Chapter 8
Different Systems, Similar Responses: Policy Reforms on Asylum-Seekers' and Refugees' Access to Healthcare in Germany and Sweden in the Wake of the 2015–17 'Migration Crisis'

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8.1 Introduction

Who has – and who deserves – full or partial access to a state's healthcare system? This question has become an issue of controversial political debate in many countries, not least in the context of recent crises such as the Covid-19 pandemic and, previously, the so-called 'migration crisis' of 2015–17. This chapter focuses on the latter crisis and its repercussions on the political regulation of healthcare access for a group at the very margins of society: asylum-seekers and refugees. By analysing recent asylum and health policy reforms in two main recipient countries in the EU, this chapter sheds light on the intensifying level of politicisation of both health and incorporation policies in times of crisis.

Specifically, this chapter studies recent developments in the political regulation of refugees' and asylum-seekers' access to healthcare in Germany and Sweden – two countries which stood out in various ways during the 'migration crisis'. Both countries underwent similar processes of initial demonstrative openness to incoming refugees, presenting themselves as 'moral superpowers' (Bradby, 2019, 185) in comparison to other European countries. They took in high numbers of people but, later, changed their stance towards refugees and asylum-seekers and adopted increasingly restrictive policies under the impression of growing anxiety *vis-à-vis* those seeking shelter in Europe. These similar reactions are particularly remarkable considering the fundamental systemic and normative differences between Sweden's and Germany's incorporation and healthcare regimes (Roos, 2020; Sainsbury, 2012).

This chapter contributes to a better understanding of how and why policy provisions in Germany and Sweden were changed, along similar lines, following the

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M.-L. Jakobson et al. (eds.), *Anxieties of Migration and Integration in Turbulent Times*, IMISCOE Research Series, https://doi.org/10.1007/978-3-031-23996-0_8

above-mentioned 'crisis'. It seeks to do so by studying what drove governmental action – as a decisive factor in states' crisis responses – in the two countries. To this end, the chapter seeks to answer the following research question:

- What objectives determined the German and Swedish governments' similar responses regarding the political regulation of asylum-seekers' and refugees' access to healthcare in the wake of the 2015 'migration crisis'?

The answer to this research question is sought through the methodological approach of a policy analysis, following Treib (2014). This approach seeks to explain the emergence, adoption and implementation of policies with a focus on the objectives of the actors involved and on the respective institutional frameworks within which they act (Treib, 2014, 211). By studying the German and Swedish government's behaviour and their underlying objectives, the following comparative analysis juxtaposes two cases which differ in virtually all dimensions when it comes to the systemic and normative parameters of the respective health and incorporation regimes but which, nonetheless, produced similar policies in the wake of the 2015 'migration crisis'. The chapter thus contributes to a better understanding of these similar outcomes, which stand in contrast to what established welfare, healthcare and incorporation-regime models would have us expect.

This analysis of policy change is based on a dataset consisting of policy documents such as government declarations, statements by ministries and responsible state agencies and speeches by members of government during parliamentary plenary sessions, providing insights into the examined policy-making processes. These documents are accessible and have been collected from the various official websites and digital archives of the examined actors (governments, individual ministries and agencies, parliamentary chambers).

After a section briefly outlining the theoretical framework of this chapter – the conceptualisation of policy change at the intersection of incorporation and healthcare regimes – the following comparative analysis identifies and discusses three main political objectives which both the German and the Swedish governments pursued and which shaped both countries' political reaction to the 'migration crisis' in more generally turbulent times marked by a complexity of exogenous and endogenous challenges to incorporation, welfare and healthcare systems. In short, the analysis sheds light on the impact of both governments' objectives:

- to communicate to *(potential) asylum-seekers* that only those with a rightful claim to protection would get (near) full access to the host country's welfare and healthcare system, whereas those who unjustly sought asylum would have to count on significant access restrictions – to prevent rumours of a too-favourable healthcare and welfare access becoming a 'pull factor';
- to show *voters* that their government put them first and would be careful to prevent an overburdening of – already strained – national healthcare and welfare systems; and
- to emphasise – *vis-à-vis the EU and other EU member states* – exemplary compliance with international rules and conventions on the one hand (i.e. to uphold

their own image of a 'moral superpower') and the inability to uphold high(er) standards in the long term on the other. If other member states kept their standards low, (which the Swedish and German governments feared), it made those few in a vanguard position regarding asylum-seekers' and refugees' social rights target countries of greater numbers of asylum-seekers than their respective welfare systems could absorb.

As stated above, the target group of the policies analysed here is *asylum-seekers and refugees*. The applicability of the policies examined below regulating access to healthcare is determined not only by a person's asylum application status but also by the length of their stay in the respective host country. Given that the majority of asylum-seekers wait for months, sometimes years, for a final decision on their legal status, they become part – even if a segregated one – of the host country's administrative and social system for a notable period of time already prior to the determination of their status. Regardless of this latter, asylum-seekers and refugees may have to undergo medical treatment or enter preventive healthcare schemes beyond that which emergency care can provide. Consequently, this chapter examines the (changing) extent of asylum-seekers' and refugees' healthcare access regarding their rights both before and after their legal status is confirmed.

8.2 Conceptualising Policy Change at the Intersection of Incorporation and Healthcare Regimes

This chapter juxtaposes developments within the Swedish and German incorporation, welfare and healthcare regimes. To this end, it argues that, when it comes to explaining developments in migrants' social rights – among them their access to healthcare – the comparative analysis of merely the examined countries' welfare *or* healthcare *or* incorporation regimes does not suffice (cf. Sainsbury, 2012). Rather, changes in related national policies can arise from factors shaping either the entirety or only one of these interconnected regimes.

With regard to immigrants' and, more particularly, asylum-seekers' and refugees' rights and duties and the state's role and responsibility regarding their regulation and implementation, this research accepts Sainsbury's (2012, 16) definition of incorporation regimes as 'rules and norms that govern immigrants' possibilities to become a citizen, to acquire permanent residence, and to participate in economic, cultural and political life'. Sainsbury distinguishes between inclusive and restrictive incorporation regimes. She identifies the Swedish incorporation regime as an example of the former and the German regime as an example of the latter (2012, 19).

Given that access to healthcare is regulated in Germany and Sweden in the context of social welfare, national welfare traditions have an impact on different groups of persons' healthcare rights. In the typologisation of healthcare and welfare regimes, this chapter builds on Esping-Andersen's seminal work (1990) and on Rothgang (2006) who – among others – rightfully argues that the three dimensions

underlying Esping-Andersen's welfare regime typology (de-commodification, social stratification and state-market-family relations) are not the only focal elements of distinction when it comes to the analysis of healthcare regimes. Instead, Rothgang proposes a typologisation of healthcare systems, taking into consideration further dimensions such as financing (state funding vs insurance contributions vs private funding), service provision (privately vs publicly operated and profit vs non-profit) and the role and interaction of different actors (e.g. financing actor, service provider, beneficiary) in the regulation and provision of healthcare. In his model, Rothgang (2006, 304) presents three ideal types (in the Weberian sense) of healthcare regimes:

- the state/public healthcare system, with Sweden as a model case study;
- the social insurance system, with Germany as a model case study; and
- the private healthcare system (which does not, in its 'ideal' form, appear in any EU member state).

In the combination of these three regime typologies, Sweden and Germany are model cases of a *most different systems* study: Sweden as a state with a social democratic welfare regime, a state/public healthcare system and a liberal incorporation regime is juxtaposed to Germany as a state with a conservative-corporatist welfare regime, a social insurance healthcare system and a restrictive incorporation regime. Considering their fundamental systemic differences, which include both rule and norm dimensions (see, *inter alia*, Roos, 2020), the regime models introduced above would, in their combination, lead to the expectation that the Swedish and German governments would have reacted entirely differently to arising (perceived) public anxiety about asylum-seekers' and refugees' access to the respective welfare state and healthcare system in the wake of the 2015 'crisis'. The following analysis scrutinises why that was not the case; indeed, why the opposite happened and both governments pursued similar paths in their reactive policy-making. By showing a) that both countries moved away from their model case position by adopting aspects of other regime types and b) that, in times of crisis, other factors seem to have a greater impact on policies and policy change than regime-type parameters, the analysis contributes to the growing corpus of literature questioning the applicability of static regime models such as those presented above for the areas of welfare, healthcare and incorporation.

8.3 Policy Analysis: Why So Similar?

Both Germany and Sweden experienced a significant increase in asylum applications, with climaxing numbers in 2015 (Sweden) and 2016 (Germany) respectively, way above those of previous years (Eurostat, 2020). In the years thereafter, application numbers decreased rapidly. Indeed, already by 2016, applications in Sweden fell below the level of 2010, whereas German numbers fell below the pre-2015 level in 2018 (Eurostat, 2020). Despite the swift turnaround of asylum application

numbers after 2015/16, the significant increase rather than the following decrease marked healthcare policy provisions for asylum-seekers and refugees in both countries beyond short-term measures, as this section shows. Following the above-mentioned changes in asylum application numbers, access to healthcare was restricted in both countries.

It should be noted that, in both Germany and Sweden, the national legislator is responsible only for setting the *rules and (minimum) standards* of healthcare provision for asylum-seekers and refugees, whereas the regional and communal levels are responsible for the *implementation* and actual *provision* of health services (Bradby, 2019, 188; Wenner et al., 2019, 53–4). In consequence, the *practical dimension* of governmental policy-making in the area during the 'migration crisis' was largely limited to the (short-term) objective of helping the implementation levels to handle the situation, implying mechanisms of burden-sharing and relief, administrative support and the provision of necessary resources – as well as the introduction of border controls to prevent an administrative overburdening to the point of inability to cope with the ongoing developments.[1]

The *political dimension*, in contrast, which swiftly gained space alongside the above-mentioned practical measures (Beinhorn & Glorius, 2018; Fernández, 2020, 229), went beyond mere short-term crisis management. Governmental actors in both Germany and Sweden began to use tools such as adopted measures, draft bills, parliamentary debates and press briefs on asylum-seekers' and refugees' access to healthcare to transmit broader messages of political ambitions and ideological lines, thus contributing to the incremental politicisation of the policy area. In particular, both governments sought to demonstrate their power and willingness to regulate the level of arriving persons' access to healthcare in the pursuit of three main political objectives. The following policy analysis sheds light on these three objectives and the resulting increase in politicisation in the wake of the 'migration crisis' in the two countries under examination.

8.3.1 The Objective of Preventing High Health-Care Standards as a Pull Factor

Following the first months of sharply increased numbers of arriving asylum-seekers – marked by a demonstrative openness and intensive short-term crisis management – the German and Swedish governments perceived mounting pressure to develop mid- to long-term perspectives of tenable incorporation strategies for

[1] See Swedish Government: Regeringens skrivelse 2016/17:206. Riksrevisionens rapport om lärdomar av flyktingsituationen hösten 2015 – beredskap och hantering, 1 June 2017, *inter alia* pp. 3 and 20; German Ministry of the Interior, Communication 'Vorübergehende Wiedereinführung von Grenzkontrollen', 13 September 2015 (https://www.bmi.bund.de/SharedDocs/kurzmeldungen/DE/2015/09/grenzkontrollen-an-der-grenze-zu-oesterreich-wiedereingef%C3%BChrt.html (accessed 16 January 2022).

administrations and society.[2] A necessary element of these strategies, in the view of both governments, was not only to either integrate into society, the labour market and the social system or to deport those who had arrived but also to lastingly reduce their number. Border closure was not considered a possible – or desired – long-term solution (at least not at the national level; EU border and asylum policy is not the subject of this analysis). Hence, governmental actors sought other options for action, among them to address (potential) asylum-seekers' possible reasons to pick Germany or Sweden as a target country.

Note that the tactics of making one's own country less attractive to those seeking shelter – in order to reduce their number – is no invention of the 2015 crisis. The German government – a coalition of Christian Democrats and Liberals – had resorted to this method in the early 1980s, when it 'sought to deter asylum-seekers by introducing welfare benefits in kind and removing their right to work' (Sainsbury, 2012, 182). This, in turn, forms the 'main principle of entitlement to social benefits' (2012, 56) in Germany. With regard to healthcare, the German government applied this strategy of deterrence even more clearly in the wake of the Yugoslav Wars – which brought about a sharp increase in arriving asylum-seekers – with the introduction of the German Asylum-Seekers' Benefit Act. This act was specifically meant to prevent asylum-seekers from choosing Germany as their target country – because of material incentives – by introducing lowered benefits (Kuhn-Zuber, 2018, 23). Article 4 of the act set the tone of asylum-seekers' access to healthcare for the following decades: it stipulated the entitlement to healthcare during the first 15 months of stay in Germany only in the case of an emergency, pregnancy or childbirth and introduced the need for health vouchers to access care, issued by administrative (rather than medical) staff (Wenner et al., 2019, 53).

During the 'migration crisis', both the German and the Swedish governments resorted to similar strategies in pursuit of making their country less attractive in asylum-seekers' eyes. While neither government lowered healthcare levels collectively for all groups of asylum-seekers and refugees, both introduced restrictive measures notably for one group: those applying for asylum and all concomitant rights with a low probability of being entitled to a refugee/subsidiary protection status – for instance because of their nationality from a 'safe country of origin'. For this group of persons, the German governing coalition of Christian Democrats and Social Democrats proposed in late September 2015 – as part of the draft Asylum Procedure Acceleration Act (adopted on 20 October 2015)[3] – that benefits, not least in the area of healthcare, were henceforth to be granted as in-kind (rather than cash) benefits wherever administratively possible. The political intention behind the benefit-in-kind principle, which came with greater administrative efforts than the

[2] See, *inter alia*, a speech by Thomas de Maizière, German Minister of the Interior, during the plenary debate of the *Bundesrat* on 16 October 2015 (Plenarprotokoll 937, p. 388); Regeringens proposition 2015/16:174: Tillfälliga begränsningar av möjligheten att få.

[3] Draft bill: Entwurf eines Asylverfahrensbeschleunigungsgesetzes, Drucksache 18/6185, 29 September 2015. Adopted law (Asylverfahrensbeschleunigungsgesetz): see Bundesgesetzblatt, Part I No 40 (2015), 23 October 2015, pp. 1722–1735.

previously provided 'pocket money', was to convey the message of controlled and limited access only to what could be justified as absolutely necessary. Implicitly, such rules were meant as 'disincentives' – namely, to counter the image among potential asylum-seekers of immediate and automatically granted access to high German living standards, including welfare and healthcare. In the same vein, the Asylum Procedure Acceleration Act stipulated that, once a person's asylum procedure was concluded by a negative decision and with the enforceable obligation to leave the country, access to healthcare (amongst other benefits) would be significantly restricted to merely the utmost necessary – i.e. emergency care – regardless of how much time had passed between the decision and the person's actual departure.

In a similar pursuit of abolishing 'incentives', the Swedish government introduced a bill providing for the primary issuance of temporary rather than permanent residence permits, which had been 'the general rule in asylum policy' in Sweden until then (Boräng, 2018, 155). This bill was introduced by the government in April 2016[4] and adopted by parliament in June 2016. It entered into force on 20 July 2016, with an initial applicability of three years, which was later extended to 20 July 2021.[5] The new law did not explicitly change asylum-seekers' and refugees' access to healthcare. In Sweden, however, healthcare access depends on residency. This means that refugees and asylum-seekers with temporary residence permits are only entitled to 'care that cannot be delayed' and maternity care (somewhat more favourable rules apply to minors).[6] The interpretation of which health services can or cannot wait, in turn, is up to individual clinicians, leading to very different levels of care access for those concerned (Bradby, 2019, 189).

The Swedish government's course of action to restrict access to healthcare on temporary residence permits was, again, no invention of the 2010s. It had already been applied in another period of turbulence and resulting political anxiety: in 1993, the centre-right government under Prime Minister Carl Bildt introduced the strategy 'of issuing temporary permits which limited access to regular medical care' (Sainsbury, 2012, 224) – alongside the halving of costs for asylum-seekers' medical examinations – in an attempt to reduce 'the rising costs of asylum-seekers' in times of financial crisis. Rather than merely seeking to reduce costs (which evidently also carried a broader message of prioritising some target groups of public expenditure over others), the Swedish (centre-left minority) government's post-2015 pursuit of restricted healthcare access for asylum-seekers followed another course. Its main objective was to 'temporarily adjust the [Swedish] asylum regulations to the minimum level in the EU so that more people choose to seek asylum in other EU

[4] See Regeringens proposition 2015/16:174, *op. cit*.

[5] See Lag (2016:752) om tillfälliga begränsningar av möjligheten att få uppehållstillstånd i Sverige, 22 June 2016.

[6] See Lag (2008:344) om hälso- och sjukvård åt asylsökande m.fl., in force since 1 July 2008, §6.

countries',[7] as the government expressly and repeatedly declared in the wake of the 2015 'crisis'.

8.3.2 The Objective of Pleasing Voters

In a democracy, the extent to which a group of *outsiders* is admitted into a contribution- and/or tax-based healthcare system comes with costs beyond the mere financing of the additional demand for the actors who hold the responsibility of regulating access standards. These actors have to consider the political costs of providing aid and enabling integration at the expense of the *insiders*. Such considerations played a significant role in both the Swedish and the German governments' policy-making with regard to asylum-seekers' and refugees' access to healthcare in response to the 2015 'crisis'. Evidently, the question of these persons' healthcare access could not be regulated as an isolated policy issue, given that it inextricably links the two – in themselves complex and increasingly politicised – policy areas of incorporation and healthcare. In consequence, governments could not, for instance, simply weigh arising short-term healthcare costs borne by the current tax/contribution payers against potential long-term contributions by those now admitted into the healthcare system. Nor could governmental actors refer to the universal right to healthcare[8] without taking into account what impact the outsiders' admission into the system would have on insiders' (perception of their) own healthcare access. Rather, governmental decision-making in the area was strongly influenced by a dense web of policy issues and societal dynamics connected by voters to policy outcomes.

Among the most notable such issues faced by political actors holding governmental responsibility in both Germany and Sweden were shifts in public opinion and media coverage regarding their country's openness to refugees and the limits of its incorporation capacity (Heath & Richards, 2019). Another, to some extent, related factor with an impact on governmental policy-making was the perceived threat of far-right parties' electoral success in the respective national elections (Germany in 2017; Sweden, 2018) – the Sweden Democrats (*Sverigedemokraterna*, SD) and Alternative for Germany (*Alternative für Deutschland*, AfD).[9] The looming electoral gains of these parties became relevant for policies regulating asylum-seekers' and refugees' access to healthcare because of the far-right parties' immigration-critical campaigns and promises of more-restrictive migrant- (and

[7] Quote from a press release by the Swedish Prime Minister's Office: 'Government proposes measures to create respite for Swedish refugee reception', 24 November 2015 (https://www.government.se/articles/2015/11/government-proposes-measures-to-create-respite-for-swedish-refugee-reception/ (accessed 16 January 2022).

[8] See, for example, Article 35 of the Charter of Fundamental Rights of the EU.

[9] The impact of the Sweden Democrats on Swedish asylum and incorporation policies and party discourses is addressed below. For the impact of the AfD on German asylum and incorporation policies and party discourses see, amongst others, Atzpodien (2022); Heinze (2021).

particularly refugee-)related policies.[10] Such promises, in turn, have the potential to force governing parties either to adapt policies in similar directions in order to win (back) voters from the far-right parties or to make a point of adopting policies representing explicit openness to immigrants seeking shelter in the respective country, thus underlining the fundamental differences in attitudes and values between the far-right contestants and themselves (see Abou-Chadi, 2016; Boräng, 2018; Fernández, 2020; Sainsbury, 2012). In the case of the 2015 'crisis' and its aftermath, both dynamics appear in the political and discursive (re)actions of the German and Swedish governments (Hertner, 2022; Krzyżanowski, 2018; Mushaben, 2017). When it comes to governmental action regarding asylum-seekers' and refugees' access to healthcare, however, pleasing voters by protecting the system from possible overburdening through outsiders seems to have been largely prioritised over making a point of their own humanitarian superiority by overcoming outsider–insider differences and equalising rights.

In part, this strong focus on voters in policy-making at the intersection of incorporation and healthcare can be explained by a significant level of politicisation of both areas. Whereas incorporation and asylum policy have been highly politicised areas across Europe for some time (Scholten & Verbeek, 2015; see also Hutter & Kriesi, 2021 on the catalyst effect of the 2015 'crisis' on the politicisation of immigration), the area of healthcare has only lately experienced 'a significant increase in party system attention' (Green-Pedersen, 2019, 162). This is the case particularly in Sweden – and, according to Green-Pedersen (2019, 168), more generally in states with some kind of national healthcare system – whereas party attention to healthcare is less pronounced in countries with health insurance systems, such as Germany. However, even there, demographic development and the increasing economisation of healthcare with its consequences for the healthcare system and services, amongst other factors, have moved healthcare policy into the focus of election campaigns and party programmes.

In light of these developments, the intersection of healthcare and incorporation policies has become a lens of larger dynamics – and, indeed, of rising anxiety – in politics and society because 'public debates about the welfare state increasingly place welfare beneficiaries in the spotlight and discuss whether people are taking advantage of the welfare system' (Roosma et al., 2016, 178). In consequence, '[n]egative images of beneficiaries play an increasingly important role in political debates and the mass media' (2016, 181) across Europe, with immigrants traditionally receiving the lowest level of solidarity when it comes to public perceptions of deservingness (Van Oorschot, 2008).

The question of deservingness is deeply ingrained in the normative fundaments of both the German healthcare and incorporation systems (Roos, 2020). When it

[10] See, *inter alia*, the SD's 2018 election manifesto 'Sverigedemokraternas valmanifest 2018' (https://sd.se/wp-content/uploads/2018/08/Valmanifest-2018-1.pdf (accessed 16 January 2022, pp. 3–4 and 6–7); AfD's 2017 election manifesto 'Programm für Deutschland' (https://www.afd.de/wp-content/uploads/sites/111/2017/06/2017-06-01_AfD-Bundestagswahlprogramm_Onlinefassung.pdf (accessed 16 January 2022, pp. 29–31 and 59–60.

comes to healthcare access, asylum-seekers and refugees consequently have to demonstrate their rightful and justified claims – even more so in times of crisis and the resulting fears of overburdening of the system, as the situation post-2015 showed. With a view to concrete policy change, this meant, in the case of Germany, that the government used healthcare (amongst other social benefits) to get asylum-seekers and refugees to play by the rules as regards integration measures – and to demonstrate to the resident population (read: voters) that non-compliance by immigrants would be punished. The government added several provisions to the Asylum Seekers' Benefit Act over the course of 2015 and 2016 which obliged certain groups of asylum-seekers to take part in integration courses or accept opportunities to work (within given limits) – or otherwise face a restriction of social benefits, including healthcare.[11] Importantly, instead of a collective reduction in healthcare access, these measures were addressed exclusively at select groups of persons, such as asylum-seekers with a higher or lower likelihood of getting refugee/subsidiary protection status and persons either waiting for their deportation because their asylum application had been refused or whose application was refused but who could not be deported because of threats to their health or freedom. In this way, the German government could demonstrate to its citizens that those seeking and deserving protection would receive it and that Germany would thus fulfil its moral and legal duties as a host country. At the same time, voters were shown that access to the healthcare and welfare system built on their taxes and contributions would not be granted freely and unchecked. In the same vein, the government was at pains to point out that 'there was no lowering of the well-known very high standard of [healthcare] provision for the German population' through increased efforts in the provision of healthcare for asylum-seekers and refugees.[12]

Interestingly, a similar deservingness factor for outsiders can be traced in the Swedish government's political response to the 'crisis'. This is noteworthy because the Swedish incorporation and healthcare systems are built on a principle of universality and asylum-seekers' and refugees' contribution to the state and society have been sought not so much in the past and present but, rather, in the future, as they have traditionally been considered potentially permanent members of, and hence contributors to, society (Roos, 2020, 5215; Sainsbury, 2012, 278). This perception evidently changed with the government's decision to grant temporary rather than permanent residence permits to persons arriving and to turn the temporary permits into permanent ones only for those who really need it – now implying a strong element of required individual deservingness.

[11] See Federal Government Commissioner for Migration, Refugees and Integration: 11. *Bericht der Beauftragten der Bundesregierung für Migration, Flüchtlinge und Integration – Teilhabe, Chancengleichheit und Rechtsentwicklung in der Einwanderungsgesellschat Deutschland*, December 2016, p. 587.

[12] Speech by the German government's spokesperson Steffen Seibert during the governmental press conference on 9 December 2015 (https://www.bundesregierung.de/breg-de/suche/regierungspressekonferenz-vom-9-dezember-845916 (accessed 17 January 2022; translation by the author).

Conditions for such deservingness were clearly expressed in the government bill on 'temporary restrictions on the possibility to obtain a residence permit in Sweden' from April 2016. These conditions reflect not only the government's declared ambition to lower Swedish asylum and incorporation standards to the minimum EU level so as to make more persons choose other EU member states as host countries but also its intention to relieve the strained Swedish welfare and healthcare systems. The government bill provided that asylum-seekers and refugees could turn their initially issued temporary permit into a permanent one if they were able to support themselves financially, e.g. through employment taken up after their arrival. In other words, under this provision, asylum-seekers and refugees were entitled to full access to the Swedish welfare and healthcare system only once they could contribute to it. This deservingness dimension also becomes clear in the government's provisions for persons younger than 25: permanent residence permits were to be granted to them only if they had completed high-school education (or an equivalent), thus lowering the likeliness of their becoming unemployed; in other words, becoming recipients rather than contributors in the social system.[13] Children – as non-contributors *per se* – would have to suffer 'particularly distressing circumstances related to a permanently impaired health condition' to receive a permanent permit.[14]

The politicisation of full access to the Swedish healthcare system is visible not least in the fact that the government ignored different state agencies' warnings that the intended – and later adopted – issuance of temporary instead of permanent residence permits might lead to a deterioration of asylum-seekers' mental and physical health. This, in turn, might later produce an increased financial and administrative burden on the healthcare system.[15] Despite these rational and economic arguments against temporary permits and subsequent restricted access to healthcare, the government pursued its course of action for the political reasons mentioned above, and in pursuit of alleviating related anxieties in society/among voters.

In the same vein, the government's choice of action is also noteworthy considering the objective of preventing an overburdening of the state's welfare and healthcare system.[16] The Swedish government justified the introduction of 'drastic restrictions […] as a necessary but morally painful action to salvage the administrative functionality of the Swedish welfare state, not a prioritization of national interests over those of the refugees' (Fernández, 2020, 229). This shows that the Löfven government was acutely aware of the moral U-turn which this course of action represented for Swedish incorporation policy and of the resulting pressure to justify it (see also Hagelund, 2020, 7–10). This pressure was particularly high considering that the positions regarding welfare-state capacity and incorporation now adopted by the governing coalition – consisting of the Swedish Social Democratic and Green parties – had previously 'been reserved for the S[weden] D[emocrats]' (Fernández,

[13] See Regeringens proposition 2015/16:174, *op. cit*., p. 56

[14] See 2015, pp. 62–3 and 82.

[15] See Regeringens proposition 2015/16:174, *op. cit*., pp. 68 and 71.

[16] Repeatedly emphasised 2015, for instance on pp. 3 and 21.

2020, 229), from which all other parties sitting in the Swedish parliament had previously sought to distance themselves. Indeed, demands for more restricted asylum and incorporation policies by the Sweden Democrats had been collectively rejected and, at times, even countered by the adoption of particularly liberal measures. An example from the area of asylum-seekers' healthcare regulation is the legal improvement of undocumented immigrants' access to medical care, adopted in the wake of the Swedish national elections of 2010 following which the Sweden Democrats moved into the *Riksdag* or parliament (Sainsbury, 2012, 227).

While the priority of preventing an overburdening of the healthcare system can also be found in the German government's policy response to the 2015 'crisis', it appears here in a different argumentative context. Specifically, the German government proposed measures a) to safeguard the health of all people residing in Germany by improving the general health status of new arrivals, and b) to reach a higher degree of efficiency in the provision of healthcare, alongside a decrease in the administrative burden notably on the part of regional and communal actors. Neither of these two approaches implied an extension of asylum-seekers' and refugees' entitlements regarding their access to the German healthcare system. Instead, the measures were distinctly addressed to the personnel and members of the German health and incorporation system, thus implicitly also to the host (i.e. voting) population.

Specifically, among other measures, the government proposed in the draft Asylum Procedure Acceleration Act to improve the vaccination protection of all asylum-seekers 'so as to protect the health of all people in our country' and 'reduce examination and bureaucratic efforts in the provision of services'.[17] This improvement was to be reached via the stipulation of a federal-level common standard, replacing the previous regulation at the *Länder* level – which had in some cases been more favourable. In the same vein, the act sought to facilitate the introduction of an electronic health card for asylum-seekers at the regional level. This health card was intended to replace the previously established system of health vouchers issued to asylum-seekers by administrative – i.e. non-medical – staff of the responsible regional or local agencies (Kuhn-Zuber, 2018, 87–88; Wenner et al., 2019, 53). It allows asylum-seekers, instead, to go directly to a health professional and let them decide whether or not treatment is necessary and covered by legislation regulating asylum-seekers' access to healthcare. First it should be emphasised, however, that this health card did not extend the range of health services to which asylum-seekers and refugees were legally entitled. Second, the Asylum Procedure Acceleration Act left it up to the *Länder* to stick to the old health-voucher system or to adopt the electronic health card, instead of a uniform country-wide introduction of the card. The health card's primary aim was thus not an improvement of asylum-seekers' access to healthcare but a reduction of the administrative and financial burden on the German multi-level healthcare and incorporation system.

[17] Entwurf eines Asylverfahrensbeschleunigungsgesetzes, *op. cit*., pp. 26 and 46 (translated by the author).

8.3.3 The Objective of Upholding a Sustainable International Role-Model Position

The representation of a country's incorporation system as exemplary among EU member states played a significant role in the two governments' political reactions to the 2015 'crisis'. Moreover, both Germany and Sweden have been among the most outspoken promoters of more EU competence in the area of asylum policy (Boräng, 2018, 156–157), as well as – particularly in the case of Germany – in health policy,[18] in the pursuit of higher EU-wide standards, increased efficiency and more-balanced burden-sharing among member states. Indeed, whereas the legal regulation of asylum-seekers' and refugees' incorporation in national healthcare systems remains largely a national competence, both the areas of health and asylum policy have experienced increasing – if still fragmented – integration at the EU level over the past three decades.

Yet, this integration process had not evolved far enough in 2015 to elicit a unified or even coordinated response among EU member states in times of crisis. As many member states closed their borders and/or refused to take in notable shares of the sharply increased numbers of people seeking asylum in Europe, both Germany and Sweden expressly went beyond EU-level agreements and EU legislation in initially opening their borders and letting in migrants seeking refuge who had entered EU territory in another member state. Thereafter, however, both governments declared that they could not uphold their openness unless other countries chipped in and contributed their part to a more even distribution of persons as well as financial and administrative costs. On this basis, the issues of solidarity among EU member states, of (moral and legal) duties and of capacities in particular became inherent elements of debate concerning incorporation policies at the national level in both Sweden and Germany.

In the case of the Swedish government's communication of crisis-induced measures, the EU played a particularly prominent role: governmental declarations and draft bills alike pointed out repeatedly that, because of its leading role among member states in accepting asylum-seekers, Sweden had reached a point in autumn 2015 where administrative, welfare and healthcare systems would be unable to cope with the situation if the influx of high numbers of asylum-seekers continued. Seeking to safeguard the systems' functionality by making displaced persons seek asylum elsewhere, the government declared – as mentioned above – that it saw no other way but to temporarily adjust asylum regulations to the minimum level in the EU and to bring Swedish legislation 'in line with the minimum requirements in international

[18] See, for example, the German Ministry of Health: Germany's Presidency of the Council of the EU 2020: Review by the Federal Ministry of Health, 31 December 2020 (https://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/E/EU2020/Review_GER_EU_Presidency_EN_Version.pdf (accessed 17 January 2022).

conventions and EU law'.[19] This course of action explicitly included the policy measure of granting temporary rather than permanent residence permits: the government emphasised that Sweden did not have to offer the latter in order to fulfil its international and supranational legal obligations.

Despite being presented as a short-term crisis response enabling the Swedish incorporation and healthcare systems (amongst others) to cope with the situation, the government's policy measures turned out not to constitute a mere short-term emergency lowering of incorporation standards. Indeed, when the government outlined Sweden's future migration policy in June 2019, it declared that, for the country's migration and incorporation system to be sustainable, Swedish regulations should generally, now and in the future, 'not deviate significantly from those of other EU countries'.[20] Their low standards, together with the state and (non-)functioning of the EU's asylum policy, provided the Swedish government with welcome arguments to justify the legal restrictions discussed above.[21]

Whereas the German government – like the Swedish – demanded a better functioning EU asylum system with a higher degree of solidarity, its reference to its own 'moral superpower' role within Europe differs in one major aspect from the Swedish government's. While also emphasising that Germany had taken on a disproportionately high share of asylum-seekers and, hence, of the overall challenge facing Europe in 2015,[22] Germany's model role was presented as an achievement of its short-term political reaction to the 'crisis' and as a lasting responsibility in the future build-up of a sustainable EU asylum system, rather than a (currently untenable and hence in part abandoned) status of the past. However, like one of the Swedish government's lines of argumentation, the German government emphasised that the country's high incorporation standards, not least in the area of healthcare access, could only be upheld if they were established across the EU.[23]

Generally, it is noteworthy that the Swedish government made the EU one of its main references in justifying its action in the context of the 'migration

[19] Press release by the Swedish Prime Minister's Office: 'Government proposes measures to create respite for Swedish refugee reception', *op. cit*. The same argument also appears prominently, amongst others, in Regeringens proposition 2015/16:174, *op. cit*.

[20] Kommitédirektiv Dir. 2019:32 'Den framtida svenska migrationspolitiken', adopted at the government meeting on 14 June 2019, p. 9 (translation by the author).

[21] See Kommittédirektiv 2016:47 'Utvärdering av hanteringen av flyktingsituationen i Sverige år 2015', adopted at the government meeting on 9 June 2016, p. 2.

[22] See, for example, Besprechung der Bundeskanzlerin mit den Regierungschefinnen und Regierungschefs der Länder zur Asyl- und Flüchtlingspolitik am 24. September 2015 https://www.bundesregierung.de/resource/blob/998616/435184/a0892e3d6adfceffbefc537c19c25d99/2015-09-24-bund-laender-fluechtlinge-beschluss-fr-data.pdf?download=1 (accessed 22 March 2022), p. 1.

[23] See the speech by Thomas de Maizière, Minister of the Interior, during plenary debate of the German *Bundestag* on 1 October 2015 (Plenarprotokoll 18/127, p. 12270); also speech by Eva Högl (member of the SPD group in the *Bundestag*, former Minister on Employment and Social Affairs and former member of the party executive), during plenary debate of the German *Bundestag* on 15 October 2015 (Plenarprotokoll 18/130, p. 12581).

crisis' – indeed, attributing to it the role of a scapegoat for its political reaction to the situation. This discursive behaviour of shifting the blame for controversy or morally questionable politics at the national level to action (or a lack thereof) at the EU level fits in well with the larger phenomenon of blame games in multilevel governance systems (Heinkelmann-Wild & Zangl, 2020). The German government, in comparison, referred to the EU less often and not in as harsh a tone. While demanding more EU-level solidarity, it largely took on the responsibility for its own action. One reason for this differing behaviour may be that, considering the German tradition of incorporation policy-making, the government's answer to the 'migration crisis' constituted no U-turn but, rather, a recourse to political action taken in previous crisis situations. For the Swedish government, the break with the previously established perception of traditionally liberal Swedish incorporation policies was significantly more acute.

8.4 Conclusion

In mid-to-late 2015, in the face of drastically rising numbers of asylum-seekers, the governments of Germany and Sweden demonstratively opened their countries' borders and declared their will to stand up to a humanitarian challenge on which most other EU member states would choose to turn their backs. However, when *Willkommenskultur* gradually turned into mounting societal and political anxiety, both governments started to implement a series of measures restricting asylum-seekers' and refugees' social rights, amongst others concerning their access to healthcare.

This chapter has outlined three main objectives which shaped governmental actors' policy-making with regard to asylum-seekers' and refugees' access to healthcare post-2015 in Germany and Sweden. First, policy-makers sought to avoid (or abolish) the granting of extensive social rights to asylum-seekers and refugees – with access to healthcare beyond the utterly necessary as an element thereof – because they considered that these potential pull factors incited more persons to try and attain refuge in the respective host country. Second, policy-makers echoed growing concerns regarding the overburdening of existing healthcare resources and infrastructures. In this context, governmental actors connected healthcare access to fundamental questions of entitlement and deservingness, not merely with regard to the asylum-seekers' and refugees' individual situations but in comparison to the entitlement and deservingness of the host country's citizens. Third, both countries' governments emphasised, at the EU and international level, their model role as 'moral superpowers' during the 'crisis', whilst also pointing out that their high standards in accepting and incorporating asylum-seekers and refugees were unsustainable unless and until more solidarity in the distribution of persons seeking protection would be reached at the EU level.

Through its focus on these three main objectives, this chapter helps to explain why the two governments (re)acted similarly despite the fundamentally different

systemic contexts of incorporation and healthcare regimes and traditions. By analysing what induced the two governments to behave differently to what a regime approach might lead one to expect, this chapter contributes to the ongoing re-evaluation of the applicability of the established regime models presented at the beginning of the chapter and to the questioning of Germany's and Sweden's representation as respective model cases for certain regime types. It discusses why the Swedish government moved away from its liberal incorporation tradition and universal welfare and healthcare regime by restricting asylum-seekers' and refugees' access to healthcare (alongside a range of other social rights) and by introducing a deservingness dimension in the provision of care for 'outsiders' which had not previously figured prominently in the normative frame of its incorporation system. The chapter demonstrates, furthermore, that, while the deeply ingrained deservingness dimension of the German healthcare and incorporation regimes appears clearly in governmental action post-2015, further dimensions not traditionally embedded can also be traced in the case of the government's policy-making. Specifically, the measures introduced moved away from the tradition of decentralised care and incorporation organisation by setting German-wide standards regarding healthcare access and promoting (albeit not uniformly implementing) the country-wide introduction of an electronic health card.

The chapter also shows, however, that the deviation from established regime models was greater in Sweden than in Germany, where the government by and large followed previously established adaptation patterns of rights and restrictions. One factor facilitating the drastic U-turn in Sweden's incorporation politics might be the fact that politicians have traditionally been keen 'to uphold the image of a "generous" country', both in terms of incorporation and welfare (Boräng, 2018, 12, 77). The concept of generosity, however, 'implies that something is offered that did not necessarily have to be offered; the actual offer could then be seen as going beyond what could rightfully be demanded' (2018, 152), which means that 'generously granted' access to healthcare can legitimately be taken away if the state is – or claims to be – unable to afford the level of generosity any longer.

This underlines the fact that times of crisis and turbulence have the potential to make political actors question previously established policy lines and change their course of action in order to answer unexpectedly arising challenges. This chapter shows that the same is true for the German and Swedish governments' reaction to the 2015–17 'migration crisis'. The policy changes in the respective national regulation of asylum-seekers' and refugees' access to healthcare which the chapter has analysed were adopted in the context of crisis management. Yet, the lasting impact of restrictive measures with regard to asylum-seekers' social rights implemented both in Germany and Sweden in the 1990s demonstrates that political-crisis management can shape legislation far beyond the problem it was meant to remedy. In this light, we need to analyse the action taken by the German and Swedish governments under the impression of the 2015 situation as more than mere reactive politics with a short-term perspective. Processes of profound politicisation may well steer policy-making beyond times of acute political and societal anxiety and along paths once chosen under the impression of near-overburdened systems and unsustainable

situations. The governmental measures analysed in this chapter may thus shape German and Swedish policies at the intersection of incorporation and health for years to come.

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