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What Would Gunnar Myrdal  
Say? Sweden, the Right to  
Health and Ethnic and Racial  
Minority Migrants.

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# Summary

In the 1940s, Swedish Nobel laureate Gunnar Myrdal noted a disconnect between the American creed (liberty and justice for all, equality) and the status of African-Americans (marginalization, disenfranchisement, segregation). Decades later, a similar disconnect is currently reflected in Myrdal's Sweden. The state of health for ethnic and racial minority migrants clashes with Swedish policy dictated by its anti-discrimination legislation and international human rights treaty obligations.

Those who are not born in Sweden and who are not ethnically Swedish are more likely to suffer from poor mental and physical health. For documented migrants, the contrast between law and status is most dramatic. Domestic Swedish law is fairly consistent with what is required by Sweden's treaty obligations regarding the right to health and anti-discrimination. Nonetheless, discrimination and adherence to societal mores impede these migrants from attaining the highest possible standard of physical and mental health by creating conditions that foster unemployment and social exclusion – two important underlying social determinants of health. For undocumented migrants, both Swedish law and Swedish practice are inconsistent with Sweden's treaty obligations. For these migrants, care is unsubsidized and limited to immediate and emergency situations. Care is difficult to access and prohibitively expensive in many cases. For asylum seekers and failed asylum seekers who are not in hiding, their legal rights are more akin to undocumented migrants than legal Swedish residents. Domestic law entitles them only to subsidized care that cannot wait or emergency care. For all of these groups, a lack of cultural competence amongst caretakers may have a detrimental impact on the quality of care given when it is accessed. Consequently, Swedish compliance with international law regarding the right to health for its ethnic and racial minority migrants is mixed with triumphs and challenges.

In order to conform its practice and legislation to its treaty obligations, Sweden can look to domestic and international examples of good practice. These examples include more progressive legislation for undocumented migrants, making cultural competency a priority, involving ethnic and racial minority migrants in the health care process and identifying and targeting specific disparities. Ultimately, bridging the gap between treaty obligations and ethnic and racial minority migrants' health status will have a positive impact on the entire population.

# Methodology

This thesis has a dual purpose. Its first and principle purpose is to determine Sweden's international obligations regarding the right to health and to compare these obligations with current Swedish legislation and practice. Consequently, many international legal materials will be used to extrapolate these obligations. In order to determine with precision where Sweden is not fulfilling its obligations, it is necessary to take an interdisciplinary approach that includes the use of sociological, medical, political and anthropological sources. The right to health, in particular, is closely associated with States' medical and societal cultures. Legal materials are insufficient to evaluate these cultures. Therefore, medical sources are used to reinforce the assertion that there are health disparities between ethnic and racial minority migrants and ethnic native-born Swedes. Sociological and anthropological sources are used to extract relevant information about Swedish mores and the nature of discrimination in Sweden. While an interdisciplinary approach employs normativities distinct from the normativity of human rights law, this approach provides the essential tools necessary to evaluate how culture and societal norms influence legislation and the fulfillment, or lack thereof, of legal obligations.

The second purpose of this paper concerns good practice: to whom can Sweden look to address its challenges regarding the right to health for racial and ethnic minority migrants, regardless of status? In order to answer this question, it was imperative to look beyond bare legal solutions in order to determine what the content of such solutions would entail. Accordingly, examples of good practice were drawn from the legal and medical fields.

As this thesis concerns migrants who are ethnically and racially distinct from Swedes, the use of statistics was necessary in order to explore and develop many assertions. Sweden does not collect or maintain detailed statistics on ethnicity and race. Indeed, under the Swedish Personal Data Act, it is illegal to process personal data that identifies race or ethnicity.<sup>1</sup> Rather, Sweden records citizenship and country of birth. This proves problematic on a number of levels, some of which are discussed in this thesis. Nonetheless, it is not problematic for this work in and of itself. The primary focus of this thesis is the right to health as it pertains to ethnic and racial minority migrants and the most important facts are that these populations were neither born in Sweden nor are they ethnically Swedish. Thus, broad characterizations (born in Turkey, as opposed to Kurdish and born in Turkey) are not a detriment.

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<sup>1</sup> Personal Data Act (1998:204) sec. 13.

# Abbreviations

CERD	Convention on the Elimination of All Forms of Racial Discrimination
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CESCR	Committee on Economic, Social and Cultural Rights
CHD	Coronary Heart Disease
CRC	Convention on the Rights of the Child
CLAS	Culturally and Linguistically Appropriate Services
CVD	Cardiovascular Disease
EU	European Union
HSAN	Health and Medical Liability Care Board
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
OECD	Organisation for Economic Co-operation
OMH	Office of Minority Health (United States of America)
PTSD	Post Traumatic Stress Disorder
SMER	Swedish National Council on Medical Ethics
UDHR	Universal Declaration on Human Rights
VCLOT	Vienna Convention on the Law of Treaties

# 1 Introduction

*[R]ecognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world.* ~ Preamble, Universal Declaration of Human Rights<sup>2</sup>

Asylum seekers with untreated Post Traumatic Stress Syndrome (“PTSD”). Pregnant Somali women who travel to Germany to give birth. An apartment that is available for rent if your last name is “Svensson” but not if it is “Abdul”. An eleven-year-old girl forced to undergo a gynecological exam due to fear she had been circumcised. Welcome to public health policy and human rights in Sweden. Sweden is the birthplace and was home to famed Nobel laureate Gunnar Myrdal. Myrdal’s book “An American Dilemma: The Negro Problem and Modern Democracy”<sup>3</sup> had a profound effect on American racial policies. The problem with the United States, Myrdal asserted, was that ideals and practice simply did not match. Currently, this classic disconnection between ideals and policy are evident in Myrdal’s country of origin as Sweden struggles to conform practice to its international human rights law obligations related to the right to health. Discrimination, poor legal implementation, exclusion and lack of cultural competence are impediments to Sweden’s guaranteeing the highest attainable standard of health for its documented and undocumented migrant populations.

Sweden’s challenges, related to its migrant population, require examination for two important reasons. First, Sweden faces serious economic, social and cultural tensions and disruptions if its growing regular migrant population remains marginalized and vulnerable. Second, Sweden risks persistent violation of its human rights obligations if it continues to legally deny undocumented migrants and asylum seekers their internationally guaranteed right to health.

Like most of Europe, Sweden faces a dilemma in the coming decades. It risks becoming a financially insolvent welfare State as the population ages and the ratio of workers to pensioners decreases.<sup>4</sup> Immigration has been posed as one solution. However, for it to be a successful solution, any migrant population, like everyone else, must be physically and mentally healthy. Currently, the full realization of immigrants’ right to health in Sweden is complex as their immigration status and “otherness” combined with their race, ethnicity, gender and age make them targets for discrimination. For instance, regular migrants have lower employment rates, reside in segregated housing and are subjected to racial and ethnic based discrimination; guaranteeing their right to the highest attainable standard of health has proven difficult.

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<sup>2</sup> Universal Declaration of Human Rights, U.N. Doc A/810 (1948) preamble [hereinafter UDHR].

<sup>3</sup> G. Myrdal, *An American Dilemma: Volume 1: The Negro Problem and Modern Democracy* (Harper Collins, New York, 1944).

<sup>4</sup> C. Kesler, ‘Social Policy and Immigrant Joblessness’, 85:2 *Social Forces* (2006) p. 743.

Sweden enjoys a reputation of safeguarding human rights, providing a haven for asylum seekers and providing an efficient and generous subsidized health care system for its residents. This does not extend to the undocumented population (*gömda*). In addition to the adversity they face because they are ethnically distinct, undocumented migrants are also casually dismissed as “illegal aliens,” a nonsensical and prejudicial term whose use tacitly spurs racist and xenophobic sentiments and policies. Moreover, they are legally denied most forms of health care in Sweden. Health care for asylum seekers is also severely limited under Swedish law.

This thesis will examine the challenges Sweden faces in fulfilling its international obligations regarding the right to the highest attainable standard of health for documented and undocumented migrants whose backgrounds are ethnically and racially distinct from that of the Swedish majority. It does not include “national minorities” but rather, *de facto* minorities who do not have special status in Sweden. It is also limited to international law and does not delve into regional law.

Chapter one discusses race and ethnic theory under international human rights law and sociology, before establishing Sweden’s obligations toward ethnic and racial minority migrants and their right to health under international and regional law. Chapter two presents Sweden’s legislation, policy and practice on discrimination and the right to health. It also identifies the subjects of this thesis by briefly detailing Sweden’s migration patterns. Here, the Swedish paradox of integration in theory and assimilation in practice is introduced. Unemployment and social exclusion are explored as underlying social determinants of poor health. Chapter three utilizes medical studies to illustrate specific mental and physical health disparities between Sweden’s migrant minorities and the majority. For regular migrants, it examines disparities in access, including those caused by lack of cultural competence, racism and stereotyping. For undocumented migrants, stress caused by their hidden status, legal restrictions on care and lack of cultural competence are evaluated as the major impediments to attaining the highest standard of health. For asylum seekers, pre and post migration stress contribute to health disparities. Chapter four analyzes Sweden’s compliance with its responsibilities under the right to health by comparing its treaty obligations with its legislation, policy and practice. It examines the gap between policy and practice for documented migrants, as evidenced by unemployment, social exclusion, discrimination, a poorly implemented integration policy and mores. For undocumented migrants and asylum seekers, the focus shifts toward discriminatory laws and discriminatory practice. Lastly, chapter five explores international and domestic examples of good practice that, while not perfect, Sweden can look to for guidance in fulfilling its obligations under the right to health. Specific strategies and practices that are examined include an Italian law, regional Swedish rules, United States’ cultural competence practice and a Swedish multicultural hospital.



## 2 Ethnic and Racial Minority Migrants and International Law

*In the end anti-black, anti-female, and all forms of discrimination are equivalent to the same thing – anti-humanism. ~ Shirley Chisholm*<sup>5</sup>

Migrants compose 3% of the world population, numbering approximately 200 million.<sup>6</sup> Roughly half of these migrants are women.<sup>7</sup> In 2007, refugees numbered 11.4 million.<sup>8</sup> In 2008, 83,318 non-Swedes migrated to Sweden<sup>9</sup>, 24,353 applied for asylum and 11,237 residence permits were granted based on refugee status or subsidiary protection.<sup>10</sup> The number of undocumented migrants in Sweden is estimated between 15,000 and 100,000 persons with the 15,000 figure confined to failed asylum seekers who have remained in Sweden following unfavorable asylum decisions.<sup>11</sup>

Migration is a complicated and dynamic concept that is contingent on a number of factors. Migrants are a heterogeneous group that includes women, men and children of all ages. They may have migrated voluntarily or forcibly. Forced migration has a variety of complex and interrelated causes but the UNHCR counts “gross violations of human rights, including armed conflict, poverty and economic disruption, political conflicts, ethnic and inter-communal tensions and environmental degradation” among them.<sup>12</sup> Forced migration is usually identified with refugees and asylum seekers.

Voluntary migration is also contingent on a number of factors. Among these factors are economic conditions in the receiving and sending countries including the availability of employment and wages, family reunification, globalization, age and the presence of migrant networks in the receiving State.<sup>13</sup> Undocumented migrants are often affiliated with this category. However, as refugee status is not contingent on state recognition, but on fulfilling the criteria established by the Refugee Convention, some

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<sup>5</sup> Shirley Chisholm

<sup>6</sup> International Organisation for Migration, *Global Estimates and Trends*, <[www.iom.int/jahia/Jahia/about-migration/facts-and-figures/global-estimates-and-trends#1](http://www.iom.int/jahia/Jahia/about-migration/facts-and-figures/global-estimates-and-trends#1)>, visited on 4 April 2009.

<sup>7</sup> *Ibid.*

<sup>8</sup> *Ibid.*

<sup>9</sup> Statistiska Centralbyrån, *A Year of Milestones for Sweden*, 17 February 2009.

<[www.scb.se/Pages/Product\\_\\_\\_25799.aspx?produktkod=BE0101&displaypressrelease=true&pressreleaseid=262431](http://www.scb.se/Pages/Product___25799.aspx?produktkod=BE0101&displaypressrelease=true&pressreleaseid=262431)>, visited on 4 April 2009.

<sup>10</sup> Migrationsverket, *Facts and Figures 2008*, <[www.migrationsverket.se/english.html](http://www.migrationsverket.se/english.html)>, visited on 4 April 2009.

<sup>11</sup> Läkare Utan Gränser (Médecins Sans Frontière), *Experiences of Gömda in Sweden: Exclusion from Health Care for Immigrants Living Without Legal Status* (2005) p. 8.

<sup>12</sup> UNHCR *Executive Committee Conclusion No. 80 (XLVII)* (1996).

<sup>13</sup> S. Castles, ‘Why Migration Policies Fail’, 27:2 *Racial and Ethnic Studies*, (2003) pp. 208-210.

undocumented migrants may be refugees who have not applied for asylum or who have been denied asylum.

The nature of migration affects the individual's immigration status. Migrants may be documented or regular. These migrants reside in States with permission and have proper documentation to support this status. Migrants may also be undocumented or irregular. Undocumented status may result from several circumstances including entry without valid travel documents, illegal or irregular residence where the person entered legally but has overstayed their visa and illegal or irregular employment.<sup>14</sup> Asylum seekers, refugees and victims of trafficking may fall within gray areas under domestic laws. All of these migrants face challenges, particularly hostility from the receiving State. This xenophobia against non-nationals, particularly asylum seekers, refugees and migrants, is considered one of the main sources of contemporary racism and is linked to human rights violations.<sup>15</sup> Therefore, migrants' ethnic and racial backgrounds, gender and age necessitate protection from various forms of discrimination.

Regardless of discriminatory practice, migrants are entitled to most of the human rights that nationals are entitled to. Most human rights are inherent; they are not affected by migration status. While some civil and political rights can be limited to citizens, States must avoid differential treatment regarding unequal enjoyment of economic, social and cultural rights.<sup>16</sup>

The promotion and protection of human rights is a self-proclaimed priority of the Swedish government and Sweden has ratified an impressive number of international and regional treaties that safeguard human rights. Among those that are most pivotal for the right to health are the International Covenant on Economic, Social and Cultural Rights ("ICESCR"), International Convention on the Elimination of All Forms of Racial Discrimination ("CERD"), Convention to End All Forms of Discrimination Against Women ("CEDAW"), Convention on the Rights of the Child ("CRC") and the Refugee Convention.<sup>17</sup>

Under the principle of *pacta sunt servanda*, all treaties in force are binding on the parties who have ratified it.<sup>18</sup> These States must perform their obligations under the treaty in good faith.<sup>19</sup> Human rights treaties also contain *erga omnes* obligations that are owed to the entire international

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<sup>14</sup> S. Loue, 'Immigrant Access to Health Care and Public Health: An International Perspective', 17:2 *Annals of Public Health* (2008).

<sup>15</sup> *World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance, Programme of Action Declaration*, 8 September 2001, U.N. Doc. A/CONF.189/5 (2001) art. 16 [hereinafter Durban Declaration].

<sup>16</sup> UNHCR, *The Rights of Non-Citizens*, HR/PUB/06/11 (2006).

<sup>17</sup> International Covenant on Economic, Social and Cultural Rights, U.N. Doc. A/6316, 993 U.N.T.S. 3 (1966) art. 2 [hereinafter ICESCR]; International Convention on the Elimination of All Forms of Racial Discrimination, 660 U.N.T.S. 195 (1969) [hereinafter CERD]; Convention on the Elimination of All Forms of Discrimination Against Women, U.N. Doc. A/34/46 (1981) [hereinafter CEDAW]; Convention on the Rights of the Child, U.N. Doc. A/44/49 (1990) preamble [hereinafter CRC]; Convention Relating to the Status of Refugees, 189 U.N.T.S. 150 (1954) [hereinafter Refugee Convention].

<sup>18</sup> Vienna Convention on the Law of Treaties, U.N. Doc. A/Conf 39/28, 1155 U.N.T.S. 331, art. 31 [hereinafter VCLOT].

<sup>19</sup> *Ibid.*

community.<sup>20</sup> Failure to fulfill these obligations may constitute a breach for which the State is potentially responsible. The International Law Commission's well-received Draft Articles on Responsibility of States for Internationally Wrongful Acts specifies the general principles and basic rules that govern States in this regard.<sup>21</sup>

The draft articles apply responsibility when obligations are owed to States, an individual, groups or international communities as a whole.<sup>22</sup> This includes human rights obligations. In order for States to incur responsibility, the act must be attributable to the State and it must constitute a breach of an international obligation.<sup>23</sup> First, acts are attributable to a State when committed by the legislative, executive or judicial organs or other organs that exercise functions.<sup>24</sup> An organ includes persons or entities that have status under internal law.<sup>25</sup> Responsibility is also incurred when persons exercise government authority and when they act under the direction, control or instruction of the government.<sup>26</sup> Adopting and acknowledging conduct as its own will create State responsibility.<sup>27</sup> Second, breaches occur when a State does not conform to its treaty obligations regardless of the origin or character of the non-conformity.<sup>28</sup>

Thus, Sweden is responsible for official acts, instructions to act, omissions and/or behavior it adapts as its own that do not conform to its treaty obligations on the right to health. By ratifying treaties, Sweden has legally bound itself to the provisions within them. Accordingly, it must take measures to ensure that the rights detailed within the conventions are realized by its citizens and, regarding most rights, those within Sweden's jurisdiction.

## 2.1 Sweden's Obligations Under the Prohibition Against Discrimination

At times, it is difficult to determine if it is race and ethnicity or migration status that fuels animosity toward migrants. When the leader of a Swedish political party advocates for sending Ugandans back to Uganda<sup>29</sup>, is this because they are Africans? Foreigners? Black or Asian? Such animosity may lead to discrimination, so it is important to determine the scope of anti-discrimination under international law.

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<sup>20</sup> G. Noll, Email Correspondence, 2 April 2009.

<sup>21</sup> International Law Commission, *Draft Articles on Responsibility of States for Internationally Wrongful Acts with Commentaries* (2001), paras. 1, 2, p. 31. <[untreaty.un.org/ilc/texts/instruments/english/commentaries/9\\_6\\_2001.pdf](http://untreaty.un.org/ilc/texts/instruments/english/commentaries/9_6_2001.pdf)> visited on 1 April 2009 [hereinafter Draft Articles].

<sup>22</sup> *Ibid.*, para. 5, p. 32.

<sup>23</sup> *Ibid.*, art. 2, p. 34.

<sup>24</sup> *Ibid.*, art 4(1), p. 40.

<sup>25</sup> *Ibid.*, art. 4(2), p. 40.

<sup>26</sup> Draft Articles, *supra* note 21 arts. 5, 8, pp. 42, 47.

<sup>27</sup> *Ibid.*, art. 22, p. 52.

<sup>28</sup> *Ibid.*, art. 12, p. 54.

<sup>29</sup> J. Guillou, Aftonbladet, *SD's Svarta Kärna*, 19 February 2008 <[www.aftonbladet.se/nyheter/article4449732.ab](http://www.aftonbladet.se/nyheter/article4449732.ab)>, visited on 5 April 2009.

Racial discrimination, proscribed by a myriad of human rights instruments<sup>30</sup>, is defined as

any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life.<sup>31</sup>

Clearly, the prohibition against racial discrimination is multifaceted. It includes race as well as color, descent and ethnicity. The prohibition applies to civil and political as well as economic, social and cultural rights.

Under international law, States have many positive obligations to combat racial discrimination. Of particular importance and directly related to migrants' right to health is the obligation to "take effective measures to review governmental, national and local policies, and to amend, rescind or nullify any laws and regulations which have the effect of creating or perpetuating racial discrimination wherever it exists" detailed in CERD.<sup>32</sup> Although CERD's provisions do not apply to distinctions, exclusions, restrictions or preferences made by State parties between citizens and non-citizens, this does not give States permission to freely discriminate against undocumented migrants.<sup>33</sup> Differential treatment based on citizenship or immigration status can still constitute discrimination. In this case, discrimination occurs when the criteria for differentiation, when judged in light of the Convention's object and purpose, are not proportional to the achievement of this aim.<sup>34</sup> This is further developed in section 2.2.2.

The prohibition against racial discrimination is so ingrained in domestic and international law that it has risen to the level of customary international law.<sup>35</sup> When a prohibition or rule rises to the level of custom, every State is legally bound to follow it. In order for a rule of international law to become custom, there must be widespread and consistent state practice and *opinio juris*. *Opinio juris* is the psychological phenomenon of feeling bound to the norm. In this case, the domestic laws of individual States as well as wide ratification of international treaties forbidding racial discrimination, demonstrate State practice and *opinio juris*.

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<sup>30</sup> UDHR, *supra* note 2 arts. 2, 7 16; Refugee Convention, *supra* note 17 art. 3; ICESCR, *supra* note 17 art. 2; International Covenant on Civil and Political Rights, U.N. Doc. A/6316, 999 U.N.T.S. 171, arts 2, 4, 24, 26 (1966) [hereinafter ICCPR]; CERD, *supra* note 17; International Convention on the Suppression and Punishment of the Crime of Apartheid, U.N. Doc. A/9030, 1015 U.N.T.S. 243 (1976), CRC, *supra* note 17 preamble; European Convention for the Protection of Human Rights and Fundamental Freedoms, 213 U.N.T.S. 222 (1953) art. 14; American Convention on Human Rights, U.N.T.S. 123 (1978) art. 1; African [Banjul] Charter on Human and Peoples' Rights, 21 I.L.M. 58 (1986) preamble, art. 2.

<sup>31</sup> CERD, *supra* note 17 art. 1.

<sup>32</sup> *Ibid.*, art 2(1)(c).

<sup>33</sup> *Ibid.*, art. 1(2).

<sup>34</sup> Committee on the Elimination of Racial Discrimination, *General Recommendation 30: Discrimination Against Non-Citizens*, U.N. Doc. CERD/C/64/Misc.11/rev.3 (2004) para. 4 [hereinafter CERD Committee General Recommendation 30].

<sup>35</sup> M.N. Shaw, *International Law* (Cambridge University Press, Cambridge, 2003) p. 266.

While the legal norms and obligations are well established, the definitions for “race” and “ethnicity,” as international law concepts, are imprecise. In social science, ethnicity refers to a genuine “process of historical individuation,” namely dynamic linguistic and cultural practices that create a collective identity which carries through subsequent generations and produces roots.<sup>36</sup> Ethnicity is not defined in international law, but instead is often connected to race and, as aforementioned, is included under the penumbra of racial discrimination. However, elucidation on ethnicity is provided by “minority” status in international law.

Ethnic minority status in international law is connected to having a language, religion and/or culture distinct from the dominant societal group. The International Covenant on Civil and Political Rights (“ICCPR”) envisages ethnic minorities as those whose rights to culture, religion and language should be protected and enjoyed.<sup>37</sup> Moreover, these rights are not contingent on residential status or State recognition of the minority; they apply where minorities “exist”.<sup>38</sup>

More so than ethnicity, race is a complex concept that is difficult to define. In fact, social scientists and biologists often avoid the use of the word “race” as a biological concept as “there are no measurable characteristics among the human populations that allow classifications into races”.<sup>39</sup> Race, commonly understood as the physical markers of difference such as hair color, skin color and features, is denounced by these critics as a purely social construction produced by the process of racism.<sup>40</sup> This definition is consistent with international human rights law.

There is a tendency in international law to avoid defining race and to separate race from biology. The Durban Declaration and Report of the World Conference Against Racism, Racial Discrimination and Xenophobia both refer to “socially constructed races” but do not define race.<sup>41</sup> The Report of the World Conference’s preamble “strongly rejects the existence of so called distinct human races”.<sup>42</sup> The Declaration on Race and Racial Prejudice also declines to define race but asserts that, “all human beings belong to a single species and are descended from a common stock”.<sup>43</sup> In distilling the essence of the prohibition against racial discrimination, the Declaration does appear to identify origin, culture and difference as indicators of race. Finally, the pivotal treaty regarding racial discrimination, CERD does not define race but, like the aforementioned critics, chooses to utilize racial discrimination as its focus.

Consequently, this paper adopts the definition of race as a social construction produced by the process of racism, which has been defined in

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<sup>36</sup> S. Castles and M. Miller, *The Age of Migration: International Population Movements in the Modern World*, (Palgrave Macmillan, Hampshire, 2003) p. 33 citing P. Cohen and H.S. Bains (eds.), *Multi-Racist Britain* (Palgrave Macmillan, London, 1988) pp. 24-5.

<sup>37</sup> ICCPR, *supra* note 30 art. 27.

<sup>38</sup> *Ibid.* See also General Comment No. 23: Art. 27. CCPR/C/21/Rev.1/Add.5 (1994); *Greco-Bulgarian Communities*, 31 July 1930, PCIJ Series B, No. 17, para. 16.

<sup>39</sup> Castles and Miller, *supra* note 36 p. 34.

<sup>40</sup> *Ibid.*

<sup>41</sup> Durban Declaration, *supra* note 15 para. 171; U.N. Doc. A/CONF189/12 (2001).

<sup>42</sup> U.N. Doc. A/CONF189/12 (2001) preamble.

<sup>43</sup> *Declaration on Race and Racial Prejudice*, E/CN.4/Sub.2/1982/2/Add.1 (1982).

international law as including “racist ideologies, prejudiced attitudes, discriminatory behaviour, structural arrangements and institutionalized practices resulting in racial inequality as well as the fallacious notion that discriminatory relations between groups are morally and scientifically justifiable.”<sup>44</sup>

Accordingly, at minimum, Sweden is forbidden from discriminating against migrants based on ethnicity and the social construction of race and must take positive steps to combat such discrimination. Curtailing of rights based on migration status violates international law if such action is disproportionate and contrary to the object and purpose of CERD and other conventions. This will be explored in greater depth, especially as it related to the right to health, in the next chapter.

## **2.2 Sweden’s Obligations Under the Right to the Highest Attainable Standard of Health**

The right to health and other economic, social and cultural rights, the so-called “second generation of human rights” are subject to progressive realization. However, Sweden, as a wealthy, developed welfare State, is entitled little latitude regarding the fulfillment of its economic, social and cultural rights obligations. The international covenants that Sweden has ratified will be examined and discussed in order to determine the scope of the right to health generally and, more specifically, the right to health for migrants. General comments by the committees charged with interpreting the treaty provisions will provide clarity. In the case of economic, social and cultural rights, this responsibility lies with the Committee on Economic, Social and Cultural Rights. Any discussion of the right to health would be considerably less relevant without the clarification provided by general comments. The Committees’ interpretation possesses a “considerable degree of legitimacy.”<sup>45</sup> While general comments are not binding, they have highly persuasive authority. The comments are written by treaty committees composed of respected jurists; their teaching are considered a source of international law.<sup>46</sup> States are expected to respect the general comments and Courts often apply them.

### **2.2.1 ICESCR Article 12**

Before the right to health was recorded in an international instrument, Swiss writer Henri Frederic Amiel described it perfectly, “In health there is

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<sup>44</sup> *Ibid.*

<sup>45</sup> M Sepúlveda, *The Nature of the Obligations Under the International Covenant on Economic, Social and Cultural Rights* (Intersentia Uitgevers, New York, 2003) p. 88.

<sup>46</sup> Statute of the International Court of Justice, 26 June 1945, 59 Stat. 1055, art. 38(d).

freedom. Health is the first of all liberties.”<sup>47</sup> Amiel was alluding to the interrelation and interdependence of human rights. The right to health is an excellent example of this. It is indispensable for the exercise of other human rights and is essential for living a life of dignity.<sup>48</sup> Health affects one’s right to family, right to be free of torture, right to employment, right to religion and many other rights.

The conception of health is broad, subjective and influenced by geographical cultural and socio-economic factors.<sup>49</sup> The scope of the right to health is expansive and State obligations are detailed and numerous. Article 12 of the ICESCR, and its general comment, demonstrate this. Article 12 reads:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.<sup>50</sup>

Article 12 highlights the two distinct, but connected, types of health: mental and physical. Deterioration of either mental or physical health can have a detrimental effect on the realization of other human rights.

Article 12 also presents States with challenges that it must address. It effectively distills the right to health into two parts that were established in the UDHR’s Article 25(1), which recognizes the right to a standard of living adequate for health including medical care and necessary social services.<sup>51</sup> The first part “standard of living adequate for health” concerns underlying determinants of health.<sup>52</sup> These include, but are not limited to, food and nutrition, access to safe drinking water, adequate sanitation, safe and healthy working conditions and a healthy environment.<sup>53</sup> The second part concerns the care itself. Quality healthcare should be accessible, acceptable and available.

Obligations arising from article 12 are not limited to what is explicitly in the convention. In 2000, the Committee on Economic Social and Cultural Rights published a comment to clarify States’ responsibilities under the

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<sup>47</sup> Henri Frederic Amiel

<sup>48</sup> Committee on Economic, Social and Cultural Rights, *General Comment 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (2000) para. 4 [hereinafter CESCR General Comment 14].

<sup>49</sup> B. Toebes, ‘The Right to Health’ in A. Eide, C. Krause and A. Rosas (eds), *Economic, Social and Cultural Rights*, (Martinus Nijhoff, Dordrecht, 2001) p. 174.

<sup>50</sup> ICESCR, *supra* note 17 art. 12.

<sup>51</sup> UDHR, *supra* note 2 art. 25(1).

<sup>52</sup> *Ibid.*

<sup>53</sup> Toebes, *supra* note 49 p. 174.

right to health. As with many other rights, States must abide by the mantra of respecting, protecting and fulfilling the human right to health. The duty to respect reinforces the duty to refrain from discrimination. In order to adequately respect the right to health, States must refrain from denying or limiting equal access to everyone.<sup>54</sup> The duty to protect includes drafting legislation and taking other measures to ensure equal access to healthcare and ensuring that third parties do not interfere with a person's right to health.<sup>55</sup> Lastly, the duty to fulfill means that States must adopt detailed national health plans. They must also address the underlying determinants of the right to health and ensure equal access to these determinants or combat the negative determinants.<sup>56</sup>

The comment lists determinants such as safe nutritious food, potable drinking water and adequate housing. The use of "such as," coupled with the Committee's insistence that socio-economic preconditions are included in the normative definition of the right to health, indicates that this list is not exhaustive. There are also social determinants of health. The World Health Organization identifies poverty, employment, social exclusion and equal treatment as social determinants.<sup>57</sup>

The right to health also contains four "interrelated and essential" standards: availability, accessibility, acceptability and quality.<sup>58</sup> States must provide functioning public health and healthcare facilities, goods, services and programs in sufficient quantities in order to comply with the availability standard under the right to health.<sup>59</sup> These facilities must also successfully address the underlying determinants of health and should have essential and non-expired drugs as well as competitively paid staff.<sup>60</sup>

The accessibility standard adopts non-discrimination as a principal value. Accessibility must be realized in law and in fact.<sup>61</sup> Health facilities, goods and services must be accessible to all including the most vulnerable and marginalized people without discrimination on any of the grounds prohibited by international law.<sup>62</sup> These facilities, goods and services must be designed to respect confidentiality and to improve health. States also have to ensure that their facilities are physically and economically accessible. Information accessibility is a further requirement. This includes the right to seek, receive and dispense ideas concerning health issues.<sup>63</sup>

The acceptability standard also has roots in anti-discrimination. It requires that all health facilities be both respectful of medical ethics and culturally appropriate.<sup>64</sup> This translates into respect for individuals' and

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<sup>54</sup> CESCR General Comment 14, *supra* note 48 para. 34.

<sup>55</sup> *Ibid.*, para. 35.

<sup>56</sup> *Ibid.*, para. 36.

<sup>57</sup> World Health Organization, Commission of Social Determinants of Health, *Health Equality Through Action on the Social Determinants of Health* (2008) pp. 34, 39, 152-53, 171-72.

<sup>58</sup> *Ibid.*, para. 12.

<sup>59</sup> CESCR General Comment 14, *supra* note 48 para. 12(a).

<sup>60</sup> *Ibid.*

<sup>61</sup> *Ibid.*

<sup>62</sup> CESCR General Comment 14, *supra* note 48 para. 12(b).

<sup>63</sup> *Ibid.*, para. 12(b).

<sup>64</sup> *Ibid.*, para. 12(c).



minorities' cultures in addition to gender and life-cycle sensitivity.<sup>65</sup> One measure implied by the acceptability provision is the implementation of policies that encourage cultural competence. Cultural competence is defined as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations".<sup>66</sup> Here, culture refers to the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups.<sup>67</sup> Competence is reached when an individual or organization has the capacity to function effectively in regards to the cultural beliefs, behaviors and needs presented by consumers and their communities.<sup>68</sup> The practitioner must treat the patient as an individual and must avoid stereotyping, while keeping culture in mind. This is not an easy task and it requires training.

Cultural acceptability is a prerequisite in the quality standard as well. Quality further dictates that health facilities, goods and services must be scientifically and medically appropriate.<sup>69</sup> It includes the hiring of skilled personnel, stocking appropriate and unexpired drugs and having safe and potable drinking water.<sup>70</sup>

As the requirements above demonstrate, the right to health imposes both positive and negative obligations on States. They must refrain from certain behaviors and adopt others. While the right to health is not synonymous with the right to *be* healthy, States are obliged to take certain measures to ensure that people's pursuit of the right to the highest attainable standard of health is both unencumbered and State supported. Nonetheless, States are not legally bound to ensure good health. The presence of genetic factors, individual susceptibility and lifestyles are influences that are often beyond the State's control.<sup>71</sup>

Though not responsible for everyone's "good health," States have core, concrete obligations under the right to health. These core obligations are non-derogable and any failure to comply with them is unjustifiable under "any circumstances whatsoever".<sup>72</sup> The following core obligations are the most relevant for ethnic and racial minorities and their right to health in Sweden:

- (a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and

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<sup>65</sup> *Ibid.*

<sup>66</sup> See generally, T. Cross et al., *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed* (1989).

<sup>67</sup> *Ibid.*

<sup>68</sup> *Ibid.*

<sup>69</sup> CESCR General Comment 14, *supra* note 48 para. 12(d).

<sup>70</sup> *Ibid.*

<sup>71</sup> *Ibid.*, para. 10.

<sup>72</sup> *Ibid.*, para. 47.

transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.<sup>73</sup>

The Committee also includes the following as obligations of “comparable priority”:

- (a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care;
- (b) To provide immunization against the major infectious diseases occurring in the community;
- (c) To take measures to prevent, treat and control epidemic and endemic diseases;
- (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;
- (e) To provide appropriate training for health personnel, including education on health and human rights.<sup>74</sup>

Both sets of obligations echo the availability, accessibility, acceptability and quality standards detailed earlier in the comment. They also address the two branches of the right to health.

The core obligations emphasize the underlying determinants of the right to health. Discrimination, outlined in obligation a, may be both an underlying determinant of health and an issue that influences access. The final core obligation, regarding the implementation of a national public health regime, establishes a transparent process for realizing the right to health and once again reaffirms the right’s application to vulnerable groups.

The high priority obligations build on this by identifying women and children as particularly vulnerable groups whose right to health might require extra effort to safeguard. Obligations b and c both relate to reducing diseases and epidemics. Obligations d and e both focus on information as an essential tool for realizing the right to health.

In addition to these obligations, there is the question of remedies when the right to health is violated by a State. A person or group must have access to “effective judicial or other appropriate remedies” under international law.<sup>75</sup> Victims are entitled to remedies, restitution, satisfaction or guarantees of non-repetition given by a national ombudsman, patient’s rights group, consumer forum or similar institutions.<sup>76</sup>

Without question, the right to health is broad and demanding. Under this regime, Sweden is obliged to respect, protect and fulfill the right to the highest attainable standard of both mental and physical health. In doing so, it must address both health care and the underlying determinants of health. Sweden is further compelled to ensure that availability, accessibility, acceptability and quality are present in the public health plan and its execution. It is also bound to address the core and high priority obligations

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<sup>73</sup> *Ibid.*, para. 43.

<sup>74</sup> CESCR General Comment 14, *supra* note 48 para. 44.

<sup>75</sup> *Ibid.*, para. 59.

<sup>76</sup> *Ibid.*

proscribed by the Committee and implicit in the ICESCR. Sweden must draft legislation and take measures to ensure the right to health. It must refrain from employing discriminatory laws, practices and policies. Lastly, it must ensure that proper remedies are available when violations do occur.

## 2.2.2 Migrants and the Right to Health

The “healthy migrant” phenomenon dictates that migrants tend to be stronger and healthier than the populations that they have left in their countries of origin.<sup>77</sup> However, once they settle in their countries of destination, the full realization of their right to the highest attainable standard of health is often impeded by discrimination.<sup>78</sup> Discrimination, in its many forms, affects migrants’ mental and physical health as well as access to healthcare and quality of care. Social isolation, poverty, downgraded status and a hostile local population often triggers poor mental health.<sup>79</sup> This can exacerbate pre-existing mental health conditions for those who have faced persecution, danger, violence and/or who suffer from PTSD.<sup>80</sup>

Documented migrants are entitled to the full enjoyment of the right to the highest attainable standard of health. In fact, the right to health becomes arguably more stringent when applied to migrants in a manner consistent with the principle of non-discrimination. Healthcare facilities, goods and services must respect individual and minority culture. In placing the burden on States to devise a public health care strategy that addresses the needs of “the whole population,” the Committee clearly contemplated discrimination and its effect on both health itself and access to healthcare.

Several classes of migrants are identified under the right to health including asylum seekers, those who require subsidiary protection, refugees and the undocumented. Refugees legally in a State are entitled to social security that addresses occupational diseases, sickness, old age, maternity and disability.<sup>81</sup> These refugees are entitled to the same healthcare as nationals.<sup>82</sup> Those granted subsidiary protection are entitled to “core benefits.”<sup>83</sup>

International treaty law is not as clear regarding undocumented and asylum seeking migrants and States are less amenable to guaranteeing their right to the highest attainable standard of health. There are several concerns that States express to justify denying undocumented migrants health care that is identical to residents or nationals: costs, strains on resources and fear of an influx of undocumented migrants. For a State like Sweden, where

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<sup>77</sup> Global Equity Gauge Alliance, *Global Watch 2: An Alternative World Health Report* (2008) p. 63.

<sup>78</sup> *Ibid.*, p. 63. See also J. Bustamante, World Health Organization, *Health of Migrants: Report of Secretariat; Report of the Special Rapporteur on the Human Rights of Migrants*, E/CN.4/2006/73 (2006).

<sup>79</sup> Global Equity Gauge Alliance, *supra* note 77 p. 63.

<sup>80</sup> *Ibid.*

<sup>81</sup> Refugee Convention, *supra* note 17 art. 24(1)(b).

<sup>82</sup> *Ibid.*, art. 29.

<sup>83</sup> *Ibid.*

income tax is a large contributor to health care funds, equity is a concern. Undocumented migrants do not contribute income taxes in the same way or to the same degree as residents and nationals may. Finally, States may point to the migrants themselves. Some may be in transit and unlikely to use the health care system while others are in hiding and may not use it out of fear. These concerns are legitimate, practical and political. They are not legal. They do not consider the treaty obligations that States have bound themselves to via ratification and as members of the international community. From an international law perspective, the right to health must not be contingent on immigration status. Surely, human dignity and human rights are not confined to one's country of birth, naturalization or residence.

Treaty interpretation supports the assertion that the right to health is not dependant on immigration status, especially in developed States. A treaty must be interpreted in good faith with ordinary meaning given, in context, to terms in light of the treaty's object and purpose.<sup>84</sup> A treaty's purpose can be gleaned from its preamble and annexes.<sup>85</sup> State practice and relevant rules of international law are also applicable.<sup>86</sup>

When interpreted in light of the object and purpose of the treaty, the prohibition against discrimination based on "other status" in the ICESCR accommodates undocumented and asylum seeking migrants. The ICESCR's preamble recognizes inherent human dignity and the equal and inalienable rights of all human beings.<sup>87</sup> Article 2 of the ICESCR forbids discrimination based on "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status."<sup>88</sup> Article 3 dictates that only developing nations may alter guarantees of covenant rights for non-nationals.<sup>89</sup> According to this article, developed nations may not distinguish between non-nationals and nationals in their application of the rights listed in the covenant. Finally, the inclusive language in the covenant is important: article 12 grants "everyone" the right to enjoy the highest attainable standard of physical and mental health and States are obliged to create conditions which would assure medical service and medical attention to "all" in the event of sickness. The articles and preambles demonstrate that failing to protect undocumented migrants' full right to health is inconsistent with the ICECSR's object and purpose of safeguarding human dignity and preventing discrimination.

Denying undocumented and asylum seeking migrants' their right to health is also inconsistent with the treaty's interpretation by the Committee on Economic, Social and Cultural Rights. The Committee singles out undocumented migrants by asserting that States have a specific legal obligation to respect the right to health by "refraining from denying or limiting equal access for all persons...including minorities, asylum seekers and illegal immigrants to preventative, curative and palliative health

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<sup>84</sup> VCLOT, *supra* note 18 art. 31.

<sup>85</sup> *Ibid.*, art. 31 (2).

<sup>86</sup> *Ibid.*, art 31(3)(c).

<sup>87</sup> ICESCR, *supra* note 17 preamble.

<sup>88</sup> *Ibid.*, art. 2 (2).

<sup>89</sup> *Ibid.*, *supra* note art. 3.

services”.<sup>90</sup> They also advocate that socially disadvantaged groups be entitled to affordable services.

The same interpretation holds true for CERD. Its preamble includes similar language underscoring the importance of equality and dignity.<sup>91</sup> More than that, the Committee on the Elimination of Racial Discrimination urges States to remove obstacles to economic, social and cultural rights including the right to health and echoes the CESCRC’s respect standard concerning access to preventative, curative and palliative health services”.<sup>92</sup> Finally, denying health care to undocumented and asylum seeking migrants could also be considered a “disproportionate” response to their presence be it irregular or semi-regular.

### 2.2.3 Migrant Women and Children and the Right to Health

Due to their relatively low status, migrant women and children are very susceptible to maltreatment and denial of the right to health. In addition to non-discrimination and rights applicable to migrants, women and children are afforded special protection under the right to health. Health facilities, goods and services must be accessible to women and children.<sup>93</sup>

The combination of migration, sex and ethnicity create numerous obstacles for migrant women concerning the realization of their right to health. They often face greater difficulty than their native counterparts in accessing sexual and reproductive health services.<sup>94</sup> Restricted access to these services renders migrant women more susceptible to death or injury during childbirth, unwanted pregnancy and sexually transmitted diseases.<sup>95</sup>

Accordingly, States are required to abstain from imposing discriminatory practices related to women’s health.<sup>96</sup> This includes policies directed toward family planning, pregnancy and the post-natal period.<sup>97</sup> In order to eliminate discrimination, States should develop and execute a comprehensive national strategy that promotes women's right to health throughout their lives.<sup>98</sup> This strategy should target the prevention and treatment of diseases affecting women and create policies that ensure access to a wide range of “high quality and affordable health care, including sexual and reproductive services”.<sup>99</sup> The Committee recommends that States integrate a gender perspective into their public health plan in order to

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<sup>90</sup> CESCRC General Comment 14, *supra* note 48 para. 34.

<sup>91</sup> CERD, *supra* note 17 preamble.

<sup>92</sup> CERD Committee General Recommendation 30, *supra* note 34 paras. 29, 36.

<sup>93</sup> CESCRC General Comment 14, *supra* note 48 para. 12(b).

<sup>94</sup> A. Haider, ‘Out of the Shadows: Migrant Women’s Reproductive Rights Under International Law’, 22 *Georgetown Immigration Law Journal* (2008) p. 448.

<sup>95</sup> *Ibid.*

<sup>96</sup> CEDAW, *supra* note 17 art. 12; CESCRC General Comment 14, *supra* note 48 para. 34.

<sup>97</sup> Committee on the Elimination of Discrimination Against Women, *General Recommendation No. 24: Women and Health*, U.N. Doc. A/54/38 at 5 (1999) para. 2 [hereinafter CEDAW General Comment 24].

<sup>98</sup> CESCRC General Comment 14, *supra* note 48 para 21.

<sup>99</sup> *Ibid.*

promote health in both sexes.<sup>100</sup> Such a gender rights approach recognizes “that biological and socio-cultural factors play a significant role in influencing the health of men and women”.<sup>101</sup> All barriers that interfere with women’s access to health services, education and information must be removed in order to fully realize women’s right to health.<sup>102</sup> These barriers include discrimination, disrespect or ignorance of culture and access difficulties.

Special attention should be given to women who belong to vulnerable and disadvantaged groups including migrant women and refugee and asylum seeking women.<sup>103</sup> Women should also be protected in their roles as mothers. Maternal care, including pre and post-natal care are included within the right to health. A key goal of any national strategy must be the reduction of maternal mortality.<sup>104</sup> States should further ensure that women are provided adequate nutrition during pregnancy and lactation.<sup>105</sup>

The attention given to women in their roles as mothers is related to children’s rights. The CRC reinforces the importance of maternal care by expressing concern for the unborn child. It obliges States to ensure proper pre and post-natal care for mothers.<sup>106</sup> The ICESCR also requires States to take steps to reduce stillbirth-rates and infant mortality.<sup>107</sup>

Children have an unambiguous right to health under international law regardless of their ethnic or racial backgrounds or their immigration statuses. This is demonstrated in the inclusive language used to define the right to health for children. The CRC requires States to “strive to ensure that *no* child is deprived of his or her access” to health care services and facilities.<sup>108</sup> States must pursue “full implementation” of this right by taking appropriate measures including diminishing infant mortality, ensuring necessary healthcare to *all* children with an emphasis on primary care, combating disease and malnutrition and developing preventative healthcare.<sup>109</sup> Additionally, *every* child has the right to a standard of living adequate for her or his physical and mental development with States providing any necessary material assistance and support programs for nutrition, clothing and housing.<sup>110</sup>

The unequivocal right to health is especially relevant for migrant children, as they often do not have a choice concerning where they live. Migrant children, such as refugees and asylum seekers who have been subject to “neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts” are entitled to an environment that fosters their self respect, health and dignity

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<sup>100</sup> CESCR General Comment 14, *supra* note 48 para. 20.

<sup>101</sup> *Ibid.*

<sup>102</sup> *Ibid.*, para. 21.

<sup>103</sup> CEDAW General Recommendation 24, *supra* note 97 para. 6.

<sup>104</sup> *Ibid.*

<sup>105</sup> CEDAW, *supra* note 17 art. 12 (2).

<sup>106</sup> CRC, *supra* note 17 art 24(2)(d).

<sup>107</sup> ICESCR, *supra* note 17 art. 12(2)(a).

<sup>108</sup> CRC, *supra* note 17 art. 24 (1).

<sup>109</sup> *Ibid.*, arts. 24 (2)(a), (b), (c), (f).

<sup>110</sup> *Ibid.*, art 27.

and promotes physical and psychological recovery.<sup>111</sup> Asylum seeking and refugee children must not be subjects of discrimination regarding the right to health.<sup>112</sup>

## 2.3 Enforcement

The international community and its custom and laws have set certain minimum standards. There is a right to health. There is a right to be free from ethnic, racial, gender and age discrimination. When States ratify a treaty, they bind themselves to the provisions within. States are also responsible for the actions of their governments, municipalities and for certain third parties regarding these treaty obligations. These obligations, however, do not address the matter of enforcement, which is vital for the realization of human rights.

International Courts, treaty committees, NGOs and the international community are entrusted to guarantee that human rights are realized. Under all of the aforementioned international treaties, States are required to submit reports on the measures they have taken and the progress they have made concerning the rights in a convention.<sup>113</sup> The Committee attached to the treaty will read the report and then write a report of their own commenting on their view of the State's compliance with the treaty provisions. Reports contain praise, criticism and suggestions. These reports can be forwarded to the United Nations Human Rights Council, General Assembly or other United Nations bodies. Treaty committees also publish their reports for public viewing. Publishing reports and forwarding them to the United Nations is a part of the "shame game" that helps to regulate international human rights law. The thought behind this is that no State wants to be viewed as a human rights violator and, in order to safeguard their reputations and to avoid criticism, States will do their best to uphold human rights.

When the State has recognized the competence of the treaty committee to do so, the committee may receive complaints from individuals and render decisions. The Committee on Economic, Social and Cultural Rights cannot receive individual complaints yet, though an optional protocol has been opened for ratifications. Sweden has recognized the competence of several committees including those attached to the ICCPR, CERD and CEDAW. It tends to comply with the judgments issued against it and has appeared before the committees on numerous occasions.

Beyond these enforcement measures, States may also be subject to United Nations' intervention if the human rights abuses reach the point where they constitute a threat to international peace and security. The General Assembly may then issue declarations or resolutions. In extreme cases, Security Council may exercise their Chapter seven powers to

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<sup>111</sup> CRC, *supra* note 17 art. 39.

<sup>112</sup> *The Rights of Non Citizens*, HR/PUB/06/11 art. 34.

<sup>113</sup> ICESCR, *supra* note 17 art. 16; CERD *supra* note 17 art. 9; CEDAW, *supra* note 17 art. 18; CRC, *supra* note 17 art. 44.

intervene via military presence, economic sanctions or other measures.<sup>114</sup> These are not actions that are done lightly and it takes serious violations and much political wrangling to accomplish.

## 2.4 Conclusion

The right to health was designed to protect vulnerable and marginalized groups. As a developed nation, Sweden does not have the option of limiting economic, social and cultural rights to nationals. Rather, it has a responsibility under international law to guarantee the right to health for migrants, migrant women and migrant children whose ethnic and racial backgrounds trigger discrimination regardless of residential status. The Economic, Social and Cultural Committee explicitly requires Sweden to refrain from denying or limiting equal access to healthcare for undocumented migrants. Swedish health care facilities, goods and services must be accessible to and sensitive to people's cultural backgrounds, gender and age. Sweden also has a positive obligation to ensure pre and post-natal care for migrant women in order to safeguard their health and the health of their unborn child. Regardless of their residential status or ethnic background, children are entitled to health care in Sweden. For all populations, Sweden must address underlying determinants of health including housing and segregation. Though not automatically subject to sanctions or penalties for violating the right to health, Sweden has a legal obligation to guarantee this right is fulfilled for everyone regardless of ethnicity.

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<sup>114</sup> Charter of the United Nations, 59 Stat. 1031 (1945) arts. 39-51.



### 3 Sweden: Legislation, Policy and Practice Regarding Discrimination and the Right to Health

*A universal welfare state is neither a sufficient nor a necessary determinant of a strong health development. ~ Finn Diderichsen*<sup>115</sup>

Sweden is not a traditional immigration country. Unlike the United States, Sweden was not “built” on immigration or supported via the slave trade. Moreover, Sweden did not colonize in the same way as Great Britain, France or the Netherlands. Consequently, Sweden’s population remained quite homogenous for an extensive period. This history of homogeneity has colored Swedish perceptions of migrants, integration, what it means to be Swedish and assimilation. These perceptions, in turn, have influenced legislation, policy and practice.

Immigration to Sweden was fairly sporadic until World War II when four distinct periods of massive migration, complete with different groups of migrants, began. First, the 1940s and 1960s’ German, Nordic and Baltic refugees transformed Sweden from an emigration State to an immigration State.<sup>116</sup> Though Sweden lacked an infrastructure to properly incorporate this group, labor was in high demand and they integrated with relative ease.<sup>117</sup> During the second period from 1949 to 1971, labor migrants from Finland, Southern Europe and Yugoslavia who were recruited for jobs in Sweden’s flourishing export industry.<sup>118</sup> These labor migrants were treated as prospective citizens.<sup>119</sup> In 1967, Sweden began to apply immigration law in order to regulate the migration flows; it ended labor migration from non-Nordic countries five years later.<sup>120</sup> During the third migration period from 1972 to 1989, asylum seekers from developing countries and their families dominated immigration to Sweden.<sup>121</sup> Asian Ugandans, Chileans, Kurds, Iraqis and Iranians sought asylum in high numbers. The current immigration pattern began in the early 1990s with the arrival of Bosnian asylum seekers. Additionally, the United States led interventions in the Middle East created an influx of Iraqi asylum seekers. This trend of immigration based on asylum seekers, refugees and family reunification continues to this day.

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<sup>115</sup> F. Diderichsen, Presentation, Nordic School of Public Health, 30 September 2008.

<sup>116</sup> *Ibid.*

<sup>117</sup> *Ibid.*

<sup>118</sup> C. Westin, Migration Information Source, *Sweden: Restrictive Immigration Policy and Multiculturalism* <[www.migrationinformation.org/Profiles/display.cfm?ID=406](http://www.migrationinformation.org/Profiles/display.cfm?ID=406)>, visited on 5 April 2009.

<sup>119</sup> *Ibid.*

<sup>120</sup> *Ibid.*

<sup>121</sup> *Ibid.*

Clearly, these migration flows have had a profound effect on Swedish ethnic demographics. In 2007, approximately 1.2 million people, or 12 percent of the population, were foreign born.<sup>122</sup> Those described as being of “foreign background,” having two foreign born parents or foreign born, constituted 17.3 percent of the population.<sup>123</sup> The Finnish, those from the former Republic of Yugoslavia and Iraqis constitute the largest ethnic minorities.

### 3.1 Swedish Legislation

Faced with an increasingly diverse population, Sweden recognized that many of its law and practices required alteration including those related to health care. Health care in Sweden is heavily subsidized with the government shouldering most of the economic burden. Patient fees only cover three percent of health care costs while taxes cover approximately 75 percent.<sup>124</sup> Legal residents are entitled to the same health care as Swedish citizens.

The domestic implementation of the right to health in Sweden is governed by several pieces of legislation. The most fundamental laws include the Secrecy Act<sup>125</sup>, Discrimination Act<sup>126</sup> and Health and Medical Services Act<sup>127</sup>. In May of 2008, the parliament also passed a Law Concerning Health Care for Asylum Seekers and Others in order to codify existing practice.<sup>128</sup> Together, these laws address access to health care, health care quality, confidentiality and discrimination.

The Secrecy Act proscribes breaching confidentiality of certain public activities and disclosure of public documents.<sup>129</sup> Under this act, individuals are legally entitled to privacy concerning information about their residences.<sup>130</sup> This extends to data that would disclose whether someone is residing in Sweden permanently, temporarily or legally.

While the Secrecy Act covers confidentiality generally, the new Discrimination Act, effective from January 2009, was designed to combat discrimination and promote equal rights and opportunities regardless of sex, transgender identity, ethnicity, religion, disability, sexual orientation or age.<sup>131</sup> Ethnicity is defined as national or ethnic origin, skin color or other circumstances.<sup>132</sup> Race has been removed from the Act but the government contends that this does not weaken protection based on grounds of

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<sup>122</sup> Statistiska Centralbyrån, *Summary of Population Statistics*, <[www.scb.se/Pages/TableAndChart\\_\\_\\_\\_26041.aspx](http://www.scb.se/Pages/TableAndChart____26041.aspx)> visited on 5 April 2009.

<sup>123</sup> *Ibid.*

<sup>124</sup> Swedish Institute, *Swedish Health Care Factsheet* (2007) p. 2.

<sup>125</sup> Secrecy Act, (1980:100).

<sup>126</sup> Discrimination Act, (2008:58).

<sup>127</sup> Health and Medical Services Act, (1982: 723).

<sup>128</sup> Law Concerning Health Care for Asylum Seekers and Others (2008:344) (translation by Magnus Engelin).

<sup>129</sup> Secrecy Act, *supra* note 125 ch.1, sec. 1.

<sup>130</sup> *Ibid.*, ch 7, sec 1(a).

<sup>131</sup> Discrimination Act, *supra* note 126 ch. 1, sec 1.

<sup>132</sup> *Ibid.*

ethnicity.<sup>133</sup> The act prohibits five distinctive forms of discrimination: direct discrimination, indirect discrimination, harassment, sexual harassment and instructions to discriminate.<sup>134</sup> These prohibitions extend to several areas including employment, education, goods, services, housing and health and medical services. There are also active measures that must be undertaken concerning most of these areas. However, there are no active measures connected to health and medical care discrimination.

The newly established Equality Ombudsman is responsible for supervising execution of the Act. In addition to supervision, the Ombudsman has political and educational roles that target the elimination of discrimination and that promote equal rights. He or she must follow relevant research, propose legislative amendments and other measures and initiate any relevant actions.<sup>135</sup>

The Health and Medical Services Act covers health care and access to health care. The goals presented in this legislation strongly reflect fundamental human rights law principles. The Act aspires to provide: good health to everyone on equal terms, health care respecting the equal human dignity of all human beings and individuals and priority for those most in need of care.<sup>136</sup> Health care and medical services should be of good quality, readily available and based on respect for the patient's self-determination and privacy.<sup>137</sup> Patients should be consulted regarding care and treatment.<sup>138</sup> Good contact between patients and personnel should be fostered.<sup>139</sup> The act further establishes prevention of disease, through both treatment and dissemination of information, as a priority.<sup>140</sup>

The Swedish system divides responsibility for the right to health and medical care amongst the State, county councils and municipalities.<sup>141</sup> While the State is responsible for monitoring and ensuring that the law is properly implemented, the Health and Medical Services Act delegates responsibility of health care and medical services to County Councils (*landsting*) and municipalities. County councils and municipalities are obliged to offer "good" health and medical services to people living within their boundaries.<sup>142</sup> Moreover, City councils must offer "immediate" health and medical services to non-residents present in the jurisdiction. This has been interpreted as including tourists, temporary visitors and undocumented migrants.<sup>143</sup> These people are expected to pay full costs for their care, but may not be refused the required treatment.<sup>144</sup>

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<sup>133</sup> Government Offices of Sweden, *Factsheet: New Anti-discrimination Legislation and a New Agency, The Equality Ombudsman* (2009) p. 1.

<sup>134</sup> Discrimination Act, *supra* note 126 ch. 1, sec 4.

<sup>135</sup> Act Concerning the Equality Ombudsman (2008:568), sec. 3.

<sup>136</sup> Health and Medical Services Act, *supra* note 127 sec. 2.

<sup>137</sup> *Ibid.*, secs. 2a(1)(2) and (3).

<sup>138</sup> *Ibid.*, sec 2(a)(4).

<sup>139</sup> *Ibid.*

<sup>140</sup> Health and Medical Services Act, *supra* note 127 sec 2(c).

<sup>141</sup> Ministry of Health and Social Affairs, August 2006, *Health and Medical Care in Sweden, Factsheet No. 16*.

<sup>142</sup> Health and Medical Services Act, *supra* note 127 secs. 3, 18.

<sup>143</sup> Läkare Utan Gränsea, *supra* note 11 p. 9.

<sup>144</sup> *Ibid.*

Where the previous laws are directed at protecting racial and ethnic minority migrants and their right to health, Sweden's Law Concerning Health Care for Asylum Seekers and Others is a limiting instrument. The Act extends to individuals who have applied for refugee status in Sweden, are being held in custody for possession of invalid papers or failing to possess papers and those currently temporarily residing in Sweden because they have agreed to cooperate with a criminal investigation.<sup>145</sup> It also applies to asylum seekers when they have been notified of an extradition order.<sup>146</sup> It does not apply to adults who are hidden in a way that inhibits the authorities from carrying out extradition.<sup>147</sup> All foreigners under 18 in each group are entitled to health care on the same basis as Swedish citizens and residents.<sup>148</sup> So are all persons who are cooperating with the authorities in criminal investigations.<sup>149</sup> All other eligible classes are entitled to emergency treatment or care that cannot wait, birth care, treatments related to abortion and birth control counseling.<sup>150</sup> The county councils are only obligated to offer these services to those residing within the area each council is responsible for.<sup>151</sup> Asylum seekers pay relatively low fees for emergency care and care that cannot wait under Swedish law, 50 SEK (6.26 USD) for hospital visits and for any prescriptions required.<sup>152</sup> For asylum seeking women, birth control counseling and birth care are offered free of cost.

Thus, Swedish legislation endeavors to protect the right to health for documented racial and ethnic minorities by forbidding discrimination based on ethnicity in many fields, including health and medical services. While asylum seekers and undocumented migrants are severely restricted in the type of care they can receive by law, they are granted slight protection concerning any disclosure of their residential status. To each group's benefit and detriment, laws are not always faithfully followed and their application is influenced by societal mores.

## 3.2 Remedies

If an individual feels that her or his right to health has been violated due to discrimination, poor care or other means, s/he should be able to redress the harm via State offered remedies. Sweden offers several types of remedies, both judicial and extrajudicial. Patients may invoke the Discrimination Act, file a complaint with the Health and Medical Liability Care Board ("HSAN") or request compensation for injury via Patient Injury Insurance.

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<sup>145</sup> Law Concerning Healthcare for Asylum Seekers and Others, *supra* note 128 sec. 4(2).

<sup>146</sup> *Ibid.*, sec. 4(4).

<sup>147</sup> *Ibid.*, sec. 4.

<sup>148</sup> *Ibid.*, sec. 5.

<sup>149</sup> *Ibid.*

<sup>150</sup> Law Concerning Healthcare for Asylum Seekers and Others, *supra* note 128 sec. 6.

<sup>151</sup> *Ibid.*

<sup>152</sup> Asyl December 2008, *Reception of Asylum Seekers in Sweden*, <[www.migrationsverket.se/infomaterial/asyl/allmant/mottagandet\\_en.pdf](http://www.migrationsverket.se/infomaterial/asyl/allmant/mottagandet_en.pdf)>, visited on 5 April 2009 p. 2.

They may also use more informal channels.

For judicial remedies, chapter six of the Discrimination Act allows a person to bring a civil case if they feel that they have been discriminated against based on ethnicity or other prohibited grounds.<sup>153</sup> If the individual consents, the Equality Ombudsman or a non-profit organization may bring suit on their behalf.<sup>154</sup> The burden of proof is shared. The alleged victim must demonstrate that it is reasonable to believe that s/he has been discriminated against or subjected to a reprisal.<sup>155</sup> The accused must demonstrate that the discrimination or reprisal has not occurred.<sup>156</sup>

Though not a judicial remedy, HSAN is the national authority charged with evaluating incidences of medical negligence and taking disciplinary action. If discrimination has led to an injury or a failure to meet the standard of care, this is also a matter for HSAN. Their website, which details information on how to file a claim, is accessible to many ethnic and racial minorities with pages in Arabic, English, French, Spanish, Serbo-Croatian, Swedish and Suomi. HSAN is composed of nine members, including eight with experience in the health sector and an attorney chairperson with judicial experience.<sup>157</sup>

According to HSAN, *anyone* who is or has been a patient may file a complaint as long as the treatment occurred in Sweden.<sup>158</sup> The complaint must be received within two years of the maltreatment. It must be a signed, original writing that details the actual examination, a description of the care or treatment, when and where the treatment took place and, if possible to ascertain, who was at fault.<sup>159</sup> The complaint is shared with the accused party who then has a chance to respond. The patient may offer a reply to this response. Medical experts affiliated with HSAN review the case. Their opinions are considered when HSAN reviews the case and makes a decision. In some cases that do not involve serious negligence or malpractice, the chairperson alone may review the case after the medical expert review is complete. Copies of the decision are sent to both parties and the filing party must file any appeal within three weeks.

When a patient desires compensation for his or her injury, this falls under the Patient Injury Act. All patients, regardless of residential status are covered by this Act.<sup>160</sup> The Act obliges all health care providers to carry Patient Injury Insurance. Furthermore, compensation is not contingent on full payment for the medical service in question.<sup>161</sup> The scheme heavily restricts who is entitled to compensation. Compensation will not be paid if: the procedure was necessary for the diagnosis or treatment of an illness that was life threatening or would cause severe disability, the injury was unavoidable, the injury was minimal, expected infection occurs or an illness

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<sup>153</sup> Discrimination Act, *supra* note 126 ch. 7, sec. 1.

<sup>154</sup> *Ibid* at ch. 7, sec 2.

<sup>155</sup> *Ibid* at ch 7, sec. 3.

<sup>156</sup> *Ibid* ch 7, sec. 3.

<sup>157</sup> Hälso- och Sjukvårdens Ansvarsnämnd (“HSAN”) Website, <[www.hsan.se/eng/hsan.asp](http://www.hsan.se/eng/hsan.asp)> visited on 5 April 2009.

<sup>158</sup> I. Eckerberg, HSAN Employee, Phone Conversation, 11 March 2009.

<sup>159</sup> HSAN, *supra* note 157.

<sup>160</sup> L. Mansnerus, Patientforsakring, Email Communication, 25 February 2009.

<sup>161</sup> *Ibid*.

has naturally progressed.<sup>162</sup> Nor will compensation be awarded when the injury was one that could have happened anywhere unless it can be connected to the treatment or lack of a safety measure.<sup>163</sup> Injuries that result from traffic accidents, work accidents or pharmaceuticals are covered under other insurance schemes.<sup>164</sup> Finally, there is a statute of limitations attached to the scheme. Patients have three years from one of these dates: when the injury became noticeable, when the patient learned that the injury may have been connected to the treatment and compensation was possible or when the patient learned which insurance company to make a claim to.<sup>165</sup> The absolute maximum statute of limitations is ten years from when the injury was caused.

There are several less formal options that may redress harm. Complaints can be made to the regional Independent Patients' Advisory Committee. Though they lack decision-making power, they aid in problem solving by speaking directly to medical staff.<sup>166</sup> Patients may also discuss the matter with the hospital manager or any patient ombudsman, service manager or special representative of hospital management where such positions exist.<sup>167</sup>

### 3.3 Sweden's Paradoxical Multiculturalism in Policy and Practice

Laws and remedies are instrumental in the realization of the right to health but can be rendered illusory when not enforced by practice. Practice is influenced by many factors including State history. Sweden's history of homogeneity, fairly recent influx of immigrants, increasingly xenophobic climate and Scandinavian affinity for conformity all affect the way migrants are received. Though Sweden is generally perceived as a tolerant, open society as dictated by their official policies, mores reduce these policies to little more than rhetoric. Low employment, segregated housing and social segregation tend to characterize the lives of immigrants. All are underlying social determinants of the right to health. These conditions are problematic not only because of their negative influence on migrants' mental and physical health but also because this results in migrants' inability to fully exercise their right to health.

The aforementioned conditions do not reflect Swedish policy. Sweden is the only European country to adopt an official multicultural policy.<sup>168</sup> This model was initially based on equality, freedom of choice and cooperation. Under equality, migrants were entitled to the same rights, obligations and

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<sup>162</sup> Patientförsäkringen, *If You Are Injured in the Healthcare System*, <[www.patientforsakring.se/pdf/patientinfo\\_engelska.pdf](http://www.patientforsakring.se/pdf/patientinfo_engelska.pdf)>, visited on 5 April 2009 pp 4-6.

<sup>163</sup> *Ibid.*

<sup>164</sup> *Ibid.*

<sup>165</sup> *Ibid.*, p.8.

<sup>166</sup> K. Essinger, *Pamphlet: The Swedish Patient Injury Compensation System* (2005) p.1.

<sup>167</sup> HSAN Website, *supra* note 157.

<sup>168</sup> M. Eastmond, Presentation Notes: *Migration, Inequities and Health: Policy and Local Implementation*, 30 September 2008, p. 5.

opportunities as Swedish citizens.<sup>169</sup> Freedom of choice meant that migrants had the option of deciding to what extent they wished to assimilate or maintain their own culture.<sup>170</sup> Cooperation referred to ideal Swedish and immigrant interaction. However, this initial approach was abandoned because it was said to perpetuate division. In the 1990s, Sweden outlined a new integration policy designed to have a mutual society based on diversity. The new policy largely echoes the old one; the equality and cooperation concepts were retained. Mutual respect and tolerance for everyone, regardless of ethnicity or culture, was added instead of freedom of choice.<sup>171</sup>

Sweden has been praised, rightfully, for taking this multicultural, integration based approach. Its balance of rights and duties and support for diversity is a near perfect reflection of the principles embodied in international human rights law. This policy has also been supported by action. Sweden has ratified treaties, passed legislation and established bureaus and offices to aid in the implementation of its multicultural policy. Successful integration of immigrants and refugees requires that these groups be extended opportunities identical to native Swedes regarding employment and housing.<sup>172</sup> This has been accomplished in law.

Nonetheless, there is a noted gap between the official policy and its realization. Specifically, racial hierarchies are continuously perpetuated, leading to discrimination in violation of the equality principle. The tolerance and respect principle is of little value due to the overwhelming demand for conformity from Swedish society. Finally, employment, housing and social segregation challenge the principle of cooperation in that they limit interactions and contribute to ongoing ethnic, cultural and racial segregation.

Since the inception of the multicultural Swedish State, conditions have changed and will continue to change. Support for far-right parties with racist, xenophobic and misogynistic ideologies has increased in Europe. In Sweden, one such party is the Swedish Democrats. This party has been decried in Sweden as xenophobic, sexist and “outright racist.”<sup>173</sup> For their part, the Swedish Democrats claim to disassociate themselves from racism and consider the UDHR fundamental to their politics.<sup>174</sup> Yet, one of the party’s central objectives is to “stop the development of the multicultural society!”<sup>175</sup> They also advocated for the return of refugees as “the normal final solution to the refugee problem”.<sup>176</sup> Invoking the phrase “final solution” here, which is unambiguously associated with the Holocaust is, at

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<sup>169</sup> C. Englund, Raxen 3 Report to the European Monitoring Centre on Racism and Xenophobia, *Migrants, Minorities and Employment in Sweden* (2003) p. 9.

<sup>170</sup> *Ibid.*

<sup>171</sup> *Ibid.*

<sup>172</sup> E. Forsberg et al., ‘Ill Health and Social Conditions Amongst Migrants and Refugees: The Case of Sweden’, 6:1 *Innovation in Social Sciences Research* (1993).

<sup>173</sup> A. Grevelius, *The Local, Strong Poll Gains for Swedish Democrats*, 9 May 2008, <[www.thelocal.se/11650/20080509](http://www.thelocal.se/11650/20080509)>, visited on 5 April 2009.

<sup>174</sup> Swedish Democrats, *Presentation* <[www.sverigedemokraterna.se/](http://www.sverigedemokraterna.se/)>, visited on 5 April 2009.

<sup>175</sup> *Ibid.*

<sup>176</sup> *Ibid.*

least, highly inappropriate. More likely, it is indicative of a profound desire for a more homogenous Sweden. Once dismissed by the BBC as “a small anti-immigrant party with a few locally elected officials,” the Swedish Democrats has gained significant support in only a few years. A recent poll of Swedish voters found that 4.1% would vote for the Swedish Democrats, up from 3.1% three years ago.<sup>177</sup> Many, including the party itself, believe that if this trend continues, the Swedish Democrats will gain entrance into parliament in the next election and will wield significant influence.

### 3.3.1 Conformity and the Welfare State

Groups like the Swedish Democrats exploit fear of difference and prejudices. The fear of difference and quickness to label immigrants as “others” is a common criticism of Swedish attitudes about race, ethnicity, assimilation and conformity. Prejudice directed toward those who are willing to integrate but not to assimilate has been documented both domestically and internationally. Special Rapporteur on Violence Against Women, Yakin Ertürk, observed that “new Swedes” are expected to quickly adopt the values of “Sweden’s consensus society”.<sup>178</sup> Anthropologist Marita Eastmond notes that Swedishness remains the norm with immigrant identity being assigned the permanent status of “other”.<sup>179</sup>

Eastmond explains that conformity is a Nordic cultural value.<sup>180</sup> She traces this to the roots of the Nordic welfare State, which strived to achieve social harmony through equality, homogeneity and togetherness.<sup>181</sup> To its advantage, the welfare state that emerged from this process is universalist, legitimate and effective with a strong presence.<sup>182</sup> The disadvantage is that this system is also “generalist and authoritative with a rather low tolerance for difference”.<sup>183</sup>

This is personified in the *folkhemmet* (People’s Home), which represents Sweden’s Welfare State. Coined by Prime Minister Albin Hansson, the *folkhemmet* is:

The basis of the home is togetherness and common feeling. The good home does not consider anyone as privileged or unappreciated; it knows no special favorites and no stepchildren. There no one looks down upon anyone else, there no one tries to gain advantage at someone else’s expense, and the strong do not suppress and plunder the weak. In the good home equality, consideration, co-operation and helpfulness prevail. Applied to the great people’s and citizen’s home this means the breaking

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<sup>177</sup> Grevelius, *supra* note 173.

<sup>178</sup> Y. Ertürk. *Special Rapporteur on Violence Against Women, its Causes and Consequences, Mission to Sweden*, A/HRC/4/34/Add.3 (2004) para. 16.

<sup>179</sup> M. Eastmond, ‘Equalitarian Ambitions, Constructions of Difference: The Paradoxes of Refugee Integration in Sweden’, to appear in *Journal of Ethnic and Migration Studies* p.19.

<sup>180</sup> *Ibid.*

<sup>181</sup> *Ibid.*

<sup>182</sup> *Ibid.*

<sup>183</sup> *Ibid.*, citing J-P. Brekke and T. Borchgrevnik, *Talking About Integration. Discourses, Alliances and Theories on Labour Market Integration in Sweden* (Oslo: Institute for Social Research, Report No. 2007:9, 2007)



down of all social and economic barriers that now divide citizens into the privileged and the unfortunate, into rulers and subjects, into rich and poor, the glutted and the destitute, the plunderers and the plundered.<sup>184</sup>

In the people's home, sameness is a valued and expected characteristic. It is also the basis for equal treatment and access. This model cannot be sustained in a diverse society where some people begin life with a disadvantage due solely to their ethnicity as opposed to their social or political status. Breaking down of social and political barriers is insufficient if the roots of this inequality, namely ethnicity and migration status, are not also addressed. These are the differences that the Welfare State has a lower tolerance for.

The Welfare State's low tolerance for difference is reflected in societal attitudes and interpretations of what integration and assimilation constitute. Traditionally, integration has referred to a two way process whereby minorities have become incorporated into a society thus increasing their socio-economic status as measured by housing, employment and educational conditions. For their part, migrants contribute to diversity by maintaining many of their own cultural identities and traditions. Assimilation on the other hand, refers to a one-way process of shedding distinctness and conforming to majority practice and norms. Eastmond argues that in the Nordic sense, these definitions become muddled with integration referring not only to measurable successes in employment and housing but also the ability to conform to social norms and cultural values.<sup>185</sup> As one journalist noted, "to many, integration means that immigrants should abandon their culture, speech and ethnic distinctiveness, embracing only that which is Swedish".<sup>186</sup>

Conformity is a powerful idea because it guides perceptions of who belongs and who does not.<sup>187</sup> Social equality becomes contingent on conformity.<sup>188</sup> Eastmond notes that immigrants are expected to "undergo a normalization process to enter Swedish society guided in a rather top-down approach by the various programs offered".<sup>189</sup> Integration, then, is reduced to assimilation. This push for conformity and perceived "otherness" creates psychological and physical strains for migrants and leads to marginalization and disenfranchisement.

### 3.3.2 Employment Discrimination

Migrants' failure or inability to conform to Swedish society influences employment opportunities. Unemployment has been concretely linked to harmful health effects.<sup>190</sup> Both underemployment and unemployment may lead to high levels of stress. Stress, in turn, affects both mental and physical

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<sup>184</sup> Albin Hansson, 1982, Graham's translation *infra* note 383 p. 201.

<sup>185</sup> Eastmond, *supra* note 179 p. 19.

<sup>186</sup> A. Sains, Europe, *Stockholm: A Closer Look at Immigration*, September 2001 p. 43.

<sup>187</sup> *Ibid.*

<sup>188</sup> Eastmond, *supra* note 179 p. 19.

<sup>189</sup> *Ibid.*, p.16.

<sup>190</sup> P. Böckerman and P. Ilmakunnas, 'Unemployment and Self Assessed Health: Evidence from Panel Data', 18 *Health and Economics* (2009) p. 161.

health.

The unemployment rate for ethnic and racial minority migrants in Sweden is disheartening. The CERD Committee has expressed its concern about lower employment rates among those with immigrant origins in Sweden, particularly women.<sup>191</sup> According to the latest statistics available, the unemployment rate for men born outside of Sweden was 11.4 percent compared with native Swedes four point five percent.<sup>192</sup> For women it was 12.4 percent and five point four percent respectively.<sup>193</sup> People with the lowest employment rates are those whose cultures are most distinct: Africans, Asians and Europeans from outside of the EU fifteen.<sup>194</sup> In fact, the closer the country of origin is to Sweden, the easier it is to obtain employment.<sup>195</sup> Consequently, Sweden has been described as being “far from successful when it comes to integrating immigrants into its economy”.<sup>196</sup> Less than half of immigrants from non-industrialized nations are actively involved in the Swedish labor market.<sup>197</sup> Furthermore, the vast majority of immigrants tend to have jobs that are more physically demanding and monotonous.<sup>198</sup>

Regardless of the labor market’s state, unemployment has often been considerably higher for refugees than for native born ethnic Swedes despite the fact that refugees are generally better educated.<sup>199</sup> The underemployment of immigrants is especially evident in African born Swedish residents who hold more menial jobs despite having higher levels of education.<sup>200</sup> Evaluation and recognition of foreign degrees aid employment integration.<sup>201</sup> The process for validating foreign degrees in Sweden has been criticized as giving insufficient or superfluous results that do not convey enough information or that do not convey the required information.<sup>202</sup>

A principle reason for employment disparity is discrimination. Employers are admittedly reluctant to hire those with immigrant backgrounds due to their lack of “social competence”.<sup>203</sup> This has been interpreted to mean Swedishness.<sup>204</sup> Speaking fluent Swedish with an accent and having a non-Swedish name are both impediments for obtaining

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<sup>191</sup> CERD/C/SWE/18 (2007) para. 17.

<sup>192</sup> Regeringens Skrivelse, *Egenmakt Mot Utanförskap – Regeringens* (Skr 2008/09:24). Strategi för Integration p. 10 [hereinafter Strategi för Integration]

<sup>193</sup> *Ibid.*

<sup>194</sup> CERD/C/SWE/18 (2008) para. 110

<sup>195</sup> Englund, *supra* note 169 p. 11.

<sup>196</sup> N. Sanandaji, New American, *Sweden Unsuccessful Integrating Immigrants*, 2 December 2008, <[www.thenewamerican.com/world-mainmenu-26/europe-mainmenu-35/561](http://www.thenewamerican.com/world-mainmenu-26/europe-mainmenu-35/561)>, visited on 5 April 2009.

<sup>197</sup> *Ibid.*

<sup>198</sup> Englund, *supra* note 169 p. 25. See also J. Bustamante *supra* note 78 para. 8.

<sup>199</sup> W. Knocke, ‘Integration or Segregation? Immigration Populations Facing the Labour Market in Sweden’, 21 *Economic and Industrial Democracy* (2000) p. 368.

<sup>200</sup> J. Heape, The Local, *Segregation “Widespread” for Swedish Immigrants*, 18 December 2008, <[www.thelocal.se/16452/20081218/](http://www.thelocal.se/16452/20081218/)>, visited on 5 April 2009.

<sup>201</sup> E. Dingu-Kyrklund, ‘Migration and Recognition of Diplomas in Sweden’, 40:2 *European Journal of Education*, (2005) p. 136.

<sup>202</sup> *Ibid.*, p. 137.

<sup>203</sup> Knocke, *supra* note 199 p. 370; Eastmond, *supra* note 179 p. 8.

<sup>204</sup> Eastmond, *supra* note 179 p. 8.

employment.<sup>205</sup> At least three distinct studies have shown that applicants with Arabic names have a much more difficult time obtaining employment than those with traditionally Swedish names, despite having similar credentials. A 2004 study by newspaper *Dagens Nyheter* found that people with Swedish names had a 15% higher chance of receiving a positive response compared with applicants who had Arabic names.<sup>206</sup> Findings of the 2006 study by the International Labour Office were even more dismaying. In this study, pairs of test subjects, one native Swede and one Swede of immigrant background, applied for identical jobs in Malmö, Stockholm and Göteborg. The applicants' credentials, attitudes and personalities were as similar as possible. In order for the Swedish women with immigrant backgrounds to be chosen for one job, they had to send out approximately 26 applications in Göteborg, 12 in Malmö and seven in Stockholm.<sup>207</sup> Ethnically Swedish women had to send out approximately four applications in Göteborg and Stockholm and five in Malmö.<sup>208</sup> For men, those with immigrant backgrounds had to send out approximately 18 applications in Malmö, eleven in Stockholm and seven in Göteborg. Ethnically Swedish men had to send out approximately five, four and three applications respectively to reach the same result.<sup>209</sup> Consequently, Swedes with immigrant backgrounds had to send at least twice as many applications before they received one job and, in the case of women in Göteborg, six times as many. The authors of the study noted "to be repeatedly rejected takes its toll on self confidence and motivation".<sup>210</sup> The study concluded that, "the outcome of this study reinforces concerns articulated in other studies and government commissioned investigations: marginalisation in Sweden remains a serious challenge".<sup>211</sup> This study involved Swedish citizens only and no migrants. If results are this dramatic for Swedish ethnic and racial minorities, it could not be any better for migrants.

On the other hand, critic Nima Sanandaji, cautions that racism in employment in Sweden is "grossly exaggerated" and that "intellectuals exaggerate the case for racism, misleading many immigrants into believing that success is not possible for them".<sup>212</sup> He cites a recent study by researchers Magnus Carlsson and Dan-Olof Rooth. Their study alleged that discrimination is only visible in the in the steps preceding an interview. While those with Arabic names had to apply for five jobs to receive one interview, compared with approximately three for those with Swedish names, this was only problematic if there were a lack of vacancies since "immigrants can compensate for discrimination by applying for a greater

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<sup>205</sup> Knocke, *supra* note 199 p. 370; Eastmond, *supra* note 179 p. 8.

<sup>206</sup> N. Sanandaji, *The Local, Reports of Routine Swedish Racism 'Grossly Exaggerated'*, <[www.thelocal.se/14522/20080923/](http://www.thelocal.se/14522/20080923/)>, visited on 5 April 2009.

<sup>207</sup> International Labour Office, *Discrimination Against Native Swedes of Immigrant Origin in Access to Employment* (December 2006) p. 3 [hereinafter ILO Study].

<sup>208</sup> *Ibid.*

<sup>209</sup> *Ibid.*

<sup>210</sup> *Ibid.*

<sup>211</sup> *Ibid.*, p. 11.

<sup>212</sup> Sanandaji, *supra* note 206.

number of jobs”.<sup>213</sup> This conclusion ignores the fact that the burden should not be placed on immigrants to compensate for discrimination directed at them. Moreover, as the processes leading to obtaining an interview are crucial for obtaining jobs, the fact the discrimination “only” exists in this phase is problematic because this also may contribute to health related issues. Finally, the fact that immigrants can “compensate” for discrimination does not negate the fact that discrimination exists nor is it a legitimate solution for fully addressing it.

Employment is important for health because of its profound effect on household income and sense of well-being. In 2005, five and a half percent of Swedish citizens lived below the poverty line compared with nine point eight percent of migrants and 11.2 percent of ethnic migrants.<sup>214</sup> In other words, twice as many ethnic minority migrant households had an income that was 50 percent or less than the median Swedish income. Undocumented migrants, for their part, are unemployed and underemployed. When they do obtain work, their wages are generally insufficient to cover food and housing. Some make as little as 30SEK (3.74 USD) per hour.<sup>215</sup>

### 3.3.3 Segregation and Social Exclusion

Besides unemployment and underemployment, residential segregation is another growing concern in Sweden. Residential integration is influenced by employment, discrimination, societal attitudes toward immigrants and immigrants’ segregation into stigmatized areas.<sup>216</sup> Immigrants usually begin their housing careers at the lowest end of the market – public housing, sublets and employer owned housing.<sup>217</sup> Ethnic Swedes also tend to actively move away from areas with a high concentration of immigrants, especially African and Asian immigrants.<sup>218</sup> According to a survey by Statistics Sweden, 80 percent of native Swedes live in areas where the majority or almost all of nearby residents are also native Swedes.<sup>219</sup> Among this 80 percent, 20 percent live in areas that are virtually 100 percent Swedish.<sup>220</sup>

The roots of this segregation can be traced to Swedish policies and to the choices of immigrants themselves. New refugees and those lacking

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<sup>213</sup> *Ibid.*

<sup>214</sup> A. Morissens and D. Dainsbury, ‘Migrants’ Social Rights, Ethnicity and Welfare Regimes’, 34:4 *Journal of Social Policy* (2005) p. 644.

<sup>215</sup> Läkare Utan Gränser, *supra* note 11 p.18.

<sup>216</sup> M. Abramsson, ‘Housing Careers: Immigrants in Local Swedish Housing Markets’, 17:3 *Housing Studies* (2002) p. 446 *citing* A. Lange, ‘Ethnic/National Identifications, Stereotypes and Perceptions of Culture Difference (Stockholm, Centre for Research in international Migration and Ethnic Relations, Stockholm University, 1990) and R. Andersson, ‘Svenskglea Bostadsområden (Swede Sparse Housing Areas)’, 2 *Invandrare och Minoriteter* (1997) pp. 19–24.

<sup>217</sup> Abramsson, *supra* note 216 p. 445. *See also*, R.A. Murdie and L-E. Borgegard, ‘Immigration, Spatial segregation and Housing Segmentation of Immigrants in Metropolitan Stockholm 1960-95,’ 35 *Urban Studies* (1998) p. 1884.

<sup>218</sup> J. Heape, The Local, *Segregation “Widespread” For Swedish Immigrants*, 18 December 2008, <[www.thelocal.se/16452/20081218/](http://www.thelocal.se/16452/20081218/)> visited on 5 April 2009.

<sup>219</sup> *Ibid.*

<sup>220</sup> *Ibid.*

economic resources were, and are still, actively directed toward specific residential areas, namely public housing.<sup>221</sup> Most public housing was constructed during Sweden's "Million Program" era when the State pledged to build one million houses in ten years. The location of the Million Program housing, occasional lack of public transport and decreased demand for new homes meant that filling these homes proved to be problematic.<sup>222</sup> Therefore, the State began to allocate them to young families and both Swedish and international migrants.<sup>223</sup> Those who could afford to left within a few years and high turnover became a problem.<sup>224</sup> The areas then became a solution for those in need of social assistance and suffered from stigmatization as a result.<sup>225</sup> Currently, immigrants remain over-represented in public housing; they also remain there longer than native Swedes.<sup>226</sup>

In order to address the segregation caused, in part, by this housing scheme, Sweden implemented the "Sweden wide" or "All of Sweden" refugee reception strategy. One of the strategy's explicit goals was to settle immigrants away from larger urban areas, where local politicians cited their segregation and unemployment as problems.<sup>227</sup> While this plan was successful in that it made Sweden a generally more diverse State, it also spurred secondary movements of immigrants back to bigger cities where new refugees were settling into the same low-income areas.<sup>228</sup>

In addition to migration status, ethnicity and race play a role, sometimes a significant one, in residential segregation.<sup>229</sup> Discriminatory treatment for owner occupied and cooperative housing, discrimination by brokers and mortgage institutions and generally feeling unwelcome in "Swedish" neighborhoods are all additional barriers to residential integration.<sup>230</sup>

Employment discrimination and segregation can leave immigrants, and even their Swedish born children, feeling wholly excluded from Sweden. The experience of a New York Times reporter visiting the Bredby School in Rinkeby, a neighborhood on the outskirts of Stockholm that is predominately immigrant, illustrates this:

Ethnic Swedes seldom come to Rinkeby, and many of these students get nervous and feel they are being "looked at" when they travel far from the neighborhood. What divides the students most sharply is the question of whether they are Swedish. When asked, half of them nod vigorously yes; the others nod vigorously no. "I'm Swedish," says one Somali girl. "And

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<sup>221</sup> R. Andersson, 'Socio-Spatial Dynamics: Ethnic Divisions of Mobility and Housing in Post-Palme Sweden', 35 *Urban Studies* (1998) p. 419. See also C. Caldwell, New York Times, *Islam on the Outskirts of the Welfare State*, 5 February 2006 <[www.nytimes.com/2006/02/05/magazine/05muslims.html?scp=1&sq=Islam%20on%20the%20Outskirts%20of%20the%20Welfare%20State%20&st=cse](http://www.nytimes.com/2006/02/05/magazine/05muslims.html?scp=1&sq=Islam%20on%20the%20Outskirts%20of%20the%20Welfare%20State%20&st=cse)>, visited on 5 April 2009.

<sup>222</sup> Andersson, *supra* note 221 p. 420.

<sup>223</sup> *Ibid.*

<sup>224</sup> *Ibid.*

<sup>225</sup> *Ibid.*

<sup>226</sup> Andersson, *supra* note 221 p. 399.

<sup>227</sup> *Ibid.*

<sup>228</sup> R. Andersson, 'Divided Cities as a Policy Based Notion in Sweden', 14:5 *Housing Studies* (1999) p. 613.

<sup>229</sup> *Ibid.*

<sup>230</sup> *Ibid.*, p. 614. See also Heape, *supra* note 200.

I'm proud to be Swedish. I'm born here." One of her friends snorts.<sup>231</sup>

In Sweden, the hyphenated and hybrid identities that overwhelm the United States (Italian-American, African-American, Chinese-American and Chicano among them) are absent. Instead, there appears to be a push to fully assimilate and identify purely as Swedish or to reject the Swedish label and identify with the migrant's country of origin or parent's country of origin. The extremity of such identity culture reinforces the potential for isolation, discrimination and segregation that ethnic and racial minority migrants face in Sweden. The tension between pressure to join the dominant culture and to maintain ethnic culture can have a profound effect on health.

### **3.4 Conclusion**

Sweden is neither traditional immigration State nor a colonizer and this has shaped its demographics and legislation, policies and practice. In order to address its growing diversity, Sweden has adopted an official multicultural policy and has legislated to realize this policy. Swedish law provides protection for documented racial and ethnic minority migrants by prohibiting discrimination in health care, employment and housing. Undocumented migrants also receive protection from the law as disclosure of their residential status is contrary to the law. Nonetheless, they are limited to immediate health care. Asylum seekers and failed asylum seekers who can be found by the authorities are entitled to subsidized emergency care and care that cannot wait. All migrant groups have access to a variety of remedies guaranteed by international law. For documented migrants, though they are protected under the law, societal mores and the blending of integration and assimilation contribute to unemployment, underemployment and segregation.

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<sup>231</sup> Caldwell, *supra* note 221.

# 4 The State of Health for Racial and Ethnic Minority Migrants in Sweden

Health disparities develop as a result of discrimination, income inequalities, unequal access to employment and social exclusion - conditions to which vulnerable immigrant or refugee populations and trafficked persons are “disproportionately prone”.<sup>232</sup> Discrimination, in particular, is an attack on human dignity, confidence, self-esteem, well-being and equality. As such, it is not surprising that experts have found a correlation between discrimination and health.<sup>233</sup>

Different groups of migrants in Sweden face different health challenges. This thesis does not presume to discuss and dissect all of them. Rather, it will focus on the areas where it has been documented that ethnic and racial minority migrants face health challenges distinct, or more advanced, than ethnic and native-born Swedes. The health concerns of asylum seekers will be considered along with those of undocumented migrants as their treatment under Swedish law and in Swedish society is more aligned with this group than with Swedish nationals or citizens.

## 4.1 Documented Racial and Ethnic Minority Migrants

### 4.1.1 Mental and Physical Health

Forced assimilation and pressure to conform influences mental health outcomes. Mental health, in turn, has an impact on physical health. Mental health deterioration in ethnic and racial minority migrants is attributed to stress, loss of control, marginalization and “loss of inner integrity”. Stress results when demands made by the environment exceeds individuals’ ability to cope.<sup>234</sup> When resources are inadequate to address the situation, the individual loses his or her sense of control.<sup>235</sup> Offensive treatment, like discrimination, leads to stress, regardless of the motives behind the treatment.<sup>236</sup>

Loss of control may manifest itself in poor health, particularly mental health. One source of loss of control is loss of inner integrity. Loss of inner integrity occurs when there is a discrepancy between the dominant culture and the internalized culture of the migrants that affects the migrant’s ability

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<sup>232</sup> Bustamante, *supra* note 78 p. 11.

<sup>233</sup> Ombudsmannen Mot Etnisk Diskriminering, Health and Discrimination Project, *Discrimination: A Threat to Public Health* (2006) p. 25.

<sup>234</sup> *Ibid.*

<sup>235</sup> *Ibid.*

<sup>236</sup> *Ibid.*

to identify with social groups or classes in the new society.<sup>237</sup> Loss of inner integrity may be especially acute in Sweden where not only are immigrants distinct from the population but they are expected to fully assimilate and discard their native culture. For many, their culture tends to protect and sustain them as they adapt to a different environment. One study found that loss of inner integrity among Iranian immigrants in Sweden resulted in increasing suicide attempts, depression, aggressiveness and nervous breakdowns.<sup>238</sup> This may have been aggravated by Iranian's inability to find jobs despite their middle and upper class backgrounds.<sup>239</sup> Unemployment has been linked to nervous and depressive mental health symptoms; suicide and self-harm are common among the unemployed.<sup>240</sup>

In addition to loss of inner integrity, one study found that all first and second-generation immigrants have elevated rates of schizophrenia compared with the Swedish population, particularly those from Eastern and Southern Europe.<sup>241</sup> Social adversity, characterized by unemployment, marginalization and poverty, is a risk factor for schizophrenia.<sup>242</sup> Various studies have also found that foreign-born Swedish residents are at higher risk for attempted suicide, suicide, psychological stress and psychosomatic complaints.<sup>243</sup>

Beyond relatively poor mental health, ethnic and racial minority migrants have poorer self-reported health and suffer more often from certain physical ailments than ethnic Swedes. Data from the National Institute of Public Health indicates that foreign-born residents are more likely to suffer from ill health than native-born ethnic Swedes, especially those born outside of the

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<sup>237</sup> F. Ahmadi Lewin, 'Identity Crisis and Integration: The Divergent Attitudes Between Iranian Men and Women Towards Integration into Swedish Society', 39:3 *International Migration* (2001) p. 123.

<sup>238</sup> *Ibid.*, p. 122.

<sup>239</sup> *Ibid.*, p. 126.

<sup>240</sup> S. Akhavan et al., 'Health in Relation to Unemployment and Sick Leave Among Immigrants in Sweden From a Gender Perspective', 6:3 *Journal of Immigrant Health* (2004) p. 103 citing M. Voss, *Work and Health—Epidemiological Studies of Sickness Absence and Mortality With Special Reference to Work Environment, Factors Outside Work and Unemployment* (Doctoral Dissertation, Karolinska Institutet, Stockholm 2002).

<sup>241</sup> A. Hjern et al., 'Social Adversity Contributes to High Morbidity in Psychoses in Immigrants: A National Cohort Study in Two Generations of Swedish Residents', 34 *Psychological Medicine* (2004) p. 1030.

<sup>242</sup> *Ibid.*, p. 1026 citing G. Harrison et al., 'Association Between Schizophrenia and Social Inequality at Birth: Case-control Study', 179 *British Journal of Psychiatry* (2001) pp. 346–350. See also D. Castle et al., 'Does Social Deprivation During Gestation and Early Life Predispose to Later Schizophrenia?' 28 *Social Psychiatry and Psychiatric Epidemiology* (1993) pp. 1-4.

<sup>243</sup> E. Robertson, *Aspects of Foreign Born Women's Health and Childbirth Related Outcomes: An Epidemiological Study of Women of Childbearing Age in Sweden* (Karolinska Institutet, Stockholm, 2003). See also L.M. Johansson et al., 'Self Reported Long Standing Psychiatric Illness as a Predictor Premature All Cause Mortality and Violent Death; a 14 Year Follow Up Study of Native Swedes and Foreign-born Migrants', 33:10 *Social Psychiatry Epidemiology* (1998) pp. 491-496; L.M. Johansson, *Migration, Mental Health and Suicide; a Epidemiological Psychiatric and Cross Cultural Study* (Department of Clinical Neuroscience and Family Medicine, Psychiatric Section, Huddinge University Hospital, Karolinska Institutet, Stockholm, 1997) p. 115; L.M. Johansson et al., 'Ethnicity, Social Factors, Illness and Suicide; a Follow Up Study of Random Sample of the Swedish Population, 95:2 *Acta Psychiatrica Scandinavica* (1997) pp.125-131.



EU.<sup>244</sup> Some figures show that nearly twice as many immigrants report health problems compared to Swedes.<sup>245</sup> Another study found that limiting long-standing illness is more prevalent in immigrants from Southern Europe and non-Western, non-European States.<sup>246</sup> The researchers emphasized the marginalization of these groups, specifically those from Africa, Asia and Latin-America. Further medical research demonstrates that immigrants are at a higher risk for diabetes.<sup>247</sup> This is attributed to weight and stress but researchers found potential for unemployment and lack of acculturation to be contributing factors.<sup>248</sup> Various studies have also shown that unemployment can have a severe negative effect on physical health including increased blood pressure, reduced immunity functions, increased mortality rates and a high risk for developing assorted somatic and psychosomatic conditions.<sup>249</sup>

Many racial and ethnic minority migrants face higher risks for Cardiovascular Disease (“CVD”) and Coronary Heart Disease (“CHD”). Poles, Bosnians, Turks, Iraqis Asians and Iranian women all have higher instances of CHD.<sup>250</sup> CHD is influenced by physical and psychological stress.<sup>251</sup> After adjusting for education and occupational status, Polish, Turkish, Iraqi, Arabic speaking and Asian men along with Bosnian women all have a higher risk for CVD than native-born Swedes. After adjusting for socio-economic status, all of these groups are at an “overrisk” for CHD compared to Swedes.<sup>252</sup> The same applies to Southern Europeans, Iranians, Eastern Europeans and all Bosnians. This study indicates that immigrants’ relatively low status and type of employment in Sweden accentuate these stresses and cause CHD. Moreover, high unemployment affects the cardiovascular profile negatively.<sup>253</sup>

## 4.1.2 Access

Currently, domestic law guarantees documented ethnic and racial minority migrants’ equal access to health care. Therefore, access impediments are practical rather than legal. Among the most common are lack of awareness of public health services, language barriers, cultural barriers and structural

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<sup>244</sup> European Commission Employment and Social Affairs DG, *Study on Immigration, Integration and Social Cohesion*, 21 October 2005 at 35 citing Swedish National Institute of Public Health, *Annual Health Survey* (2003).

<sup>245</sup> M. Hjerm, *Integration Into the Social Democratic Welfare State*, 70 *Social Indicators Research* (2005) p. 125.

<sup>246</sup> J. Sundquist and S.E. Johansson, ‘Long-term Illness Among Indigenous and Foreign Born People in Sweden’, 44:2 *Social Science Medicine* (1997) pp. 189-198.

<sup>247</sup> P.-E. Wändell et al., ‘Increased Prevalence of Diabetes Among Immigrants from non-European Countries in 60 Year Old Men and Women in Sweden’, 33 *Diabetes and Metabolism* (2007) p. 34.

<sup>248</sup> *Ibid.*

<sup>249</sup> S. Akhavan et al., *supra* note 240 p. 104.

<sup>250</sup> M. Gadd et al., ‘Morbidity in Cardiovascular Disease in Immigrants in Sweden’, 254 *Journal of Internal Medicine* (2003) p. 238.

<sup>251</sup> *Ibid.*

<sup>252</sup> *Ibid.*, p. 239.

<sup>253</sup> *Ibid.*, p. 242.

barriers.<sup>254</sup>

Being aware of services, including specialized services and tests, is important. In order to ensure that all members of a community are aware of services, they should be offered in more than one language. Recently, it was discovered that foreign-born women are less likely to have mammograms than Swedish born women. Mammograms are considered an essential tool for early detection of breast cancer. The report revealed that only seven of 21 counties surveyed urged women to have mammograms.<sup>255</sup> Moreover, only five of the counties offered the service in a language other than Swedish.<sup>256</sup> This reflects a minimal effort on the part of medical professionals to make the female population aware of an important test. The lack of language accessibility also reflects a minimal effort to include non-Swedish women.

The language barrier and lack of a common language is a problem in Sweden especially amongst newer and smaller minorities and in multicultural communities.<sup>257</sup> One study of primary health care professionals in a diverse Stockholm community found that use of interpreters was generally limited to physicians.<sup>258</sup> Nurses and other health care professionals deemed use of interpreters to be “too time consuming” although communication problems have an adverse affect on care.<sup>259</sup> When patients and staff cannot use language as a tool for establishing a relationship with their patients and for effective communication, severe problems may result.<sup>260</sup>

Alongside linguistic knowledge, knowledge of a patient’s culture is an invaluable tool for health care professionals. It may aid them in correctly interpreting their patients’ expressions, understanding and acceptance of proposed treatment, relationship with authority figures and assistance acceptance behaviors. One study on conceptions of pain in Somali women in Sweden validates this. A cultural interpreter explained to the researcher that the Swedish and Somali words for pain were not wholly consistent.<sup>261</sup> In Somali, the word *xanuun* expresses pain, discomfort and illness.<sup>262</sup> Some women described their fevers and allergies as being painful; this is a broader use of the term that most medical personnel are used to.<sup>263</sup> In addition, crying is an unacceptable way to express pain in Somali culture where pain

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<sup>254</sup> M. Norredom et al., ‘Access to Healthcare for Asylum Seekers in the European Union – A Comparative Study of Country Policies’, 16:3 *European Journal of Public Health* (2005) p. 287.

<sup>255</sup> Cancerfonden, *Kvinnor Deltar Olika i Mammografiscreening*, 29 September 2008 <[www.cancerfonden.se/sv/Om-Cancerfonden/Press/Pressmeddelanden/Kvinnor-deltar-olika-i-mammografiscreening/](http://www.cancerfonden.se/sv/Om-Cancerfonden/Press/Pressmeddelanden/Kvinnor-deltar-olika-i-mammografiscreening/)>, visited on 2 April 2009.

<sup>256</sup> *Ibid.*

<sup>257</sup> S. Bäärnhjelm et al., ‘Historical Reflections on Mental Health Care in Sweden: The Welfare State and Cultural Diversity’, 42 *Transcultural Psychiatry* (2005) p. 402.

<sup>258</sup> *Ibid.*

<sup>259</sup> *Ibid.*

<sup>260</sup> *Ibid.*

<sup>261</sup> B. Finnström and O. Söderhamn, ‘Conceptions of Pain Among Somali Women’, 54:4 *Journal of Advanced Nursing* (2005) p. 421.

<sup>262</sup> *Ibid.*

<sup>263</sup> *Ibid.*, p. 421.

is viewed as a natural part of life and a burden one must bear.<sup>264</sup> Without this knowledge, it is easy for miscommunication to lead to a wrong diagnosis, treatment or misunderstanding of proposed treatment. The study concluded that health care workers must improve their cultural competence in order to interpret body language and communications from culturally diverse groups.<sup>265</sup>

Lack of cultural competence may reflect structural discrimination. The barrier of structural discrimination includes rules, norms and generally accepted approaches and behaviors utilized by institutions and other structures that create obstacles for subordinate groups.<sup>266</sup> These obstacles prevent groups from achieving equal rights and opportunities.<sup>267</sup> A study of Turkish women in Sweden discovered that health care workers found it difficult to “fit” the patient’s understanding of suffering into their medical model.<sup>268</sup> This was due to a lack of organizational support and shared models that would adapt their work to include a multicultural population.<sup>269</sup>

Other forms of discrimination also inhibit access to health care services. Negative and offensive treatment by caretakers may make patients reluctant to access services. In one Swedish study, perceived ethnic discrimination was connected with a significant increase in refraining from seeking treatment.<sup>270</sup> Frequent exposure to personal discrimination was strongly associated with refraining from seeking treatment, even when there was no socio-economic disadvantage.<sup>271</sup> A different study involving female genital mutilation victims found that midwives’ attitudes, unsolicited stares and insults caused women to avoid seeking maternal care.<sup>272</sup>

### 4.1.3 Women and Children

Ancillary to the barriers that regular ethnic and racial minority migrants face as a whole, maternal health care for migrant women in Sweden is a source of concern. Women born outside of Sweden suffer more complications when giving birth.<sup>273</sup> Compared to native-born Swedes, women from Sub-Saharan Africa and Latin America are 50 percent more likely to suffer from complications; Iranian and Asian women are 30 percent more likely to

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<sup>264</sup> *Ibid.*, p. 422.

<sup>265</sup> *Ibid.*, p. 424.

<sup>266</sup> Ombudsmannen Mot Etnisk Diskriminering, *supra* note 233 p. 15.

<sup>267</sup> *Ibid.*

<sup>268</sup> S. Bäärnhielm and S. Ekblad, ‘Turkish Migrant Women Encountering Health Care in Stockholm: A Qualified Study of Somatization and Illness Meaning’, 24 *Culture, Medicine and Psychiatry* (2000).

<sup>269</sup> *Ibid.*

<sup>270</sup> S. Wamala et al., ‘Perceived Discrimination, Socioeconomic Disadvantage and Refraining from Seeking Medical Treatment in Sweden’, 61 *Journal of Epidemiology and Community Health* (2007) p. 411.

<sup>271</sup> *Ibid.*

<sup>272</sup> V. Berggren, *Female Genital Mutilation: Studies on Primary and Repeat Female Genital Cutting*, Thesis, Karolinska Institutet, Stockholm (2005) p. 38.

<sup>273</sup> The Local, *Healthcare Worse for Immigrant Women*, 20 August 2007

<[www.thelocal.se/8232/20070820/](http://www.thelocal.se/8232/20070820/)>, visited on 5 April 2009. *See also* E. Robertson, *supra* note 243.

suffer from complications.<sup>274</sup> Another study demonstrated that foreign-born women access pre-natal care on a less than average basis.<sup>275</sup> According to researcher Eva Robertson, who conducted both studies, this is not caused by genetic factors, but by structural discrimination where a patient is expected to “fit into a certain mold to receive quality service and be listened to”.<sup>276</sup> For women from cultures where childbirth is a cause for concern, this is problematic.<sup>277</sup> While migrant women do not regard communication in their native language as necessary for adequate maternal care, they do cite the caretaker’s positive and helpful affect as an important factor. A one size fits all approach coupled with ethnic stereotyping does not foster smooth caretaker/patient relationships. According to Robertson, over-treatment and over-medicalization of childbirth can lead to complications and, ironically, under-treatment.<sup>278</sup> She points out that several studies have shown the importance of going beyond stereotyped assumptions, based on the woman’s ethnic background, in order to create a trusting relationship based on the woman’s responsibility and participation.<sup>279</sup>

The problems that result when health care providers expect migrant women to conform totally and unconditionally to Swedish models are illustrated by a study of Somali women. The women in the study felt that they were being blamed for their high fertility and that this affected the standard of care.<sup>280</sup> In fact, many of the women traveled to Germany for treatment, despite the additional costs, because they felt it was necessary in order to ensure proper care.<sup>281</sup> These women explained that, in direct contravention of Swedish law, they were not consulted regarding the delivery method.<sup>282</sup> The lack of consultation may have been due the prevalence of female circumcision among the study subjects. Doctors largely ignorant of female genital mutilation performed caesarian sections without consent or explanation.<sup>283</sup> After being informed that more than a certain number of caesarians would be fatal, the women in the study began to believe that caesarians were a method to discourage them from becoming pregnant.<sup>284</sup> The presumption of conformity in this case, that these women would prefer caesareans or that cesareans were necessary, resulted in women developing mistrust for medical professionals and dissatisfaction with quality of care. Some of these women were willing to travel a fairly long distance, while pregnant, to pay for care they would have received at minimal cost in Sweden. The lack of cultural competency, evidenced by a failure to consult patients regarding a vital decision, disrupted the quality of

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<sup>274</sup> *Ibid.*

<sup>275</sup> E. Robertson, *supra* note 243 p. 36.

<sup>276</sup> The Local, *supra* note 273.

<sup>277</sup> E. Robertson, *supra* note 243 p. 48.

<sup>278</sup> *Ibid.*

<sup>279</sup> *Ibid.* p. 48.

<sup>280</sup> B. Ahlberg et al., *Research Report on Partners for Health – Phase II, Identifying Patterns of Discrimination in the Context of the Swedish Patient Pathway*(2003)

<[www.salutepertutti.org/sweden.pdf](http://www.salutepertutti.org/sweden.pdf)>, visited on 5 April 2009 p. 6.

<sup>281</sup> *Ibid.*

<sup>282</sup> *Ibid.*, p. 7.

<sup>283</sup> *Ibid.*

<sup>284</sup> *Ibid.*

care.

Lack of competence is not the only cultural concern. Presumptions and stereotypes of women's cultural backgrounds have led to discriminatory behavior. In a lawsuit filed by the Ombudsman Against Ethnic Discrimination, an 11-year-old Somali-Swedish girl was forced to undergo a gynecological exam following her family's return from Kenya.<sup>285</sup> The exam was requested by Social Services who suspected that the girl had been circumcised.<sup>286</sup> She had not. In another case, health care workers refused to tell a Middle Eastern couple the sex of their unborn twins even though this is a routine disclosure.<sup>287</sup> The husband believed that the workers feared that the couple would abort if they were informed that the fetuses were girls.<sup>288</sup> In these cases the discrimination is based on "good intentions" of saving or protecting ethnic and racial minority women from an assumed patriarchal culture. This protection, however, may lead to discrimination that is damaging to women physically and psychologically. Women may avoid seeking treatment because of these attitudes or may suffer discomfort during unnecessary procedures.

Like women, children also face special health challenges in Sweden. Refugee children have trauma related mental health concerns that may not abate after arriving to safety in Sweden. A study of Iranian child refugees in Sweden revealed identical rates of PTSD one year after their arrival in Sweden as well as three and a half years later.<sup>289</sup> The author of the study warned that PTSD and other psychological conditions caused by trauma, will not get better without professional support.<sup>290</sup>

## 4.2 Undocumented and Asylum-Seeking Racial and Ethnic Minority Migrants

### 4.2.1 Mental and Physical Health

Undocumented migrants' ethnicity and status combine to create legal and physical barriers to care in Sweden that impedes their attainment of the highest possible standard of health. While data is lacking concerning this group in Sweden, there is evidence that undocumented migrants' health may worsen as a result of the stress of living hidden and their inability to access basic medical care due to legal and physical barriers. According to a survey by *Läkare Utan Gränser (Médecins Sans Frontières/Doctors Without Borders)*, 65 percent of the respondents' mental health and 64 percent of respondents' physical health deteriorated following their irregular arrival in

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<sup>285</sup> M. Bideke and M. Bideke-Thema, European Network Against Racism, *Shadow Report 2007: Racism in Sweden* (2008) p. 12.

<sup>286</sup> *Ibid.*

<sup>287</sup> Ahlberg et al., *supra* note 280 p. 7.

<sup>288</sup> *Ibid.*

<sup>289</sup> K. Almqvist and M. Brandell-Forsberg, 'Refugee Children in Sweden: Post Traumatic Stress Disorder in Iranian Pre-School Children Exposed to Organized Violence', 21:4 (1997) *Child Abuse and Neglect* pp. 351-366.

<sup>290</sup> *Ibid.*, p. 365.

Sweden.<sup>291</sup> The authors of the survey revealed that undocumented migrants who visited their clinic suffered from an assortment of severe and chronic diseases including asthma, tuberculosis and diabetes.<sup>292</sup>

This study was based on a group of undocumented migrants who used the health care facilities provided by *Läkare Utan Gränser*. Those who have not managed to access health care may be in a more desperate situation in terms of physical and mental health. Those who wait to seek medical attention until it is “legal” to do so endanger their health and the health of others. Health care that is only available for acute cases may exacerbate psychological distress.<sup>293</sup> It may also affect physical health in the ultimate way- by leading to death. The Swedish Red Cross and medical personnel have reported patients dying from preventable illness or diseases or being close to death as a direct result of inadequate health care.<sup>294</sup>

Asylum seekers are offered a medical exam upon their arrival in Sweden. However, the new law drastically limits their access to non-emergency care, even though the asylum process may take up to 18 months. For asylum seekers, recent events coupled with previous traumatic experiences also have a debilitating effect on mental health.<sup>295</sup> Prejudice, unemployment and socio-economic marginalization contribute to migration stress and can lead to a sense of loss of control.<sup>296</sup> It may also aggravate existing mental conditions. PTSD in asylum seekers and refugees is an established cause for concern. Special Rapporteur for Health Paul Hunt cited that up to 25 percent of those who apply for asylum in Sweden might be suffering from this type of disorder when they arrive.<sup>297</sup>

On the other hand, this figure may be exaggerated due to PTSD’s “discreet definition” which may become combined with traumatization.<sup>298</sup> This is problematic because traumatization encompasses a wide range of symptoms from grief responses to serious psychiatric disorders.<sup>299</sup> The tendency to place all asylum seekers in the PTSD category leads to treating them as a homogenous and medicalized segment of the population, which may contribute to marginalization.<sup>300</sup>

It is also difficult to determine where pre-migration symptoms begin and how they effect post-migration symptoms but at least two studies among migrants in Sweden have demonstrated that post migration factors may have

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<sup>291</sup> Läkare Utan Gränser, *supra* note 11 p. 6.

<sup>292</sup> *Ibid.*

<sup>293</sup> M. Taloyan et al., ‘Psychological Distress Among Kurdish Immigrants in Sweden’, 36 *Scandinavian Journal of Public Health* (2008) pp. 194-95.

<sup>294</sup> United Nations Association of Sweden et al., *Alternative Report to Sweden’s Seventeenth and Eighteenth Periodical Reports to the Committee on the International Convention on Ethnic and Racial Discrimination* (July 2008) p. 52.

<sup>295</sup> S. Bäärnhielm et al., *supra* note 257 p. 402.

<sup>296</sup> Taloyan et al., *supra* note 293 p. 195.

<sup>297</sup> P. Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mission to Sweden*, 28 February 2007, A/HRC/4/28/Add.2 para. 44.

<sup>298</sup> M. Eastmond, ‘The Disorders of Displacement’, in R. Jenkins et al (eds), *Managing Uncertainty: Ethnocentric Studies of Illness, Risk and the Struggle for Control* (Museum Tusulanum Press, Copenhagen, 2004) ch. 7.

<sup>299</sup> *Ibid.*

<sup>300</sup> *Ibid.*

some bearing on PTSD and mental health. The researchers found increased rates of PTSD in refugees from Kosovo who had lived in Sweden for one and a half years that was attributed to post migration stress factors.<sup>301</sup> Another study found that Kurdish women and men are both at high risk for anxiety due to the combination of negative pre-migration experiences and post migration stress attributed to unemployment, economic difficulties, perceived discrimination and poor control over their lives.<sup>302</sup>

## 4.2.2 Access

Generally, migrants' physical and mental states are influenced by their inability to access care. Undocumented migrants, asylum seekers, failed asylum seekers and victims of trafficking who have not yet agreed to cooperate with police are all entitled to the similar care under Swedish law. The principal difference is that undocumented migrants' care is unsubsidized. For these migrants, the laws' restriction of health care to "emergency care," "immediate care" or "care that cannot wait" coupled with the obligation to pay full cost, are distinct legal barriers to health care. The ambiguity attached to "emergency," "immediate" and "care that cannot wait" provides an additional barrier by leaving it up to the administrative staff, rather than the doctors themselves, to decide who is entitled to what type of care. Administrative staff may not feel the same moral obligation to treat patients regardless of status that many doctors do as a result of the oath they take as physicians. Moreover, the imprecise phrases increase the risk of racial and ethnic discrimination. Health care professionals will be able to act on their personal prejudices without consequence. The burden will be on the undocumented migrant to prove that their ethnicity, not their condition or status, led to their rejection. Fear of exposure might stop a migrant from filing a complaint in any case.

Legal barriers aside, undocumented migrants also face practical barriers related to cost and risk of exposure. The cost of health care is disproportionately expensive for them:

<sup>303</sup> Consultation/Medication	Costs for Swedish Nationals/ Those With Residence Permits	Cost for Undocumented Migrants
Consultation with a doctor in emergency room	260 SEK/ 32 USD	2000 SEK/ 249 USD
Consultation with doctor at primary health care clinic	140 SEK / 17 USD	1400 SEK/ 174 USD
Consultation with a midwife at a maternity center	0 SEK	500 SEK/ 62 USD
Delivery without complications	0 SEK	21,000 SEK/ 2,616 USD
Insulin treatment for Type 1 diabetes	1800 SEK/ 224 USD per year	13,200 SEK /1,644 USD per year

<sup>301</sup> G. Roth et al., 'A Longitudinal Study of PTSD in a Sample of Adult Mass-Evacuated Kosovars, Some of Whom Returned to Their Home Country', 21 *European Psychiatry* (2006) p. 157

<sup>302</sup> Taloyan et al., *supra* note 293 pp. 194-95.

<sup>303</sup> Platform for International Cooperation on Undocumented Migrants, *Access to Healthcare for Undocumented Migrants in Europe* (2007) p. 91 [hereinafter PICUM].

Based on the cost and typically low wages, even a basic consultation would be prohibitively expensive for most undocumented migrants. In the survey conducted by *Läkare Utan Gränser*, almost a quarter of undocumented migrants cited cost as a reason for why they could not access medical service.<sup>304</sup>

*Läkare Utan Gränser* criticizes the Swedish government's refusal to recognize undocumented migrants as a patient group because it has led to their "near total exclusion" from routine and non-emergency care.<sup>305</sup> They also fault the government for failing to subsidize undocumented migrants' care by reimbursing hospitals and care facilities, which are reluctant to treat this vulnerable group, believing them to be a costly liability.<sup>306</sup> This is the case even if there will be "serious medical consequences" if the condition is left untreated.<sup>307</sup>

On the other hand, not all services are prohibitively expensive. Practice indicates that undocumented migrants can receive free treatment at specialized clinics for sexually transmitted diseases including gonorrhea, chlamydia and syphilis.<sup>308</sup> Other clinics will screen for HIV/AIDS and tuberculosis at no cost.<sup>309</sup> There are several hospitals, clinics and at least one region where some undocumented migrants can receive the care guaranteed to them by international law. These programs will be discussed later as examples of good practice.

Another aspect of poor access is undocumented migrants' trepidation at being turned in or caught while seeking medical care. As aforementioned, health care workers are legally prohibited from divulging information relating to a patient's residential status. However, they must provide the police with yes and no answers if asked directly about an individual's current whereabouts.<sup>310</sup> Administrative staff may also unwittingly alert the authorities. Sometimes in an attempt to receive payment for services, staff will contact the Migration Board because they believe the patient to be an asylum seeker.<sup>311</sup> When this is not the case, the staff has given sensitive information to the Migration Board,<sup>312</sup> the body responsible for executing expulsion orders.<sup>313</sup>

Of course, medical conditions occur where undocumented migrants feel compelled to seek treatment despite all of their concerns. According to *Läkare Utan Gränser's* experiences, when migrants do go to public hospitals with an urgent or immediate health need like a heart attack or to

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<sup>304</sup> *Läkare Utan Gränser*, *supra* note 11 p. 16.

<sup>305</sup> *Ibid.*, p. 7.

<sup>306</sup> *Ibid.*

<sup>307</sup> *Ibid.*, p. 9.

<sup>308</sup> PICUM, *supra* note 303 p. 89.

<sup>309</sup> *Ibid.*

<sup>310</sup> *Läkare Utan Gränser*, *supra* note 11 p. 10.

<sup>311</sup> PICUM, *supra* note 303 p. 92.

<sup>312</sup> *Ibid.*

<sup>313</sup> Migrationsverket, *Migration Policy*,

<[www.migrationsverket.se/english.jsp?english/emigration/emigrpol.html](http://www.migrationsverket.se/english.jsp?english/emigration/emigrpol.html)>, visited on 2 April 2009.



deliver a baby, they are not refused the required treatment.<sup>314</sup> By contrast, primary health care centers rarely accept undocumented patients.<sup>315</sup>

### 4.2.3 Women and Children

Denial of access is of particular concern to migrant women who are expecting or who are in need of contraceptive services. Maternity centers in Sweden will accept undocumented women but generally only after advanced payment in full.<sup>316</sup> As a result, many pregnant undocumented women do not receive prenatal check-ups and only seek medical attention on the day of delivery.<sup>317</sup> This may soon change, however. After backtracking from his initial statement that offering subsidized health care to undocumented migrants would “send the wrong signal,” the Swedish Minister for Migration, Tobias Billström, softened his position, saying, “you can’t punish children – born or unborn– for their parents’ decision to live here in hiding”.<sup>318</sup> The law is already more generous for asylum seeking women who are entitled to birth care, contraceptive counseling and abortions at little or no cost. Besides these reproductive rights services, asylum seeking and failed asylum seeking women are restricted to “emergency care” or “care that cannot wait”.

Unlike their adult counterparts, asylum-seeking children whose claims have failed are entitled to the same health and dental care as Swedish children. Technically, undocumented children who have not applied for asylum are only entitled to immediate care. Fortunately, in practice, full health care is provided to all children regardless of status.<sup>319</sup> Nevertheless, as their parents’ rights to health care are strictly limited and the same concerns over discovery exist when bringing a child in for care, undocumented children often do not receive adequate care.

Furthermore, children’s health is affected by the health of their parents and families. The time spent hidden can exacerbate all family member’s psychological and physical conditions. Many times, the parent’s health and well being have a direct effect on their children’s. A dramatic study of children suffering from depressive devitalization illustrates this. Though the study was small and concentrated on five children from former Soviet States accepted as in-patients, it accurately portrays how pre-migration experiences combined with living hidden may have a detrimental effect on children’s health. Moreover, it concerns a group of asylum-seeking children that the Special Rapporteur specifically identified as those requiring study, attention and care: asylum seeking children who suffer from severe withdrawal behavior marked by refusal to eat and to communicate.<sup>320</sup>

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<sup>314</sup> Läkare Utan Gränser, *supra* note 11 p. 9.

<sup>315</sup> *Ibid.*

<sup>316</sup> Läkare Utan Gränser, *supra* note 11 p. 9.

<sup>317</sup> PICUM, *supra* note 303 p. 90.

<sup>318</sup> P. Vinthagen Simpson, *Hospitals Offer Care to Illegal Immigrants*, 17 May 2008 <[www.thelocal.se/11824/20080517/](http://www.thelocal.se/11824/20080517/)>, visited on 5 April 2009.

<sup>319</sup> Läkare Utan Gränser, *supra* note 11 p.10.

<sup>320</sup> P. Hunt, *supra* note 299 para. 76.

In a study of children suffering from a severe form of this disorder, all of subjects were exposed to various forms of violence including witnessing their mothers' sexual assault, physical violence, murder, intimidation, threats and persecution of family members.<sup>321</sup> Three of them had shown signs of psychological problems in their countries of origin; of these, two were subject to racial harassment due to their ethnic Asian background.<sup>322</sup> After fleeing to Sweden, all of the children began to display a range of symptoms including depression, withdrawal, eating disorders, nightmares and anxiety.<sup>323</sup> Some had aggressive outbursts and made suicide attempts.<sup>324</sup> All of them expressed a wish to die.<sup>325</sup> By the time they were admitted for in-patient treatment, they could not eat, drink, walk, talk or tend to personal hygiene.<sup>326</sup> They were completely withdrawn from contact and required hospital care.<sup>327</sup> The children began their descent into this state after making active suicide attempts or after their parents became "acutely incapacitated".<sup>328</sup> For their parts, the mothers began to behave as if they were taking care of children who would most certainly die.

The researchers found that the children's recovery was directly linked toward their parent's psychological state. This, in turn, was predicated on the family's status in Sweden. At the time of the study, none had been granted residence permits and all had moved several times.<sup>329</sup> Two families were in hiding after living in Sweden for 40 and 29 months respectively.<sup>330</sup> Both had been issued removal orders after their asylum applications were repeatedly rejected.<sup>331</sup> Ultimately, all five families were granted permanent residence permits on humanitarian grounds, as the children would have been unable to receive adequate health care for their psychological conditions if returned to their countries of origin.<sup>332</sup>

The "real breakthrough" came when the families were given permanent residence, though they were slow to show optimism regarding their changed status.<sup>333</sup> When the mothers began to show a revitalized zeal for life and began to care for their children in a way that did not presume inevitable death, the children began to get better.

The author was careful to point out that the small size of the study could not indicate what proportion of asylum seeking-children in Sweden could be suffering from similar conditions.<sup>334</sup> However, he did note that there was a possibility that the findings were due to an overrepresentation of depressive

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<sup>321</sup> G. Bodegård, 'Life-threatening Loss of Function in Refugee Children: Another Expression of Pervasive Refusal Syndrome?', 10 *Clinical Child Psychology and Psychiatry* (2005) p. 340.

<sup>322</sup> *Ibid.*, p.339.

<sup>323</sup> *Ibid.*

<sup>324</sup> *Ibid.*

<sup>325</sup> Bodegård, *supra* note 321 p. 339.

<sup>326</sup> *Ibid.*, p. 338.

<sup>327</sup> *Ibid.*

<sup>328</sup> *Ibid.*, p. 340.

<sup>329</sup> Bodegård, *supra* note 321 p. 340.

<sup>330</sup> *Ibid.*

<sup>331</sup> *Ibid.*

<sup>332</sup> *Ibid.*

<sup>333</sup> Bodegård, *supra* note 321 p. 347.

<sup>334</sup> *Ibid.*, p. 349.

devalitalization in asylum-seeking children in Sweden, which “would then indicate that the particular Swedish handling of asylum cases is of significance in the aetiology of this condition”.<sup>335</sup> In his last statement, the author cautioned, “inferiority, dependency and deprivation of normal ego-strengthening activities drain and deitalize our fellow human beings”.<sup>336</sup>

### 4.3 Conclusion

The obstacles that ethnic and racial minority migrants face in Sweden affect their health in interconnected ways. The social segregation, increasingly xenophobic climate and conformity continue to make all immigrants feel like outsiders. It pressures them to become more “Swedish” and to abandon their culture. This may affect their inner integrity and lead to feelings of loss of control and alienation, causing physical and psychological stress that manifests itself in a number of ailments. Unemployment and widespread discrimination add to feelings of isolation and has a detrimental effect on their sense of self worth, confidence, well-being, and overall health. These are added sources of psychological and physical stress that can lead to everything from schizophrenia and anxiety to cardiovascular disease. In addition, both discrimination and perceived discrimination can lead to migrants refraining from seeking health care. This may contribute to poor health practices and poor health. Children are not spared from these challenges. Asylum seeking children who have been exposed to violence are especially vulnerable to psychological distress.

Furthermore, access issues are practical barriers to the receipt of care. The lack of cultural competence results in miscommunication, limited health care seeking, impaired or poor relationships between patients and caretakers, poor quality of care, baseless assumptions, invasive procedures performed without consent and patients seeking treatment in other States. This was most evident in maternal care. In addition to the aforementioned problems, undocumented and asylum seeking ethnic and racial minority migrants are legally restricted from almost all types of care. Undocumented migrants face the same cultural competence and discrimination challenges as other migrants combined with disproportionately expensive fees. These fees are either the sources of rejection or of substantial debt. Though practice indicates that all undocumented children can receive care, fear of exposure prevents or limits parents from taking advantage of this policy.

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<sup>335</sup> *Ibid.*

<sup>336</sup> *Ibid.*

## 5 Sweden, Ethnic and Racial Minority Migrants and The Right to Health: Inconsistent Compliance

*If doctors and nurses have to sort our patients before deciding the kind of treatment they should be given, we are violating basic principles of medical ethics since Aristotle! ~ Henry Ascher<sup>337</sup>*

Sweden has been commended for its overall performance regarding the availability, accessibility, acceptability and quality of health care facilities, services and goods.<sup>338</sup> The government has a detailed public health plan that considers racial and ethnic minority migrants. Various government offices have commissioned and completed studies on discrimination and health. Nevertheless, there are still several areas that require attention and improvement. Specifically, marginalized groups have difficulty accessing health care services for a variety of reasons. For documented racial and ethnic minority migrants, this is because Sweden has failed to adequately remedy two important underlying social determinants of health: unemployment and social exclusion. Discrimination is a basis for these problems that the multicultural policy, though comprehensive and progressive, has yet to overcome. Access problems may also be attributed to the lack of a nationally mandated cultural competence scheme. Many medical professionals do not have the necessary cultural capital required to treat diverse patients. For undocumented and asylum-seeking racial and ethnic minority migrants, there are also cultural competence issues; however, their biggest obstacle is legal. The new law limits their access of health care to emergency situations and even then, at disproportionate costs for undocumented migrants. Women and children within each of these groups face special challenges related to cultural dissimilarities and politicization of care.

### 5.1 Realizing the Right to Health for Documented Migrants: Triumphs and Challenges

Ethnic and racial minority migrants who reside legally in Sweden are guaranteed the right to health *sans* discrimination in law, but not in fact. The

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<sup>337</sup> H. Ascher, Power Point Presentation, *Human Rights and Public Health Strategies*, PICUM, Brussels, 28 June 2007.

<sup>338</sup> P. Hunt, *supra* note 297 para. 40.

laws in Sweden relating to discrimination are recent, unambiguous and comprehensive. The socio-economic state of ethnic and racial minority migrants is dire. Society, it seems, has not caught up to law and this has real world implications for the right to health for migrants of distinct ethnicity who reside legally in Sweden. Sweden has not adequately addressed two principle underlying social determinants of the right to health: unemployment and social exclusion. In addition, there is tension between “old” and “new” Sweden. When forced to choose between conforming to the mores of the Nordic Welfare State or conforming to the ideas of Sweden’s official multicultural society, Swedish society chooses the former. This influences participation in integration programs and even the content of the programs themselves, which at times simply serve to perpetuate the “us” and “them” classifications. Lack of cultural competence means that ethnic and racial minority migrants do not always receive quality care. Insufficient emphasis on this principle means that the situation might not change. This particularly affects pregnant women and mothers and asylum seeking children. Fortunately for some, Sweden offers a range of remedial services to address right to health and discrimination issues.

### **5.1.1 Legislation and Measures: Equality Under the Law**

After visiting Sweden in 2006, Special Rapporteur Hunt accused the State of “not practicing what it preaches” due to the “rudimentary” integration of the right to health into domestic law.<sup>339</sup> That is, when Sweden ratifies treaties, these treaties do not automatically become part of Swedish law. Instead, the parliament designs laws that reflect the articles within the conventions. Sometimes these reflections fall short of what the UN, treaty bodies and Special Rapporteurs believe is required under international law. While Swedish legislation does not often explicitly mention the “right to health”, it does reflect many of the standards contained within this right. The same is true of measures taken by the government.

Sweden has fulfilled its obligation to design measures and strategies to eliminate health discrimination. The Discrimination Act prohibits ethnic discrimination in health care, employment and housing. The Equality Ombudsman actively accepts complaints and investigates discriminatory acts. These measures also are a strong indication that Sweden is protecting and respecting the right to health, which requires States to adopt legislation that guarantees equal protection.

Sweden’s recent public health plan makes an effort to include “everyone” as required by international law. Sweden’s health care identifies eleven objectives including:

participation and influence in society, economic and social security, secure and favorable conditions during childhood and adolescence, healthier working life, healthy and safe

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<sup>339</sup> P. Hunt, *supra* note 297 para. 23.

environments and products, health and medical care that more actively promotes good health, effective protection against communicable diseases, safe sexuality and good reproductive health, increased physical activity, good eating habits and safe food, reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.<sup>340</sup>

Of these, every objective except “health and safe environments and products” includes at least one of two goals designed to improve health for ethnic and racial minority migrants. One goal is commitment to equal rights, obligations and opportunities for all regardless of ethnic and cultural background.<sup>341</sup> The other is the dismantling social, ethnic and discriminatory segregation in metropolitan regions and working for equality and equal living conditions.<sup>342</sup>

Swedish documentation shows a profound understanding of health care disparities. A sizeable portion of the foundational white paper for the health care plan was dedicated to addressing ethnic health care disparities. The paper discussed immigrants’ general poor health in relation to native-born Swedes. It acknowledged the problems of PTSD amongst refugees and child refugees. It linked stressful and monotonous work, unemployment, discrimination, exclusion and residential segregation with ill health in immigrants.<sup>343</sup> The paper restated Sweden’s multicultural policy and encouraged monitoring and evaluation that includes ethnic and class perspectives.<sup>344</sup> Finally, it advocated for an interdisciplinary approach to combat health disparities.

Though it did not cite the comment, the white paper also clearly adopted several of the standards and principles established in General Comment 14 including those related to accessibility, quality and protection of marginalized groups. In the document, the government asserts that people with poor Swedish skills and people from different ethnic backgrounds should be able to access accurate and factual health information.<sup>345</sup> This is consistent with the obligation of information accessibility. Accessibility is also included in the paper’s advocacy of health care of good quality.<sup>346</sup> Its concentration on children, women, asylum seekers and immigrants clearly reflects the Comment’s focus on the most vulnerable groups in society.

Another credit to Sweden’s record on the right to health for regular migrants is that it abstains from adopting discriminatory practices as State policy, in correlation with the duty to respect the right to health. Swedish legislation actively forbids discrimination against immigrants on the basis of ethnicity. Official acts reflect this. The former office of the Ombudsman Against Ethnic Discrimination actively worked to uphold anti-discrimination legislation. In 2007, it received and investigated 30

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<sup>340</sup> G. Ågren, Swedish National Institute for Public Health, *Sweden’s New Public Health Policy: National Public Health Objectives for Sweden* (2003) p. 8.

<sup>341</sup> Regeringens Proposition, *Mål för Folkhälsan*, (2002/03:35) pp. 119-130 [hereinafter *Mål för Folkhälsan*].

<sup>342</sup> *Ibid.*

<sup>343</sup> *Mål för Folkhälsan*, *supra* note 341 pp. 40-41, 56-57.

<sup>344</sup> *Ibid.*, p. 89.

<sup>345</sup> *Ibid.*, p. 96.

<sup>346</sup> *Ibid.*, p. 57.

complaints regarding discrimination in health care.<sup>347</sup> Inadequate or non-existent care cannot be traced to a pattern of simply refusing treatment to documented ethnic and racial minority migrants. The problems are more related to cultural misunderstandings and lack of cultural competence.

The law and public health policy in Sweden include an ethnic perspective and a strong anti-discrimination stance. Nonetheless, Sweden is lacking in specific and targeted measures directed toward ethnic and racial minority migrants. While Sweden's new anti-discrimination law addresses the right to health and discrimination, it does not include a plan or obligations to aid in its facilitation. Such measures for the right to health do not appear to be a legal priority in Sweden. However, including active measures for health, medical and social services in the Discrimination Act would assist Sweden in fully complying with the duty to promote the right to health.

## **5.1.2 Discrimination and Underlying Social Determinants: Inequality in Fact**

In order to fully comply with its responsibilities under the right to health, Sweden must adequately address the principle underlying determinants of the right to health in law *and* in fact. Currently, this is not the case as practice falls short of legal guarantees as they relate to discrimination, employment and segregation.

### **5.1.2.1 Employment and Renumeration**

Indian born Profella described to a New York Times reporter how his employment opportunities in Sweden were not equal to the native-born ethnic Swedes, despite his Ivy League American Masters in Business Administration, "This is my first respectable job and I had to make 150 applications. When my Indian colleagues at Cornell got summer jobs, they worked at places like Proctor and Gamble. Here, they wash dishes".<sup>348</sup>

Sweden's New Integration Strategy (2008) appears to acknowledge the unemployment and underemployment plight of migrants like Profella while simultaneously downplaying it. The document outlining the strategy takes great pains to demonstrate that, while there is a significant gap between Swedes and immigrants regarding employment, this situation is improving. It relies on a "sharp" decrease in the unemployment rate for foreign men between 2005-2007 and an increase in the number of immigrants that have begun to work. A table illustrates this analysis:

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<sup>347</sup> M. Bideke and M. Bideke-Themas, *supra* note 285 pp. 12-13.

<sup>348</sup> W. Hoge, New York Times, *A Swedish Dilemma: The Immigrants' Ghetto*, 6 October 1998, <[www.nytimes.com/1998/10/06/world/a-swedish-dilemma-the-immigrant-ghetto.html](http://www.nytimes.com/1998/10/06/world/a-swedish-dilemma-the-immigrant-ghetto.html)>, visited on 5 April 2009.

**Unemployment Among Domestic and Foreign Born Workers (Percentage)<sup>349</sup>**

Year	Domestic Men	Foreign Born Men	Domestic Women	Foreign Born Women
2005	6.8	14.8	6.8	13.5
2006	5.9	13.2	6.3	13.0
2007	5	11.4	5.4	12.4
Difference Between 2005-2007	-1.8	-3.4	-1.4	-1.1

The unemployment rate of foreign-born men has decreased by more than three percent. The same figure for Swedish men was approximately two percent. This indicates that employment for foreign-born men is beginning to increase on a larger scale than native-born Swedish men. The same is not true for foreign-born women who are unemployed at higher rates and whose unemployment rate is shrinking at a lower percentage than Swedish women. Thus, for foreign born men, there are signs of substantial improvement in the reduction of unemployment rates.

However, this table does not tell the entire story. When the percentages are compared, the proportion of unemployment for those who are foreign born compared with Swedish born are generally the same, with a slight increase. In 2005, foreign-born men had an unemployment rate two point one times that of Swedes. In 2006 and 2007, this number was two point two and two point three times respectively. Thus, despite the general decrease in unemployment and an increase in the number of available jobs, foreign-born men are consistently unemployed at approximately twice the rate of Swedish born men. The disparity for women is slightly larger, with foreign women being between two point one times and two point three times more likely to be unemployed than Swedish women. Moreover, this table is only indicative of the broad categories of “foreign born” and “native born”. People of African and Asian ancestry are unemployed at several times the rate of ethnic Swedes. Based on the most recent statistics Sweden sent to the CERD Committee, African men had an unemployment rate of 20.8 percent; African women had an unemployment rate of 21.8 percent.<sup>350</sup> Asian men were unemployed at a rate of 21.9 percent and Asian women at 18.4 percent.<sup>351</sup>

In addition, it is not enough that people are employed. They must be employed in jobs that pay enough to advance their socio-economic status. Twice as many migrants live below the poverty line than Swedes. They are more likely to receive means tested social assistance. There is also a large income difference between Swedes and racial and ethnic minority migrants. In 2005, migrants from North Africa and the Middle East earned 140,000 SEK while Swedish-born people earned 217, 000 SEK.<sup>352</sup> Here, the average North African and Middle Eastern migrants’ salary constitutes a

<sup>349</sup> Strategi för Integration, supra note 192 table 3, p.10.

<sup>350</sup> CERD/C/452/Add.4 (2004) p. 18

<sup>351</sup> *Ibid.*

<sup>352</sup> Statistiska Centralbyrån, Press Release; Incomes of Young People Increased the Most, <[www.pubkat.scb.se/Pages/PressRelease\\_\\_\\_217177.aspx](http://www.pubkat.scb.se/Pages/PressRelease___217177.aspx)>, visited on 2 April 2009.



mere 65 percent of the average native-born Swede's. On the other hand, salaries for these migrants increased by 42% between 2000-2005,<sup>353</sup> indicating that length of stay in Sweden has a positive impact on earnings. Whether this trend will continue is unclear and the OECD has found that non-European men have a substantial earnings disadvantage even when they have resided in Sweden for twenty years.<sup>354</sup>

As a way of addressing the obvious employment disparities, the integration strategy puts an emphasis on education as a means of combating labor market discrimination. According to the strategy document, receiving a Swedish education is an asset for obtaining employment.<sup>355</sup> Unfortunately, the emphasis on education undermined by research demonstrating that speaking with an accent or having a foreign name is a detriment to job applicants regardless of education level.

A March 2009 report of the Swedish Confederation for Professional Employees found that even when foreign-born applicants attended primary, secondary and higher education in Sweden, they had a more difficult time finding jobs and often took jobs for which they were overqualified.<sup>356</sup> This disproportionately affected those born in Africa, Asia and Latin-America.<sup>357</sup> Then, there is the education that migrants' receive in their countries of origin. For employment in Sweden, there is no statistically significant effect of having more education if this education was earned outside of Sweden.<sup>358</sup> Education is generally associated with better adaption partially because of its correlation with occupational status and income.<sup>359</sup> Here, its value is diminished by discrimination.

Due to discrimination, the government's allusion to the improved employment situation of racial and ethnic minority migrants is not yet reflected in reality. Professor Roger Andersson noted it is paradoxical that since declaring itself multicultural in 1974, labor market integration has only become increasingly problematic in Sweden.<sup>360</sup> Nor is there any indication that the decrease in unemployment has anything to do with government sponsored integration programs or as an effect of anti-discrimination laws. It is more plausibly connected to immigrants' willingness to send out more applications, their acceptance of jobs that they are overqualified for and, as one scholar states, "improved macroeconomic conditions".<sup>361</sup>

It is difficult to tie Sweden's immigration strategy thus far to an improvement in the socio-economic conditions of racial and ethnic minority migrants. However, now there is new legislation, a new ombudsman and a

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<sup>353</sup> *Ibid.*

<sup>354</sup> G. Lemaître, OCED, *Social, Employment and Migration Working Papers No. 48, The Integration of Immigrants into the Labour Market: the Case of Sweden* (2007) para. 78.

<sup>355</sup> Strategi för Integration, *supra* note 190 pp. 20-21.

<sup>356</sup> TCO Granskar, *Samma Villkor för Alla Akademiker?* 9 March 2009, p. 5.

<sup>357</sup> *Ibid.*

<sup>358</sup> Lemaître, *supra* note 354 para. 98.

<sup>359</sup> J. Berry, 'Lead Article: Immigration, Acculturation and Adaption', 46:1 *Applied Psychology* (1997) p. 22.

<sup>360</sup> K. Schönwälder (Ed.), Social Science Research Center Berlin, *Residential Segregation and the Integration of Immigrants: Britain, the Netherlands and Sweden* (2007) p. 83.

<sup>361</sup> *Ibid.*, p. 84.

new strategy. The presence of new and more stringent anti-discrimination may improve employment conditions for migrants as the Integration Strategy predicts. On the other hand, implementation of anti-discrimination law at a municipal level has been criticized as lackluster and evasive.<sup>362</sup> There are considerable differences in the way each municipality adopts laws. Municipal autonomy is constitutionally established in Sweden. While municipalities must act in a manner consistent with national law, they are permitted to make independent decisions on how the law will be executed and administered.<sup>363</sup> This permits local initiative but may not insure minimal performance.<sup>364</sup>

### 5.1.2.2 Social Exclusion

Sweden is not blind to the existence of social exclusion and its effect on its immigrant population. The government agrees that combating social exclusion and poverty and incorporating those furthest from the labor market are important issues of discussion.<sup>365</sup> It declares that many determinants of health like unemployment and housing segregation are better addressed outside of the medical sector in municipal or other democratic institutions.<sup>366</sup> The government has also acknowledged that,

Discrimination, depriving groups of people of their chance to influence, definitely has a negative impact on health and this may explain the much poorer health of a number of immigrant groups. The deteriorated health of the long-term unemployed may be connected to some extent to reduced powers of influence. Less influence probably also leads to less of a chance to 'choose' a reasonably healthy lifestyle.<sup>367</sup>

Thus, the government recognizes that segregation is a problem in Sweden that affects employment and health outcomes. Its integration policy and anti-discrimination laws are supposed to deconstruct these barriers, but equity in law does not translate into equity in fact.

Equity in fact in Sweden is dependant on the successful execution of integration measures. One problem with integration initiatives in Sweden is that, though well intentioned, they may have the opposite effect of what they wish to achieve. That is, they may focus on difference and relate it to otherness instead of focusing on how diversity is beneficial for society.

A study of integration measures in Malmö indicates how integration programs may reinforce differences and paternalism instead of encourage diversity and independence, despite good intentions. Malmö has the third

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<sup>362</sup> M.A. Diakté, The English International Association of Lund, *The Policies and Strategies Used in the Integration of Immigrants in Sweden* (2006) p. 4.

<sup>363</sup> The Swedish Government's Human Rights Website, *At Local Level: Municipalities* <[www.humanrights.gov.se/extra/pod/?module\\_instance=2&action=pod\\_show&id=76](http://www.humanrights.gov.se/extra/pod/?module_instance=2&action=pod_show&id=76)>, visited on 5 April 2009.

<sup>364</sup> Lemaître, *supra* note 354 para. 95.

<sup>365</sup> Swedish Ministry of Health and Social Affairs, *Reply from Sweden on the Consultation on Action at EU level to Promote the Active Inclusion of the People Furthest from the Labour Market*, 16 April 2008.

<sup>366</sup> Ågren, *supra* note 340 p. 6.

<sup>367</sup> *Ibid.*, pp. 8-9.

largest immigrant population in Sweden, with migrants composing approximately 34% of the city's population.<sup>368</sup> In Malmö, migrants are unemployed four times more often than Swedes (six point four percent to one point six percent respectively).<sup>369</sup> The city, home to the infamous Rosengård public housing complex, is marked by socio-economic and urban segregation.<sup>370</sup> Malmö's municipal council passed the *välfärd för alla* (Welfare for All) program in 2004 to address these problems and to encourage integration.<sup>371</sup>

The Link-Workers Project, endorsed by Welfare for All, employs people to work daily with immigrant children to build a link between the parents, the school system and society.<sup>372</sup> It concentrates on "cultural transitions and clarifications" with a mind to "establish an understanding of how one should live and behave in order to improve the chances of a good life in Sweden".<sup>373</sup> Once again, the onus is on the immigrant to adopt Swedish behaviors in order to "integrate" into Swedish society. Another criticism of this program, and others in Malmö, was that though they aimed to empower immigrants and help them to integrate, these projects contributed to exclusion due to their limited understanding of culture.<sup>374</sup> Role playing exercises used in school for a diversity day project illustrate this. Children were instructed to create dialogue from stories written by their teachers. All of the stories involved a girl from an immigrant background conflicting with her patriarchal culture.<sup>375</sup> In one, a father arrives early to pick his daughter up from school and finds she has stopped wearing her veil. In another, a young woman clashes with her father because she has a Swedish boyfriend.

This role-play reinforced stereotypes about immigrants and their "patriarchal culture," and continued to subtly reinforce the superiority of Swedish culture. Among many Swedes, cultural differences are viewed as less than [Swedish culture] rather than simply different or diverse. Having children design the dialogue contained in these stories indoctrinates them into believing that migrants who alter themselves to fit into Swedish culture have correct behaviors (the young women in this story). Immigrants who do not (the fathers) are sources of concern and objects of ridicule. These integration programs point to something profound in Swedish popular perception of immigrants. Immigrant women are often seen as passive and repressed.<sup>376</sup> Immigrant men are viewed as oppressive and chauvinistic. This way, social problems can be interpreted as cultural problems; instead of Swedish society and Sweden being the problems, the immigrant is the problem.<sup>377</sup>

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<sup>368</sup> S. Scuzzarello, *National Security versus Moral Responsibility: An Analysis of Integration Programs in Malmö, Sweden* (Oxford University Press, 2008) p. 9.

<sup>369</sup> *Ibid.*

<sup>370</sup> *Ibid.*, p. 10.

<sup>371</sup> *Ibid.*

<sup>372</sup> Scuzzarello, *supra* note 368 p. 19.

<sup>373</sup> *Ibid.*, Scuzzarello's translation.

<sup>374</sup> *Ibid.*, p. 23.

<sup>375</sup> *Ibid.*, p. 22.

<sup>376</sup> P. Lappalainen, *Det Blågula Glashuset*, (SOU 2005:56) p. 44.

<sup>377</sup> *Ibid.*, p. 45.

This “blaming the victim” behavior is just one problematic societal trend. The ingrained preoccupation with sameness and conformity is another. This explains why the further a migrants’ country of origin is from Sweden, the more difficult it is for them to access employment regardless of their qualifications. The less “Swedish” someone appears, the more difficult it is for them to obtain employment, “competence” and housing. All of these elements have a devastating effect on ethnic and racial minority migrants’ ability to attain the highest standard of mental and physical health as well as other human rights. Despite valiant, but late, efforts by Sweden to legislate against discrimination and to encourage diversity, the economic, social and cultural conditions of migrants are not improving.

This situation is an outgrowth of how Sweden perceives itself and its role as a welfare state and the focus on conformity as means of ensuring equality. As not all cultural and political differences are tolerated, the demand for conformity sets up “quite impenetrable boundaries of inclusion and exclusion”.<sup>378</sup> This is also intensified by Sweden’s multiculturalism manifesto. Although cultural diversity is celebrated as a goal, it makes cultural and ethnic differences inherent and inescapable.<sup>379</sup> Social and cultural differences, either real or incorrectly perceived, can then be transformed into potential personal and political threats.<sup>380</sup> The paradoxical result is that ethnic and racial minorities can never truly become Swedish and therefore, equal.

Of course, this is not to say that bias and discrimination would vanish from Sweden if conformity were not such a cherished social value. Nations that do not value conformity as highly, like the United States, have serious problems with the disenfranchisement of immigrants and ethnic and racial minorities. The particular problem in Sweden is that reducing prejudices and bigotry to a demand for conformity does two disservices. First, it perpetually separates people into “us” and “them”. Second, it masks the true issue: racial bias. Unlike conformity, racism is not an acceptable value in Swedish society. Racists are described in Sweden as isolated groups of people with social problems who are at odds with society, on the margins and only socialize with one another.<sup>381</sup> This makes it difficult to see how racial bias invades everyday socialization because discrimination can be, and often is, hidden under “ideological rhetoric”.<sup>382</sup> It may not be acceptable to exclude someone from a job interview because they are Iraqi but it is less problematic if this is justified in terms of their “social competence”.

When the demand for conformity is used as a cover for bigotry, it thwarts exposure of the real problem and permits people to feel justified and comfortable with illegal and immoral behavior. Deconstructing a more is not an easy task. It takes time and effort, but in order to adequately address the social determinants most threatening to health in Sweden, unemployment and social exclusion, something must be done. Failure to

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<sup>378</sup> K. Norman, ‘Equality and Exclusion: “Racism” in a Swedish Town’, 69:2 *Ethnos* (2004) p. 224.

<sup>379</sup> Eastmond, *supra* note 179 p. 20.

<sup>380</sup> Norman, *supra* note 378 p. 224.

<sup>381</sup> *Ibid.*, p. 210.

<sup>382</sup> *Ibid.*

adequately address and combat these determinants undermines Sweden's obligation to fulfill the right to health.

Pressure to conform and assimilate has a direct influence on ethnic and racial minority migrants' right to health. Sweden, as a welfare State with standard services for all has never created much space for ethnically different service.<sup>383</sup> Public services both assume and actively seek to create cultural standardization and "equality".<sup>384</sup> Ironically, providing the same care to ethnic and racial minority migrants based on standardized models is actually providing inferior care to ethnic minority groups.<sup>385</sup> Swedish care workers have reported problems when they cannot fit ethnic minority patients into the pre-established models they have created. Cultural competence, a "new" model for Sweden, is not consistently pursued as a means for expanding health care and socio-economic models and addressing health disparities. This dependence on and comfort with sameness, manifested in conduct and models, contradicts and frustrates the right to health for people who are not ethnically Swedish.

### 5.1.3 Systemic Lack of Cultural Competence

Thus far, unemployment, discrimination, social exclusion and societal mores have been identified as barriers to the right to health for racial and ethnic minority migrants. Lack of cultural competence is another. If all other things were equal, the right to health would still suffer because care would suffer. It has been proven that being proficient in cultural competence has a positive effect on the caretaker-patient relationship, the quality of care and health outcomes. This is because cultural competence is based on both the patient's and the caretaker's needs. The patient requires a certain level of competence from the caretaker in order to be understood. The caretaker requires a certain amount of competence not only to decipher the patient's needs but also to determine which course of action is best.

A survey of physicians in the United States in seven specialties (medicine, surgery, obstetrics– gynecology, psychiatry, family medicine, pediatrics and emergency medicine) revealed that the overwhelming majority of doctors surveyed (96 percent) believe that it was important to consider a patient's culture when providing care.<sup>386</sup> Those surveyed also reported that poorly handled cross cultural issues "often" resulted in negative consequences like longer office visits, patient non-compliance, delays in obtaining informed consent, unnecessary tests and lower quality of

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<sup>383</sup> M. Graham, 'Emotional Bureaucracies: Emotions, Civil Servants and Immigrants in the Swedish Welfare State', 30:3 *Ethos* (2003) p. 206.

<sup>384</sup> *Ibid.*, p. 201.

<sup>385</sup> D. Ingleby et al., 'The Role of Integration in Health' in M.L. Fonseca and J. Malheiros (eds.), *Social Integration and Mobility: Education, Housing and Health* (2005).

<sup>386</sup> J.R. Betancourt, 'Cultural Competence and Medical Education: Many Names, Many Perspectives, One Goal', 81:6 *Academic Medicine* (2006) p. 499.

care.<sup>387</sup> In order to avoid these pitfalls, cultural competence must become ingrained into medical culture.

The failure to educate for, adopt and use cultural competence standards on a broad, national scale has compromised Sweden's ability to make health care accessible and acceptable to racial and ethnic minorities. While instruction about others' cultures has been introduced in medical programs in Sweden, there is no urgency or measures attached to its realization. A decade ago, the Swedish National Board of Health and Welfare proposed including a cultural competency curriculum in all medical programs in Sweden.<sup>388</sup> A 2003 study of Lund University Medical School revealed that though cultural competency was included in the curriculum, it was hidden.<sup>389</sup> That is, it was not clearly defined or thematically presented.<sup>390</sup> The study concluded that there was no verification that all students leave the program with the adequate skills and knowledge required to treat patients of different racial and ethnic backgrounds.<sup>391</sup>

The integration of cultural competence into Lund University Medical School's curriculum remains insufficient. One Lund medical student reported, "I have had some but very little education on the difference of how patients from other origins perceive a doctor".<sup>392</sup> Another added, "This semester, we talked shortly about how communication might differ between cultures, the way you say something, how you touch a patient, how you look at him or her etc. Among our literature we have a book 'Culture, Health and Illness' that probably nobody is going to read".<sup>393</sup> Based on these students' responses, it is clear that Lund is continuing to make an effort to incorporate cultural competence into its curriculum via seminars and literature.

Nonetheless, it appears that some students will leave the program with very little knowledge about how to treat a non-Swedish patient because instruction and practice of culturally competent medicine is not a significant part of the curriculum. This is due to low exposure to the topic and/or low motivation to master culture competence among the students. Including cultural competence in the curriculum is a waste if it is not impressed on students that it is mandatory to acquire knowledge in this area.

It is significant that this study concentrated on Lund University's Medical School. The school is considered one of the best in Sweden, if not Scandinavia. It is located in an area of southern Sweden with a large immigrant population. If cultural competence standards are not incorporated into this program, where it appears to be particularly relevant,

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<sup>387</sup> *Ibid.*

<sup>388</sup> C. Wachtler and M. Troein, 'A Hidden Curriculum: Mapping Cultural Competency in a Medical Programme,' 37, *Medical Education* (2003) p. 861 *citing* The Swedish National Board of Health and Welfare, *Mångkulturell Sjukvård: En Lärarhandledning för Läkarutbildning* [Multicultural Health Care: a Guide for Medical School Teaching] (Stockholm: NBHW Report, 1999).

<sup>389</sup> Wachtler and Troein, *supra* note 388 p.861.

<sup>390</sup> *Ibid.*, p. 866.

<sup>391</sup> *Ibid.*

<sup>392</sup> G. Asp, Lund University Medical Student, Email Correspondence 27 February 2009.

<sup>393</sup> R. Arvidsson, Lund University Medical Student, Email Correspondence 1 March 2009.

this does not bode well for what one will find as standard practices of schools located in smaller, more isolated and homogenous settings.

Medical schools are not the only relevant training programs for introduction of cultural competence as an educational tool. Cultural competence applies to many fields including social work, psychology and nursing. In Sweden, nursing documents push for cultural competence as a means of meeting patient's cultural needs but they do not give a specific explanation for what this means nor do they provide general guidelines.<sup>394</sup> In 2002, less than half of all of the nursing students in Sweden said that their education contributed to an understanding of people with different cultural backgrounds.<sup>395</sup>

Understanding those with different cultural backgrounds is key to providing quality health services. In order to provide the high quality and effective care mandated by both domestic and international law, the focus must shift from the ethnocentric point of view to one of cultural relativism that pursues the understanding of individual beliefs and needs.<sup>396</sup> In Sweden, this means abandoning the notion that everyone can fit into a prescribed Westernized medical model. It also means impressing on all medical professionals a need to become culturally competent. This can be accomplished in a number of ways, some of which shall be explored in the next chapter.

It must be stressed that cultural competence is not the sole solution for eliminating health disparities. Its mandate and effectiveness cannot be overstated. Cultural competence cannot rectify many of the underlying determinants of health like socio-economic status, employment, segregation and education. On the other hand, its importance cannot be underestimated as being necessary for

all physicians who wish to deliver the highest quality care to all patients. For some patients who are culturally distant from us, our skill set in this area will make all the difference in the world; for others, to whom we are culturally closer, some of the tools and skills will still come to bear and make a marked difference that will lead to better health outcomes.<sup>397</sup>

Cultural competence is essential where the right to health is concerned as a method that will aid in providing culturally accessible and acceptable service for everyone. In addition to ensuring that societal practice reflects the laws regarding the aforementioned underlying social determinants of health, Sweden must strive to ensure that cultural competence is employed to support ethnic and racial minority migrants' attainment of the highest standard of health.

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<sup>394</sup> M. Jirwe, *Cultural Competence in Nursing* (Karolinska Institutet, Stockholm, 2008) p. 10.

<sup>395</sup> *Ibid.*, p. 12.

<sup>396</sup> L-L. Ozolins and K. Hjelm, 'Nurses Experiences of Problematic Situations with Migrants in Emergency care in Sweden,' *7 Clinical Effectiveness in Nursing* (2003) p. 92.

<sup>397</sup> Betancourt, *supra* note 386 p. 500.

## 5.1.4 Women and Children

Competence is especially applicable to women's and children's health. In some ways, Sweden has proven to be extremely competent regarding gender. Sweden's obligation to fulfill obliges the State to utilize a gender sensitive approach. To this end, Sweden's public health policy asserts that a gender perspective must be an integral part of the entire public health scheme.<sup>398</sup> Once more, in law Sweden is fulfilling this obligation under the right to health. Another triumph in the Swedish health care system is the economical accessibility of many forms of health care related to women. For documented racial and minority migrant women, few, if any, services are cost prohibitive. Sexual and reproductive services, pre and post-natal care and access to family planning are all heavily subsidized and affordable regardless of socio-economic background. Consultations with midwives, consultations to discuss birth control and giving birth are all free of cost to regular Swedish residents.

Though economic and legal accessibility are credits toward the realization of the right to health for migrant women in Sweden, the acceptability standard has not yet been fully met. The blending of gender and ethnicity complicates accessibility in practice. Ethnic and racial minority migrant women, especially those seeking maternal care, do not have full access to the best possible care. A lack of cultural competency can lead to troubling consequences in this situation. This is notable for women from cultures that are perceived as patriarchal. Presumptions about their culture have led to invasive procedures (forcing a prepubescent girl to undergo a gynecological exam) and unjustified withholding of information (refusing to tell a couple the sex of their fetuses). Both of these actions have physical and mental health consequences. African women who have been circumcised or who have many children identify the behaviors and actions of Swedish professionals as reasons that they either avoid seeking care or choose to seek care elsewhere. Additionally, health care workers' inability to fit these women into the typical medical model may result in serious problems like pregnancy complications and providing medical procedures to which women have not consented.

In addition to culturally accessible care, the right to health stresses the reduction of infant mortality. The term "infant mortality" is broad and encompasses several periods. The term itself refers to number of deaths per 1000 within a year of birth. Sweden has one of the lowest infant mortality rates in the world. Sweden's low rate is attributed to better post-natal care and improved socioeconomic conditions.<sup>399</sup> Infant mortality is an indicator of socio-economic conditions while perinatal mortality is an indicator of health service efficiency. Perinatal mortality refers to number of stillbirths and deaths within seven days of birth per 1000 births.<sup>400</sup> No national study

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<sup>398</sup> Ågren, *supra* note 340 p. 21.

<sup>399</sup> B. Essén et al., 'Qualitative Study of Pregnancy and Childbirth Experiences in Somalian Women Resident in Sweden', 107 *British Journal of Obstetrics and Gynaecology* (2000) p. 1507.

<sup>400</sup> World Health Organization, Health Statistics, Mortality, <[www.who.int/healthinfo/statistics/indneonatalmortality/en/](http://www.who.int/healthinfo/statistics/indneonatalmortality/en/)>, visited on 5 April 2009.



has shown any general increase in infant mortality amongst women from ethnic and racial minority backgrounds. However, a city focused study found a higher risk of perinatal mortality. The study of 15,639 deliveries in Malmö revealed that the perinatal mortality was higher among foreign-born women.<sup>401</sup> The increase was minor for all groups except women of African origin, mostly Somalis.<sup>402</sup> The higher mortality was not related to any of the common risk factors like diabetes, anemia and smoking.<sup>403</sup> The study declined to link the increased rate to socio-economic factors without further investigation. Nonetheless, it is telling that one of the most marginalized groups has a higher perinatal mortality rate. This may imply that health service is less efficient for sub-Saharan African women and would be another cause for concern.

### **5.1.5 Remedies**

When Sweden fails in its obligations, regular migrant victims have access to diverse and plentiful domestic remedies. There are informal channels that result in direct communication, disciplinary channels and compensatory schemes. Both HSAN and the Patient Insurance Scheme are accessible to people who are not fluent in Swedish. HSAN's website features languages reflective of Sweden's largest ethnic minority groups. The HSAN Board is composed of medical and health care professionals and a President with judicial experience; each brings varying assets to a seemingly fair and burden-sharing process. On an international scale, Sweden has recognized the competence of the CEDAW and CERD, which may receive individual complaints. Thus, there are viable international remedies available for racial and ethnic minority migrants, including those with a special focus for women and children.

## **5.2 Realizing the Right to Health for Undocumented and Asylum-Seeking Migrants: Triumphs and Challenges**

Where Sweden has mixed compliance related to documented ethnic and racial minority migrants, it has failed to recognize the right of everyone to the highest attainable standard of mental and physical health because of its legislation and policy related to the undocumented and asylum seekers. First, Sweden has virtually prohibited undocumented migrants and asylum seekers from using its public health system save in emergencies. Second, it has failed to ensure health care for the most marginalized and vulnerable groups. In addition, this policy prevents the nation as a whole from taking adequate steps to prevent, treat and control diseases. Third, denying

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<sup>401</sup> B. Essén, et al., 'Increased Perinatal Mortality Among Sub-Saharan Immigrants in a City in Sweden', 79 *Acta Obstetrica et Gynecologica Scandinavica* (2000) pp. 737-743.

<sup>402</sup> *Ibid.*, p. 741.

<sup>403</sup> *Ibid.*, p.742.

undocumented migrants and asylum seekers equal access to preventative, curative and palliative care defies the respect standard established by the Committee. Fourth, the application of this law is inconsistent with the acceptability element, which requires that health facilities and services respect medical ethics. Fifth, the legally limited care available to undocumented migrants and asylum seekers diminishes their right to remedies under international law. Finally, Sweden has failed to create conditions where everyone is assured medical attention in the event of sickness.

## 5.2.1 Inequity Under the Law

The Committee makes it clear that “everyone” includes marginalized and vulnerable groups such as asylum seekers, failed asylum seekers, victims of trafficking and undocumented migrants, all of whom are denied routine and preventative health care under Swedish law. This denial of care conflicts with the ICESCR’s focus on care of infectious diseases. Currently, only some clinics will screen undocumented migrants for HIV and tuberculosis, both of which are highly contagious. There is no indication that these clinics will always provide these people with the medications necessary to control or cure the diseases. This is a public health issue as much as a human rights issue, as failure to control epidemics amongst certain portions of the population all but guarantees its spread to the rest of the population.

Besides failing to control the spread of disease, Sweden has not respected the right to health because it has not refrained from denying or limiting equal access for all persons to preventative, curative and palliative care. The Committee explicitly applies this obligation to “asylum seekers and illegal immigrants”. Sweden, for its part, explicitly denies these people the right to preventative and almost all palliative care. Preventive care, by definition, should occur before the condition has reached an emergency or acute phase. Undocumented and asylum seeking patients are only entitled to palliative, or analgesic care, when their conditions have reached an advanced stage. Curative care is available, at full cost for the undocumented, only when an administrator considers that the condition has reached the phase where “immediate” or emergency care is required and therefore permitted by law.

The levying of disproportionately expensive costs against disadvantaged groups blatantly violates the principle of economic accessibility. The application of this law as it relates to medical staff is also problematic where discussion of costs are concerned.<sup>404</sup> One study detailed how a woman’s heart ultrasound had to be postponed because she did not have documents and could not prove she had insurance.<sup>405</sup> This evidences a lack of knowledge that everyone is entitled to emergency care regardless of his or her insurance or residential status.<sup>406</sup>

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<sup>404</sup> Ozolins and Hjelm, *supra* note 396 p. 89.

<sup>405</sup> *Ibid.*

<sup>406</sup> *Ibid.*

The situation for asylum seekers and failed asylum seekers is better and more consistent with international law. While this group is not entitled to the full range of care guaranteed to them by international law, the care available to them is subsidized and economically accessible. They are also given an exam upon arrival in Sweden which may aid in realizing their right to preventative, curative and palliative care, depending on the result of such an exam and the availability of continuing care. Mental health care is a distinct concern with the Special Rapporteur observing that asylum seekers had difficulties accessing the mental health services they required.<sup>407</sup>

Ironically, State expense has not been used as a justification for Sweden's restrictive policy.<sup>408</sup> During his trip to Sweden, Special Rapporteur Hunt stated that it was never suggested that including undocumented migrants and asylum seekers in subsidized care was prohibitively expensive.<sup>409</sup> He believes that expanding health care to include these groups is unlikely to produce significant costs, relatively speaking.<sup>410</sup>

## 5.2.2 Discrimination and Ethical Concerns

The discrimination against undocumented migrants and asylum seekers is nearly impossible to reconcile with doctors' ethical obligations. Failure to respect medical ethics weakens the acceptability of health care, reduces the authority of the health care provider and has a negative impact on facilities and services. To the extent that Swedish doctors are subject to ethical rules, the Swedish government should make an effort to ensure that policies and legislations are consistent with their ethical guidelines. In Sweden, the Swedish Medical Association is guided by several codes of ethics that are highly reflective of the human rights principles of dignity and equality. One code guideline insists that doctors must never depart from the principle of equal value and must never expose a patient to discriminatory treatment.<sup>411</sup> In March of 2008, while the Parliament was considering the Law Related to Asylum Seekers and Others, the Swedish National Council on Medical Ethics ("SMER") on Medical Ethics wrote to the Ministry of Social Welfare to offer their advice. In their letter SMER voiced an ethical concern.

SMER stated that one cornerstone of medical ethics is that care should be provided to all based on medical need.<sup>412</sup> Other factors such as economic, social or legal status, political or religious affiliation, ethnic background, gender and age should not affect medical professionals' actions, which should be based on science and proven experience.<sup>413</sup> SMER denounced the classification of adults into categories other than those related to care as

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<sup>407</sup> P. Hunt, *supra* note 297 para. 44.

<sup>408</sup> P. Hunt, *supra* note 297 para. 74.

<sup>409</sup> *Ibid.*

<sup>410</sup> *Ibid.*, para. 74.

<sup>411</sup> Läkarens Etiska Regler i Nutid

<[bengtdahlin.se/HoSStoryn1/filer\\_del\\_1/etiska\\_regler.html](http://bengtdahlin.se/HoSStoryn1/filer_del_1/etiska_regler.html)>, visited on 5 April 2009.

<sup>412</sup> Statens Medicinsk-etiska Råd, 3 October 2008, *Skrivelse om Hälso- och Sjukvård för Asylsökande, Gömda och Papperslösa*, <[www.smer.se/Bazment/289.aspx](http://www.smer.se/Bazment/289.aspx)>, visited on 5 April 2009.

<sup>413</sup> *Ibid.*

contrary to humanitarian principles.<sup>414</sup> They encouraged the government to review their policy concerning health care for failed asylum seekers and undocumented migrants, bearing in mind that there were strong arguments for increasing the scope of care to these groups.<sup>415</sup>

Restricting care based on residential status intrudes on the doctor patient relationship and attempts to regulate whom doctors can and cannot treat in direct violation of medical ethics. It effectively forces them to choose between potentially violating a law or violating their ethical standards by failing to treat someone based on residential status. As this law only affects racial and ethnic minority migrants, doctors may also be placed in the awkward position of believing that they are somehow contributing to institutional or structural racism<sup>416</sup> in addition to being perceived as racist themselves by patients and potential patients.

### 5.2.3 Systemic Lack of Cultural Competence

In addition to ethical concerns, medical personnel will also be confronted with cultural competence challenges that affect their ability to give the best care to undocumented and asylum seeking ethnic and racial minority migrants. Such challenges are intensified during an emergency context. Emergency care is characterized by brief encounters between the patient and the caretaker in high technology settings such as ambulances, emergency rooms and intensive care units.<sup>417</sup> The quality of this type of care is contingent on many factors but two important ones are culture and ethnic background.<sup>418</sup> Dissimilar cultural beliefs may cause tension especially in the hospital environment.<sup>419</sup> This tension may influence the patient's health.<sup>420</sup>

A study of immigrants in emergency care found that caretakers experienced the most difficulties with asylum seekers. These patients behaved in unexpected ways due to their cultural differences, anxiety concerning their residency status and language barriers. Asylum seekers in emergency care provoked very strong reactions from caretakers including frustration.<sup>421</sup> The staff expressed that they felt the problems were due to their limited knowledge of other cultures, difficulty in motivating cooperation, difference in health care expectations and difficulty deciphering behaviors related to cultural ceremonies.<sup>422</sup>

The different behavior was a particular cause of concern. Staff struggled at times to determine the severity of the illness in light of the way the asylum seeker was expressing him or herself. Caretakers also expressed that they felt "a great burden" when deciding whether the non-Swedish speaking

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<sup>414</sup> *Ibid.*

<sup>415</sup> *Ibid.*

<sup>416</sup> Email Correspondence with G. Asp *supra* note 392.

<sup>417</sup> L-L Ozolins and K. Hjelm, *supra* note 396 p. 84.

<sup>418</sup> *Ibid.*

<sup>419</sup> *Ibid.*

<sup>420</sup> *Ibid.*

<sup>421</sup> S. Hultsjö and K. Hjelm, 'Immigrants in Emergency Care: Swedish Healthcare Experiences', 52 *International Nursing Review* (2005) p. 283.

<sup>422</sup> *Ibid.*, p. 279.

person on the phone was in need of emergency care.<sup>423</sup> In addition, they were exposed to situations where they were unable to help suffering asylum seekers because there was no institution that they could be referred to for continuing care. Continuing care is neither emergency nor immediate. Nonetheless, it could be essential in attaining a high standard of health and of avoiding another emergency medical situation.

These studies revealed that staff must be in a position to understand the specific problems of asylum seekers.<sup>424</sup> That is, this group of people suffer from high levels of stress due to the wait for a residence permit, migration background and adapting to Sweden as a new environment.<sup>425</sup> Therefore, the responsibility is on caretakers to compensate by developing culturally congruent care that reduces the risk of misinterpretation.<sup>426</sup>

As a result of the new law, Sweden has one of the most restrictive policies in Europe for access to health care for undocumented migrants and asylum seekers.<sup>427</sup> This has drawn attention and disapproval. For Special Rapporteur Hunt, the differential treatment of asylum seeking adults amounts to discrimination under international human rights law.<sup>428</sup> He insisted that that asylum seekers and undocumented people are among the disadvantaged groups that human rights law is designed to protect.<sup>429</sup> He urged Sweden to reconsider its position in order to conform its law and policies to its international human rights law obligations.<sup>430</sup>

## 5.2.4 Women and Children

By the same token, Sweden has failed to make most health care accessible for adult undocumented women in contravention of international law. Undocumented women may give birth at full cost. Such services are disproportionately expensive for these women who earn low wages, if they earn money at all. Most will not go to the hospital until they are ready to give birth. This increases the risk of complications from home births. Again, there is a difference for asylum seeking women and failed asylum-seeking women who are not in hiding. These women are entitled to free birth care, abortions and contraceptives. This is consistent with the accessibility standard under international law and a credit to Sweden's health care system. Nonetheless, all migrant women tend to under-utilize the pre and post-natal care necessary to ensure the health of themselves and their babies.

The legislation and its treatment of asylum seeking and failed asylum seeking children who are not in hiding is fully consistent with Sweden's treaty obligations. This is especially relevant where respect and accessibility are concerned. Currently, Swedish law prohibits

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<sup>423</sup> *Ibid.*

<sup>424</sup> *Ibid.*, p. 283.

<sup>425</sup> *Ibid.*

<sup>426</sup> Ozolins and Hjelm, *supra* note 396 p. 84.

<sup>427</sup> United Nations Association of Sweden et al., *supra* note 294 para. 52; PICUM, *supra* note 303 p. 8.

<sup>428</sup> *Ibid.*, para. 69

<sup>429</sup> *Ibid.*

<sup>430</sup> P. Hunt, *supra* note 297 para. 75.

discrimination against these groups by giving them the same care as Swedish children.

Unfortunately, practice and the law are not consistent where undocumented children are concerned. Undocumented children are not provided access via the law though they are in practice. Moreover, their parent's severely limited access to health care and fear of being caught restricts their access to care. Sweden's refusal to provide legal guarantees for undocumented children means that it has not fully conformed to its duties to respect the right to health, to provide health care to all children and to act in the best interests of the child. The fact that its civil society has decided to treat these children anyway is commendable and should influence future legislation.

### 5.2.5 Remedies

The type of care that undocumented migrants, failed asylum seekers and asylum seekers are entitled to, by its nature, impedes their right to remedies under international law. Some remedies, such as discussing the matter with Independent Patients' Advisory Committee, filing a complaint with HSAN, civil suits and reporting to the Ombudsman are curtailed due to fear of being caught or exposed. The government's restriction of care to that which cannot wait and emergency care eliminates the possibility of compensation for undocumented migrants who require such care. The Patient Injury Insurance will not pay compensation when the procedure was necessary for the diagnosis or treatment of an illness that was life threatening or would cause severe disability, the injury was unavoidable, expected infection occurred or if an illness has naturally progressed.

Under the HSAN system, there may be privacy issues for undocumented migrants. In one instance, a HSAN employee insisted that the Board does not care if the patient filing the complaint is undocumented but she was personally unaware of any such cases ever being filed.<sup>431</sup> She attributed this to undocumented migrants' desire to stay hidden.<sup>432</sup> The complaint filing status with HSAN may indeed compromise undocumented migrants' clandestine status. The complaint is "generally public," but can be declared private in "exceptional circumstances".<sup>433</sup> It is unclear whether or not undocumented status would be considered an exceptional circumstance and this would be subject to the chairperson's discretion. On the other hand, HSAN will not release an un-edited complaint unless the Board makes a decision to do so.<sup>434</sup> Even then, it is within the chairperson's discretion to exclude personal information.

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<sup>431</sup> Eckerberg, *supra* note 158 .

<sup>432</sup> *Ibid.*

<sup>433</sup> HSAN Website, *supra* note 157; I. Eckerberg, *supra* note 158 .

<sup>434</sup> Eckerberg, *supra* note 158.

## 5.3 Conclusion

In Sweden's case, classifying results and practice as either consistent or inconsistent with international law is a complicated process. Sweden's implementation of the right to health is mixed with challenges and triumphs. In most circumstances, Swedish *law* fulfills requirements while *practice* deviates from it or fails to fully execute the law. Due to discrimination, the underlying determinants of health are insufficiently addressed. Practice deviates from law partly because the multiculturalism ideal clashes with the ingrained conformity more. For undocumented migrants and asylum seekers, the right to health is clearly in jeopardy because these groups cannot access health care on the same basis as the majority due to legislation, cultural differences and/or disproportionate costs.

## 6 Good Practice

*Nothing is so contagious as example; and we never do any great good or evil which does not produce its like.* ~ François de la Rochefoucauld<sup>435</sup>

No State can claim perfect implementation of the right to the highest attainable standard of health. This is especially true concerning ethnic and racial minority migrants regardless of their residential status. All States have challenges, but many of them are common. Every State struggles with disparities between racial and ethnic minority migrants and the majority. Every State has to determine to what extent they will provide care to undocumented migrants. Sweden is not alone in its difficulties but it can look to others for examples of good practice.

As a general good practice measure employed by many, Sweden should first re-examine the option of disaggregating data. This will provide an objective and fact based database useful for determining the state of all citizens. In order to address accessibility, acceptability and quality, Sweden can look toward the United States for good instruction and practice for cultural competence. For legal standards that are more inclusive and economically accessible for undocumented migrants, it should examine Italy's current law. Finally, Sweden can look internally to address problems with both groups: rules in Skåne that subsidize certain care for hidden refugees and a multicultural hospital in Göteborg planned with community input.

### 6.1 General Good Practice: Disaggregation of Data

Disaggregation of data refers to the process of separating data into categories in order to identify a specific problem or trend. Official Swedish statistics do not disaggregate data based on ethnicity or race because the State fears such data would be vulnerable for abuses and regarded as a form of discrimination.<sup>436</sup> Sweden's position is understandable, especially considering its history as the birthplace of racial biology theory. Still, the lack of disaggregated data is highly criticized by UN bodies and agencies. They believe the benefits gained from disaggregated data outweigh the effort Sweden would have to put in to ensure it was being utilized properly or to minimize any racially motivated damage. With regard to the right to health, use of disaggregated health indicators is vital to discern which population faces which challenges.

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<sup>435</sup> François de la Rochefoucauld

<sup>436</sup> CERD/C/362/Add.5 (1999) para. 33.



Health indicators, like infant mortality, are important markers for various aspects of the right to health.<sup>437</sup> In light of the right to health's progressive realization, indicators have three important functions. First, they aid States in monitoring progress over time, alerting them when it is time to make adjustments or take additional measures.<sup>438</sup> Second, they hold the State accountable for how it is discharging its duties under the right to health.<sup>439</sup> Third, they can improve the effectiveness of programs and policies.<sup>440</sup> It is important to use health indicators in a manner consistent with a human rights approach.

A human rights approach to health indicators requires disaggregation of health indicator data.<sup>441</sup> As Paul Hunt explained, from a human rights perspective, health data should be disaggregated in relation to as many of the internationally prohibited grounds as possible.<sup>442</sup> Disaggregated health indicators can reveal which communities and individuals are suffering from *de facto* discrimination.<sup>443</sup> Simply knowing that they do is not enough. Special Rapporteur Hunt noted this when he commented on the absence of disaggregated data on ethnic and racial grounds in Sweden, which he determined was "very significant because...it is widely understood that ethnic minorities in Sweden have comparatively poor health status".<sup>444</sup> He then posed a series of questions to Sweden that reflect the sentiments of many organizations and people who are frustrated with Sweden's refusal to disaggregate data:

Without data disaggregated on the grounds of race and ethnicity, how do the authorities know the scale and nature of this problem? If they do not know the scale and nature of the problem, how can they devise the most appropriate interventions? If an intervention were introduced, how would they know whether or not it was effective?<sup>445</sup>

The Special Rapporteur explained that he understood Sweden's concerns, but that it was possible to address the issue of abuse of data as other countries have without refusing to collect it at all.<sup>446</sup> Sweden could put conditions on access to its data, it could regulate by law what the data could be used for or it could adopt other measures designed to curtail misuse.

The use of disaggregated health indicators would greatly improve Sweden's chances of fulfilling its international human rights obligations for the right to health for ethnic and racial minority migrants. Currently, the government is aware that there is a problem. This data would allow them to

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<sup>437</sup> P. Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, E/CN.4/2006/48 (2006) para. 26.

<sup>438</sup> *Ibid.*, para. 35.

<sup>439</sup> *Ibid.*

<sup>440</sup> *Ibid.*

<sup>441</sup> *Ibid.*, para. 26.

<sup>442</sup> A/HRC/4/28/Add.2 (2007) para 49(a).

<sup>443</sup> P. Hunt, *supra* note 437 para. 26. *See also*, UNHCR, *The Right to Health, Factsheet No. 31*(2008) p. 24; CESCR General Comment 14, *supra* note 48 para. 57.

<sup>444</sup> *Ibid.*

<sup>445</sup> *Ibid.*, para. 120.

<sup>446</sup> *Ibid.*, para. 121.

determine, with precision, which populations are in need of what type of care. Country of origin data is not specific enough. A person born in Great Britain, for example, could belong to one, or several, of hundreds of ethnicities. Moreover, Sweden could use disaggregated data to determine if the disparities are caused by risky behavior, environment, discrimination or other factors. It could then formulate an appropriate response and set concrete goals in conformity with its international obligations.

## **6.2 Cultural Competence and Community Involvement Good Practice: The United States and Angered's Närsjukhus**

Use of disaggregated data to pinpoint disparities is important but is only a preliminary step. Measures must also be taken to target, reduce and eliminate disparities. When then President Bill Clinton signed the Minority Health Disparities Research and Education Act in 2000, he explained that “Eliminating disparities will require additional research and new approaches, but in the process of addressing the health needs of our most vulnerable populations, we will improve the Nation's health care system for everyone”.<sup>447</sup> The eradication of health care disparities is an oft-discussed topic in the United States that is not limited to academic or medical settings. It is also considered highly relevant for politics and business. Eradicating disparities is not viewed as simply improving the health of certain minority groups, but ultimately, for the country as a whole. The United States' minority population will become the majority in less than 30 years, prompting an intensive effort to decrease disparities. One such effort includes strong advocacy of cultural competence, a concept that began and is continuously developed in the United States of America.

While the United States is distinct from Sweden in many ways – from its larger ethnic and racial minority population to its mores– it still provides a valuable example of good practice as the pioneer of cultural competence. The United States government, spurred by civil society, has established offices and initiated countless projects and research and passed legislation to establish cultural competency as a necessary catalyst for good health.

The Office of Minority Health (“OMH”) was founded in 1986 with the mission to “improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities”.<sup>448</sup> It works with governmental agencies, State agencies and consumer networks on various projects, research and outreach programs. Cultural competency is one of the services for which

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<sup>447</sup> The American Presidency Project, William J. Clinton: *Statement on Signing the Minority Health and Health Disparities Research and Education Act*, <[www.presidency.ucsb.edu/ws/index.php?pid=990](http://www.presidency.ucsb.edu/ws/index.php?pid=990)>, visited on 5 April 2009.

<sup>448</sup> The Office of Minority Health, *About OMH – The Office of Minority Health*, <[www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=7](http://www.omhrc.gov/templates/browse.aspx?lvl=1&lvlID=7)>, visited on 5 April 2009.

OMH is responsible. It crafts initiatives, funds projects, offers guides to professionals and mandates national standards that are related to cultural competency. Having an office targeted at improving the health of ethnic and racial minorities where information is copious and easily accessible is a credit to the United States' federal system.

Another strength of the United States' federal system is that it makes funding contingent on fulfilling certain standards. The Culturally and Linguistically Appropriate Services ("CLAS") standards are fourteen national cultural competency principles for health organizations that should be undertaken in partnership with the communities served.<sup>449</sup> There are three types of standards: culturally competent care (standards 1-3), language access services (standards 4-7), and organizational supports for cultural competence (Standards 8-14).<sup>450</sup> These are classified into mandates, guidelines and recommendations. Hospitals and health care providers who receive federal funding must ensure that the language mandates are provided for. They include having bilingual staff and interpreters at no cost, limiting the use of family and friends as interpreters and providing information in preferred and commonly used languages.<sup>451</sup> These mandates focus on the importance of linguistics as a tool for improving the quality and accessibility of care. Health care organizations that do not comply with these standards risk losing their federal funds, so motivation is quite high.

The guidelines OMH recommends for adoption as mandates from the federal government to be met by State governments and accreditation agencies include culturally competent care and organizational supports for cultural competence. Clearly, States' adoption of these guidelines would establish a minimal standard and a consensus regarding cultural competency. Most States, from necessity to provide quality care, have elected to adopt them. There is also strength in recommending guidelines to accreditation agencies, as they are responsible for determining which schools are providing appropriate educations in different disciplines.

The most trusted medical school accreditation agency, Liaison Committee on Medical Education ("LCME"), has incorporated cultural competence into its accreditation standards:

D-21. The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to

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<sup>449</sup> Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services (CLAS)* <[www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15](http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15)>, visited on 5 April 2009.

<sup>450</sup> *Ibid.*

<sup>451</sup> *Ibid.*

such material, and demonstrate the extent to which the objectives are being achieved.<sup>452</sup>

According to LCME, the word “must” means that meeting the standard is “absolutely necessary for the achievement and maintenance of accreditation”.<sup>453</sup> “Should” indicates expected compliance unless extraordinary and justifiable circumstances preclude full compliance.<sup>454</sup> This establishes a high standard for medical students and professors. It also establishes a *de facto* mandatory standard. Losing accreditation is not an option for United States’ medical schools. Without accreditation, the school cannot receive federal funding.<sup>455</sup> Moreover, its students cannot receive federal loans and may not be able to take the licensing exam.<sup>456</sup> Many States will not grant students from unaccredited schools licenses to practice even if they do pass the exam.<sup>457</sup> By tying cultural competence standards to federal funding and accreditation, the United States’ federal government has stressed the necessity of cultural competence and increased the level of competency in caretakers. This, in turn, has had a positive effect on health.

The United States is not an example of good practice because it has fewer health disparity issues than Sweden does. It does not. It is not an example of good practice because everyone follows cultural competency standards. They do not. The United States is an example of good practice because of the way the federal government effectively “forces” cultural competence to become an educational and social issue. It is also an example of good practice because it has an office that is responsible only for issues of minority health. Finally, all of this indicates that the United States recognizes that health disparities are a problem not simply for its citizens and non-citizens of African, Asian, Latino, Indigenous and Pacific Islander descent. Instead it is a national problem that requires a comprehensive and detailed national solution.

Sweden and the United States have similar national-State (regional) relations. As it leaves many of the details to its municipalities, Sweden should look toward American practice of connecting funding to particular measures in order to ensure compliance. It should also consider establishing a special office, with an interdisciplinary focus, that addresses health disparities. Finally, Sweden must impress on its politicians, academics, workers and civil society at large that cultural competency is a necessary tool in the fight against health disparities.

Elements of cultural competency are not completely absent in Sweden. A project in Göteborg is attempting to take Sweden’s multicultural mantra from aspiration to reality. Currently, construction for a hospital specifically designed to address health disparities is underway in Göteborg, Sweden’s second largest city. *Angereds Närsjukhus* has been coined a community

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<sup>452</sup> Liaison Committee on Medical Education, *Accreditation Standards*, <[www.lcme.org/functionslist.htm](http://www.lcme.org/functionslist.htm)>, visited on 5 April 2009.

<sup>453</sup> *Ibid.*

<sup>454</sup> *Ibid.*

<sup>455</sup> Liaison Committee on Medical Education, *Accreditation Standards Frequently Asked Questions*, <[www.lcme.org/faqlcme.htm](http://www.lcme.org/faqlcme.htm)>, visited on 5 April 2009.

<sup>456</sup> *Ibid.*

<sup>457</sup> *Ibid.*

hospital in a multicultural urban setting.<sup>458</sup> It will serve the Northeast part of Göteborg, which is home to 95,000 people, half of whom were born outside of Sweden.<sup>459</sup> Its vision is to improve the population's health by creating an innovative hospital that helps to mobilize the community thus increasing a sense of safety and security.<sup>460</sup> The hospital has identified specific community health challenges including higher mortality rates for cardiovascular disease, higher rates of lung cancer, daily smoking and stress. The disparities for these districts are dramatic. For women, chronic obstructive pulmonary disease mortality rates are 61 per 100,000 compared to 31 for the region and 27 for the country.<sup>461</sup> For men, the district mortalities are 56 per 100,000 compared to 31 for the region and 31 for the country.<sup>462</sup> In this case, people who live in the districts served by this hospital are more likely to die from chronic obstructive pulmonary disease than people in their region or the rest of Sweden. These are just a few examples of the disparities suffered by the population the hospital has been designed to serve.

*Angereds Närsjukhus* has concrete objectives and has involved the community in defining them. First, it aims to improve the health of the population so that it matches the rest of the city.<sup>463</sup> This is important because in many cases city health reflects national trends and in some cases is slightly better. Second, it will decrease daily smoking by 50 percent in two years.<sup>464</sup> Third, it will decrease the number of sick days taken off from work due to chronic pain.<sup>465</sup> These goals were identified with extensive dialogue between medical professionals, administrators, patients and citizens, particularly those who are foreign born.

*Angereds Närsjukhus* is an example of good practice not only because it is designed to decrease disparities but also because it has adopted the right to the highest attainable standard of health as an explicit guideline for its work. This means breaking with patriarchal practice and involving affected people in discussions about what they need, what services they would use and how they would like to access them. It has set goals and developed plans of action for their realization. Finally, this hospital embodies the principle of equity. Recognizing that not everyone begins at the same point, they strive to serve the entire community while noting that ethnic and racial minorities in these districts require targeted, culturally sensitive care to improve their health. *Angereds Närsjukhus* understands that when the right to health is realized for the most vulnerable within a community, safety and security will improve for the entire community.

The hospital will not be completed until 2011 but temporary facilities are already running including psychiatric care, an anti-smoking campaign, a multi-disciplinary pain center and weekend and weeknight general

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<sup>458</sup> M. Olsson, Power Point Presentation on Angereds Närsjukhus, Nordic School for Public Health, 30 September 2008.

<sup>459</sup> *Ibid.*

<sup>460</sup> *Ibid.*

<sup>461</sup> *Ibid.*

<sup>462</sup> *Ibid.*

<sup>463</sup> Olsson, *supra* note 457.

<sup>464</sup> *Ibid.*

<sup>465</sup> *Ibid.*

practitioner services.<sup>466</sup> It may be too early to determine how successful this hospital is, but it can certainly serve as a regional model. Sweden leaves it to the regions to target particular populations. Every hospital should invite community participation to determine what needs are present. Every hospital should have community goals and benchmarks. Every hospital should strive to minimize health disparities. As this is not the case, other regions must look to *Angered's Närsjukhus*' progress in order to replicate their successes and address any challenges.

### 6.3 Legislative Good Practice: Italy and Skåne

Beyond reviewing others' practices, Sweden should also examine legislation and rules. Italy has emerged as an unlikely example of good legislative practice. The relatively progressive laws governing health care for undocumented migrants is somewhat surprising coming from Italy, which has been consistently condemned for racial and ethnic minority related human rights abuses. While Sweden has one of the most restrictive health care access laws in Europe for undocumented migrants, Italy has one of the most generous. This cannot be distilled to costs or numbers. Italy has more undocumented migrants than Sweden but it provides extensive subsidized health care to this population. As a common point of entry country, Italy's undocumented migrant population is currently estimated at 349,000 and was much larger (more than 700,000) before a series of amnesties.<sup>467</sup>

The Italian law provides comprehensive health care for undocumented migrants contingent on their attainment of an STP code (temporary residing foreigner code).<sup>468</sup> Possessing this code entitles undocumented migrants to essential and urgent subsidized care. "Urgent medical care" is care that cannot be delayed without endangering the patient's life or damaging his/her health.<sup>469</sup> By law "essential medical care" includes "diagnostic and therapeutic care, related to pathologies, which are not immediately dangerous but could lead to serious damages and risks for the patient's health".<sup>470</sup> "Essential" primary and secondary care, hospitalization and medicine also fall within this scope.<sup>471</sup> For both urgent and essential care, the course of care will only end when the patient's entire therapeutic and rehabilitation period is completed.<sup>472</sup> The Italian interpretation of these phrases is much broader than similar phrases in Sweden.

Obtaining the code to get this care is a relatively easy process. The renewable STP code is anonymous, free, valid for six months and valid throughout Italy.<sup>473</sup> It is obtained from hospital or local health

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<sup>466</sup> *Ibid.*

<sup>467</sup> *Ibid.*, pp 31-32.

<sup>468</sup> PICUM, *supra* note 303 p. 51.

<sup>469</sup> *Ibid.*, p. 52.

<sup>470</sup> *Ibid.*, p 53.

<sup>471</sup> *Ibid.*

<sup>472</sup> *Ibid.*

<sup>473</sup> PICUM, *supra* note 303 p. 53.

administration. At the same time undocumented migrants obtain this code, they may also apply for indigence status. This combination is important because a migrant possessing both is entitled to free care in some situations. In others, she or he is expected to pay the same fee that an Italian resident or citizen would pay. Thus, in no circumstances will an undocumented migrant pay more for her or his care than an Italian national or legal resident.

This law, which has been in effect for more than a decade, gives undocumented migrants access to the following fully or partially subsidized State care: urgent and essential medical care including continual treatment, preventative care and care provided to protect public health including prenatal and maternity care, care for children, vaccinations and diagnosis and treatment of infectious diseases.<sup>474</sup> Other care is always free for undocumented migrants, regardless of whether they are classified as indigent: emergency care, basic essential care (primary care and all types of inpatient care), inpatient treatment or contagious diseases like HIV, maternity care, any care for the elderly over 64 years of age and any care for children under six years of age.<sup>475</sup> A fee must be paid to see a specialist recommended by a general practitioner and for outpatient treatment for contagious and chronic diseases including HIV.<sup>476</sup>

Clearly more compassionate than the Swedish law, the access of health care services available in the Italian law is not perfect. It requires registration to access “essential and urgent care,” an act that some undocumented migrants may be unwilling to perform. It does not grant free care to children over six even though the internationally recognized definition of a child is someone under 18. Italy is also considering repealing the law.

These, and other shortcomings aside, this law is an example of good practice. It incorporates core legal principles of the right to health. It provides a vulnerable and marginalized group with economically accessible care. It does not discriminate against undocumented migrants by requiring them to pay more than Italian nationals or residents. It gives undocumented migrants access to preventive, curative and palliative health services. Pregnant women have access to pre and post-natal care at no cost or at subsidized costs. Finally, the STP code registration system employed in Italy could be incorporated into the Swedish system with relative ease as receiving subsidized care in Sweden is contingent on having a Swedish personal number.

It is not necessary to look outside of Sweden for all examples of good legal practice regarding the right to health for ethnic and racial minority migrants, especially where care for the undocumented is concerned. The southern region of Skåne, which includes Malmö, is an example of domestic good practice. When Skåne council members met in Kristianstad to discuss expanding subsidized emergency and acute care to hidden refugees, they were met by a handful of Social Democratic protestors, with signs, insisting that hidden refugees were criminals and therefore not entitled to state

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<sup>474</sup> PICUM, *supra* note 303 p. 52.

<sup>475</sup> *Ibid.*

<sup>476</sup> *Ibid.*

subsidized care.<sup>477</sup> Council members had another thing to consider in addition to those opinions – there was no guarantee that the national government would reimburse them for any care given. Despite these concerns, Skåne, has been providing a range of medical services to hidden refugees since April of 2008. Citing the UDHR, the Council decided that human rights take precedence over economic concerns.<sup>478</sup> They believed extending subsidized health care to hidden refugees would eliminate ethical dilemmas and increase patient safety.<sup>479</sup> The decision was nearly unanimous amongst the political parties present, only the Swedish Democrats opposed the rule.<sup>480</sup>

Skåne did not simply stop with its mandate. Free emergency dental care was considered a natural consequence of subsidizing emergency and acute medical care.<sup>481</sup> Costs for providing emergency care are expected to be low, between one and two million kroner per year (124,592 – 249,185 USD) but the region may negotiate with the State for compensation.<sup>482</sup> Skåne has also taken steps to aid its 4000 health care employees in providing the best care under the new rules. It has developed a 20-minute internet based training program designed to assist medical personnel in treating hidden refugees patients.<sup>483</sup> The program is supposed to make caretakers feel more secure about treating hidden refugees so that they can shed the role of gatekeeper and concentrate on providing the best care.<sup>484</sup>

Like Italy's laws, Skåne's rules are not ideal. In many ways, they are less ideal. Care for hidden refugees is still restricted to emergency and acute cases. The subsidized care also has not formally been extended to undocumented persons who have not applied for asylum or who do not fulfill the formal refugee definition under international law. In practice, however, the two groups may be difficult to distinguish. Nonetheless, the Skåne rules go beyond the standard set by the current national law.

The Skåne rules are good practice because they strive to remove economic inaccessibility from the barriers that hidden refugees face as a vulnerable and marginalized group. Moreover, Skåne has shown an inclination to slowly provide more care to this group. It began with subsidizing emergency and acute care for hidden refugees and has continued to do this by offering free emergency dental care. Finally, it has taken steps to remove the gatekeeper mentality from its health care workers so they can concentrate less on who is entitled to what care and more on the quality of the care and the ability to provide that care.

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<sup>477</sup> S. Daran, *Region Skåne Ger Subventionerad Vård till Gömda Flyktingar*, 24 April 2008, available at <[www.uppmana.nu/content/view/5600/123/](http://www.uppmana.nu/content/view/5600/123/)>, visited on 5 April 2009.

<sup>478</sup> Region Skåne, *Policy för Vård till Gömda Flyktingar Antogs*, <[www.skane.se/templates/page.aspx?id=213511](http://www.skane.se/templates/page.aspx?id=213511)>, visited on 5 April 2009.

<sup>479</sup> *Ibid.*

<sup>480</sup> *Ibid.*

<sup>481</sup> P. Roijer, *Gömda i Skåne får Gratis Akuttandvård*, 18 September 2008, <[sydsvenskan.se/sverige/article369651/Gomda-i-Skane-far-gratis-akuttandvard.html](http://sydsvenskan.se/sverige/article369651/Gomda-i-Skane-far-gratis-akuttandvard.html)>, visited on 5 April 2009.

<sup>482</sup> *Ibid.*

<sup>483</sup> Norra Skåne, *Vårdutbildning om Gömda Flyktingar*, 30 January 2009. <[www.nsk.se/article/20090130/NYHETER/773177458/1125/\\*/\\*KRISTIANSTAD/vardutbildning-om-gomda-flyktingar](http://www.nsk.se/article/20090130/NYHETER/773177458/1125/*/*KRISTIANSTAD/vardutbildning-om-gomda-flyktingar)>, visited on 5 April 2009.

<sup>484</sup> *Ibid.*



## 6.4 Conclusion

The goal of examining others' good practice must be to figure out what can be discarded and what can be extracted and modified to fit into that particular State's laws and policies. First, Sweden should consider disaggregating its data in order to identify which disparities are suffered by which groups and at what intensity. Sweden can turn to Italy and Skåne for examples of good practice regarding legislation for undocumented migrants in general and hidden refugees in particular. The Italian law embodies the principle that the right to health should be free from discrimination and available to all regardless of status. The Skåne rules demonstrate how limitations can slowly be expanded to include more care for a particularly vulnerable group. Another good example of expansion is the way the United States has incorporated cultural competency into its educational, medical and social service practice arenas by creating mandates and making it in institutions' best interests to comply with them. Domestically, *Angereds Närsjukhus* is an example of targeting a specific population and actively eliciting participation from immigrant groups.

From these examples, it is clear that non-discrimination legislation designed to protect undocumented and asylum-seeking ethnic and racial minority migrants and their right to health is necessary. Then, data collection should aid in pinpointing the disparities. Next, to concretely address health care disparities, cultural competence standards must be widely disseminated and employed. Finally, before any targets are identified, ethnic and racial minorities must be part of the dialogue and development that presumes to identify individual and community needs.

## 7 What *Would* Gunnar Myrdal Say? Conclusion

In “An American Dilemma” Gunnar Myrdal plainly stated, “the simple fact is that an educational offensive against racial intolerance, going deeper than the reiteration of the ‘glittering generalities’ in the nation’s political creed has never seriously been attempted”.<sup>485</sup> Of course, Myrdal was referring to the United States, but this quote readily describes the Swedish dilemma of realizing the highest attainable standard of health for racial and ethnic minority migrants in the face of structural, institutional and individual discrimination. Sweden must move past the “glittering generalities” within its laws and State sponsored multiculturalism in order to address the underlying social determinants of health that are barriers to the full realization of the right to health for its migrant population.

Sweden’s laws and policies are dazzling in many respects while the reality of what they attempt to rectify is dismal. Unemployment, segregation, discrimination and social exclusion have a detrimental impact on the right to health. These conditions lead to psychological distress, stress, reluctance to seek medical attention and increased risks of life threatening conditions. Moreover, Sweden’s failure to incorporate cultural competence into its educational curricula and health care services means that while migrants may visit facilities, the caretaker’s unfamiliarity with their culture can lead to miscommunications, misunderstandings, incorrect diagnosis and inappropriate treatments or conduct. An unhealthy, disenfranchised and marginalized migrant population is not an option for Sweden. Such a population would be incapable of forming a productive workforce and social strife and tension would erode State security.

Of course, these “glittering generalities” apply to health care for the undocumented and asylum-seeking racial and ethnic minority migrants in Sweden. Sweden cannot champion the dignity of all human beings via treaty ratifications and declarations while denying many of them essential care. As cost does not appear to be a concern and the unfortunate fear of being caught would discourage many migrants from regularly taking advantage of subsidized care, there is no reason why a wealthy developed State like Sweden cannot expand its health care system to include the undocumented.

No one knows what Myrdal would say about Sweden and its current dilemma. Yet it is not unreasonable that he would urge his country of origin to do the same thing he urged of the United States. He cautioned the United States not to wait to make changes and to create better conditions for its most marginalized minority when he wrote, “History can be made. It is not necessary to receive it as mere destiny”.<sup>486</sup> In order to guarantee the right to health for all, Sweden must construct its own history by guaranteeing this right to its most marginalized ethnic and racial minority migrants.

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<sup>485</sup> Myrdal, *supra* note 3 p. 49.

<sup>486</sup> *Ibid.*, p. 520.

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Musical scholars, The Beatles, have asserted, “I get by with a little help from my friends; Gonna try with a little help from my friends...I’m going to make it with my friends”.<sup>487</sup> Their sentiments were clearly echoed in the thesis writing process. This thesis was accomplished with the support and encouragement of Linda, Cigdem and Natasa whose consistent library presence motivated me to leave my room for the “comfort” of the RWI’s Council of Europe Reading Room. The library would certainly be less welcoming without the RWI’s librarians, Habteab and Lena, whose warmth and support made the library a mandatory thesis writing destination. I would also like to thank Armando who proved to be a skillful and invaluable opponent and Magnus who lent a hand in translating from Swedish to English.

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<sup>487</sup> J. Lennon and P. McCartney, ‘With a Little Help From My Friends’, *Sgt’s Lonely Hearts Club Band* (1967).

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M. Eastmond, Presentation Notes: *Migration, Inequities and Health: Policy and Local Implementation*, Nordic School for Public Health, 30 September 2008.

M. Olsson, Power Point Presentation on Angereds Närsjukhus, Nordic School for Public Health, 30 September 2008.

## **Song**

J. Lennon and P. McCartney, 'With a Little Help From My Friends', *Sgt's Lonely Hearts Club Band* (1967).