



UNIVERSITY OF GOTHENBURG  
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# Healthcare based on need, not judicial status

- A qualitative study of professionals' view on EU-migrants' right to healthcare in Sweden

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## Abstract

**Title:** Healthcare based on need, not judicial status – A qualitative study of professionals' view on EU-migrants' right to healthcare in Sweden

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**Key words:** EU-migrant, free movement, healthcare, right to health.

The aim of this research was to investigate right to healthcare for deprived EU-migrants in Sweden. This was done by gathering the views of professionals working with EU-migrants. The objectives were to explore their view of the obstacles EU-migrants met when accessing healthcare in Sweden and explore which actions the participants perceived were necessary to undertake. Seven professionals were interviewed using qualitative semi-structured method. The participants performed work in Sweden's two largest cities; Stockholm and Gothenburg. A thematic analysis was applied to the interviews to determine coherent categories and themes. Two theoretical approaches were used in the analysis. Those were social justice and social citizenship.

Findings from the research showed that access to healthcare for EU-migrants differed between the cities, where access was better in Gothenburg than in Stockholm. It was also found that the right to healthcare for EU-migrants is not subscribed in any legal entitlements in Sweden, consequently EU-migrants are excluded from subsidized healthcare due to their legal status. Obstacles for access to healthcare were identified to be financial, legal, gatekeepers and administrative barriers. The participants indicated that the non-access to healthcare had negative implications on EU-migrants' life. Participants highlighted that under international law EU-migrants should have the right to healthcare. It was also found that children to EU-migrants did not have access to healthcare in Sweden. The participants emphasized that legal entitlements would be a great improvement for the health of EU-migrants. They also stressed that the EU should take more responsibility for the situation and that Sweden does not follow international law human rights standards. The participants saw the improvements as necessities to follow international law, promote equality and help those who are most in need. The result also suggested that healthcare should be based on need and not judicial status.

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## **Abbreviations**

CFR- European Union Charter of Fundamental Rights

EEA- European Economic Area

EHIC- European Health Insurance Card

EU- The European Union

EU-migrants- people migrating within the European Union, in this study it especially refers to poor/deprived people.

IFSW- International Federation of Social Work

IOM- International Organization for Migration

NGO- Non Governmental Organization

OECD- Organization for Economic Co-operations and Development

UN- United Nations

WHO- World Health Organization

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## 1. Introduction

“There was this man, he had cancer in his throat. First he received help from the health centre for homeless people, they remitted him to the hospital where they found cancer and stated that he was in need of an immediate operation. But they did not do it, what they did do though was to translate his medical records to English so he could bring them home and give to the doctors. The problem was, he would not receive the care in his home country, Romania, he was too poor to pay all the corrupted fees, I mean he lived in a dump. I do not think he is alive today, he is dead, that is my feeling. It makes me angry though, couldn't they just have operated on him, what could the expenses be? 40 000, 50 000? Whatever, that is nothing! [...] It is troublesome for me when I know that people are actually dying because we do not do anything” (Participant 1).

The situation above was told by one of the participants in this research and illustrates the problems and consequences EU-migrants have in relation to access to healthcare in Sweden. It is also an illustration of that the problem is based on violations of human rights where the right to life is deprived an individual due to his or her judicial status, citizenship or nationality.

In the last few years, the situation for EU-migrants in Sweden have been widely exposed and highlighted in the media. Their plight has gained interest in the voluntary sector and in the public debate. Organizations and human rights activists have shed a light on the very hard situation that many face, both in their home country and in Sweden. This chapter intends to introduce the main concepts of this study and provide the reader with a background to migration within the European Union (EU) and its relation to health from a human rights perspective.

### 1.1. Background and problem area

The economic crisis in Europe has had an impact on the migration pattern and as a result the number of economic migrants has increased. More people migrate in order to find employment in countries with a more stable economy. The Organization for Economic Co-operations and Development (OECD) estimated in June 2013, that the migration in the European Union increased after years of declining numbers (International Federation of the Red Cross, 2013). In the Swedish context, the City Mission is the main Non Governmental Organization (NGO) who have highlighted and worked with the increased number of EU-migrants both in Gothenburg and in Stockholm. They report that the number of people coming to Sweden has increased and that the majority come to find a job. Many of the migrants are low educated and language knowledge is restricted to one language and, in some cases, a little bit of English. These are factors that affect their chances to find a job negatively. Due to this, many people end up in homelessness or social deprivation, begging in the street or working as street musicians (Göteborgs Kyrkliga Stadsmission, 2013; Stockholms Stadsmission, 2012). The economic crisis motivates people to migrate and look for happiness in another country and even though they might end up in poverty, the chances of earning ones living are alluring.

Sweden has been a member of the EU since 1995 and accordingly comes under the principle of free movement. The regulations of free movement give all EU citizens the right to move

and reside freely within the territory of the member states (European Union, 2009). As the regulations of free movement states that the person migrating has to be able to earn a living for himself and his/her family there may be reasons for EU-migrants to avoid contact with authorities if one does not fulfil the requirements. This may be one of the reasons to why EU-migrants often approach the non-profit sector when looking for help (Socialstyrelsen, [The National Board for Health and Welfare] 2013). In both Gothenburg and Stockholm there are organizations targeting the group, in media often referred to as EU-migrants. The concept of EU-migrants will in the following chapter *Terminology* be discussed and explained in relation to this study.

Many studies have showed the connection between health and migration (Cuadra 2009; IOM 2010). The International Organization for Migration concludes that migrants often suffer from poor health status, both physically and mentally (IOM, 2010). Anyhow, most studies do not focus on voluntary, legal migration but asylum seekers, refugees or undocumented migrants. Migration itself, under normal circumstances, is not a risk for health but the conditions surrounding the migration process and particularly the inequalities in access to health services, have a direct and indirect effect of a person's health status. Migrants as a group are often at risk of not receiving the same level of direct healthcare or preventive services that the general population receive, both in the sending and in the receiving country (IOM, 2010).

Social work engages people in social change and liberation with the aim to promote people's welfare, it concerns with people's rights and has grown from humanitarian ideas with values based on respect for the equality, worth and dignity of all people. The International Federation of Social Work (IFSW) states that:

"The social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work." (in Hare, 2009 p. 409)

According to IFSW, social work addresses barriers, inequalities and injustices in society (Hare, 2009). These thoughts permeate this study. As noted before, this research connects to the field of social work as well as the field of human rights and health. The author's background in public health has created an interest for the subject of migrants' health, hence health is also an area of social work. It has connections with social problems and poverty as well as migration. In the Social Report from 2010 focus lies particularly on health in relation to migration and migrants.

## 1.2. Terminology

### EU-migrant

The terminology around this study has proved to be complex. Especially the main term defining the target group needs to be well described and explained. It has been carefully thought through both in the writing process as well as in the data collection.

The term EU-migrant is used in the media to describe people who are financially deprived and who come from east European countries, are Roma or third country citizens (e.g. Attefall, 2014; Magnusson, 2014). Differences in meaning between the term "migrant" and the term

“citizen” are discussed in this chapter to create an understanding for the complex terminology of this research.

### *Migrant*

The UN defines migrant as “an individual who has resided in a foreign country for more than one year irrespective of the cause, voluntary or involuntary, and that means, regular or undocumented, used to migrate” (Goldin, Cameron & Balarajan, 2011, p. 16). Under such a definition, the people who this study aims to focus on would not all be seen as migrants since many stay for shorter periods of time than one year. Anyhow according to the IOM (2010) the term migrant commonly also includes people who stay in another country than their country of residence, for example seasonal workers.

Another factor of importance to understand the concept migrant is their judicial status. Migrants can either be referred to as *documented*, meaning a person who entered a country lawfully and remains there under this criterion. Migrants can also be *undocumented*, which refers to someone who enters a country illegal or remains in a country even though the visa has expired. The latter term *undocumented migrant* can also be called irregular migrant/immigrant, illegal migrant or clandestine migrant (Boswell & Geddes, 2011). The term undocumented migrant is of importance for this research since it occurs in previous research as well as in laws and regulations in relation to health and healthcare in Sweden.

### *Citizenship and nationality*

Being a citizen of a country gives one a lot of power and rights. Citizenship goes hand in hand with nationality, which signifies the legal relationship between an individual and a state. Nationality is the legal basis for the exercise of citizenship and being a citizen entitles a person to protection of their state. In the globalizing world where migration is a part of the globalisation process, nationality and citizenship are important for immigration policy (European Commission, 2013). A citizenship is a part of belonging to something but it also denotes a status that entitles one to participate in the political process or exercise civil, social and political rights. People who lack the nationality or citizenship of the state they reside in are regarded as aliens. Being an alien but residing in a state may incur a range of legal consequences that have practical and personal disadvantages such as limited access to social services and benefit, access to healthcare, right to work or right to education. Each state is entitled to decide its own rules governing the grant of nationality. The construction of a population goes through their nationality laws and is often based on place of birth, ancestral claim or by laws regulating citizenship in accordance with migration. To be a citizen entitles you to certain rights. National laws that differ from countries to countries regulate who is or can become a citizen (Delanty, 2002).

### *Citizenship and migration within the EU*

The point of constructing a European Union is stated to be economical and political partnership over borders (Boswell & Geddes, 2011). But is there any such thing as European citizenship? Well, any person who holds the nationality of a European country is by definition also a EU citizen. Yet, the state is sovereign to decide who holds a nationality or a national citizenship. Being a EU citizen does, just as being a national citizen, entitle you to certain rights, for example the right to move and reside freely within the EU and the right to vote for the European parliament (European Commission, 2013). The European Commission monitors EU citizenship rights and in their report from 2010 they state that 48% of the European citizens do not consider themselves as well informed about their rights as EU-citizens, which for this research means that many EU-migrants might not be aware of the conditions of free



movement or of their rights in Sweden (European Commission, 2010). People who are not permanent citizens of a EU-country are described as third country nationals, this refers to people who are nationals of a country outside the EU but have a temporary permit visa in a country within the EU; for example a Nigerian who holds a work permit in Spain (Socialstyrelsen, 2013). Whenever anyone of those people are moving across one border to another they become a migrant, when they move within the EU over borders they become a EU-migrant. To become a EU-migrant, you do in other words need to hold a citizenship, permanent or temporary, in one of the 28 EU member states or in the European Economic Area (EU plus Iceland, Norway and Lichtenstein) and move from one country to another.

Something problematic with the term EU-migrant is that it can describe anyone who has come to Sweden under the free movement agreement, therefore the word deprived, vulnerable or poor gives extra strength to the concept. It notes that the term *EU-migrants* in this research do not refer to someone who for example works in the financial sector in Germany as a general director and who moves to Sweden to be the director of a large Swedish company. These people are of course also EU-migrants, but they are neither poor, deprived nor vulnerable. The majority of EU-migrants referred to in this research are here legally. From their legal status they differ from another large group that often is mentioned in the discourse of health and migration: undocumented migrants. EU-migrants are here under the agreements of free movements and they have the right to reside in Sweden, which is important to have in mind during this research (Socialstyrelsen, 2013).

In conclusion, this research uses the term EU-migrants, which will include two categories of people:

- **EU-citizens** people who hold a citizenship from a country within the EU or EEA. The people referred to in this study are poor and vulnerable people. Many do not have a social security or health insurance (EHIC) in their home country and are unemployed.
- **Third country citizens**, this refers to people who have a temporary residence permit in another European country than Sweden. For example; a person from Nigeria who holds a work permit in Spain but has, due to the economic crisis in Spain, come to Sweden to look for work.

In research and in the discourse about poor EU-migrants in Sweden the term EU-migrant refers to the categories declared above, therefore this research will use the same word and definition as people who work in this area refers to (e.g. Stockholms Stadsmission 2012; Göteborgs Kyrkliga Stadsmission, 2013; Socialstyrelsen, 2013).

One should also keep in mind that the majority of the EU-migrants coming to Sweden do not have a problem with access to healthcare. Everyone who has a health insurance in their home country can hold the European Health Insurance Card (EHIC) and then have the right to the same healthcare as a Swedish person do, but the country of residence pays the bill. Therefore it is important to keep in mind that most EU-migrants, for example those who have a job or have worked in their country of residence, can visit Swedish healthcare centres without any problems and receive subsidized care.

### Health and healthcare

The concept of healthcare includes diagnosis and treatment of disease, injury, illness and other physical or mental impairments a human being can suffer from, it includes the prevention of these as well (Backman, 2012). According to the World Health Organization “health is a state of complete physical, mental and social well-being and not merely the

absence of disease or infirmity” (World Health Organization, 1948). These views on healthcare and health permeate this research.

### 1.3. Objectives

This thesis aims to gestalt views and perceptions that exist among professionals who work with EU-migrants. This in order to explore access to health and healthcare for deprived EU-citizens and third country citizens (from now on referred to as EU-migrants). The purpose of the research is to identify possible obstacles to access to healthcare in the Swedish society for EU-migrants as well as to explore which actions the participants perceive would improve the situation for this group.

To focus on professionals’ perceptions of the situation make sense by likening the situation of EU-migrants access to health with the previous situation for undocumented migrants and their access to healthcare in Sweden. The group undocumented migrants did not have any right to healthcare in Sweden before July 2013. Thus, the situation was changed due to advocacy work from professionals who highlighted the situation and created a public debate that eventually led to legal entitlements to healthcare for undocumented migrants. This is a motive for this research, to explore the perceptions of professionals working with EU-migrants might be the best way to advocate for a change.

#### Research questions

- How do professionals who work with EU-migrants perceive EU-migrants right to healthcare in Sweden?
- Which possible obstacles for access to healthcare for EU-migrants can be identified?
- What kind of actions or improvements are according to the professionals needed to be undertaken in order to improve access to healthcare for EU-migrants?

### 1.4. Structure

In the first part of this paper the reader will be given an introduction to EU-migration in Sweden and the relation to health and social work in order to understand the scope of the research. In chapter 2 the concept migration will be outlined and its relation to migration within the EU. Chapter 3 will give an overview of the policies and legal entitlements that are of importance for this research. It will give a presentation of international law, European policies and Swedish health care regulations. In chapter 4 previous research is presented within the field of migration, health and human rights. Following this, recent articles from NGO’s and national newspapers that have reported on the situation of EU-migrants in Sweden will be reviewed, this due to that the research topic is very up to date. The theoretical framework for the analysis includes social citizenship and social justice and these are explained further in chapter 5, those theories have been used in the analysis to create an understanding of the findings. Thereafter chapter 6 presents the methodology of the study and the theoretical and practical tools for the analysis along with information about how the literature search was conducted. Subsequently chapter 7 will consist of a presentation of the results of the data together with an analysis before final conclusions are drawn in chapter 8. The bibliography is to be found in chapter 9 followed by the appendixes that consist of the informed consent and the interview guide used during the qualitative semi-structured interviews.

## 2. Migration

People have always migrated throughout history. Movement of people have spread ideas, brought globalization, and relieved poverty. In the world today the number of people who migrate have increased and will continue increasing in the future along with motivation to migrate. Migration can for many people be a promise of opportunity, a chance to a better life or a chance to employment. One trigger for migration is the economic trigger. People move in order to improve their welfare and livelihoods (Boswell & Geddes, 2011). The migration within the EU is a visa free migration, all EU nationals have the right to free movement between countries within the EU. It is estimated that two-thirds of all migrants in the EU come from other EU-countries (Rechel, 2011).

### 2.1. What triggers the movement?

The push and pull factors associated with migration are outcomes from the local or national context in both the sending country as well as the destination country. In migration research, one often talks about three factors that influence the migration process: individual, societal and national influences (Goldin, Cameron & Balarajan, 2011), these factors will be presented and applied to the EU-migrants' situation, this has been done with caution since EU-migrants are not a homogenous group.

#### Individual

The individual factors that influence a migration decision for EU-migrants is first of all that it is a choice they made. Unlike asylum seekers or refugees, EU-migrants have chosen to migrate, they have not been forced to escape due to war or persecution. The personal decision have to do with mainly economy. The majority who come to Sweden, comes here to find a job and to make a living. Their level of education and financial resources are low (Socialstyrelsen, 2013). On the individual level the migration can be a household decision, which may be a reason why statistics show more men than women. Much migration is based on a will to move closer to ones family, but the migration of EU-migrants often involve leaving your family or children behind. To migrate for economic reasons is a way of investing your human capital (Goldin, Cameron & Balarajan, 2011). Most people want a higher wage. For example, a hairdresser can earn around 1100 SEK a month in Romania, in Sweden the salary would most probably overcome 15 000 SEK (Göteborgs Kyrkliga Stadsmission, 2013).

#### Societal

Another thing that can trigger a movement is the individual's social network. Contacts serve to spread knowledge and information about the destination country and triggers the movement. This is for example why we can see that people from a certain village or city often migrate to the same destination country or city. The word is spread and the migration process can become easier if you already know someone who is there (Goldin, Cameron & Balarajan, 2011). Networks can also serve as a great resource in the job seeking, an example of that is the increase of polish construction workers in Sweden the latest decade. For the EU-migrants, the social network is the main key for housing. People live together in small apartments and sleep in shifts (Stockholms Stadsmission, 2012).

#### National influences

The demographic, economic and political structure in both the sending country and the receiving country is of importance to trigger the movement. In general people tend to move from areas of economic contraction toward areas of growth, as is the situation of migration in this study (Goldin, Cameron & Balarajan, 2011). As noted earlier, many of the EU-migrants are poor or financially deprived, the economic crisis in Europe have forced people to look else where for a job. Before the crisis, people could find unqualified work in the agriculture sector,

but after the crisis, this opportunity is gone (Göteborgs Kyrkliga Stadsmission, 2013). The economic crisis has not affected the member states of EU evenly but is unevenly distributed across social class and ethnicity. For people that already are vulnerable due to poverty, ethnicity, age or migrant status, the situation has worsened and the crisis has stroke them harder than others (International Federation of the Red Cross, 2009).

Another national influence of migration is the national discrimination that many people face in their home country. Especially Roma people have in history, and do still today, face discrimination and marginalization. Institutionalized racism makes it harder to find a job in the home country and to migrate becomes an opportunity for something new. Discrimination and social exclusion can be seen as a consequence of the enlargement of the EU according to Lyder Andersen (2010). She argues that the enlargement of the EU has broadened the gap between poor and rich and that social exclusion and poverty goes hand in hand and triggers one another. The economic crisis in Europe may have affected Roma people more than others, the marginalized have been utterly marginalized. Lyder Andersens (2010) research about social exclusion from a EU-perspective is interesting to note whilst understanding why Roma is representing a part of the group EU-migrants.

## **2.2. Numbers and facts**

Since 1990 the migration to Sweden has increased, the migration today reflects a number of motives for migration. Refugee and asylum migration as well as family reunification still represent the bulk of migration but the pattern begins to change. In 2007 almost half of the migrants in Sweden were moving under the free movement regulation or came from countries outside EU to work or study (Socialrapport, 2010, p. 26). Since the free-movement regulations were adopted in 2004 the number of people who have migrated to Sweden has increased steadily. In Europe in general it is common that people move from their home country for a short period to earn money and then move back. People coming to Sweden have mainly come here for job opportunities and most people have succeeded in their job seeking (Boswell & Geddes, 2011).

The migration that this study focuses on has mainly taken part after 2007 when Sweden opened up the borders for the two new EU-membership countries; Romania and Bulgaria, and when the economic crisis took place and affected countries such as Spain, Italy and Greece. The economic crisis in Europe, and especially in Spain, has had its effects on the migration population, they have been the first to loose their jobs in hard times (International Federation of the Red Cross, 2013). When some European countries have a high level of unemployment and bad economy more people migrate to countries with a more stable employment market such as Sweden (Socialstyrelsen, 2013). After the enlargement of the EU in 2004 and 2007 there has been an increase in migration from East-European countries to west European countries, but not at all as large increase as researchers and citizens were frightened of according to Christensen (2010).

The City Mission in Gothenburg declares in their report about poor EU-citizens in Gothenburg, that the number of EU-migrants has increased in Sweden. The same situation is seen in Stockholm (Göteborgs Kyrkliga Stadsmission, 2013; Stockholms Stadsmission, 2012). To show number of how many that have come to Sweden is nearly impossible, since people who are here within the free movements regulations are not obliged to register their arrival or departure. Anyhow during the first six months of 2013, Crossroads, (a project by the City Mission to help EU-migrants) in Stockholm, had 843 unique visitors and a total number of 19 650 visits (Crossroads, Stockholm, 2013, internal material). The statistics from

Crossroads Gothenburg shows that they have met 450 individuals from their opening in November 2012 until April 2013, they also indicate that since the start of their project in November 2012, the number of migrants have increased steadily (Göteborgs Kyrkliga Stadsmission, 2013).

The group this research focuses on is in no way heterogeneous. People come from different places and have different life stories, but one thing they have in common is that they are poor and vulnerable. Many of them are also homeless. In May 2013, the National board for Health and Welfare in Sweden released a report on homelessness among people without a permanent residence in Sweden, mapping the number of people in homelessness in Sweden (Socialstyrelsen, 2013 [National board of Health and Welfare]). The report showed that there are 370 homeless people in Sweden who are born abroad. Most of these people are found in big city regions; Stockholm, Gothenburg and Malmö. The report also shows that 80% of the EU-migrants are men with an average age of 38 years. However oral sources indicate that a change have been noted during 2013. The gender pattern is adjusting, indicating that around 40% of this group now are women (Crossroads Gothenburg, personal communication, February, 2014). Notably the organizations that meet EU-migrants indicate that there is a huge hidden statistic. They believe that the number that the National board of Health and Welfare have reported can be “the top of an iceberg” (Socialstyrelsen, 2013, p. 31). Parts of the group of EU-migrants are the Roma people. The Saving Mission, a Swedish NGO, accounted for this group in 2012 and came up with a number of 120 in Gothenburg, where 25% were children (Räddningsmissionen, 2012). Numbers for Stockholm have not been found but are likely to extend the number in Gothenburg (Crossroads Gothenburg, personal communication, February, 2014).

### 2.3. The future of migration

The European Union has during the latest years faced an increasing amount of migrants, it has been called fortress Europe by people who claim that the European Union has build walls around its territory. Every day people try to get to Europe, both in legal and illegal ways and many have faced death in the Mediterranean Sea. The migration flow within the EU has had a greater intensity since the economic crisis in Europe (Boswell & Geddes, 2011). In the case of EU-migration, many researchers think that this is just the beginning of a migration flow or mobility. Sweden has not had that many poor people coming, most of the EU-migrants have stayed in warmer countries, Spain, Italy and Germany in particular, but the economic crisis have changed this pattern (IFRC, 2013).

The public debate often mentions pressure on the national welfare system as the backdrop of mobility within the European Union (Boswell & Geddes, 2011). Ever since the former prime minister of Sweden, Göran Persson, said the worlds of *social tourism* in an interview in 2003 people in Sweden have been scared of thousands of people coming to Sweden to access the welfare system and receive healthcare (Reckman, 2004). Anyhow, this has in reality never been true. A newly released report from Germany shows that unemployment among migrants from Bulgaria and Romania was lower than for German citizens and that they are accessing the social system more than the general German but less than the average citizen with a foreign background (Juravle, Weber, Canetta, Fries Tersch & Kadunc, 2013).

For Sweden migration is a great resource and trends show that migration and mobility flow will be continuous. When it comes to EU-migrants in Sweden, Crossroads Gothenburg predict that more EU-migrants will come to Sweden as long as the situation in their country of residence is not improved and that Gothenburg will see the same development as

Stockholm has, which is an increase of third country nationals (Crossroads Gothenburg, personal communication, February, 2014).

### 3. Legal rights

This chapter will pay attention to regulations in Sweden as well as international law and human rights. All of these are of importance to understand the problem area of this research.

#### 3.1. International law

The Human Rights cover many parts of human life, they aim to guarantee all human beings opportunities to live a decent life and, are considered the birth right of every human being. The human rights are universal and indivisible, meaning that all rights are of equal importance. The human rights are expressed and guaranteed by law in the international instruments as well as in national legislation (Smith, 2010).

The United Nations High Commissioner for Human Rights states in relation to migrants and human rights that:

“Human rights are at the heart of migration and should be at the forefront of any discussion on migration management and policies... Although countries have a sovereign right to determine conditions of entry and stay in their territories, they also have an obligation to respect, protect and fulfill a wide range of human rights of all individuals under their jurisdiction, regardless of their nationality or origin and regardless of their immigration status” (OHCHR, 1996).

Every state is compelled to respect, protect and fulfil the rights. For this research the Right to Health is of special importance. The right to health can be traced back to the 1945 Charter of the United Nation (UN) where health was first mentioned as something that the UN should work with and promote. The World Health Organization was started as a pursuance of the objective in 1946. WHO is a specialized agency of the UN. The right to health was developed and became a part of the non-binding document *The Universal Declaration of Human Rights* article 25(1). The right is regulated in the International Convention on Economic, Social and Cultural Rights article 12 as well as in article 35 in the European charter of fundamental Human Rights (CFREU). Article 12 ICESCR states:

The right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN General Assembly, 1966).

And article 35 CFREU states:

Everyone has the right of access to preventive healthcare and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities (CFREU, 2000).

Sweden has ratified both of these conventions and subsequently Sweden is obliged to: *Respect*; through not interfering with the right to health and to not have policies that are discriminatory or that intervene with article 12 or have policies that can cause morbidity or preventable mortality.

*Protect*: Ensure equal access to all and to control the market to health goods and services by third parties.

*Fulfil:* Sweden is to give enough and sufficient recognition to the right to health through policy document and through law (UN Committee on Economic, Social and Cultural Rights, 2000).

A state fails to fulfil a Human Right when it fails to take all necessary steps to ensure the realisation of a human right. This can for example be by misallocating public resources so that some people cannot enjoy their rights (Smith, 2010). In Sweden the responsibilities do not solely lay on the state but its bodies as well, for example municipalities and the county councils.

As Human Rights never stand alone, the right to health depends upon the realization of many other rights for example the right to education, housing and food and the right to security. The general comment N.14 and N.20 of UN committee on Economic, Social and Cultural Rights provides us with an interpretation of the convention, which while not legally binding still gives an authoritative and comprehensive overview of the meaning and implication of the right to health. It states that everyone who stays in a territory is entitled to the right of the highest attainable standards of care despite the judicial status of the person (UN Committee on Economic, Social and Cultural Rights, 2000). The UN committee adopts four criteria for healthcare called the *AAAQ criteria*, they stand for *Availability, Accessibility, Acceptability* and *Quality* of healthcare services. The principle *Accessibility* contains four dimensions which are of importance for this research: *non-discrimination, physical accessibility, economic accessibility* and *information accessibility* (Forman & Bomze, 2012). Economy creates a problem in relation to accessibility. Charging a patient the full amount for a simple thing like blood pressure can have a negative effect on the current health status as well as it might cause further complications for the patient in the future if he or she waits until the situation is of emergency (Forman & Bomze, 2012).

Sweden has ratified these conventions but been criticized by Paul Hunt, the former UN Special Rapporteur on the Rights to Health for violating the Human Rights by discriminating and failing to provide undocumented migrants with access to healthcare on an equal basis as Swedish citizens. His critic was mainly directed toward healthcare for undocumented migrants in Sweden (Wright & Ascher, 2012).

Hammonds & Ooms (2012) discusses why wealthy countries should care about the health of the world's poorest. This is an interesting question that they argue for by stating that the human rights are universal and therefore the right to health entails both national and international obligations. The right to health is meant to be enjoyed by all and is especially important for vulnerable individuals and groups. "Migrants are precisely the sort of disadvantaged groups that the International Human Rights law is designed to protect" (Wrights & Ascher, 2012, p. 305).

### **3.2. The European laws**

The laws and regulations in the EU are what mainly control the movement of people. These regulations will hereafter be presented though they are of importance to understand that people reside in Sweden legally.

#### **Free movement**

The regulations of free movement were adapted as a part of the economic collaboration between the member countries and give EU-citizens and their family members the right to move and reside freely within the territory of the member states (Socialstyrelsen, 2013). In summary, the directive gives the right to all EU citizens who can present a valid identity card

or passport, to enter another EU member state freely, that person's family members share the right (Boswell & Geddes, 2011). The directive is implemented in Swedish law through the Aliens Act (SFS 2005:716), which states that EU-citizens and their families reside in Sweden with a right of residence provided that they meet any of the following criteria according to the Aliens Act 2005:716 chapter 3: *A Right of residence for EEA nationals and others*, § 1-9:

An EEA national has a right of residence if he or she:

- is a worker or a self-employed person in Sweden,
- has come to Sweden to seek work and has a real possibility of obtaining employment,
- is enrolled as a student at a recognised educational institution in Sweden and, according to an affirmation to this effect, has adequate assets to support himself or herself and family members and has comprehensive health insurance for himself or herself and family members that is valid in Sweden or
- has adequate assets to support him or herself and family members and has comprehensive health insurance for him or herself and family members that are valid in Sweden (SFS 2005:716).

The above mentioned rules, gives one the right to reside in Sweden for more than six months. Anyhow some of the people that this study indirectly focus on, only stay in Sweden for short periods of time, often less than three months. People who are not planning on staying in Sweden more than three months do not have to register, which is why the statistic of EU-migrants in Sweden can be skew (Migration board, 2014). The social assistance for EU-migrants is limited to emergency help. That usually means the Swedish social services pay for a ticket to the person's home country (Socialstyrelsen, 2013). In summary EU-migrants are somewhere in between, on one hand they do not have a permanent residence permit, on the other hand they are here legally under the regulations of free movement. In general EU-migrants can be deported due to two reasons: they have engaged in criminal activity or they are a burden for the welfare system in Sweden. The latter one also has its effect that people do not want to receive help from the social services in Sweden out of fear for being a burden and sent home as a consequence.

### Healthcare in the European Union

The regulations of EU are applicable in all member states of the EEA area. To be able to access healthcare in another country you need to hold the European Health Insurance Card (EHIC). People receive this card from their home country as a proof that they are covered by the national health insurance. For a EU-migrant to be entitled to subsidized healthcare in Sweden, he or she needs to show the EHIC. Everyone in Sweden has the right to the EHIC, it is not tied to one's insurance company or to one's status in the labour market. Swedish citizens receive their EHIC from the Swedish Social Insurance Agency. EU-migrants who hold the EHIC have the right to care that is required. This to a subsidized price or paid for by their country of residence. People are only granted necessary care, not care that can wait, the health professionals are the one who makes this assessment (Försäkringskassan [Swedish Social Insurance Agency], 2014).

Member states have sovereignty on how to form their health insurance system. Many EU-migrants therefore lack the EHIC and are thus not entitled to subsidized healthcare. For example in Romania, the health insurance is based on employment or on monthly payment (Socialstyrelsen, 2013), this means that people who stand outside the system are left without a general health insurance and they end up in the same situation as undocumented migrants in Sweden but stand without the right to healthcare that undocumented migrants have under



Swedish law. The same situation has recently occurred in Spain, which has undergone cutbacks in their welfare system due to the economic crisis. These cutbacks have mainly affected poor people, many of them third country nationals (Navarro, 2012). All people have the right to necessary and emergency care in Sweden, but will have to pay for the care they receive. A normal visit at a healthcare centre costs 1500 Swedish crowns, an emergency visit is estimated to cost 2000 SEK and delivering a baby about 21 000 SEK (Migrationsinfo, 2014b). This leads to that many people do not seek healthcare when in need due to financial incapability, in the long run this can be seen as life threatening (Socialstyrelsen, 2013).

### **3.3. The Swedish healthcare system**

Healthcare in Sweden is a welfare institution and the responsibility is divided between state, county council and municipalities. Healthcare is regulated in the Health and Medical Services Act and was adopted as Swedish law in 1982. It focuses on actions to medically prevent, investigate and treat sickness and injuries. The goal for Swedish healthcare is good health and care on equal terms for the entire population. The act emphasizes that healthcare shall be given with respect of all human beings equality and the individual humans dignity (Johnson & Sahlin, 2010). The National board for Health and Welfare writes in a publication from 2011 “There is a constant development going on in the area of healthcare but still, health and healthcare is not accessible for all, neither is it equal” (Authors translation, Socialstyrelsen, 2011, p.10).

#### **Undocumented migrants right to healthcare**

Due to pressure from activist groups, healthcare professionals and politicians, Sweden today has a law that gives undocumented migrants the right to healthcare. It was adopted 1<sup>st</sup> of June 2013 and is regulated in the Health and Medical Services Act. The act imposes an obligation on county councils to provide healthcare to asylum seekers, undocumented migrants and persons held in custody waiting for deportation (SFS, 2013:407).

According to the act §7, these people shall be offered:

1. Care that can not be deferred,
2. Antenatal care
3. Care at abortion and
4. Contraceptive counselling

(Authors translation, SFS 2013:407)

Noteworthy, §5 of the Act states that the act applies to foreigners who reside in Sweden without the support of public authority decision or statue. The law does not cover aliens whose stay in Sweden is intended to be temporary (Authors translation, SFS 2013:204 §5).

## **4. Previous research**

Previous research conducted within the field of the target group EU-migrants have mainly explored two fields; elderly who move to warmer countries during pension and EU-migrant workers. The literature search showed a gap in research concerning especially EU-migrants and health, which is a motive for this study. This chapter intends to give an overview of existing research. It is structured according to common themes of the included research and ends with an overview of recent newspaper articles on the subject EU-migrants and healthcare.

#### 4.1. Migration within the EU

Since the enlargement of the EU in 2004 and 2007, the migration flows have increased and many people migrate to find a job. The migration-flow from the east to the west of Europe has been investigated by Olofsson (2011) among others (e.g. Barrell, Fitzgerald & Riley, 2010). Olofsson (2011) shows in her study of migration from the east to Sweden that the migration has increased after 2004 but that the 'mass migration' that was expected by the EU15 countries never took place, especially not in Sweden where the migration have been modest due to both political structure and social structures (for example social networks and job-opportunities). Olofsson (2011) argues that economic motives have become the most common trigger for migration today, in the 90's most people migrated due to social or political motives. This is in line with other studies, which indicate that not only getting a job is the trigger but that the most important is that the job is better paid (e.g. Blanchflower, Saleheen & Shadforth, 2007; Barrell, Fitzgerald & Riley, 2010).

#### 4.2. Migration, inequalities and health

When it comes to the health status, inequalities and implications on health for migrants, this area has been well explored both in Europe and in Sweden. In this paragraph research is presented and structured in accordance to this.

##### European Union

What most articles have in common (see e.g. Mladovsky, 2009; Mackenbach et al., 2013; Rechel et al., 2013) though is that migrants as a group experience inequalities in health and access to healthcare. The International Organization for Migration (IOM) states in their report: *Migration Health: better health for all in Europe* (2010) that particularly the inequality in access to healthcare services for migrants can increase vulnerability for ill health, indicating that their in-access can have an effect on their overall well-being, especially long term. The report also stresses that to create a Europe of social justice it is essential to narrow the health gap and make good health a reality for everyone in Europe (IOM, 2010). The IOM and WHO argue that the health gap in Europe is an effect of inequality in health that mainly depend upon the social determinants for health. They stress that the socioeconomically disadvantaged groups (including migrants and Roma) are the ones that need to be targeted in health interventions and policy changes (IOM, 2010; Commission on Social Determinants of Health, 2011).

Already with the EU enlargement in 2004, research indicated that it would be necessary to form new policies to be able to bridge the health gap and reduce health inequalities within the EU. The enlargement in 2004 would bring together a diverse group of countries with variations in health status and who lack financial resources to provide high quality healthcare and found equity in access to care (Avgerinos, Koupidis & Filippou, 2004). While looking into equality of health in the European union, economy and financial costs for healthcare are of importance (Commission on Social Determinants of Health, 2011). A study by Mackenbach, Meerding & Kunst (2011) has measured the economic costs of health inequalities in the EU in order to support the case for inter-sectorial policies to be able to address inequalities in health. The authors demonstrate that there is not only a humanitarian angle to reducing inequalities in health in the EU but that there is also a huge economic reason to do so by calculating the costs of inequalities in health. The study shows that the economic costs of the socioeconomic inequalities in health in Europe are extensive and the authors suggest that health inequalities shall be tackled by investing in policies and in preventive healthcare for all (Mackenbach, Meerding & Kunst, 2011).

## Sweden

The Swedish public health report from 2009 shows a similar phenomenon (Socialstyrelsen, 2009). It states that the bad health among migrants can be traced to the social determinants of health. For example many migrants find themselves in a very socially vulnerable position and this has great effect on their well-being. Poverty, homelessness and unemployment are factors that especially affect the health of migrants (Socialstyrelsen, 2009). The same view is found in the report on homelessness conducted by the National board of Health and Welfare in Sweden focusing especially EU-migrants in Sweden. It also finds that people who were in good health at arrival found their living conditions in Sweden extremely hard and that their health becomes worse after the migration (Socialstyrelsen, 2013). Hopelessness and feeling excluded can lead to drug abuse or mental illness. A qualitative study conducted in Sweden among migrants shows that disparities in health among the migrant population and the non-migrant population can be an effect of service user's perception of inequalities in care quality and discrimination. The study reflects that structural conditions in access to healthcare as well as the client's perceptions of feeling discriminated are the reason for a non-seeking behaviour rather than their socio-economic status (Akhavan & Karlsen, 2013).

## The healthy migrant effect

A considerable amount of literature in the field of migration and health, discusses the concept "*Healthy migrants effect*". It is a concept that describes migrants as a more healthy group than the non-migrant population, this as an effect of that mainly young and healthy people are able to migrate due to that the act of migration usually requires one to be in good health both physical and mental. This does somewhat change after the migration process as the migrant tends to have worse health than the general population in the receiving country after a short period of time (Rechel, Mladovsky, Ingleby, Mackenbach, Karanikolos & McKee, 2013). The healthy migrant effect has also proven to be evident in Scotland. A study showed that in spite of the increased migration from east European countries, it has not caused an excessive workload on the National Health System (NHS) in UK, referring to the healthy migrants effect as the cause. The study does interestingly also note though that the health-seeking behaviour among EU-migrants, even though they hold the EHIC is very low. The study found that 90% of the migrant workers had never consulted medical facilities and that among polish migrants, it is very common to return home when in need for healthcare. The reason for this was found to be due to lack of knowledge about rights and concerns about provision. Those findings reject the concept of health tourism (Catto, Gorman, & Higgins, 2010).

## 4.3. Undocumented migrants and healthcare

Rechel et al. (2013) state that undocumented migrants face the greatest problems in accessing healthcare and it is an effect of that they in many countries have to pay the full cost of their medical treatment. It is also an outcome of poor legislation. Rechel et al. (2003) problematize that the obstacles for undocumented migrants to access healthcare in Europe still are extensive and that much need to be done to implement human rights in practice, meaning that access to health services is a basic human right and claiming the right for everyone to access preventive healthcare and to benefit from medical treatment under the European Charter of Fundamental Human Rights.

These views are also evident in a report from the European Unions Agency for Fundamental Rights (FRA, 2011), which has identified five main obstacles for undocumented migrants access to healthcare;

1. *Cost and reimbursements*: The costs for healthcare services can be a major obstacle to access, healthcare is very expensive, prenatal care for example can cost several hundred

euros, a sum difficult for many people to afford. It can also be costly for the hospital to deliver care due to lack of reimbursement policies from the state.

2. *Unawareness of entitlements*: Knowledge about rights to healthcare both of the migrants themselves but also from the health providers serves a great problem according to the study. People in the healthcare clinic do not know how to handle the situation neither administratively nor practically.
3. *Reporting migrants to the police*: countries shall separate healthcare from national immigrant policies so that healthcare providers are not obliged to report an undocumented migrant. This is a huge problem since it creates a fear among migrants to seek care even in emergency need.
4. *Discretionary power of public and healthcare authorities*: Discretion concerning primary and secondary healthcare as well as emergency care was showed to be a obstacle for access. The healthcare staff as well as authorities are superior the client in power position and this may lead to differences in healthcare. For example one doctor might argue it is an emergency situation, which in some countries entitles an undocumented migrants to free healthcare while another doctor might think it is care that can be deferred.
5. *Quality and continuity of care*: the lack of legal entitlements to care leads to a problem in continuity, which affects the quality. Undocumented migrants are often treated informally and hence no medical records are kept of their health history. Cultural and linguistic barriers also affect the quality of care (FRA, 2011).

Similar obstacles were identified on national level in a report from the Swedish Red Cross on undocumented migrants access to healthcare (Stålgren, 2008). The FRA (2011) report points out that to “exclude undocumented migrants from healthcare endangers their lives and well-being, increase the cost of future emergency treatment and can also potentially pose a health risk to the wider society” (FRA, 2011, p. 7). An interesting point for this research is that the report argues that there may be other people and groups, as for example poor, deprived people and people without health insurance that also are excluded from access to healthcare in many countries (FRA, 2011, p. 3). A study that includes 27 member states shows that access and right to healthcare for undocumented migrants differs a lot between member states (Cuadra, 2012). In consistency with the study from the European Unions Agency for Fundamental Rights (FRA, 2011) it concludes, “international obligations articulated in human rights standards are not fully met in the majority of Member state” (Cuadra, 2012, p. 1). In another research similar barriers have been found within different areas of importance for the access and right to healthcare for undocumented migrants in Europe. Biswas, Toebe, Hjern, Ascher and Norredam (2012) investigate ten member states, Sweden included. The research states that the access differs between countries and that the majority of the countries’ legal entitlements are weak or non-existing. Barriers within three different fields are identified; juridical, economical and practical obstacles. These hamper the access and availability to healthcare for undocumented immigrants. The study enhances that excluding undocumented migrants from healthcare can have implications on their life and well-being and that it also increases the costs for future emergency care. Undocumented migrants in Europe face difficulties in accessing healthcare and they often live a precarious life that may have a negative effect on their health as well. The access is regulated nationally by member states and no common directive from the EU is visible (Biswas et al., 2012). Biswas et al. (2012) argue that states that do not give undocumented migrants healthcare violate the right to healthcare under international law (ICESCR art 12 & CFR art. 35). It is also highlighted that governments that fail to provide sufficient healthcare can be held accountable for this.

On a national basis the National board for Health and Welfare (Socialstyrelsen, 2009) concludes that the health among undocumented migrants is very poor. Before the change of law 1st of July 2013, the access to healthcare for this group was very restricted (FRA, 2012). A law enacted in 2008 gave all asylum seekers right to care that cannot be deferred, the new act gives undocumented migrants the same rights as asylum seekers. Problems were found in relation to healthcare on a level of lack of knowledge among professionals. The healthcare providers are unaware of the laws and people, who shall receive free healthcare have been forced to pay (Biswas et al., 2012). As a reaction to undocumented migrants limitations to healthcare in Sweden, clinics were started by NGO's giving free healthcare by volunteering staff that are health professionals. These clinics are still open today.

#### **4.4. Healthcare as a human right**

In a discussion paper on why and how health is a human right, the philosopher Amartya Sen (2008) argues that there are two reasons to why the perspective of the right to health seems to be contradictory, first there is the legal question calling action to how health can be a right since there is no binding legislation demanding just that. And secondly, Sen questions how the state of being in good health can be a right, when there is no way of ensuring that everyone has a good health (Sen, 2008) Those questions are raised in research and argued for by meaning that the right to health is a guideline and a demand to take action to promote and work towards that goal (Sen, 2008; Cuadra, 2012). Further Sen (2008) stresses that health depends on access to healthcare, which is practically something that can be included in policies and legal entitlements. The right to health though goes beyond legislation and what can be done is to work on a structural basis with factors affecting people's health such as economic and social conditions (Sen, 2008). Another angle of the right to health can be seen if looking at the right to health as an option, this means that focus lies within the personal responsibility and that the right to health depends on ones political persuasion and moral values as well as choice of life. Kinney (2000) describes the right to health as a continuum, at a minimum it could mean a right to conditions that protect health, it can also include civil and political rights and at most it could include provision of medical care for the diagnosis and treatment of disease and injury for those unable to pay.

#### **Social justice and equity**

Human rights and social justice are often used to describe moral functions or disparities in health in societies. Equity in health means equal opportunities to be healthy for all groups of people, to achieve this, resources need to be distributed in a way that can help the equalizing process and push the disadvantaged groups upwards aiming for social justice within the field of health (Braveman & Gruskin, 2003).

Equity in relation to health is by Braveman and Gruskin (2003) described as the absence of systematic disparities in health between groups with different levels of underlying social advantages or disadvantages for example wealth, power or prestige. Braveman and Gruskin (2003) argue that inequalities like this systematically put groups of people who are already socially disadvantaged (for example by ethnicity, gender or by being poor) on yet another disadvantage in relation to health. Highlighting that health is the most essential capacity to overcome other effects of social disadvantage. Equity is in that way related to human rights, social justice and fairness. They are all ethical concepts grounded in thoughts of a distributive justice binding equity to human rights. Fox and Thomson (2013) have applied Amartya Sen's capability approach to public health interventions. They argue that governments need to include social justice in their policies and promote capabilities through including such in legal entitlements. Law play a central role in health of the people by creating institutions and

interventions as a respond to health threats in society. Hence, Fox and Thomson (2013) stresses that law is far to invisible in the area of health and public health. They mean it shall be developed and extended in order to address inequalities, discrimination and achieve a healthy society. Law is fundamental to the social structure, which determines the capability of a person (Fox & Thomson, 2013).

#### **4.5. EU-migrants and healthcare; a review of media articles**

In order to understand this quite new social problem of EU-migrants and health, some recent articles from newspapers will in the following section be presented. The articles cover a range of newspapers in Sweden, both local and national, for example the newspapers; *Sydsvenskan*, *Expressen* and *Fria Tidningen* are represented.

In the summer of 2013, a new law was implemented into the Swedish Healthcare Act ensuring undocumented migrants to receive healthcare in Sweden (SFS 2013:407). But the new law does not include EU citizens or third country nationals without health insurance. Many of the poorest people are still denied care when they get ill in Sweden (Attefall, 2013). The reviewed articles show that the number of EU-migrants coming to Sweden has increased and that there seem to be a problem for them to access the Swedish healthcare system (Olsson, 2014b). The problem is that many of them stand without a health insurance from their home country. The reason for this is poverty, that people cannot pay the monthly insurance fee or that they have not been working in their home country and are therefore not included in the general health insurance system that give people right to healthcare. This leaves poor EU-migrants in a grey zone where they receive less care than for example undocumented migrants (Magnusson, 2014; Dahlén Persson, 2014). The poorest EU-migrants, in most cases Roma from Eastern Europe are denied care when they get sick in Sweden. In one article an example is given that poor Roma from Rumania, Slovakia or Czech republic often do not hold an European Health Insurance Card due to that they have not been in the labour market, and have not paid tax to enter the national health insurance system (Magnusson, 2014). However, voices have been raised that these people are not solely Roma, for example Spain have recently changed their health insurance act and now exclude people from the general health insurance if that person leaves Spain in order to find work in another country within the European Union. These third country nationals have right to residence in Spain and therefore right to move within the EU (Olsson, 2014a).

The Swedish Red Cross makes a statement that it is absurd to base the right to healthcare on a person's legal status instead of healthcare needs. They also question that different groups have different right to subsidized healthcare and mean that this affect both patients and healthcare professionals badly (Tengby, 2014). The majority of the newspaper articles included in this paragraph empathizes that the situation for EU-migrants in relation to healthcare is very difficult and complex and that people without a health insurance are forced to pay over 1000 Swedish crowns for a regular visit at a healthcare centre, money that they do not have and therefore might avoid seeking care for treatable diseases (Attefall, 2014; Magnusson, 2014; Dahlén Persson 2014; Tengby; 2014; Olsson 2014a, 2014b).

## **5. Theoretical framework**

As guideline for research a theoretical framework is used to understand and approach the research questions. The framework for this research is based on the perspective of rights in combination with social citizenship and social justice. Principles of Human Rights and social justice are fundamental to social work and essential to challenge social problems or structures

in societies (Hare, 2009). Two main theories are applied to this research; Social Citizenship and Social Justice. The latter one consists of two perspectives on social justice where one focuses on Rawl's perspective of social justice and the second one focuses on social justice in relation to health. First the concept of social citizenship will be outlined.

### 5.1. Social citizenship

Thomas H. Marshall has studied citizenship in the context of Great Britain and developed thoughts about the civil citizenship in his famous book *Citizenship and the social class* (1950). He considers the civil citizenship to be developed during the 19th century, with political and religious rights and freedom of speech. Marshall argues that the social citizenship was developed later in the 20<sup>th</sup> century including social rights (Marshall, 1950). Marshall refers to social citizenship by the relation between the individual and the welfare state, where citizens, as members of a welfare society are granted a number of social rights through the social citizenship. Those rights assure the citizen a certain standard of living but also oblige the citizens to be a full member of society through for example education, work, and military services or to pay taxes. Anyhow, Marshall's theory have been criticised especially for talking about universal rights for all (civil, political and social rights). His critics mean that there is no such thing as rights for all and argue that Marshall fails to problematize how citizenship differs between countries and parts of the world (Dahlstedt, Rundqvist & Vesterberg, 2011).

The sociologist Ruth Lister (2003) has developed Marshall's ideas. Lister (2003) is criticising Marshall for his argument that all citizens, in their capacity of being members of society have equal access to social rights. Lister opposes this and argues that different groups and individuals have different access to such rights and that these rights are not universal as Marshall claims (Dahlstedt, Rundqvist & Vesterberg, 2011). Lister focuses in differences to access to social rights between men and women but points out that there are other groups in the society that also are disadvantaged such as for example migrants (Lister, 2003). What is of interest for this research is who is a citizen and how do you become one? Which people are included in citizenship ideas and who is left on the outside? Citizenship is about inclusion and exclusion, and Lister argues that some people are excluded from the rights granted to you by citizenship (Dahlstedt, Rundqvist & Vesterberg, 2011). Lister explores these thoughts through the concepts *excluded from without* and *excluded from within*. The concept *Excluded from without* aims to describe people who stand outside a nation, which Lister argues, is based on intersectional categories such as gender, ethnicity, age or sexuality. With *excluded from within* Lister stresses to problematize citizenship. The concept describes people who live in a nation legally, have a citizenship but are denied their fully right to access of social rights, such as for example healthcare (Lister, 2003). The more non-citizens are included in social and cultural human rights the closer we get to a universal citizenship argues Lister (2003). To investigate further the thoughts of how one becomes a citizen and who is granted the rights that come with citizenship, Hanna Arendt's thoughts of Rights to have Rights will be explored in the next chapter.

#### Right to have rights

The phrase: *Right to have Rights*, origins from one of the most influential philosophers of the 20<sup>th</sup> century, Hanna Arendt. The expression acknowledges the right of every human being to belong to some community of the world. To understand the difficult parts of Arendt's thoughts and theories Benhabib (2005) have been used as interpreter of Arendt's work.

Arendt engaged in Human Rights and criticized the connection between rights and citizenship. She thought that Human Rights had been deprived due to imperialism and that the

wars in the world created contradictions between the national state and the principles of Human Rights. Arendt argued that nationalism had its consequences and that it had a negative impact on people who did not belong to a country such as refugees or stateless people. War forced people to migrate and those people lost their rights and became deprived and inferior to the human rights. Arendt argued that stateless people, for example refugees, were deprived not only of their citizenship but also of their human rights (Benhabib, 2005). In the book *The Origins of Totalitarianism*, first published in 1951, Arendt wrote:

“The rights to have rights, or the rights of every individual to belong to humanity, should be guaranteed by humanity itself.” (Arendt, 1951 p. 177).

According to Benhabib (2005) this was Arendt’s way of criticizing the fact that once a person did not have a juridical status in a nation, he or she did not have any rights. Arendt saw this as tragic since the human rights are meant to include everyone and not be based on judicial status (Benhabib, 2005). For Arendt, human rights are not natural or inscribed in the nature of human existence (Arendt, 1951). Benhabib (2005) explores Arendt’s ideas about rights bounded to a national state by showing the development of the EU as an example, arguing that within the European Union privileges bounded to citizenship is now being untied to being a national. This empathizes that one can have for example political rights in a country without being a national. Within the EU, the right to vote in the EU-parliament is not bounded to nationality of origin but to ones EU-citizenship. Entitlements to rights is no longer dependent upon the status of citizenship within the EU, argues Benhabib (2005), but it does not go for all the human rights, at least not yet.

For this research, Arendt’s thoughts are important due to that she questions human rights and whom they are really for. Her argument that the meaning of human rights is that they should be for everyone is important in relation to EU-migrants and healthcare. Arendt shows that human rights fail to be for everyone due to states’ sovereignty to decide who can become a citizen and due to the states’ strong influence on the development of human rights. As in the case for EU-migrants who have left their national state, do they still have the right to human rights?

## 5.2. Social justice

Social justice can be defined as a view that everyone deserves equal economic, political and social rights and opportunities. Social work applies the theory of social justice to structural problems in the world in which they work (National Association of Social Workers, 2014). By promoting a just and equal society through the concept of social justice social work supports human rights and advocates fair allocation of community resources. Social justice points out the importance of equality and equal opportunities for all. In conditions of social justice people are “not being discriminated against, nor their welfare or well-being constrained or prejudiced on the basis of gender, sexuality, religion, political affiliations, age, race, belief, disability, location, social class, socio-economic circumstances, or other characteristic or background or group membership” (Robinson, 2014, p. 1). In this research two perspectives of social justice have been used, the first one is the perspective of the philosopher John Rawls *Justice As Fairness* and the second one is a perspective that includes health called the *health capability paradigm*. It has been developed by Jennifer Prah Ruger who has found inspiration from Amartya Sen’s theory *The Capability Approach*.



### Rawls theory of justice

The most prominent statement about social justice is made by John Rawls (2005[1971]) *Justice as Fairness*, he has constructed a theory of social justice, based upon the broad meaning of the concept. His principles are characterized by handling the conditions in which inequality can be justified. Rawls' main principle is that the only time inequality can be justified is when it benefits the most deprived (Rawls, 2005). Rawls' theory is built upon two main principles of justice:

- each person has the same inalienable claim to a fully adequate scheme of equal basic liberties, which scheme is compatible with the same scheme of liberties for all
- social and economic inequalities are to satisfy two conditions:
  - they are to be attached to offices and positions open to all under conditions of fair equality of opportunity
  - they are to be the greatest benefit of the least advantaged member of society (Rawls, 2005).

John Rawls' theory has important applications in healthcare. It suggests that socio-economic equality is acceptable, as long as it improves the lot for the least advantaged (Rawls, 2005). As a consequence of this, governments and their health politics and institutions are encouraged to observe the most vulnerable people of society and make sure they are benefitted (Porter & Venkatapuram, 2012). When it comes to Rawls' views on social policies, his principle *fair equality of opportunity* is used to justify them. The principle advocates that social institutions, laws and policies must go beyond merely preventing discrimination in society. Rawls advocates that everybody is born equal and shall have the same opportunities no matter of class or ethnicity and that the only thing that diverges people are their natural born talents. He argues that to ensure fair opportunity regardless social class or origin, the state must guarantee for example health care for all and give everyone equal opportunities to access social institutions (Rawls, 2005).

Rawls states that global justice is beyond the scope of his theory, but still points out the importance of international law in relation to social justice (Rawls, 2005) in order to capture the global angle and relate to the field of health Rawls' perspective of social justice have been complemented with Jennifer Ruger's perspective of social justice, which will be presented in the following chapter.

### The Health Capability paradigm

To connect social justice with an approach of health, the perspective of Ruger (2010b) has been applied to this research. The *health capability paradigm* can be used for analysing problems of health and social justice, which makes it suitable for this research. Ruger stresses that all people shall have access to necessary means to avoid premature death and preventable morbidity. Ruger's theory lies on the basis of fundamental human rights, where Ruger argues that the right of everyone to the enjoyment of the highest attainable standard of physical and mental health may be the most fundamental of the human rights, since health is needed to fulfil the enjoyment of the other rights (Ruger, 2010b). Ruger's perspective of social justice arises from Amartya Sen's theory *The capability Approach*. The theory of Sen has its main characteristics in the capability of people, what they are able to do and to be are their capabilities (Robeyns, 2005). The capability approach can be used to evaluate aspects of people's well-being such as poverty, inequality or the average well-being of a group, hence it is not a theory that can explain these aspects of well-being but provides a framework for understanding them. Sen notes that people's capabilities are dependent on their resources; financial, cultural and political (Robeyns, 2005). Inspired by Amartya Sen, Jennifer Prah

Ruger (2010b) have shaped a theory that offers an alternative view of justice and health and that builds on and integrates Sen's capability approach.

In the foreword to Ruger's book *Health and Social Justice* (2010b), Amartya Sen distinguishes "good health policy" from "good policy for health" arguing that it is the latter that is needed for justice in health and that all sectors in society must contribute to the well-being of the people pointing out the importance of social determinants for health (Sen in Ruger, 2010b, p.ix). The health capability paradigm envisions a shared health governance, this means people from all levels in society for example governments, healthcare staff, and citizens, shall work together in creating an environment that is healthy for all – including the legislative process (Ruger, 2010a). Ruger addresses inequalities in societies, like for example poverty and advocates that such inequalities can be defeated through the global health governance. She refers to it as a solution to reduce health disparities and inequalities in the world (Ruger, [no date]). The global health governance advocates for redistribution of resources between groups and societies by stating that states, groups and individuals must have ethical motivation, meaning all people must sacrifice some of their resources and autonomy and redistribute those to others. One way of doing this is for example through taxes (Ruger, [n.d]).

The thoughts of a shared governance also have implications on the concept of access to health and healthcare where equal access should mean equal access to high-quality care, not only care at a minimum, care that can be deferred or adequate care (Ruger, 2010b). Ruger states "it is unfair to deny any individual, or group of individuals, access to quality care if doing so could substantially decrease their chance of a significantly improved health outcome" (Ruger, 2010b, p. 9). The theory further explains that helping people to function at their best, given their circumstances is the foundation of equality.

The question whether governments should guarantee such a right as right to healthcare is often discussed. Ruger argues that right to healthcare could be justified by universal health insurance. This means that it is morally justified since it ensures the conditions for human flourishing which in their turn is a demand for health and social justice. Lack of a health insurance can for example be a barrier to receive care and that is a kind of structural discrimination against the less advantaged people of society, argues Ruger (2010b). An important factor in the debate of health insurance is economy, Ruger shows that health insurance may be costly for countries but reduces costs in the long run by reducing risk and providing a healthy population. She argues for a formal, institutional and guaranteed health insurance as the rational choice in a just society (Ruger, 2010b).

The theory also advocates resource distribution, from the rich to the poor and from the healthy to the sick she argues that people born in less advantaged environments shall not live a more miserable life than people born rich. On the other hand, the theory also includes every person's agency to take responsibility for a healthy living. The capability approach stresses that people have a responsibility to use their health agency to pursue for good health, by for example eating nutritional or engage in physical activity. But it also stresses that for people to be able to do this, governments must structure and build a society for all, with a universal healthcare (Ruger, 2010b). For the analysis for this research a model of the health capability paradigm by Ruger (2010a) has been used. The model shows factors that impact the health capability of people and stresses that all factors are of importance for people to gain capability. The model help providers and policymakers assess individuals' societal need and current barriers to addressing these needs (Ruger, 2010a).

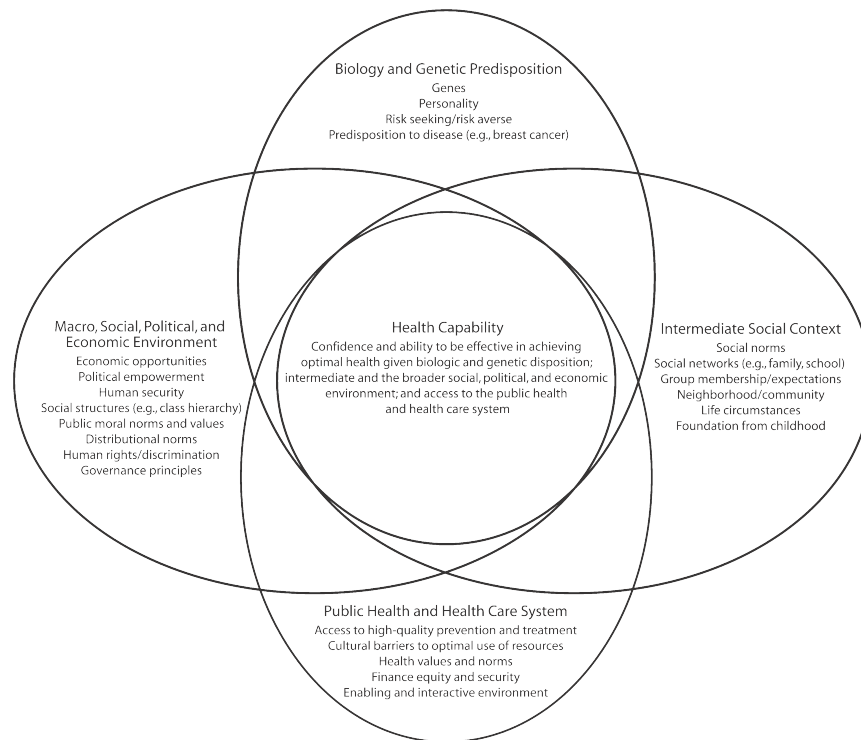


Figure 1. Conceptual model of Health Capability (Ruger, 2010a, p. 47)

Both individual factors and societal factors must be considered in order to formulate health capability. Figure 1 presents how these factors interact and effect the health capability of people, the circles overlap to show that they all influence one another and finally make up the health capability of a person. The model in Figure 1 accounts for both internal and contextual powers at the individual level, which makes it a flexible analytical tool that reveals the impact of social goods (for example social assistance and healthcare) on an individual level (Ruger, 2010a).

## 6. Method

This chapter intends to describe how the research of this paper was conducted and explain why certain approaches have been chosen. This qualitative exploratory study aims to find knowledge in a field that has not been well researched so far, as far as the author could find out, there is no existent research on the same topic. Qualitative methods are suitable when the researcher focuses on life-worlds of the participants. This includes emotions, motivations, empathy as well as the subject's experiences of something (Berg, 2009). This is why a qualitative method was chosen for this research.

### 6.1. Design of the study

The data collection for this research was done through the use of qualitative semi-structured interviews. Kvale (1996) describes this method as the most common one among qualitative research and indicate that interviews aims at the understanding of the world through the subject's viewpoint. Kvale (1996) proposes seven stages of a qualitative interviewing; thematizing, designing, interviewing, transcribing, analysing, verifying, and reporting. Those stages have been considered throughout the data collection.

Halvorsen (1989) states that qualitative interviews are relevant when the researcher by some reason cannot study the phenomenon him- or herself. Such situation encourages the use of

what Halvorsen (1989) calls replacement observers (authors translation of the Swedish word; ersättningsobservatör). This means to interview someone with first hand knowledge of the phenomenon the researcher wants to study (Halvorsen, 1989, p.85). These thoughts are applicable to this research, where knowledge has been sought from professionals and not from the main target group.

The interview guide was developed in accordance to the research aim and with inspiration from studies investigating undocumented migrants right to healthcare. The previous research in a similar topic showed the complexity in the interviewee's pre understanding of laws and regulations. Questions concerning these topics had therefore been kept very open to avoid the interview to take a turn into a juridical story telling. The interviews followed a semi-structured interview guide (Appendix 2). Semi structured interviewing contains of a number of predetermined questions and topics which are asked in a systematic way (Berg, 2009). However it is of great importance that the researcher is flexible and alert on follow-up questions, Berg (2009) illustrates the importance of using words familiar to the people being interviewed. With this in mind, some words or concepts was changed in accordance to the participant's knowledge basis.

The identified themes for the interview guide were:

- Background: interviewees former carrier and work with EU-migrants, clarification of concepts, ties to social work
- Presentation: deeper presentation of the interviewee as a professional.
- Access and availability in healthcare
- Human rights: responsibilities and obligations
- Actions and improvements
- Closure

The interviews were kept in a quiet room and were very open, with little interference from the researcher. During the interviews some themes were touched upon which came later in the interview guide, in these cases the researcher was flexible and prompted questions in that area to create a deeper understanding.

## **6.2. Sampling method**

Qualitative research diverges from quantitative research because of its' aim to focus on depth instead of width when it comes to the sampling of participants. Bryman (2012, p.418) refers to sampling in qualitative research as purposive sampling. With this he means that the sampling method, unlikely from sampling in quantitative methods are a non-probability of sampling, in other words, the sampling does not find the participants on a random basis (Bryman, 2012).

To avoid bias in the study there has been a strong will to not solely include people who work in NGOs, this because they are not obliged to follow the state or municipality guidelines. Yet it turned out that people from the municipality had little knowledge about EU-migrants especially in relation to healthcare. The work conducted in the area, both in Stockholm and in Gothenburg is mainly carried out by NGOs. A limitation on the sampling was that the participants should work with EU-migrants and meet them on a daily basis. However one of the participants more worked on a structural level in the healthcare sector, her knowledge and

experience was anyhow worthy. She has also worked for many years with healthcare for undocumented migrants.

The sampling for this research has not aimed for any diversity in the participants such as age or gender, the only inclusion criteria have been people who work with EU-migrants or with their situation in Sweden. The process started with contacting the organization known to work with EU-migrants in Gothenburg, this led to a meeting where the researcher had the opportunity to investigate if the study was needed, the meeting can be seen as a small pilot study along with email contact with an organization specialized in healthcare for undocumented migrants. Participants have been found by searching the Internet, for example some names were found in newspaper articles and contact details were found online. The search for participants was also an oral process of talking to people in the author's environment. A snowball method was used to find participants, this by asking the first participants if they knew anyone who could be appropriate for the study. This generated three participants. Along with this a person with knowledge in healthcare towards undocumented migrants was helpful in the sampling by recommending people who work in the area of interest.

People were selected by the researcher and reached out to by email or telephone. The researchers private connections made it easier to contact people and to get them interested. Anyhow, it was difficult to find participants for the study. Much because it is a narrow field, as today, in Gothenburg quite few people and organizations are working within this area. Same situation was seen in Stockholm. After the first reach-out two people responded positively and these were sent information by email about the study. The researcher called them again and settled a time for the interview. In all cases the interview was held at the persons workplace. As time went by, more matching contacts were found from talking to people and from searching the Internet. The sampling can therefore be seen as a quite time consuming process.

### Introduction and background to the participants

The semi-structured individual interviews were conducted face to face from the middle of March to the middle of April, 2014. All the interviews took place in the respondents' workplace, which provided optimal conditions for relaxed interviews. The participants were informed before hand about the purpose of the study by receiving a small information letter sent to their emails. They were informed that the interview would take maximum an hour and no interview extended the time limit. The interviews were between 30-60 minutes, only one of them was shorter than 40 minutes. Before the start all respondents were asked if they had any questions before the interview started. All participants agreed to the audio recording.

The seven participants of the study present a small range of different workplaces. Three participants had their base in Stockholm and the other four in Gothenburg. The majority of them work in the sector of Non Governmental Organizations. Anyhow the NGO's have a wide range of working areas, what they have in common is that they focus on vulnerable groups in society. Three of the respondents represent the healthcare sector, one of them is working actively with providing healthcare for EU-migrants. Gender of the participants was equally distributed, 4 out of 7 being women, although this have not been of importance for the study and were not a criteria for inclusion. Most of the participants in the same city know one another for example through work cooperation. The participants had the same motives for working with vulnerable groups in society, based on equality and the human dignity for each and every person. One participant differed from the others by having experience herself from marginalization. The participant is a EU-migrant herself who now works in a NGO where she

is a great asset as interpreter, bridge builder and cultural interpreter. The interview is interesting because it shows an inside perspective as well as an outside perspective of EU-migration. It should also be noted that the participant's former experiences in her home country compared to her experiences in Sweden made her perceptions a bit different from the other participants', she was also the only participant without a higher education.

As an introduction question the participants were asked to narrate the concept of EU-migrants, this in order to have a common understanding of which people we are talking about during the interview. All participants struggled with this concept, and many stated that the definition is not clear. Anyhow all of them described the concept the same way it has been described in this paper (see p. 2), including both people who migrate within the EU and third country nationals in the concept. Many also believed that when talking about EU-migrants, the word deprived or vulnerable serves a purpose to note that we do not mean anyone migrating within the EU but focus of people who live a hard life, are marginalized and/or vulnerable.

To ensure the anonymity the participants are not identified by name, but for the purpose of the analysis and for the citations each participant has randomly been assigned a number (e.g. participant 1, participant 2).

### **6.3. Method of analysis**

For the analysis, the data was analysed using thematic content analysis, it is an analysis approach suitable to use when you have a study design that aims to describe a phenomenon in a specific context and when the existing research is limited (Clarke & Braun, 2013). The process started with reading the transcripts two times to form a coherence of the subject and a first idea about which codes that could be appropriate for the data. Clarke & Brown (2013) describe six phases of the thematic analysis, these will be described further and explained in accordance to the analysing process of the data from the interviews:

1. *Familiarization with the data*: listening to the data, reading and re-reading and taking notes of thoughts for the upcoming themes.
2. *Coding and searching for themes*: These two phases have in the research process been done at the same time using data management software called NVivo. In accordance with the aim for the research some parts have been selected as less important, these parts have though been used in the presentation of the participants of the study. In NVivo the material was sorted into nodes, each node describes the theme of the content. All transcripts were read and sorted into different nodes depending on the content, some text could fit into two different nodes. The researcher constructed the themes after step number one and during step number two.
3. *Reviewing themes*: the researcher has reflected upon the themes, changed the name of some of them and put some of them together, furthermore the relationship between the themes have been investigated. At one point the researcher went back to step 2 and reconstructed one theme to a broader extent.
4. *Defining and naming themes*: each theme has been described in the content/description box in the software programme and named after carefully re-reading all the content sorted into one theme. NVivo separates the data in one folder for each node/theme, all nodes were printed and re-read to be sure the themes suited the data.
5. *Writing-up*: the themes have been used as headlines in the result paragraph and deeply explained in order to give the reader a coherent and persuasive story about the data and put in relation to previous knowledge within the field. The findings were thereafter connected to the theoretical framework (Clarke & Braun, 2013).

In addition to this it needs to be noted that the interviews were conducted in Swedish and therefore the researcher has translated quotes used in the analysis into English freely but strictly.

#### **6.4. Ethical considerations**

In all research ethical dilemmas need to be considered. Moral issues are embedded not only in the interview situation but also on all stages of an interview inquiry. In this research special attention has been paid to ethical considerations of the main target group; EU-migrants. Kvale (1996) declares that the consequences of the participation need to be taken into consideration as well as the knowledge should not only have scientific value, but also contribute or aim for improvement of the situation investigated. It is the researcher's hope and wish that this study can contribute with knowledge in this field and raise public awareness on the subject. Ethical issues have been taken into consideration before conducting this research. The sensitivity of the study lies within the area of researching people who are marginalized and/or discriminated. Bryman (2012) refers to this in regard to research that involve vulnerable groups or research that involve people who lack capacity. This is somewhat avoided by interviewing observers instead of the vulnerable group themselves.

Bryman (2012) discusses four main areas of ethic principles to consider when carrying out research: *harm to participants, informed consent, invasion of privacy and deception* (Bryman, 2012, p. 134). In accordance to this study the following precautionary principles have been taken into consideration. All participants have been assured anonymity and their workplaces are not referred to by name of the organization. This precaution has been taken due to the small field this research represents. If the name of the workplaces had been spelled out, the personal anonymity would have failed. The anonymity between the participants are not assured since the sampling of participants were done partly through the snowball effect, anyhow the researcher have been cautious with naming participants or revealing identities. In one interview the researcher perceived the participant to be stressed and insecure about the purpose of the research. This made the researcher turn off the tape recorder and explain further what the research was for, assure the participant was anonymous and explain how the interview would be used. The researcher got a feeling that the participant wanted to speak well of Sweden due to insecurity of the identification of the researcher. The interview continued in a much more relaxed way after this precaution.

When it comes to informed consent, participants of the study were notified shortly about their anonymity and right to end the interview at any point in the mail contact before the interview took place. At the beginning of each interview a letter of consent was handed to the participant and time was given to read and sign it. The informed consent provided the participant with information about rights and explained how the collected data would be used and stored. All informants were informed about the voluntariness and right to withdrawal orally as well.

In relation to invasion of privacy this has not been of any concern since this study does not reveal things touching personal life or sphere. Anyhow, through the anonymity people have been able to express personal opinions that can reveal their political opinions and therefore be of a private character. According to Bryman (2012, p. 143) deception occurs when the researcher present their work as something else than what it is, deception can also occur if a researcher provide the participant with a complete account of what the research is about. This can create problems of deception if the researcher after hand change the research objectives or

adjust the aim of the study, precaution have been taken in order to Bryman's (2012) recommendations.

### **6.5. Limitations**

This is a study of EU-migrants access, rights, and availability to healthcare in Sweden. Thus only migration within the EU is discussed, hence excluding migration or immigration from countries that are not a part of the European Union member states as from the date of 2014-01-01.

Furthermore it is important to note a couple of limitations of this research. As mentioned earlier the data in this study cannot be seen as first hand data since the information received during data collection, is not information from the target group themselves. This limits the variety of information and creates a necessity for insight of the concept pre-understanding. The people interviewed are all people who work in the area of migration or healthcare and the majority have worked with deprived or vulnerable groups in the society for years. This tells something about their motives and preconception as it shows a special interest of the target group. It is proof of certain solidarity and interest for improving the situation for these people. If the interviewees did not think the situation could be improved or that it is problematic, they would most certainly not work there today. Furthermore, the participants of the study mainly work in the third sector, which can have an implication on the view of responsibilities of the municipality and the state.

The participants knew beforehand what the overall purpose of the study was and some saw this as an opportunity to raise their voice and spread their opinions, which is in line with the purpose for qualitative studies. Anyhow, this may have biased their opinions. It can also be noted that the researcher conducted all analyses, thus the concepts and themes are analysed from her subjective perspective. It should also be noted, that the area that this research focuses on are under development and that at the release date of this research the situation might have changed. When it comes to geographical issues, this research has been conducted in the two largest cities in Sweden; Gothenburg and Stockholm. These cities along with Malmö (third largest city in Sweden) are also the ones with most developed methods on helping EU-migrants, though, this does not mean that this study is invalid or not legitimate.

### **6.6. Validity, reliability and generalization**

In research these concepts are used to form an understanding of how well the data collection responses to the aim. To have good validity and reliability are essential for the generalization of the study. Kvale & Brinkmann (2009) defines "reliability as the consistency and trustworthiness of the research and validity as the measure to understand whether a method investigates what it intended to investigate" (Kvale & Brinkmann, 2009, p. 327). As for this research it makes no attempts to generalization. As a strategy to achieve validity the researcher tried to not influence the answers of the participants and to keep awareness of the researcher's own preconceptions, opinions and prejudices.

Reliability has been considered through reading material of research reflexivity, the researchers awareness of her own part in the study have been considered and also explained as a way of preconceptions of the world and all human beings equal dignity. It is argued that this study does not have enough participants to claim any generalization. Also kept in mind that this study covers large cities in Sweden and that laws and regulations can vary from city to city in Sweden. One can imagine that larger cities are the ones who are better off than small



cities where there is less chance that there is a well-developed praxis for EU-migrants' healthcare needs.

### **6.7. Reflection and preconception**

In qualitative research the researcher participates in the study indirect. During this study the researcher has been one of the two people participating in the interview and the relationship between these two people are not equal as Kvale states "an interview is not a conversation between equal partners" (Kvale, 1996 p.5). Power differences between the researcher and the interviewees have not been directly visible but there have been moments where the researcher has felt inferior in the relationship due to work experience, knowledge within the field and age factors. In one interview the researcher felt superior due to language barriers and different knowledge basis, hence the relationship between the researcher and the interviewee was not equal. Bryman (2012) points out that factors such as sex, age, social class and environmental factors are things that can affect the interview and those factors were proven to have certain influence in both divisions.

Berg (2009) explains that preconception in research consists of the researcher's view of humanity and society. It is highlighted that the researcher's lifeworld cannot be distinguished from the research and therefore should be reported to the reader. As for the authors preconception of the subject it is declared that human rights and thoughts about an equal world have influenced the author in choice of topic as well as theoretical framework. This may have affected the analysis and the result of the study, however it need not be seen as something negative as long as the researcher herself declares awareness to the reader.

## **7. Results and analysis**

In this chapter, the findings of the study will be explored and presented. The findings are based on themes found in the seven interviews, these will further be analysed and discussed in relation to the theoretical framework previously outlined in chapter 5. The chapter will start with a presentation of the respondents to create a deeper understanding of them as well as of the subject of the thesis.

From the thematic analysis three main categories was developed from the data material, out of those, different themes have been found based on the stories of the participants. The categories, themes and sub-themes are presented in *Table 1* on the next page.

Table 1. Themes and categories developed from the qualitative content analysis of the transcribed material of seven interviews with professionals working with EU-migrants.

Category	Theme	Sub-theme
Access	Regional and local health politics	
	Personal strategies	
Barriers	Legal	
	Financial	
	Gatekeeper	
	Administrative	
Improvements	Legal entitlements	National level
		European level
		International law

### 7.1. Access

The majority of the participants of the research stated that they think EU-migrants' access to healthcare in general is bad. The participants declare that they have seen an increase in the number of EU-migrants and that this has affected the access to healthcare. One participant explains how and why his organization started to work with EU-migrants and healthcare:

“After the amended legislation in 2013 for undocumented migrants we raised the question of what other vulnerable groups there are in Sweden and what we saw was EU-migrants. [...] we too have eyes and ears and we had seen an increase of this group of people so there was a will to help” (Participant 5).

Access to healthcare for EU-migrants rely on the work of NGOs, and this regulates the access as well as the range of healthcare. The majority of the participants believe that there is a problem with the access to healthcare for EU-migrants in Sweden and some express anxiety for the future:

“...we are worried it will be too much for them, we are scared that door will close. I mean, this do take a lot of resources from their initial goal” (Participant 1).

Participant 1 indicates that the health centre for homeless in Gothenburg may at any time change their policies and stop accepting EU-migrants is something that would change the situation totally, it would leave Gothenburg in a position where EU-migrants cannot access care at all. Participant 2 expresses similar thoughts and argues that sure, people can receive certain care at the health centres but some care is missing:

“Women for example, who are in need of gynaecological care, abortion or family planning, they have no where to turn” (Participant 2).

This shows that even if there is access, the access that exists is in no way flawless. In both Gothenburg and Stockholm only certain kinds of care can be given. The effect of restricted access to healthcare can in some ways be vital for the group EU-migrants. Participant 5 refers to a certain marginalized group of EU-migrants, the Roma.

“We have had a few people this year who have been really sick, dying almost. One cannot deport or return them to their home country either, since they will not receive any care there. That almost means that we kill them, it is a very difficult situation” (Participant 5).

The statement above shows that there is an existing problem on how to handle these kind of questions. It also shows that the problem is not only on a national level but an international.

On the investigation of how access to health was perceived by the participants an interesting contradiction was found in one of the interviews. This participant had another “lifeworld<sup>1</sup>” than the other participants. She constructed her life and her perceptions based on another view of life than the other participants. The interesting thing is while the other participants thought availability and access to healthcare for EU-migrants in Sweden was bad, participant 4 considered it to be quite good.

“Everyone receives help and the doctors are very nice, they help them a lot even though they can’t pay” (Participant 4).

This statement was followed by a story about a relative (EU-migrant) to the participant who had some injury at the back of his head and who had received very much and good and subsidized care at the regional hospital. The difference in the stories of the other participants and the stories of participant 4, becomes understandable due to her construction of identity through describing her lifeworld and her earlier experiences in life, while not living in Sweden. In comparison to the healthcare she was able to receive in her home country and how she was treated there it becomes evident that the differences construct and form her perceptions. For example she illustrates how she gave birth in the hospital through this story:

“They did not help me at all, even though I was in the hospital, they just left me in a room, screaming and crying for 24 hours. When my little girl finally came out she was blue, almost dead” (Participant 4).

The perception of participant 4 is that access to healthcare is quite good, although she highlights that people receive healthcare from only one clinic, and that a normal clinic would not accept EU-migrants without a EHIC. She also points out that for children the situation is different and that there is no obvious place they can refer the children to. Her perceptions differ from the other participants’, which can be due to her comparison to healthcare in her home country.

### Regional and local health politics

This research only investigates two cities in Sweden and how EU-migrants can access healthcare there. The participants show that cities differ from their strategies for access. Mainly due to that in Gothenburg the health centre for homeless people provides EU-migrants care on an everyday basis. The health centre is organizational situated under the county council of the region of Västra Götaland, thus on a municipality, regional level. The perception of the three interviewees from Stockholm is that the situation of access differs a lot between the two cities. While Gothenburg has the health centre for homeless, which is open all weekdays, Stockholm basically only have one NGO driven clinic, open 2 hours once a week. Along with that they have a nurse who visits an NGO that specializes in help for EU-migrants once a week for two hours, in some cases they also grant people a medical

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<sup>1</sup> Lifeworld is the world according to how we perceive it; lifeworld for example consist of your memories and experiences from your everyday life (Dahlberg, Nyström & Dahlberg, 2007).

examination at the clinic of the Red Cross. The participants from Stockholm reveals that it for them, seems so much easier and better in Gothenburg and that the climate there is more acceptable than in the capital.

“...I experience that it is very difficult in Stockholm particularly, in Malmö and Gothenburg it seems to happen more things, they are more cooperative and it seem to function better, here in Stockholm it is harder, nobody wants to make decisions” (Participant 7).

This can be seen as an effect of the divided healthcare system Sweden has where each county council is sovereign to make decisions. The participants from Gothenburg argue that Gothenburg has in the discussion of healthcare for undocumented migrants stayed at the forefront of the debate and implemented a praxis for this in 2006 that granted all undocumented migrants the same care as the law now grants them (Sahlgrenska Universitetssjukhus, 2006).

“There seems to be a better established climate in Gothenburg for these questions” (Participant 5).

The openness towards these questions in Gothenburg is by the participants proven to affect the access to healthcare and creates regional differences. Anyhow it should be noted that EU-migrants in Gothenburg cannot access healthcare without assistance from the NGOs, hence they are the ones that call and make the appointments. The participants from Stockholm explain that they work hard with advocacy towards the county council and that they have a good cooperation, thus the willingness to establish similar practice for EU-migrants as the one in Gothenburg, have not been on the agenda. The participants from Stockholm explain that they do not know why but “perhaps it is because Stockholm is the capital, we have more eyes on us” (Participant 5).

The participants from Gothenburg admit that the situation is good for them as long as the health centre for homeless accept EU-migrants.

“...we can help almost everyone, even though they do not have money [...] but it could be better, if one had the right to go to all the health centres, especially for the children” (Participant 4).

### Personal strategies

In accordance with how the situation was with undocumented migrants in Sweden, both before and after the new law was implemented, the participants express that access depend much upon the knowledge of the healthcare staff. It is of high importance that the staff at the healthcare centre knows the regulations and knows how to handle a situation when a EU-migrant seeks for care. Since the policy basically says that a EU-migrant without a EHIC shall pay for healthcare, the most important part of the healthcare staffs knowledge is to not ask for payment before treatment is given (Participant 3). The patient is supposed to receive the bill afterwards but be informed about the cost. In some cases people have been denied care unless they pay in advance but according to participant 3 this is against the regulations. If people receive treatment and a bill afterwards the participants explain that they have personal strategies, in cooperation with NGOs to handle the payments. In some cases they call the hospital and try to cancel the bill and in some cases NGO's help individuals to ease their burden with partial payment. Anyhow participant 2 noted that this is a huge job for the NGOs and that resources allocated for preventive work falls back due to this.

In the same way as NGOs as an organisation has strategies to impact the access to care for EU-migrants, the participants have established their own personal strategies. They have during their work with EU-migrants or in earlier projects created a social network that can help them to access care. Participant 5 describes the issues they have when someone needs care beyond the care they can receive at the health centre.

“What do you do if a EU-migrant need to get healthcare beyond what you offer?”  
(Researcher).

“well, then there is fewer options, since they do not have any formal rights. We have a net of contacts so to say, which we recently updated. It consists of individuals who work in the area of healthcare that helps them access care”  
(Participant 5).

Another participant describes it as following:

“I’ve been criticized because I have openly criticized the medical treatment of these people, those who do not have health insurance. And yes, been lectured on the topic and I understand that in many cases they solve that problem in the hospital, they just conjure them past the system. But the thing is that we meet the ones who have failed to achieve this, people that have received a bill or did not get the care they needed. I do not know how many people that are slipping through the system but it seems that this strategy has become more difficult to apply after 1st July 2013” (Participant 1).

This statement demonstrates the personal strategies to handle the situation and shows that in some cases those strategies are not enough. Participant 6 describes that she often helps people access care through her personal and professional network, and that it is usually not a problem but that it obviously takes resources as well as personal engagement “I have different ways of connecting them to different healthcare sites, but clearly, everyone does not see me!” (Participant 6).

In particular the personal strategies is of importance when someone needs to be remitted to further care in hospital. Someone needs an x-ray or examination by a specialist. This care cannot be carried out at a volunteer clinic or at the health centre for homeless people in Gothenburg.

## **7.2. Analysis: Access**

Rechel et al. (2013) identified that the right to healthcare shall cover anyone and states that migrants shall not be unfairly disadvantaged in access to healthcare. The perceptions of the participants in this research shows that this is not reality in the case of EU-migrants’ access to healthcare, and they witness about many layers of inequalities. Based on legal status and ethnicity EU-migrants do not access the same care as most other people. Their rights are lost due to the lack of citizenship. Arendt (1951) criticized that once a person did not have a juridical status in a nation, she neither had any rights. She argued that human rights should not be based on judicial status. As for the EU-migrants it seems like they have lost their right to healthcare in line with their migration. Some of them would perhaps neither receive care in their home country but some of them would. When it comes to the concept of social justice and the definition of how all people deserves equal economic, political and social rights and opportunities the question is whether this is applicable also for EU-migrants. Due to their status in Sweden, being here legally, they have no right to healthcare.

Marshall (1991 [1950]) has explored the ideas about the human beings relation to society and belonging to a social community. According to his ideas about citizenship, EU-migrants do not live up the ideal of citizenship and are therefore neither granted the rights as a citizen, this because they neither engage in military services or work and pay taxes (Dahlstedt, Rundqvist and Vesterberg 2011). The human rights have been transformed to be citizen rights, argues Lister (2003). People who are EU-migrants are rarely seen as citizens, neither does the participants see them as citizens mainly due to the short period of time they spend here. This issue create a view of migrants as anti-citizens and give reason to that other citizens or governments loose the sensation of being responsible morally and political for their rights (Lister, 2003). Maybe the view of EU-migrants as non-citizens is a contributing factor to that Sweden does not grant them the right to healthcare. It is the citizenship that gives one entrance to the social rights rather than the simplicity of being a human argues Lister (2003).

Free movement within the EU has brought more people to Sweden, but even though the purpose of the EU might be to erase the borders between the countries it is evident that the nation state and its border still make a great difference in the life for migrants. Dahlstedt, Rundqvist and Vesterberg (2011) refer to this by declaring that migrants challenge the national order of things. Meaning that the imagined community of a nation is the ideal, but that migrants challenge our ideas about boundaries in relation to rights, which becomes apparent when analysing how and why Sweden adopted a healthcare act for undocumented migrants.

After the enlargement of the EU in 2004 and 2007 researchers indicated that caution should be taken in the area of health since the enlargement brought together countries on a broad range of health systems and health within the population (Avgerinos, Koupidis & Filippou, 2004). Those differences become visible through the story of participant 4 when giving birth and her perceptions of healthcare in her home country verses healthcare in Sweden set inequalities within Europe to a head. If Europe is to be seen as a place where rights can be granted to you without being a national as Benhabib (2005) suggests, the right to healthcare should also be equalized and apply to all European citizens.

The regional and local health politics are by the participants identified to differ between the two investigated cities. As for regional variances the similarity to the access to healthcare for undocumented migrants is evident (see e.g. Biswas et al., 2012). Depending on where a EU-migrant resides in Sweden, he or she will have different access to healthcare. The cities have in common that the individual has to rely on NGOs to receive the care they need. This does not follow the line with equity or equality but build on the inequalities to not only differ between states but within states as well, as Braveman and Gruskin (2003) notes equity calls for an absence of systematic disparities.

Whether or not EU-migrants are to be seen as citizens is a difficult question, hence this research argues that EU-migrants shall have the right to human rights. Since people come here under the free movement regulations of the EU, it is clear that they are citizens of a member state, and adapting the thoughts of Lister (2003) it is true, that some groups have different access to social rights. But on the other hand, Arendt (1951) stresses that all people have the right to have rights and if refugees and stateless people still are citizens and have the right to rights, so do EU-migrants. At the same way that you do not have a choice to flee war, you may not have a choice but fleeing a deprived life situation, poverty, or employment.

### 7.3. Barriers

In accordance with the objectives of this research barriers have been identified, showing which kind of problems that the participants percept exists in the access to care for EU-migrants. Those have carefully been organized into four different themes as presented down under.

#### Legal barriers

Many of the participants expressed a concern due to how Sweden legally does not give EU-migrants the right to access healthcare. All participants expressed that there has been a recent change in the access for this group, highlighting that it has been harder for EU-migrants to receive care since the new act came into force, which gives undocumented migrants the right to care that can not be deferred (SFS 2013:407).

“EU-migrants have with the new legislation fallen between the cracks”  
(Participant 5).

Further it is described that this new law, is in the broader context helpful and a great law but it is very unfortunate that this group have not been accounted for. In Gothenburg, the county council had a similar law internally, including all the hospitals under the regime of Sahlgrenska University hospital already in 2006 and as participant 3 says “we been there, we’ve done that, and we don’t want to do that journey again”. This is a perception shared by the other participants thus it is noted that the two groups (undocumented migrants and EU-migrants) are different from each other and have different needs. It is also expressed that EU-migrants, is the one and only group in Sweden that are excluded from subsidized healthcare by law and that this adventures their health both in short term and in the long perspective. Hence stressing the importance of preventive healthcare and not solely emergency care.

Two of the participants bring attention to the situation for children and describes how they cannot understand how Swedish legislation can make a difference between children due to their judicial status. As participant 3 describes it:

“We have to fix this, the children are in need of care. I simply can’t understand how we can differ Lisa Svensson from Ahmed Muhammed if they are suffering from the same disease and have the same need for care, it is completely incomprehensible to me”.

Another participant shows proof of legislative barriers for children when a boy, age 12, was in need of a medical examination. The boy’s weight was very low and he did not have a normal appetite, to the size he was much smaller than his peers. The participant tried to get him an appointment at the healthcare centre to make a medical examination but was told that he did not have the right to that based on the concept of healthcare that cannot be deferred. Another healthcare centre was then contacted and again they were told that he did not have the right to such care. Eventually they were allowed to make an appointment but while reaching the clinic it was clear that they would have to pay 1300 SEK for the assessment and an additional sum for each test they took on the boy. Money that the boy’s mother did not have.

#### Financial Barriers

“Do you understand that this will cost you 8000? You get your care but you’ll have to pay for it” (Participant 3).

All participants have identified the target group for this study, as people who do not have sufficient financial resources. Therefore money becomes an issue when they seek care. In Sweden, everyone, including EU-migrants without an EHIC, have the right to emergency care being bounded to pay for it. The question is do people seek care if they know they cannot pay for it and do people seek care in time? The financial barrier create restrictions in both the health seeking behaviour of the EU-migrants and the health indirect. There seems to be a consistency in the participants' thoughts about that the financial situation is a problem for accessing care. Participant 6 describes the access to healthcare for EU-migrants as more of a financial problem than a juridical, legal one.

“...quite a lot of people have the EHIC, or at least have the right to it in theory, but still cannot afford healthcare. I meet people who doesn't want to pay 10 SEK for a bed in a shelter but rather sleeps at the central station, so “to not afford” is a matter of definition I'd say” (Participant 6).

Likewise, the other participants problematize that the financial barrier is of great importance in the access to healthcare. People are so poor that even if they would be granted care they would have to pay 200 Swedish crowns, money that they most probably do not have, wherefore they have to rely on care given to them by NGOs for free.

Three of the participants describe how people have sought care and received an invoice afterwards that has had great implications of their lives. In one case the bill for healthcare was sent to the persons home country, which lead to that the national enforcement authority came and took everything the family owned. The financial barrier creates a fear towards seeking medical care, even though it might be necessary. According to the participants many people receive invoices for emergency care or obstetric care, which make them devastated and helpless.

“the problem is that this makes people frighten to seek care or to return to the healthcare centre for a follow-up, which also leads to that the people, who are already in bad health, becomes even worse off” (Participant 2).

The fears people have to return to healthcare once they got a bill have implications on their access. As in a case with a child, who eventually received care for a quite severe illness, but was in need for a revisit in order to make sure the medicines work properly, never come back.

“we had a chance to help that child, that we did not take, the family will not dare to come back and for me, this is very serious, we have rejected the possibility for that family to help their child” (Participant 3).

The discussion about finance also covers whether or not Sweden can afford to give people free treatment and subsidized healthcare. In this question there seems to be a consistency among the participants that first of all, it is their human right, and secondly this is no money at all for Sweden. Participant 1 describes what this would cost Sweden as “a drop in the sea, or even less”. In comparison to how this has been apperent since the implication of the new law for undocumented migrants in Sweden. It is noted from participant nr 1 that:

“there is no department in the hospital that can urge that they did not have time or money to do for example an operation due to that they have treated so many undocumented migrants, none!” (Participant 1).



### Gatekeepers

Another barrier for accessing care for EU-migrants has been identified as 'gatekeepers'. The concept is used in this research to describe the person that hinders EU-migrants from accessing care. This came up while discussing professional codes for healthcare staff and problematizing the doctoral principle to provide care to people irrespective of legal status, or ethnicity. The gatekeepers were described as being people who are not medical educated in first hand. Four participants highlighted this phenomenon. As described by participant 7:

“it is not the doctor who is the problem, it is the person they meet first who is the one to say “No” and that is where it stops. It is the person in the hatch in the reception” (Participant 7).

Another participant's (nr.2) perception is in line with this, describing that it is not the doctors who deny care, but the receptionists, the administrative staff who perhaps is in charge of bills and have a different agenda than saving lives.

### Administrative barriers

“There were two people from Spain with origins in some African country who needed healthcare. One of them had a permanent residence permit in Spain and the other had a 5-year permit. We told them that we think they have the right to an EHIC so let us investigate that for you and come back with the information. We called the embassy and the Swedish Social Insurance Agency and found out that, yes, they have the right to the insurance card and therefore have the right to subsidized care in Sweden. The problem is that they cannot apply for the card here, neither through the embassy or the Internet, only citizens can do that and non-citizens have to apply for the EHIC on site in Spain. What we have here is a very unfortunate bureaucratic problem, these people have the right to healthcare paid for by Spain, but there is bureaucratic obstacles preventing their access” (Participant 5).

Participant 5 illustrates the difficulties people have to receive their EHIC due to administrative barriers. This has an impact on the access to healthcare. In accordance to this participant 6 also states that many people have the legal right to the EHIC but that they practically are not able to receive it. From the participants' stories there seem to be certain problems with the system in Italy, Spain, Bulgaria and Romania.

The EHIC can in many cases also be tied to work, participant 6 explains that especially people from Spain says that they had the card but once they became unemployed they lost it. One participant explains that they internally made an investigation and that it showed that many people have the right to the insurance card but cannot practically access it. People are very mobile and move around, this make it harder for them to access the card. For example it is often sent to ones home address and some people do not even have an address or a home.

“Practically, this can be solved from the Swedish Social Insurance Agency or from the healthcare centres but they do not have the resources or time to engage in theses questions” (Participant 6).

The participants unanimously perceive the people who not hold a EHIC as people as who are already on the edge of society and socially excluded. Concluding it is not all people who have the right to a EHIC, but more people than they thought from the beginning have the right.

This is especially noted in Stockholm where there is a higher amount of third country nationals than in Gothenburg. The participants' opinion are that it should be easy to access your EHIC. The fact that it is not easy accessible is by participant 1 described as an "idiotic, bureaucratic problem".

#### **7.4. Analysis: Barriers**

The perceptions of the participants of this research regarding the access to care for EU-migrants ended up to be described in four barriers. These barriers were partly in line with earlier research involving undocumented migrants (e.g. FRA, 2011; Socialstyrelsen, 2013; Stålgren, 2008) where barriers were identified both in the economic sector, the legal and in the administrative, although it sometimes was proved to have different meaning. For example FRA (2011) refers to administrative barriers as national and regional health politics.

The legal barrier identified by the participants has likewise been found in research about migrants' access to healthcare. In compliance with Zimmerman, Kiss & Hossein (2011) the participants think the legal entitlements for healthcare is not given enough space on the political agenda. By their stories they show that the existing legal entitlements are not enough and that after the implementation of the law for undocumented migrants, it has become even harder for EU-migrants to access care. International coordination can be seen as something the participants demand by arguing that the EU needs to step in and take responsibility. Here the thoughts of global governance come in. Ruger (2010b) envisions in the health capability paradigm that shared governance would give positive consequences on equality in access to healthcare. Ruger (n.d) argues that shared governance involves state and international governments and institutions along with non-governmental organizations, communities, families and individuals and that all must work together for social justice in the health area (Ruger, n.d). The participants' thoughts concerning obligations of the EU indicates that they want the EU to form regulations that give all EU-migrants the same right to healthcare no matter of their citizenship or nationality. Such coordination on all levels between countries would be what Ruger (n.d) refers to as global governance.

In line with the founding in this research Stålgren (2008) refers to gatekeepers as a threat to access to care for undocumented migrants. The participants in her study likewise the participants in this research refer to the administrative staff (receptionist or as in this study described as the person in the hatch) as the one who is a barrier to access for care. This is analysed to be an effect of insufficient knowledge within the area, which as well has been problematized by the participants. Some of the participants felt there was ways of overcoming this barrier by spreading knowledge and work with advocating activities. In the interviews two participants disclosed that when they accompanied a EU-migrant to the clinic and discussed with the gatekeeper, the EU-migrants finally received care. This reveals that the participants see themselves as useful and necessary to overcome the barrier with gatekeepers.

As for the financial barrier Marshall's ideas about social citizenship as well as Rawls' ideas about social justice are applicable to the issue with financial resources. Marshall ties the ideas about social citizenship to obligation of the citizens to for example engage in military services or to work and pay taxes. For the EU-migrants this make them non-citizens since many are unemployed or do undeclared work, adapting the ideas of Marshall would therefore mean the EU-migrants stand without rights. According to Lister (2003) migrants can be seen as a disadvantaged group in society and she argues that those are the people who are excluded when it comes to the idea of citizenship. In the case of EU-migrants they are rather excluded from their rights by being citizens of another country within the EU. They are here legal and

for that they cannot receive subsidized healthcare, would they not be here legal, they would have gone under the law for undocumented migrants and be granted healthcare. If citizenship is about inclusion and exclusion as Lister argues, EU-migrants are excluded due to citizenship. This is also something the participants of the study problematize and they argue that care shall be given to those in need. Healthcare shall not be based on judicial status.

Lister's (2003) concept of *excluded from within* is applicable to the perception the participants have about the situation of EU-migrants in Sweden. They live here legally but are denied their fully right to access social rights such as the right to health. In accordance to Arendt's thoughts about citizenship and who is a citizen, the human rights are by the result of this study based on legal status, and not solely based on being a human being.

Developing the thoughts of the financial barrier the participants prove this barrier to be one of the most important ones. One of the participants explained that some people cannot pay the normal fee when seeing a doctor, in other words, most of the EU-migrants without an EHIC are very poor. At first their lack of finances may lead to not seek care when in need and at second it may make them even more deprived than before. As for the theory of Rawls about social justice, he means that inequality can only be justified when it is to the greatest benefit of the least advantaged in society. The EU-migrants may very well be the least advantaged but does the inequality benefit them? According to the participants it do not, the economic differences in the EU and in Sweden are the reason they are here and the reason that they do not hold an EHIC is due to being poor, unemployed or due to discrimination. Ruger (2010) also argues that to be without a health insurance is an affect of a structural discrimination against the least advantaged in society.

The economic barrier cannot only be seen as personal but also as a barrier within the country. The question is if Sweden has the financial resources to finance healthcare for people who are not citizens. According to the participants this is not a problem. They think the costs for it would be low and argue that Sweden can afford it. The participants contradict the concept of social tourism, this phenomenon was also dismantled by Catto, Gorman & Higgins (2010) who showed that most people went home to their origin when in need for healthcare. Ruger (2010) advocates resource re-distribution, she means that people who are born in less advantaged setting, which the EU-migrants can be seen to be, should not live a more miserable life than people born rich, the type of resource distribution she talk about refers to a tax system and for this to function in the case of EU-migrants the system need to be on an EU-level, granting everyone who is a EU-citizen the right to healthcare.

Adapting the model of Ruger (2010) available on page 22 (Figure 1) to the participants' perceptions of barriers to access to healthcare, it becomes visible that all of them are on a structural level. In the circle for macro, social, political and economic environment obstacles can be identified as a part of this section to grant people health capability. The economic opportunity can on one hand be seen to be given EU-migrants through the free movements regulations but on the other hand, once in Sweden, it is almost impossible to get a job due to bureaucratic reasons and to lack of knowledge and skills. The social structures in society are proven to be of importance. They affect the EU-migrants' health status and are according to the participants tied to the social determinants of health. People being poor are the problem, not their health initially. Social structures in society like poverty (class) and ethnicity are triggers to migration.

The social structure discrimination is another structure visible in the lives of EU-migrants. Applying discrimination while exploring the health capabilities of EU-migrants creates a deeper understanding for the lack of health capability. The responsibility does not lie solely on the individual to make health choices. As Ruger states, governments have to construct a society for all. The health capability of a person is depending on social structures. If these are not fulfilled it have an impact on the health capability of people.

The barriers presented in this research are analysed to arise out of inequality, in other words the barriers show that the society is unequal. Rawls' thoughts of *justice as fairness* highlights the concept *Fair Equality of Opportunity*, which means everyone shall have equal opportunities in life apart from the natural talents or ambitions given to them biologically. One of the things referred to as important for equal opportunity is healthcare and Rawls means that equality should prevail in all societies for everyone no matter of ethnicity, gender or social class. The equality principle promotes a kind of distributive justice, in the situation of barriers for EU-migrants this would have implications of all of them, mainly for seeking equality in financial resources.

### 7.5. Improvements

The third category of the analysis consists of the participants' perceptions of how the situation for EU-migrants can be improved. An interesting finding in the material is that none of the participants mentioned improvements or development in the non-governmental sector, for example more money for projects helping EU-migrants or another volunteer clinic. This can be seen as that they mainly demand improvements at a structural level and that they think work shall not be carried out solely by NGOs. However the participants proposed mainly legal entitlements for improvements wherefore this is the main theme under the category improvements. The participants expressed a will for changes in Swedish regulations, they highlight the importance of human rights and responsibilities of the EU. The participants' perceptions have been arranged into three sub-themes; National level, European level and International law.

#### National level

Several of the participants question why this group are the only group standing outside the Swedish healthcare system and point out that this became visible first in July when the law for undocumented migrants came into force. "EU-migrants shall be included in the policies of healthcare for undocumented migrants, this would be an easy way out" states Participant 1. In accordance to this four other participants also see this as a solution, although perhaps not a temporary one.

"People without the insurance card shall be accounted for in the policy for undocumented migrants in Sweden, I do not think that will make a huge cost for the healthcare system. [...] It does not have to be more difficult than that" (Participant 1).

Moreover, one of the participants expressed the opposite opinion.

"I think we can develop a separate law for EU-migrants instead of including them in the regulations for undocumented migrants. They are different groups with different needs and undocumented migrants stay in Sweden for a longer period of time" (Participant 7).

”EU-migrants shall be included in the law for undocumented migrants, that would be a good start, and the children, the EU-migrating children, they shall be seen as any other child in Sweden. All children shall be entitled to the same care” (Participant 2).

When it comes to children, two of the participants agree upon the fact that children shall all be treated equally. One of the participants express that children cannot be held responsible for choices their parents have made. Intending to describe how children cannot understand the concept of nationality and must feel a strong exclusion from society when not being granted healthcare. Among the participants, two have taken action in the access for healthcare for children. On the foundation of the Convention on the Rights of the Child (CRC) one participant has advocated for EU-migrant children to access the same care as Swedish children by writing an appeal towards the policy board of the local hospital. This appeal is in the moment of writing still under inquiry.

As a respond to the earlier noted problem with knowledge among healthcare staff, one participant point out the importance of informational strategies and education. Both in Gothenburg and Stockholm NGOs work with advocating for EU-migrants’ situation in Sweden and many of the participants take part in outreaching activities. In the same way participant 5 describes the work with advocacy as the most important chance to change the situation referring back to the situation with undocumented migrants;

“We helped lot of people in the clinic but the most important job we did was to advocate for undocumented migrants right to healthcare, it was this job that led to the policy change and that have helped far more people than our clinic helped” (participant 5).

There was an overall final agreement between the participants that the legal support for healthcare has to be stronger, that it cannot rely on volunteer interventions and that the state have to take responsibility. Participant 4 express her thoughts through a rights-based perspective.

“the state, they must do something, Do something so they (the EU-migrants) have the right to see a doctor here in Sweden” (Participant 4).

### European level

Perceptions of improvements were among the participants often discussed as obligations, failures and who is responsible. On an EU level the participants agreed that the EU must take a larger proportion of responsibility and that EU need to pressure countries to have a universal health insurance system for its citizens. In relation to the barriers for access, suggestions are made in line with the barriers outlined in chapter 7.4. These for example include administrative changes that make it easier for people to access the EHIC.

“[...] that we jointly on EU-level work with access to EHIC, if you have a health insurance in your home country you should be able to access the EHIC quick and in an easy way” (Participant 5).

Another aspect of overcoming administrative barriers is that the EU shall monitor the EHIC system and make sure all countries meet the conditions for good healthcare. But also that the EU should make sure that all member countries have a good healthcare system. The participants continuing thoughts of this are that as long as some countries do not have a good

healthcare system accessible and subsidized for all we must have a Swedish legislation that state that all people who reside in Sweden have access to care based on need and based on equal terms. There is a consistency among the participants that the EU should take more actions, but as long as they do not, Sweden also has to take responsibility and fulfil human rights as it is obliged to.

### International law

It is clearly stated by at least two of the participants that Sweden cannot only focus on the obligations of the EU and other countries, but also has to focus on its own obligations within human rights. With rights come obligations and responsibilities:

“There has been a lot of focus on Romania and their responsibilities and very little focus on the responsibilities of Sweden. [...] The politicians, both in Sweden and international completely miss the obligations that Sweden has, and that is deeply unfortunate. I absolutely think that there is much room for improvement in e.g. Romania, which is a large sending country, but you have to also lift Sweden's responsibilities and obligations and make sure that you talk human rights on the home arena and not only in foreign affairs” (Participant 5).

When discussing the Human Rights the participants mention individual's right and responsibilities for the first time during the interviews. Participant 2 sympathizes that due to EU-migrants unawareness of their rights they are scared of authorities and scared to seek healthcare. Participant 1 thinks that one of the most important improvements is to empower the people that come to Sweden, make them knowledgeable about their rights and inform them of their lawful right to be here.

“many people do not have a clue what the EHIC is. When I ask them about it them they throw all sorts of different card on the table and ask me –which one is it that you want?” (Participant 6).

Interpreting the statements one can conclude that the participants find it highly important that EU-migrants become aware of their rights and that social work methods like empowerment and informational strategies are valuable tools.

### 7.6. Analysis: improvements

Interpreting the answers from the participants in this research in the field of improvements clarifies that the participants propose mainly changes on structural level. In accordance with the model of Ruger (2010, see page 22 in this research) this lays within the field of macro, social, political and economic environment. An interesting finding is that none of the participants place any blame on an individual level, or argue that that these people shall go back to their home country when in need for healthcare. Five of the participants suggest that EU-migrants shall be included in the law for healthcare for undocumented migrants as a way to improve the situation. This suggestion follow in line with Sen's (2008) reasoning that healthcare for migrants easily can be included in policies and legal entitlements. The importance of legal entitlements can somehow be problematic since many people lack knowledge of their own rights. Participant 1 mentions the organization's work with empowering methods as a way to overcome this. In accordance with previous research in the field of undocumented migrants it is stated that they seldom are aware of their right to healthcare, and that they need to be informed of their rights (Biswas et al., 2012; Socialstyrelsen, 2013).

The participants extensively describe the impact the law for undocumented migrants have had for EU-migrants and how they have noticed a difference in their work, that it have made it more difficult to access care. This can be interpreted as a wish that the state should take responsibility for the situation as we are used to in a socio-democratic welfare state (Payne, 2005). Governments should be encouraged to observe the most vulnerable people of society when they implement health policies and make sure that this people are benefitted (Backman, 2012). This goes hand in hand with the thoughts of Rawls on how only inequality is acceptable when it improves the life of the least advantaged.

The beliefs of the Swedish government when implementing the new law was surely to make it better but it left a group of people on the outside, something the probably did not account for. Social work often discusses the deserving and the undeserving clients, in the discourse of being a migrant one can wonder how the group undocumented migrants differs from deprived EU-migrants? Is one more deserving due to an illegal status in a country or due to having fled than someone who have fled out of poverty and with a wish to earn some money to support his/her family? Difficulties become apparent when questioning who is deserving and who is not.

Ruger (2010) also stress the need for legal entitlements to healthcare as she argues that social rights have always stood in the shadow of political and civil rights. The loss of a law to handle the situation in Sweden can as well be seen as an effect of what Ruger argues. As Benhabib (2005) states in her article, Europe has started to give rights to people due to being citizens in Europe, for example political rights. It seems according to this that social rights yet again have been overshadowed by what is perceived to be the more important rights. On the level of European improvement the participants agreed that all countries must take responsibility for its citizens, but at the same time they argued that when it does not seem to function well, Sweden have to step in and add up for that, by for example offer free healthcare. This is interpreted as a strong will for European equality among the participants, and as Braveman & Gruskin (2003) argue, all groups of people need equal opportunities to be healthy.

On the human rights basis the perceptions of the participants can be understood as a will for social justice beyond borders. Rawls declares that a global social justice is beyond the scope of his theory of justice, since it is based on citizenship, hence Ruger (2012) brings up problems like this by referring to a global health governance which aims for global justice through equality. Ruger argues that to achieve equality in health we need a global governance approach. Both social organisation and collective action is needed to reduce inequalities in health (Ruger n.d). For this research and after analysing the perceptions of the participants the global governance perspective makes sense of the participants suggested improvements. Ruger stresses that one key function of global governance is redistribution of resources, it can be an act between groups, within societies or between societies. This is analysed as what the participants ask for by saying that the EU needs to take more responsibility and that the member states of the EU need to collaborate to improve the situation for underprivileged groups within the union. Ruger empathizes that global governance for equity in health states have to allocate some of their resources as a good will, she describes it as:

[...] developed countries have a *legal right* to spend their money in accordance with their own objectives, they have an *ethical obligation* to do so in a manner that will improve the prospects of achieving equity in health in conjunction with

the constellation of other actors in the domestic and global arena. One goal, multiple actors” (Ruger, 2012, p. 14)

The thoughts of global governance to achieve equality in health, are consistent with the ideas of the participants and referred to by asking the EU to take more responsibility and to state that Sweden also has obligations towards all human beings.

The participants’ thoughts of improvement can be analysed to that they have a perception of every human beings equal dignity. The opinions of the participants are permeated by solidarity and equality and a strong will that people shall not be judged due to their nationality or ethnicity but that there shall be equal access for all. Healthcare shall be based on needs and not status and Sweden shall help those in need. Thus becomes evident for example through that non of the participants put any guilt on the group EU-migrants but illustrate that the improvements must come from above in the organizational chain. In conclusion the participants demand national action as well as actions from the EU. Those thoughts are consistent with international law, demanding rights and obligations connected to The Right to Health.

## **8. Concluding discussion**

The purpose of this study was to explore how professionals who work with EU-migrants perceive their right to healthcare in Sweden. The findings suggest that the access to healthcare differs from regions in Sweden, hence only the two largest cities; Stockholm and Gothenburg have been investigated. The differences in access are explained by regional and local health politics and differences in non-governmental projects within the municipality. The largest difference between the cities is that in Gothenburg a municipal health centre provides care for EU-migrants whereas in Stockholm, healthcare relies on NGOs to deliver. The participants expressed jealousy towards what they referred to as “a better climate for these questions” in Gothenburg. As for the access to healthcare all participants have experienced problems in the area, where people’s health have been adventured due to loss of legal entitlements. This is therefore one of the most important findings of this study; legal entitlements are lacking and in order to live up to human rights standards, the participants argue that Sweden need to act on this issue and live up to their obligations.

The participants all referred to Human Rights during the interviews and stated that the right to healthcare is important to the precarious situation. To investigate how international law can have implications on the right to healthcare for EU-migrants concepts of social justice and social citizenship have been used for the analysis. In conclusion they show that everyone has the right to health under article 12 ICESCR and according to the general comment N.14 of the committee on Economic, Social and Cultural Rights people are entitled this right despite judicial status (CESCR, 2000). In relation to accessibility the general comment also explores four areas of accessibility; *non-discrimination, physical accessibility, economic accessibility and information accessibility*. Applying these thoughts to this research shows problems in all four of the dimensions; EU-migrants are discriminated due to ethnicity, legal status and citizenship, the health facilities that are available differ between regions in Sweden and in both of the two investigated cities the accessibility depend upon the work of people in NGOs. Economic accessibility shows that EU-migrants have received care but paid a price not affordably for deprived people. Information accessibility includes the right to seek and receive information concerning health issues, such places are available for EU-migrants but still, lies on the shoulders of NGO’s doing volunteer work.



In accordance with previous research, this study has identified barriers for access to healthcare for EU-migrants, this by investigating the perceptions of the participants in relation to access, availability and rights. The barriers identified in this research were:

- *Legal*; a loss of legal entitlements were identified by the participants to affect access to healthcare.
- *Financial*; the participants have experienced how EU-migrants have been denied care due to loss of financial resources, they have also experienced how people got extended problems after receiving care for becoming liable to pay.
- *Gatekeeper*; Access to care was mainly thought to be denied by the gatekeeper person, who was described as being administrative staff.
- *Administrative*; the participants perceived that some people may have the right to the EHIC but cannot access it due to bureaucracy. It was also noted that in some countries the EHIC is tied to labour or to monthly payments which strikes hard on poor people.

None of the barriers were proven to be more or less extensive than the other but of course, if there were legal entitlements as a foundation for healthcare for EU-migrants, the other barriers would most probably not exist or be of different nature. In the same way that the barriers are tied to one another they are also interconnected to the thoughts that this research built upon of Human Rights and Social Justice. Both of these concepts can somehow be problematic and criticism can be pointed towards both of them for advocating an almost utopian society.

In relation to the participants' suggestions of improvements, questions arise in form of economic strains for Sweden. If EU-migrants are to receive subsidized healthcare, who shall pay for it? Research from Sweden during the discussion of healthcare for undocumented migrants did for example show that once Malmö decided to provide healthcare for undocumented migrants in 2008 it became less expensive than predicted (Vård För Alla, n.d).

Another criticism can be the concept of social tourism. In the interviews this phenomenon was declined from the participants' point of view and previous research has also declined the existence of social tourism (Catto, Gorman, & Higgins, 2010). Anyhow it can be problematized if it would be costly for Sweden to provide care for EU-migrants. On one hand it is evident that healthcare has a price, Sweden today already face problems with the healthcare system. Lack of staff, financial cutbacks and long queues speak against that more people should have access to healthcare without paying for it. On the other hand a healthy population is a source of income, in terms of labour and taxes. In line with the participants' perceptions that Sweden can afford to provide healthcare for EU-migrants, this research argues that the issue of health care for EU-migrants is not an economic issue. The cost in this context is very small in comparison to the human suffering caused by the absence of healthcare. Preventive care is cheaper than emergency care (IOM, 2010). The participants have explained that many EU-migrants have received invoices after receiving healthcare. In fact, it would perhaps cost less to offer subsidized healthcare, rather than letting people wait until the condition becomes acute, since the EU-migrant probably still will not be able to pay for emergency medical services.

Furthermore, the study finds that with a European Health Insurance Card (EHIC) EU-migrants can access care, anyhow there seem to be a problem with accessing the EHIC. This due to lack of knowledge of their own rights and due to bureaucratic, complicated national systems. In this research this barrier is referred to as an administrative barrier. The

participants witness that some people who are in need for healthcare are entitled to the EHIC but either does not have knowledge about it or nor can access it practically.

The inequalities in health and access to high quality care throughout Europe mainly affect people of low socioeconomic status, who are already poor, deprived, marginalized or vulnerable (IOM, 2010). If Sweden addressed these inequalities by making healthcare more inclusive it would benefit not only the migrants themselves but also society as a whole, and Europe as a whole. Nevertheless this research still highlights the importance of advocating methods towards other member states of the EU. If all member states within the EU had a universal health insurance, all EU-migrants would have an EHIC and be granted subsidized healthcare when in Sweden.

Applying the model of Ruger (2010a) *health capability paradigm* to the issues of access for EU-migrants to healthcare in Sweden has helped this research to recognize on which level improvements needs to be done. It has shown that capabilities are of importance but advocated that the inequalities we see among the citizens of Europe have implications on their health capabilities.

The findings of this study suggest that healthcare shall be based on need and not status. The participants request changes in the area of healthcare for EU-migrants, some suggest that they shall be included in the entitlements that give undocumented migrants right to health care in Sweden and some suggest that they need to have their own law, risking to mix two groups with very different needs. Furthermore the participants perceive that the EU needs to form policies that ensure all citizens of the EU a certain standard of living. Those thoughts have been analysed to Ruger's (n.d) thought about a global health governance, which aim for equality and equity in health, defending it on distributive thoughts that interact with Rawls ideas about social justice. The findings from this study somewhat reflects that as long as there is no way to handle this in the EU, Sweden needs to step up and meet the needs of EU-migrants. Hence, it was highlighted that we can not only say what others shall do but remember that Sweden has obligations under international law and that human rights must be addressed on the home arena and not only in foreign politics.

Although this research provides a broad overview of EU-migrants' access to healthcare in Sweden, it is important to recognise that there are gaps in available knowledge about this problem and that further research needs to be conducted to get a picture of the situation in Sweden as a whole. One participant of the research had both an inside and an outside perspective. Her perceptions were very interesting and gave depth to the analysis. More research that includes this perspective needs to be conducted in order to identify EU-migrants' needs. Recommendations, based on the information found in the interviews are in summary to keep highlighting EU-migrants' right to access to healthcare in Sweden. If certain people that are living in a society are excluded from healthcare for reasons like loss of legal entitlements, financial deprivation or administrative hassle it raises a human rights issue as the theoretical framework of this research has showed. Access to certain basic forms of healthcare cannot depend on a person's judicial status.

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## Appendix 1. – Informed consent

### Informed consent

The following is a presentation of how the data collected in the interview will be used.

The research project is a part of my education in the International Masters program in Social Work at the University of Gothenburg, Sweden. In order to insure that this project meets the ethical requirements for good research I promise to adhere to the following principles:

- Interviewees in the project will be given information about the purpose of the project.
- Interviewees have the right to decide whether he or she will participate in the project, even after the interview has been concluded.
- The collected data will be handled confidentially and will be kept in such a way that no unauthorized person can view or access it.

The interview will be recorded as this makes it easier for me to document what is said during the interview and also help me in the continuing work with the project. In the analysis some data may be changed so that no interviewee will be recognized. After finishing the project the recorded interviews and transcripts will be destroyed. The data I collect will only be used in this project.

You have the right to decline answering any questions, or terminate the interview without giving an explanation.

You are welcome to contact my supervisor or me in case you have any questions (e-mail addresses below).

Student name & e-mail

Kajsa Ahlström  
Kajsa\_ahlstrom@hotmail.com

Supervisor name & e-mail

Linda Lane  
linda.lane@socwork.gu.se

Interviewee

## **Appendix 2. – Interview guide**

### **Section 1: Background**

Who are you? Can you tell me about your self as a professional?

What does the concept EU-migrant mean to you?

- Who is a EU-migrants
- What is the difference between a EU-migrant and other migrants according to you?

What is your perception of the development of EU-migrants in Sweden (demographic, age, gender, class)

### **Section 2: Presentation of interviewee**

Can you tell me a bit more about how you interact with EU-migrants?

Do you have other experiences from working with migrants, refugees or people who are socially deprived?

Which problems do you consider EU-migrants have? Which are the most problematic areas according to you and why?

Can you describe how and why you encountered the issue with EU migrants and care?

What is your perception of their state of health?

### **Section 3: Access/availability**

Please, tell me how you think the situation in Sweden is today for EU migrants, in relation to care

- availability
- access
- rights

Have you been in a situation where you felt that there are issues around access to care for a EU migrants?

- If yes, please tell me. Do you have more examples?
- On which levels can you identify problems?

The latest years there has been a big debate in the community about health care for undocumented migrants and their right to health care, can you see any similarities / differences in comparison with EU migrants right to healthcare?

### **Section 4: Human rights, responsibilities and obligations**

If you think of the human rights, the right to health is recognized in a number of declarations that Sweden have ratified, what is your perception of that in relation to EU migrants' right to health care?

How do you perceive EU migrants' own awareness of their rights?

- About how they can get care and where?

Who do you, personally think are responsible for an equal right to health and care on equal terms?

**Section 5: actions and improvements**

Do you think the situation could be improved? If so, how, can you explain?

How would you, if you got to decide and had the resources, change the situation?

- If you enjoyed free choice, how would you like it to be?

**Section 6: Closure**

Is there anything else you would like to add that I have not asked about?

Can I get back to you if I have further questions?