

## ORIGINAL ARTICLE

# Irregular migrants challenging policy hierarchies and health professions - the case of Sweden

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## Abstract

In a European comparative perspective Sweden, though upholding a universal welfare model is one of the most restrictive countries as regards irregular migrants' right to access health care. They do not access care via the legal framework beyond emergency care upon payment of the full cost. This article presents findings from a study aiming at exploring and elucidating the Swedish policy answers as regards right to access health care for irregular migrants. The current policy is outlined besides a new governmental agreement and standpoints put forward by health and welfare professionals. The analysis suggests that migration policy has primacy over health policy. Further, it suggests, that by claiming that their jurisdiction is independent from the state's interest of control of migration the hierarchy is renegotiated. The core involves the fundamental norms and principles underpinning the exclusion of irregular migrants from welfare services and their connection to controlled migration.

## Key words

Irregular migrants, Entitlement, Health policy, Migration policy, Health professions

## 1. Introduction

About one per cent of the entire population in the European Union (EU) is irregular<sup>[1]</sup>. 'Irregular' refers to persons residing in a country without authorization commonly differentiated in categories in terms of being rejected asylum seeker, visa 'overstayers' or persons who never applied for authorization. Between 1.8 and 3.9 million resides in the fifteen main countries in the EU<sup>[2]</sup>. In Sweden, which is in focus of this article, the estimates range from 15 000 to 80 000 persons, or in average 0.5% of the population. Those figures represent a comparatively moderate level within the European context<sup>[3]</sup>. In Sweden the prominent pathway into irregularity is through the asylum system<sup>[4]</sup>. Irregular migration has gained increasing attention in Sweden as well as in many EU member states in public and political discourse as well as in research during the last decade. Topics indicating a general lack of social rights, substandard living and working conditions have been addressed besides issues on health care<sup>[5-11]</sup>. This article presents findings from a study aiming at exploring and elucidating the Swedish policy answers as regards right to access health care for irregular migrants. The interest of policy involves not only how the structures of public authorities are dealing with the subject matter but involves also contesting interpretation put forward by other agents<sup>[12]</sup>. The interest is thus likewise geared towards alternative standpoints and critique articulated by health and welfare professionals.

## 1.1 Perspective on policy

From the theoretical perspective at which the interpretation of empirical observations draws upon irregular migrants' right to access health care is related to intersecting policy realms. It has to do with both basic norms and institutions of the welfare state as well as with how migration, regular as well as irregular, is dealt with. In the literature there is acknowledged strong linkages between general welfare policies as well as policies of integration and migration<sup>[13]</sup>. (Brochman and Hagelund 2011) suggesting that policies involving irregular migrants can be better understood if the intersecting character of the policy realms is recognized. Charles Tilly (1995) points out, that states' capacity to pursue social policies depends on the creation of substantial, effective controls over stocks and flows of persons<sup>[14]</sup>. Thus the linkages between the mentioned realms involve the fact that social rights are linked to control of migration<sup>[13]</sup>. Internal controls, based on administrative measures<sup>[15]</sup> imply that health and welfare staff gets an active role in enacting control of migration. Studies have revealed that when clashes occur between differing legal perspectives control of migration tends to receive the highest priority in practice<sup>[16-18]</sup>. The primacy given to control of migration over social rights might initially be interpreted as a prevailing hierarchical relationship between the policy areas.

## 1.2 Methodology

As regard methodology it draws upon the interpretative approach which frames the analysis of policy so as to entail meanings and argumentations and ask 'what is this all about'<sup>[12]</sup>. The analysis involves national policy which is also to some extent put in a European comparative perspective. The material in this regard consists of legislation, official documents, reports and statements. In addition, standpoints of health and welfare professions have been addressed in interviews with key informants and through published material in this regard besides participant observations at a public hearing in the parliament and a conference organized by health professionals. The material was analyzed as regard meanings advocated for or contested in terms of statements, contextualizations and priorities which bear upon right to access health care for irregular migrants. The study also draws upon secondary sources (literature and reports).

## 2. Result

This section presents the results in terms of three groups of empirical observations interpreted in the light of the theoretical perspective.

### 2.1 Policy answers in intersecting areas

The first group of observations is based on legislation and policy documents. They concern policy answers involving entitlement to health care. The responsibility for health service in Sweden within a publicly operated system primarily with the independent regional authorities, so called county councils<sup>[19]</sup>. Irregular migrants' do not have right to access health care and do thus not access preventive, primary and secondary care via the legal framework. They might access emergency treatment upon payment of the full cost (currently approximately 200 Euro or 270 USD). This follows from The Health and Medical Services Act (SFS 1982:763) which frames the objective for providers (i.e. county councils) so as to ensure 'the entire population a good health and care on equal terms' (para. 1) as well as 'offering care to those resident in the country' (para. 3). Hereby it is made clear, in terms of the provider's objective, that the prerequisite for receiving health care is legal residenceship. Persons not living (resident) in the county and in need of immediate care (in practice interpreted as emergency care) shall be offered such care (para. 4). However, the county council are also given the right to hold the patient accountable for fees (para. 26). In the case of irregular migrants this is in practice interpreted as the full cost.

The Act on Health Care for inter alia Asylum Seekers (SFS 2008:344) does not apply to foreigners who remain in the country clandestinely (i.e. rejected asylum seekers) if they are over 18 years of age (para. 4). Under this act, children who are irregular migrants as long as they are rejected asylum seekers are entitled to the same care as residents.

The current terms of entitlement imply that health care staff gets an active role in enacting control of migration, not only when determining if the person in front of them have right to care but also under the Patient Safety Act (SFS 2010:659 chapter 6, para. 15). Here it is outlined that staff are obliged, if asked by police or certain other authorities, to provide information (i.e. answer a direct question) as to whether a specific person is in the facility.

### **Comparative perspective**

In a European comparative study, The NowHereland project, Sweden was found to be one of the most restrictive countries as regards the right to access health care <sup>[20]</sup>. Sweden is one out of ten member states in EU 27 that does not even grant the right to emergency care <sup>[11]</sup>. Further, it is an empirical fact that irregular migrants are granted considerable and even full rights to access health care in some EU member states. This can occur in countries with both comprehensive and less comprehensive welfare models. Hence, a welfare model as such is not a sole explanant to exclusion or inclusion of irregular migrants' access in the field of health care <sup>[11]</sup>. Moreover, the countries granting rights to health care, Italy, France, Portugal, Spain and the Netherlands, do not share a welfare model <sup>[21]</sup>. (As regard Spain changes are currently ongoing). However, in those countries the irregular migrants do generally not have their pathway into irregularity through the asylum system as in Sweden but enter the host country clandestinely to find work and is thus geared towards the informal working market.

## **2.2 Intersecting policy areas**

The second group of observations concerns intersecting policy areas as policy answers involving irregular migrants might benefit from being seen in such a context.

### **2.2.1 General welfare policy**

Swedish policy answers are framed by a welfare model which in comparative studies has been characterized in a variety of concepts, all implying a model which is 'high-spender' <sup>[22]</sup> in terms of social expenditures. Some well-known denominators corresponding to different typologies are, besides universal <sup>[23]</sup>, institutional <sup>[24]</sup>, social democratic <sup>[25]</sup>, weak male-breadwinner <sup>[26]</sup>, Scandinavian <sup>[27]</sup>, Nordic <sup>[28]</sup>. The universal orientation and strivings to be general in terms of population coverage imply emphasis on equal rights for all citizens and universal access. The logic of distribution of goods within this model is discussed in connection to the promotion of integration in a society. Means tested services and specific target groups are generally disregarded as they are understood as stigmatizing <sup>[29]</sup>. According to Esping-Andersen the Swedish model came into being with the shift towards active labour market policies, social service expansion, and gender equalization <sup>[30]</sup>. It is underpinned by work oriented strategies and is basically a performance-related system <sup>[31]</sup>. For example are the social insurance system tied to the beneficiaries' success (income) at the labour market <sup>[32]</sup>. This is to say that the moral assumptions that determine the criteria for inclusion and exclusion in the system and which risks should be covered for the individual (such as sickness, disability and old age) basically involves managing risks to which the organisation of work leaves the individual exposed <sup>[33]</sup>.

### **2.2.2 Policy of migration and integration**

A salient aspect of current migration and integration policies in Sweden is their orientation towards labour market. The policy of migration aims at facilitating work migration within a framework of controlled migration <sup>[34]</sup>. The main responsibility of the 'establishment' of newly arrived immigrants and refugees belong to the Swedish Public Employment Service (Arbetsförmedlingen). The primacy given to work migration is further strengthened by the fact that rejected asylum seekers since 2008 can 'change track' and apply for a work permit <sup>[35]</sup>. As regard integration policies the main logic since the 1960th has been in line with the general welfare regime and involves universal welfare solutions. Services which are not universal but rather selective, such as means tested services or outspoken targets groups for a certain social program have, according to this logic, to be avoided <sup>[29]</sup>. According to the integration policies, migrants are to be granted equal rights as citizens. Current integration policy aims at 'equal rights, responsibilities and opportunities regardless of ethnic and cultural background' <sup>[36]</sup>. As equal rights are linked to control of migration can irregular migrants' relative lack of rights be interpreted as an element of internal control of migration.

## 2.3 Ongoing processes

The third group of empirical observation involves ongoing process in which health and welfare professions are taking an active part contesting the official interpretation of legitimate policy and the prevailing relationships between policy areas.

### 2.3.1 Health and welfare professions

Interventions have taken place during the last decades (since mid 1990s) in terms of advocacy and activities (such as demonstrations, conferences, debates and press critical releases) mostly organised by female dominated health and welfare professions and nongovernmental organisations. One activity consists of providing access to care for irregular migrants outside the mainstream public system in certain clinics. Such initiatives have run parallel to articulated strong critic against the restrictive national policy underpinned by arguments and normative principles based on human rights and medical ethics as well as those of public health and humanism. From this standpoint health and welfare professionals have questioned their role in enacting control of migration. Taken together, the initiatives are critical standpoints and can be interpreted as implying a dis-legitimisation of the national policy<sup>[37]</sup>. A network of advocacy groups has developed to champion the right to health care for irregular migrants. For example in 2007, a unified statement, ‘The Right to Health Care-Initiative’ formulated by health profession unions and associations and actors in the civil society, such as Amnesty International, Médecins du Monde and Red Cross. Furthermore, in 2009, 27 organisations whereof 17 were health and welfare profession unions and associations launched a common standpoint on asylum seekers and undocumented persons the same basis, as for other residents<sup>[38, 39]</sup>.

A prominent reference for advocacy has been Paul Hunt, the former UN Special Rapporteur on the Right to Health specifically in the wake of his mission to Sweden in 2006. He criticised the Swedish system<sup>[40]</sup>. Based on his contacts with governmental as well as non-governmental bodies, the lack of the right to health care for irregular migrants was found to constitute discrimination under international human rights law and not conforming to Sweden’s international human rights obligations<sup>[40]</sup>.

### 2.3.2 Public inquiry

A public inquiry was initiated by the government under the Social Ministry in 2010 in the wake of the special rapporteur report aiming at exploring how irregular migrants can be granted health care in what was phrased ‘a more appropriate way’<sup>[41]</sup>. Besides experts representing ministries and authorities health and welfare professionals took part in a reference group.

The inquiry<sup>[42]</sup> delivered in May 2011 agreed with the UN special rapporteur's report involving that the current regulation does not live up to international obligations. It gave unambiguous suggestions; all irregular migrants should be provided with subsidized health care by the county council where they reside on the same terms as residents. The arguments invoked human rights, medical ethics, quality and patient security as well as the principles of equal rights and universal access regardless of status. Further, health care and control of migration was outlined as pertaining to separate policy areas as health care is addressed by certain providers whose assignment should not be to compete against migration authorities<sup>[42]</sup>.

### 2.3.3 Alliance and suggestion

The inquiry was never sent to consultation (remiss) to relevant authorities and organizations as would be the standard procedure and a step towards legal changes. The delay was in media attribute to the minister of migration who, as opposed to the social minister was discontent. The previously mentioned professional networks organized among other activities (such as demonstrations, conferences, debates and critical press releases) a petition claiming the process to proceed. However, in July 2012 it was stated, that the government had decided not to proceed with the suggestions and launched an agreement involving the parties in the governmental position and one in opposition<sup>[43]</sup>. Although it covers entitlements to health care it is framed as pertaining to the migration political domain<sup>[44]</sup>. The memorandum outlines that irregular migrants (from July 2013) shall be entitled care corresponding to the level of entitlement of asylum seekers which correspond to primary care as established by The Act on Health Care for inter alia Asylum Seekers (full care for children,

and for adults maternal care and ‘care that cannot wait’ which is a kind of enlarged emergency care)<sup>[44]</sup>. The professional networks has put forward that exactly this level of care (for asylum seekers) was deemed not to be congruent with human rights standards by the UN special rapporteur as well as by the inquiry while the government assert not agreeing with this judging of international obligations<sup>[45]</sup>.

### 3 Discussion

As the title of this article suggests a prevailing hierarchical relationship between policy areas can be said to be challenged by the very presence of irregular migrants. The challenge has been first and foremost acknowledged by health and welfare professionals but also acknowledged in an overruled public enquiry. If the suggestions put forward in the public inquiry had come to fruition they would have implied a radical change of the Swedish health policy, a shift from exclusion to inclusion of irregular migrants. The proposed change and actions and advocacy of health and welfare professionals put fundamental aspect of the Swedish welfare system under renegotiation. The renegotiation do not involve the inclusion per se of irregular migrants as yet another group of beneficiaries in an otherwise intact universal system. However, the suggested change implies a renegotiation of the relationship between social policies and those of migration. The core of the renegotiation involves the prevailing hierarchical relationship between values of health care and those of controlled migration. In that sense it involves the fundamental norms and principles underpinning the exclusion of irregular migrants from welfare services and their connection to sovereign national self-determination enacted in rigorously controlled migration.

It has been argued that the norms of reciprocity that structure the welfare state interventions are above all the social organisation of work<sup>[46]</sup>. In this regard we live in a “work society”<sup>[33]</sup>. This argument finds support not only in the observations referred to regarding the welfare system as a basically performance-related system<sup>[31]</sup>. It is also supported by the observation that the EU member states that are tolerant to irregular work (i.e work within the informal economy) such as Italy, Spain, The Netherlands, Poland, Slovakia and Greece<sup>[47]</sup> grant more comprehensive rights to health care when compared to member states that are intolerant to irregular work (for example Sweden)<sup>[11]</sup>. In addition, category of irregular migrants (i.e differing pathways) seems also to have an impact on the policy answers so as to irregular migrant workers seems to get more access to health care in EU then other categories of irregular migrants. In Sweden, the most prominent pathway into irregularity goes through the asylum system. Consequently might the fact that irregular migrants are first and foremost perceived as ‘rejected asylum seekers’ contribute to an understanding of the prevailing exclusion from health care. In this context it is noteworthy that the emergence of social policy is historically related to processes of nation-building<sup>[48]</sup> and that the development of citizens’ rights came to depend on the maintenance of workers’ rights<sup>[14]</sup>. This did not only involve a collective attachment to a particular state but also a dependence on that state’s capacity to pursue social policies. Such policies depend historically on control of flows, including migration<sup>[14]</sup>.

#### 3.1 The meaning of ‘the social’

Our interest of social policy assume the distinction and the relationship between ‘state’ and ‘society’, which leave room for an interest of different responses to problems of social integration<sup>[48]</sup>. However, the meaning of ‘the social’ in terms of whose needs and risks are addressed in social policy has not been clarified. It has been argued that the notion differs among countries along with the historical ‘state tradition’ and how the ‘social question’ is put as well as structures of services. As these elements are institutional they involve values and normative patterns as well<sup>[48]</sup>. Turning to Sweden, the ‘state tradition’ enacts a hardly relevant tension between ‘state’ and ‘society’ as a modern interventionalist state developed which never got detached from ‘society’. As regard the definition of ‘social question’ it has been ‘inequality’ (as opposed to for example ‘poverty’ in England and ‘family’ in France)<sup>[48]</sup>. Hence, social policy in Sweden gave rise to universal services for the well-being of the members of the nation state<sup>[48]</sup>. It could thus be argued that the restrictive relationship to irregular migrants in Sweden when it comes to granting rights to access health care could have to do with a path dependency reflected in institutional structures and the distribution of responsibility. Furthermore, it appears as if there is

a lack of concepts to use to frame irregular migrants rights as long as the discourse is situated within a ‘territorially bounded state-centric model’ and concern rejected asylum seekers rather than workers. Irregular migrants are not included when it comes to define the meaning of ‘the social’.

The discussion on health care for irregular migrants have made the ‘territorially bounded state-centric model’ transparent and highlighted its fragility. It becomes salient that policy answers towards irregular migrants concern the role of the international human rights law within the field of social policy of today. We get a glimpse of the tension between the commitments of liberal democracies to universal human rights on the one hand and sovereign self-determination claims of the other<sup>[49]</sup>.

The rights of irregular migrants do also raise questions on the meaning of ‘the social’ in a globalized world. One interpretation could be that an internationalization of the welfare state now flows from an open concept of ‘the social’ going beyond the scope of the nation state and the needs of its authorized members. International organizations and legal conventions establish genuinely global issues and procedures that cut across nation states constituting a new global level of social policy<sup>[48]</sup>. The meaning of ‘the social’ is an issue in this process and it is yet to be seen whether new aspects will develop<sup>[48]</sup>.

### 3.2 The ‘triple mandate’

A further interpretation could be that from the perspective of welfare professionals is ‘the triple mandate’ involving an independent standpoint in relation to state and society based on scientific knowledge as well as a human rights enacted in their critic<sup>[50]</sup>. This interpretation involves also that professionals in networking with other advocates seems to have recognized and taken advantage of the international human rights regime as a supranational structure to legitimize their critical stance. It is yet to be seen to what extent the female dominated health and welfare professions’ critical standpoint implying a dis-legitimization of the national policy will contribute to national policy changes. The new governmental agreement on health care which relates to the state-centric model and downplay the relevance of international law suggests that migration policy still has primacy over health policy. Nonetheless, by claiming that their jurisdiction within health and welfare services is independent from the state’s interest of control of migration health and welfare professionals have highlighted the prevailing policy hierarchy which is made obvious by the mere presence and needs of irregular migrants.

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