down certain entitlements. Under this law, entitled Healthcare for Persons Residing in Sweden Without Permission (Government Proposition 2012/13:109, *Lag om hälso- och sjukvård till vissa utlänningar som vistas i Sverige utan nödvändiga tillstånd*), county councils are responsible for providing the same subsidised care (including dental care) to adult UDMs as to asylum seekers (as outlined in the Act on Healthcare for Asylum Seekers and Others). This involves "care that cannot be postponed," maternity care, reproductive counselling, abortion (section 7), and one health examination (section 10). Section 9 states that county councils may provide care beyond what is stated in section 7. Children (under 18 years of age) are to be offered the same level of care (i.e. full care) as children who are residents (section 6) or asylum seekers, regardless of their pathway into irregularity (Proposition 2012/13:109). The patient fee is 50 SEK (as for asylum seekers) and is regulated by an ordinance (*Förordning om vårdavgifter m.m. för utlänningar som vistas i Sverige utan nödvändiga tillstånd, 2013:412*).

Special exemptions

For UDMs, entitlement to services for infectious diseases (e.g. TB, HIV/Aids testing and treatments) was introduced parallel to the passing of the new law in 2013. Changes were made to the Communicable Disease Act [*Smittskyddslag*, 2004:168] so as to include UDMs in the target groups (implying free treatment and medication, which had previously not been accessible for UDMs). Victims of human trafficking are covered in a special track.

Barriers to obtaining entitlement

Decisions about what constitutes "care that cannot be postponed" are the prerogative of the responsible physician and can be difficult for the patient to anticipate. This room for discretion was criticized by health care professionals and human rights activists during the preparation of the 2013 law. At the time, the National Board of Health and Welfare was assigned to investigate the operationalisation of the construct "care that cannot be postponed" by providing (for example) concrete advice or guidelines, as well as examining other aspects of putting the law into practice (such as documentation, monitoring and patient safety). However, the Board concluded that discretion must rest with the physician.

As regards administration, county councils are not used to dealing with patients who lack a personal number and often have difficulty enrolling these patients in their administrative systems. The procedures vary and according to the National Board of Health and Welfare offer inadequate guarantees of patient safety (see also Swedish Agency for Public Management 2015).

6. POLICIES TO FACILITATE ACCESS

Score 62 Ranking ●●●●○

Information for service providers about migrants' entitlements

Clear and up-to-date information about migrants' entitlements is essential for their implementation. Dissemination of this information varies according to migrant categories.

- Legal migrants are entitled to full coverage and it is not considered necessary to distribute special information about this.
- The ordinance regarding asylum seekers (*Förordning om vårdavgifter m. m. för vissa utlänningar,* SFS1994:362) is available on national websites. In addition, county councils provide staff with information concerning regional implementation.
- With respect to UDMs, organisations and staff are informed in principle but there are exceptions and delays. For example, the 2013 law on UDMs is still not fully implemented due to poorly informed staff. This has been observed in a government evaluation (November 2014 – April 2015) of the implementation of the law (see Swedish Agency for Public Management (2015), as well as by NGOs providing health care to UDMs. To that extent, it cannot be said that all service provider organisations receive up-to date information on migrants' entitlements.

Information for migrants concerning entitlements and use of health services

As the Swedish health care system is decentralized, there are regional and local variations concerning the provision of information for migrants. For example, there are differences in the number of languages in which information for migrants is available. However, there is a national website set up collectively by Swedish county councils and regions. On this website ("New in Sweden - healthcare")[9] there is currently health information in 20 languages outlining entitlements (as well as information concerning illnesses and care, see below).

As stated above, information varies between county councils and this applies most obviously to information given through media other than the internet. For example, in the Skania region (Skåne), all newly arrived migrants are personally informed about the health care system, entitlements and health issues at meetings as part of the welcoming procedure (organised by the Swedish Employment Agency in cooperation with the County Administrative Board). The languages in use are the most frequent languages among asylum seekers and other migrants (for example Arabic, Dari, Pashtu, and Somali). A project is currently running which plans to distribute this kind of information nationally (MILSA 2015).

Asylum seekers are given information by the Migration Board. This includes web-based information in different languages and information given in mother tongue at organised meetings, as well as individually by public officials. Migrants in refugee centres can be informed personally by facility staff,

[9] http://www.1177.se/Other-languages/New-in-Sweden---healthcare/English--Engelska/

while those who live in their own homes might have less access to information. The Migration Board uses 22 languages on their website (where information for asylum seekers is to be found).

Information about UDMs' entitlements can be found on the national website "New in Sweden – healthcare" and on some county councils' own websites. It is not known to what extent this information is used by UDMs.

In sum, information for legal migrants and asylum seekers is not regarded as problematic, while that for UDMs is less adequate. Information is also provided to a certain extent by various NGOs.

Health education and health promotion for migrants

As a consequence of the mainstreamed approach, migrants are not targeted as a special group for health education beyond the provision of translated information on the website "New in Sweden - healthcare", currently available in 20 languages.

The information mentioned above (given in Skania region or Skåne) to newly arrived migrants covers health issues and is aimed at strengthening migrants' health literacy. This kind of education, referred to as 'health communication', is planned by national stakeholders (The Swedish Employment Agency, The Swedish Association of Swedish Association of Local Authorities and Regions, The Migration Board, The County Administrative Boards and the national social security agency, *Försäkringskassan*) to be disseminated on a national scale (MILSA 2015).

Given the universalistic healthcare approach which applies after the first 2-3 years of settlement or 'establishment', migrants are included in mainstream information provision. Information available in different languages is becoming more common regionally (for example, multilingual signs and brochures in waiting rooms), but is not systematically in use. There are growing numbers of multi-lingual staff working as health care counsellors over the telephone. In addition, in a few county councils, newly arrived migrants receive health information in their first languages.

There are local and regional examples of targeted programs (project based) - for example, for Albanian migrants on quitting smoking, and in Arabic on diabetes prevention.

After the settling-in period, migrants are supposed to be reached by health education and health promotion within the mainstream system. The extent to which this approach has been successful has not been fully investigated, but observed disparities in health could call this into question and justify further investigation. For example, a regional study has found that persons born outside Sweden reported 'good' or 'very good' self-assessed health to a lower degree than those born in the country (Fridh et al. 2013; see also e.g. Hjern, 2012 on health disparities).

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

As already mentioned, there are initiatives by certain county councils involving 'health communicators'. Such workers provide information and mediate contacts with organisations, but are not involved in the actual encounters with health professionals. These initiatives are organised in the context of settlement programmes. Health communicators reach all newly arrived refugees within the targeted area (a region or a part of a region), as well as accompanying family members and relatives.

Is there an obligation to report undocumented migrants?

Sweden is one of very few countries in Europe in which health professionals and staff are required by law to report patients (Björngren Cuadra 2014). The law in question was not amended when the new law on health care for UDMs was introduced in 2013. Although the reporting obligation is 'passive' rather than 'active', it can nevertheless act as a very real deterrent to UDMs seeking care. Swedish healthcare staff are not obliged to report a UDM on their own initiative, but under the Patient Safety Act (*Patientsäkerhetslag,* 2010:659, chapter 6, section 15) they are required, if asked by the police or certain other authorities, to provide information (i.e. answer a direct question) as to whether a specific person is in the facility. In all other cases, under the Confidentiality Act (*Offentlighets- och sekretesslag, 2009:400*), staff are obliged to keep information related to their patients confidential. This continued obligation to report has been criticized, by health professionals as well as the National Board of Health and Welfare, as a hindrance to implementing the new law (Björngren Cuadra 2014).

Are there any sanctions against helping undocumented migrants?

There are no legal or organizational sanctions against healthcare professionals or organisations assisting UDMs. However, under the Aliens Act, it is forbidden to provide such help if it is done for profit (*Utlänningslagen* 2005:716, chapter 20, para. 7).

7. RESPONSIVE HEALTH SERVICES

Score 58 Ranking ●●●●●

Interpretation services

There is a general provision for patients with inadequate proficiency in the official language (Swedish). This is under the Act of Administration (*Förvaltningslagen*, paragraph 8). This law states a right to interpreter or, more specifically, it states that whenever a public authority is communicating with a person who does not master the Swedish language, the authority should use an interpreter and pay the cost. This also covers persons with hearing problems. Interpreting services are most often organised at the level of municipalities and in practice provided by a bureau having contracts with authorized interpreters.

The most common methods in use for interpretation are ordinary face-to-face interpretation and telephone interpretation. The latter can provide for anonymity for the patient as well as enabling interpretation in a certain language not available in the region or in municipality. A third strategy, employment of competent bilingual or multilingual staff is generally not considered suitable, as it can blur professional roles. It does take place, however: not as a formulated strategy for interpretation, but rather as a spin-off of diversity in the workforce.

Requirement for 'culturally competent' or 'diversity-sensitive' services

As indicated in section 3, all human services such as health and social care are expected to have the competence to meet particular needs within mainstream provisions (Government Proposition 1997/98:16). This is discussed in terms of diversity (involving a broad understanding of the concept, such as sexual identity, gender, race/ethnicity, disabilities etc.). Needs arising due to immigration are only targeted within the reception system (involving health to a certain extent) during the first two years.

There are no official standards or guidelines relating to migrants which require that health services take account of individual and family characteristics, experiences and situation, respect for different beliefs, religion, culture, and competence in intercultural communication. Rather, the treatment and interaction with patients is framed in the Health Care Act (para. 2) in terms of providing equal conditions for the whole population, with respect to all humans' equal value and dignity, as well as providing health care according to individual needs.

Training and education of health service staff

In Sweden there are no specific policies to support training of staff in providing services responsive to the needs of migrants. Training might be a part of the core education curriculum (e.g. at university level for nurses, social workers and physicians), though not a requirement of monitoring authorities. One option is to frame this topic so that it directly relates to training on the broader topic of human rights.

Involvement of migrants

Regarding the involvement of migrants in the development and dissemination of information, we can refer to the regional initiatives mentioned in section 6. In initiatives on 'health communication', newly arrived refugees are the target group involved in planning and securing the quality of the interactions

and the information material. These examples are supported by policies at regional level (involving the County Administrative Board and the County Council). Migrants have been involved in applied research as well, specifically in developing a survey targeting newly arrived refuges.

Encouraging diversity in the health service workforce

Under the Discrimination Act (Chapter 3, paragraph 4), all employers in Sweden (given a certain minimum number of employees) are obliged to have an action plan aimed at making work conditions suitable for all employees regardless of gender, ethnicity, religion, or confessional beliefs. Under the same law, employers and employees must cooperate regarding active measures to achieve equal rights and opportunities in working life regardless of sex, ethnic background and religion or beliefs, and to work together against discrimination. However, there are no policies aiming to ensure that health care staff reflect the diversity of the wider population.

Development of capacity and methods

Given the universalistic general approach, the preferred strategy is to integrate all varieties of needs in the methods adopted within mainstream procedures.

8. MEASURES TO ACHIEVE CHANGE

Score 50 **Ranking** ●●●●○

Data collection

Data on migrant status, country of origin or ethnicity is not included in medical databases or clinical records, as it is forbidden to do so under the Swedish constitution. This approach was criticized in 2007 by the UN 'Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health', as it hampers the monitoring of health disparities along racial and ethnic lines (Hunt 2007). There are, however, possibilities to link databases subject to ethical approval. Most often, research in the field of migration and health is done on "country of birth" (or self-reported data on "ethnicity").

Support for research

Funding bodies have in the past five years supported research on the following topics: occurrence of health problems among migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, and issues concerning service provision for migrants or ethnic minorities (see Brodin et al. 2013).

"Health in all policies" approach

The principle of paying attention to the health impact of all policies is not implemented in Sweden. Nevertheless, within the reception system of new refugees there is, as already pointed out (section 6), an ongoing process involving national stakeholders as well as applied research, on how to implement a health promoting perspective (MILSA 2015). This includes addressing the individuals' health to a larger extent within the system

Whole organisation approach

Given the universalistic model, which gives primacy to an inclusive mainstream system, we can describe the approach to migrant or ethnic minority health as both 'integrated' and 'categorical'. The overarching legal commitment integrates migrants or ethnic minorities in the service providers' goal of providing equitable health care for all patients. However, the extent to which this general commitment is fulfilled on a day-today basis is unclear. In parallel with these provisions, there are initiatives undertaken only by specialised departments or organisations. This applies particularly to health initiatives in the framework of the so-called establishment programs (during the first two years after a permanent residence permit has been issued).

Leadership by government

With the exception of issues concerning the establishment process, leadership by government is integrated in the mainstream system. It is relevant to again observe that some national authorities such as The Swedish Employment Agency, The Swedish Association of Swedish Association of Local Authorities and Regions, The Migration Board, The County Administrative Boards, and the national social security agency, Försäkringskassan) are currently collectively engaged in integrating health promotion in establishment programs for migrants (MILSA 2015).

Involvement of stakeholders

In relation to leadership and governance, it is relevant to note that there is currently no policy in place to involve stakeholders in the design of (national or regional) migrant health policies.

Migrants' contribution to health policymaking

To our knowledge, there is no involvement of migrant organisations (as stakeholders and/or advocacy groups) in health related policymaking at national or regional level.

CONCLUSIONS

Sweden has a long-standing universalistic approach to welfare, which does not favour targeted and/or means-tested services as these are generally understood to be stigmatizing. The approach is instead geared towards general services, based on the assumption that universally oriented mainstream institutions should, in addition to the general orientation, also have the competence to meet particular needs as opposed to launching parallel particularistic approaches. This approach underlies policies on migration and health. Migrants with residence permits are assumed to be included in the mainstream system and to have the same right to health care as nationals. Children, independently of their parents' legal status, have the same rights as nationals.

The universalistic approach is broadly implemented, resulting in a negative attitude to disaggregating health data in terms of ethnicity, targeted health information, other measures to facilitate access, training of staff, and development of specific methods of diagnosis and treatment. The overarching legal commitment integrates migrants or ethnic minorities in the service providers' goal of providing equitable health care for all patients. It is not clear to what extent this general commitment is fulfilled in practice.

The only selective measures that are organised are those targeting newly arrived migrants who already have residence permits, involving the first period in the country as legal residents (defined as the period of establishment). There are currently ongoing processes aiming to develop a health promoting perspective at national, regional, and local level. Furthermore, information regarding entitlements and health service use is currently available in 20 languages. For asylum seekers such information is available in 22 languages.

For asylum seekers and undocumented migrants, rights to access health services are covered by special legislation. Asylum seekers have access to health services for 'care that cannot be postponed.' The situation of undocumented migrants has improved since 2013, and they are now entitled to the same level or care as asylum seekers and subject to the same out of pocket payment (50 SEK). Apart from ´care that cannot be postponed´, coverage includes maternal care, reproductive counselling, abortion, and one health examination. Discretionary power to make specific determinations rests with the responsible physician.

Recommendations

- The implementation of the law targeting undocumented migrants should be critically examined, as it is not being fully applied due to poorly informed health care staff.
- The law requiring health workers to report undocumented migrants when asked about their presence by police or other authorities should be amended.
- In line with UN criticisms (Hunt 2007), the right of the individual to access health should be expanded, so as to disconnect the right to health from migration status and residence permits.
- More should be done to promote the involvement of migrants in health care, particularly in campaigns to improve health care communication and health awareness.

- Reported shortcomings in (mental) health care for migrants in detention should be investigated and remedied.
- The application of universalistic principles to health and social care interventions should be critically examined, paying attention to the shortcomings of a “one-size-fits-all’ approach.

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