The impact of national values on health-care provisions for asylum seekers and refugees in Germany and Sweden

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Abstract: An important aspect of refugees' mid- to long-term integration into a host country's society is their access to the respective health-care system. This article sheds light on the regulation of this access in Germany and Sweden, i.e. two main destination countries in Europe. Drawing on the concept of national values as defined by Marmor et al. (2006), the article identifies different sets of norms and values in, and their impact on, national asylum and health policies. Specifically, the article discusses in a comparative analysis how these policies are shaped by national values regarding the general normative fundaments of society, as well as the roles and responsibilities attributed to state actors and individuals in the context of health care.

Keywords: Refugees; health-care system; incorporation system; asylum policy; values

1. Introduction.

At the European Council's meeting on 21-22 March 2019, migration was not on the agenda for the first time in years. The reason was not only the dominating uncertainty over Brexit, which stood in the centre of discussion, but also the fact that migration was perceived not to "qualify as a crisis any longer".[1] This change of perception at the governmental level in EU member states implies a gradual change of migration governance in Europe, both at the national and the EU level: short-term crisis management has increasingly been replaced by mid- to long-term policies aimed at the stabilisation and controllability of immigration, and at the integration of those who arrived.

This article focuses on the phase of migration governance following short-term political crisis management. Namely, it sheds light on the regulation of refugees' and asylum seekers' access to different EU member states' health-care systems as an important aspect of their mid- to long-term integration into host countries' societies. More specifically, drawing on the concept of *national values* as defined by Marmor et al.,[2] this article identifies different sets of norms and values

[1] Council official, cited in POLITICO Brussels Playbook, 20 February 2019 (https://www.politico.eu/newsletter/brussels-playbook/politico-brussels-playbook-orban-splits-the-epp-china-finally-on-europes-agenda-decisions-and-consequences/, last visit 4 August 2020).

[2] T. R. Marmor et al., *Values, Institutions and Health Politics*, in C. Wendt, C. Wolf (Eds), *Soziologie der Gesundheit*, Wiesbaden, 2006, 383-405.

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in, and their impact on, national migration and health policies, focusing specifically on Germany and Sweden, as elaborated further below. In so doing, this article seeks to help remedy a noteworthy lacuna in migration health research, and indeed in migration studies more generally: "Migrant health research has been predominantly concerned with mental health and infectious diseases, or with health inequalities between specific migrant groups and host populations, whereas policy and systems issues have been sidelined".[3]

The following analysis focuses on the area of health policy for two main reasons. On the one hand, this policy area has a multifold bridge function: "It is where biological and social factors, the individual and the community, and social and economic policy all converge";[4] moreover, it has a crucial integration function, in that a country's health-care system regulates citizens'/residents' (more or less) equal access e.g. to social security, education and the labour market.[5] On the other hand, health policy has a strong symbolic dimension: a country's health policy makes visible who is considered an insider or outsider within the given legal system, what criteria determine deservingness of help and support, and what responsibilities a state has towards the people living on its territory. This article aims to demonstrate to what extent certain normative understandings of health – e.g. as human right, legal standard, or social benefit – influence policy provisions for refugees' and asylum seekers' health-care access beyond basic checks performed upon arrival in a host country, and emergency care. It also discusses how related policies are shaped by national values regarding the state's general role in the provision of health care, individuals' claims to and common perceptions of health services – e.g. as a benefit which has to be deserved, or as an element of universal protection. In so doing, it assumes with Beckfield et al. that "observing which individuals and groups are considered worthy of assistance (e.g., universal versus targeted benefits) provides researchers with insight into the broader culture of a society and into what its members expect of their healthcare system (e.g., how it should provide services and to whom)".[6] This culture – and its constituting values – plays a "key role in defining the possibilities available to policy makers, practitioners, and other stakeholders in a particular society".[7]

Not least with regard to this cultural dimension, national health-care systems in Europe are shaped in very different ways, albeit sharing a certain common basis. Namely, every person, regardless of their nationality, is legally entitled to emergency care in all EU member states, based on the fundamental right to health care as laid down in Article 35 of the Charter of Fundamental

[3] K. Bozorgmehr, R. Jahn, *Adverse health effects of restrictive migration policies*, in 7 *The Lancet Global Health* 4 (2019), E386.
[4] J. Frenk, *The New Public Health*, in *Annual Review of Public Health*, 14 (1993), 469.
[5] J. Phillimore, *Approaches to health provisions in the age of super-diversity*, in 31 *Critical Social Policy* 1, 20 (2010); C. Wolf, C. Wendt, *Perspektiven der Gesundheitssoziologie*, in C. Wendt, C. Wolf (Eds), *Soziologie der Gesundheit*, Wiesbaden, 2006, 20.
[6] J. Beckfield et al., *Comparative Perspective: Classification, Convergence, Institutions, Inequalities, and Five Missed Turns*, in 39 *Annual Review of Sociology*, 137 (2013).
[7] *Ibidem*, 138.

Rights of the EU. This article does not, however, grant full access to the respective national health-care systems; indeed, the right to health as provided by Article 35 "could mean anything from a general right to be healthy, to a right to a basic package of medical treatments; to a right to social insurance or tax-based access to health care (either in general, or a specific set of health care entitlements, such as emergency treatment)".[8] Consequently, national legislators have much room of interpretation when it comes to the regulation of third-country migrants' (including asylum seekers' and refugees') rights in the area of health care. Given that the majority of asylum seekers wait months, at times even years for the final decision on their legal status, they become part – even if as a segregated group – of the host states' administrative and social system for a notable period already prior to the determination of their status. During this period, asylum seekers and refugees may have to, or wish to, undergo medical treatment or enter preventive health-care schemes beyond what emergency care can provide. Hence, states need to provide a legal framework for these persons' access to health services. This legal framework may be strongly influenced by norms and values beyond mere political or party preferences, as this article shows for the cases of Sweden and Germany.

By comparing these two countries, this article constitutes what is termed in comparative politics research a most different case study: Sweden's and Germany's immigration policies and their welfare and health-care systems differ considerably in a number of structural and political aspects, such as centralisation, the relevance of citizenship, and individual preconditions for the utilisation of health and welfare services.[9] Consequently, it could be expected that their response to crises and other forms of unintended events requiring political (re-)action would equally differ significantly. Yet, during the increased influx of asylum seekers 2015-17, both countries underwent similar processes of initial demonstrative openness to incoming refugees, presenting themselves as 'moral superpowers'[10] in comparison to other European countries, and taking in high numbers of people, but later changed their stance towards refugees and asylum seekers under (perceived) pressure through a shift of public opinion.

These similar reactions despite significantly different systems show that an analysis purely focussed on systemic differences, i.e. the functioning and organisation of different welfare, health-care and incorporation regimes cannot sufficiently explain national reactions to incisive events such as the above-mentioned increased influx of asylum seekers. Rather, the self-referencing to the

[8] T. Hervey, *Health Equality, Solidarity and Human Rights in European Union Law*, in A. Silveira et al. (Eds), *Citizenship and Solidarity in the European Union*, Brussels, 2013, 354.
[9] Extensively discussed by D. Sainsbury, *Welfare States and Immigrant Rights. The Politics of Inclusion and Exclusion.* Oxford, 2012.
[10] H. Bradby, *Refugee and Migrant Health: A Perspective from Sweden*, in A. Krämer, F. Fischer (Eds), *Refugee Migration and Health. Challenges for Germany and Europe*, Cham, 2019, 185-193; C. Fernández, *Cosmopolitanism at the crossroads*, in E. M. Gozdziak et al. (Eds), *Europe and the Refugee Response. A Crisis of Values?*, London/New York, 2020, 220-235.

role of a 'moral superpower' common to both countries under examination suggests a strong normative dimension of their respective behaviour. Consequently, this article applies a normative approach – the concept of national values – in its pursuit to contribute to a better understanding of the basis on which Germany's and Sweden's reaction to the 2015-17 'crisis' was built.

Specifically, the following analysis of national values sheds light, amongst other issues, on commonly shared perceptions regarding rights and claims, deservingness and insiders/outsiders in the context of asylum seekers' and refugees' integration in host societies. The area of health policy provides particularly clear insights on these perceptions and their tangible consequences: the analysis of any access to health services beyond emergency care offers an understanding of the role attributed to asylum seekers and refugees by legislators, political actors more generally, and societies as a whole. These attributed roles range from a group of persons under general suspicion of welfare fraud, to persons seeking temporary shelter but being expected to leave the host country again in the foreseeable future, to potential new members of the labour market and the society, and hence potential contributors to the state's economy, wealth, and welfare system as well as – in the most open approaches – to its future cultural development. This article studies historically developed national values which are at the basis of such role attributions, and which have a significant impact on policy-makers' actions with regard to the adoption and interpretation of incorporation and health policies in recent years.

Following a section outlining the theoretical conceptualisation of national values, the article provides an overview of national value frameworks in Germany's and Sweden's welfare, health-care and incorporation regimes. All three are relevant regarding the issue at hand, given that the access of refugees and asylum seekers is regulated at their intersection (as demonstrated by Sainsbury (2012) in her broader study of immigrants' social rights, and outlined in more detail below). In the compilation of the respective national values, this article draws on existing literature on the three above-mentioned regime types in Germany and Sweden from different disciplines, namely political science, sociology and law, and furthermore on national legislation regulating these areas.

2. Theoretical approach: national values in asylum seeker- and refugee-related health policy.

Policy-making within the remit of the welfare state is rarely driven by rationalist cost-benefit motives alone, such as financial or economic considerations.[11] The

[11] W. van Oorschot et al., *The culture of the welfare state: historical and theoretical arguments*, in W. van Oorschot, M. Opielka, B. Pfau-Effinger (Eds), *Culture and Welfare State. Values and Social Policy in Comparative Perspective*, Cheltenham/Northamption, 2008, 2.

same applies to incorporation regimes,[12] defined here with Sainsbury 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".[13] Indeed, Phillimore calls migration "possibly one of the most politicized areas in the EU, if not the world".[14] Studying health policies concerning asylum seekers and refugees as a highly politicised and normatively charged area, the following analysis builds on van Oorschot et al.'s finding that political actors are influenced in their related policy-making by "doctrines, values, and ideals in relation to the welfare state", and that "[t]he cultural values and ideals that predominate in welfare cultures do tend to restrict the spectrum of possible policies of a welfare state".[15]

In its study of such values and ideals with an impact on health-care provisions for refugees and asylum seekers in Germany and Sweden, this article applies the concept of national values. With Marmor et al., they are here defined as "summation across a broad population of varied individuals' general and potentially conflicting"[16] views about what is "worthy or important",[17] which – despite existing conflicts – have the potential to unite and guide the action of a community and its decision makers. Such values, as Marmor et al. emphasise, are "*general.* They do not dictate preferences for particular institutional structures at any level of detail".[18] Moreover, they are "relatively stable over time, changing only very gradually"[19] once they are incorporated into collective identities and narratives, "reinforced on a recurring basis by political agents, and – most importantly – […] embedded in political institutions and policy regimes".[20] National values socialise residents of the respective territory as well as political actors. Once they are commonly accepted, national values rule out certain policy choices as incompatible with resulting logics of appropriateness.[21]

In the area of health care, Marmor et al. identify "universal protection against being ruined financially by the costs of treatment"[22] as a dominant value which is largely uncontested in Western welfare states. Beyond this basic value, however, health-care systems may be embedded in sets of national values which differ quite significantly across countries. These values usually stand in some

[12] F. Boräng, *National Institutions – International Migration. Labour Markets, Welfare States and Immigration Policy*, London/New York, 2018, 6; D. Ruedin, *Citizenship Regimes and the Politicization of Immigrant Groups*, in 46 *ÖZP – Austrian Journal of Political Science*, 1 (2017).
[13] D. Sainsbury, *op. cit.*, 16.
[14] J. Phillimore, *op. cit.*, 6.
[15] W. van Oorschot et al., *op. cit.*, 11.
[16] T. R. Marmor et al., *op. cit.*, 385.
[17] *Ibid.*
[18] I*bid.*; emphasis by T. R. Marmor et al.
[19] *Ibid.*, 387.
[20] K. Banting, W. Kymlicka, *Introduction*, in K. Banting, W. Kymlicka (Eds), *The Strains of Commitment. The Political Sources of Solidarity in Diverse Societies*, Oxford, 2017, 3.
[21] J.G. March, J.P. Olsen, *The Logic of Appropriateness*, in R.E. Goodin (Ed), *The Oxford Handbook of Political Science*, Oxford, 2011 .
[22] T. R. Marmor et al., *op. cit.*, 386.

relation to key characteristics of welfare states as outlined by Esping-Andersen, such as notably the provision of services based on deservingness or means, the extent of privatisation and corporatism, the level of redistribution, and state-market-family relations.[23] Rothgang has developed Esping-Andersen's welfare regime model further, with a focus specifically on the analysis of health-care systems (rather than welfare systems more generally).[24] In his typologisation, he examines a series of dimensions of such systems which may equally be closely connected to health care-related national values, and are hence highly relevant for the following analysis, namely:

- Financing (state funding vs. insurance contributions vs. private funding),
- Service provision (privately vs. publicly operated; profit vs. non-profit),
- Regulation (role and powers of stakeholders, such as financing institutions, service providers, beneficiaries), and
- The normative basis of the respective institutional arrangement.

Taking these dimensions into consideration, Rothgang presents three ideal types (in the Weberian sense) of health-care regimes, namely the state/public health-care system (for which Sweden can be used as case study), the social insurance system (with Germany as a typical example), and the private health-care system (which does not, in its 'ideal' form, appear in any EU member state).[25] Esping-Andersen's welfare regime typology and Rothgang's health-care regime typology are compatible and can be fruitfully combined: states with a social democratic welfare regime – of which Sweden is usually named as prime example – typically have a state/public health-care system; conservative-corporatist welfare regimes – with Germany as typical example – usually come with social insurance health-care systems.

The two countries in the focus of this article are furthermore examples for different incorporation regimes. Sainsbury distinguishes between inclusive and restrictive incorporation regimes, and identifies Sweden as an example of the former and Germany of the latter.[26] The two incorporation regimes have different takes on the balance of inclusion and exclusion, on the rights of 'insiders' and 'outsiders'. These tendencies may mirror a similar "leaning towards the more inclusive or the more exclusive"[27] in the respective welfare systems. This article

[23] G. Esping-Andersen, *The Three Worlds of Welfare Capitalism*, Princeton, 1990.
[24] H. Rothgang, *Die Regulierung von Gesundheitssystemen in vergleichender Perspektive*, in C. Wendt, C. Wolf (Eds), *Soziologie der Gesundheit. Sonderheft*, Wiesbaden, 2006, 301 f.; R. Freeman, H. Rothgang, *Health*, in F.G. Castles et al. (Eds), *The Welfare State*, Oxford, 2010, 370 f.
[25] H. Rothgang, *op. cit.*, 304.
[26] D. Sainsbury, *op. cit.*, 16. While this classification is generally shared in the literature, F. Boräng (*op. cit.*, 143) points out that "when it comes to access to health care for asylum seekers, Sweden has been more restrictive than the United Kingdom" since the 1990s – with the UK being typically considered to have one of Europe's most restrictive incorporation regimes. See e.g. S. Castles, C.-U. Schierup, *Migration and Ethnic Minorities*, in F.G. Castles et al. (Eds), *The Welfare State*, Oxford, 2010, 289. On health provisions for migrants in different European countries, see also I. Beauclecq et al., *Overview of Migration and Health in Europe*, in A. Krämer, F. Fischer (Eds), *Refugee Migration and Health. Challenges for Germany and Europe*, Cham, 2019.
[27] F. Boräng, *op. cit.*, 10.

shows through the lens of national values that, in legislation as well as in the political discourse, differing fundamental attitudes towards immigration – and specifically towards asylum seekers and refugees as persons who initially cost the state more than they can contribute – are clearly discernible in the two countries under examination. This is particularly interesting considering that both states, despite the different fundamental values underlying their incorporation, welfare and health-care systems, adopted policy measures in the wake of the 2015-17 'crisis' which are to some extent quite similar. In this context, it should be noted that national values – or "collective (typically national) identities and narratives"[28] – are not entirely immune to change:

"Attitudes of mutual support may change slowly, but they are not immutable and need continuous reinforcement. Moreover, as societies become diverse, historic forms of solidarity need to be stretched to incorporate newcomers."[29]

Indeed, while the implementation of national values through concrete policy measures may be comparably easy in periods of limited and controllable refugee migration, they come under stress in times of (perceived) crisis. As Bilecen finds, "when asylum seekers flee their countries of origin in great numbers [...], it [...] leads the societies receiving them to question and reshape their own norms and values, as well as their institutional and social structures".[30] In other words, when policy makers are under the impression that a critical status quo cannot be managed based on existing legal and institutional structures, they may question the applicability and timeliness of established values. They may nurture such doubts particularly when the implementation of existing incorporation legislation – even if firmly embedded in a set of national values – has the potential to undermine (equally value-based) sets of rights of the respective country's citizens, for instance through a (perceived) overload of parts of the social system. Such questioning of established norms and values may lead to an increased visibility of these norms and values, given "that core parts of historical narratives are crucially pulled together under *crisis conditions*".[31] Such increased visibility through an intensified discourse on rights, responsibilities and deservingness etc. facilitates the analysis of national values and their impact on health-care provisions for asylum seekers and refugees in the most recent period perceived by political actors as 'migration crisis'.

3. National values in the German and Swedish welfare, health-care and incorporation regimes.

[28] K. Banting, W. Kymlicka, *op. cit.*, 33 f.
[29] *Ibidem*, 23.
[30] B. Bilecen, *Social Transformation(s): International Migration and Health*, in A. Krämer, F. Fischer (Eds), *op.cit.*, 40.
[31] K. Borevi, *Diversity and Solidarity in Denmark and Sweden*, in K. Banting, W. Kymlicka (Eds), *The Strains of Commitment. The Political Sources of Solidarity in Diverse Societies*, Oxford, 2017, 369; emphasis by Borevi.

This section identifies three sets of national values underlying German and Swedish incorporation and health policies. At a general level, it discusses national values which frame broader societal aims and principles, i.e., values which are perceived as the fundaments of the respective state and society, such as solidarity, equality, and universality. With regard to actors in policy making and legislation, this section sheds light on national values assigning certain roles and responsibilities to the state and to state actors with regard to incorporation and health care. Finally, it discusses national values constructing certain roles of different groups of individuals – citizens, residents, asylum seekers and refugees – and responsibilities attributed to them. By highlighting these three sets of national values, this section provides at the same time an inter-disciplinary overview of the state of literature on norms and values in the Swedish and German incorporation and health regimes, and their intersection.

The dominating values underlying Sweden's health-care and incorporation system are largely the same, in that they are considered as constitutive element of the state more generally. Namely, based on a Social Democratic welfare tradition,[32] and of the welfare state as a crucial element of the "national identity and self-image",[33] these dominating values are solidarity, universality and comprehensiveness of social welfare (including health care),[34] and social equality.[35] Traditionally, this system of values comprises anyone living within the Swedish state, including immigrants, specifically those considered 'forced' and in need of protection, i.e. asylum seekers and refugees. This inclusive approach builds on the role attributed to incoming persons: in Sweden, refugees and asylum seekers are traditionally seen as potentially permanent residents and members of the Swedish society.[36] As a consequence of this inclusive approach, Sweden's "postnational membership model […] is often ranked as the most immigrant-friendly in Europe".[37]

This universal and comprehensive system of the above-mentioned values on which the Swedish societal model builds has characteristically been named *'folkhem'* (people's home). The concept of the *'folkhem'* – which has an equally normatively charged health-related dimension, the *'folkhälsa'*[38] (people's health, further discussed below) – has significantly shaped Swedish welfare and health policies with its underlying values, even though "[i]n Sweden, the notion of

[32] P. A. Hall, *The Political Sources of Social Solidarity*, in K. Banting, W. Kymlicka (Eds), *The Strains of Commitment. The Political Sources of Solidarity in Diverse Societies*, Oxford, 2017, 217 f.
[33] K. Borevi, *op. cit.*, 364.
[34] Such comprehensiveness of health care is understood in the Swedish health-care system as "health in the form of access to housing, education, employment, leisure and exercise facilities. In addition to physical and mental health, the idea of health as a quality supported by social participation informs the system of provision" (H. Bradby, *op. cit.*, 188).
[35] H. Bradby, *op. cit.*, 187; W. van Oorschot et al., *op. cit.*, 9; T. R. Marmor et al., *op cit.*, 386.
[36] D. Sainsbury, *op. cit.*, 278.
[37] C. Fernández, *op. cit.*, 225.
[38] K. Johannisson, *The People's Health: Public Health in Sweden*, in D. Porter (Ed), *The History of Public Health and the Modern State*, Amsterdam-Atlanta, 1994, 181.

'people' was more or less dropped from the political vocabulary"[39] after the Second World War. This is important with regard to this analysis, because as a part of the process of abandoning the *'folk'* notion, membership of the community was defined increasingly via residency rather than citizenship. This implies that any legal resident – including refugees and asylum seekers granted a residence permit, be it permanent or temporary – is traditionally included in the welfare and health care system for the duration of their residence in Sweden.

The constitutive power of the *'folkhem'* and *'folkhälsa'* approach for the national identity becomes evident also in Sweden's regularly referenced self-understanding "as a pioneering 'moral superpower' and 'leading actor' in international refugee work".[40] Such superiority in asylum policy is supposed to be achieved through "generous" protection beyond Convention provisions and international agreements,[41] i.e., a level of protection in which Swedish standards surpass the country's obligations with regard to refugees' international rights and legal claims.[42] Indeed, Sweden has prided itself with having "an immigration policy that prioritizes humanitarian needs over national self-interest and profitability".[43]

In Germany, no concept comparable in symbolic strength or normative impact to the Swedish *'folkhem'* and *'folkhälsa'* exists. The German welfare state – typically "pointed to as the prototype of the conservative corporatist welfare regime"[44] in the literature, following Esping-Andersen's welfare state model – builds on a very different tradition than the Swedish one. The Bismarckian social insurance system had as its main objective "to safeguard the standard of living of the insured",[45] closely connected to a fundamental normative understanding of the provision of social welfare based on a person's individual deservingness. Although the German welfare state has developed a certain level of redistribution over time, the issue of deservingness can still be considered a constitutive national value underlying the German welfare and health care system.

Its broader impact is also visible in Germany's incorporation regime, which differs significantly from the Swedish one in a variety of ways, including its normative dimension. This concerns for instance the fundamental attitude of the state vis-à-vis immigrants. It is quite telling that, whereas Sweden declared to be a country of immigration as early as 1968, Germany acknowledged the same only in 2004.[46] Furthermore, in contrast to the Swedish perception of asylum seekers and refugees as potential future members of society, this group of persons, while considered to be in need of temporary protection and support, is expected in the

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[39] K. Borevi, *op. cit.*, 372.
[40] H. Bradby, *op. cit.*, 185; see also K. Johannisson, *op. cit.*, 165; K. Borevi, *op. cit.*, 374; C. Fernández, *op. cit.*, 220 f.
[41] F. Boräng, *op. cit.*, 121 and 129.
[42] *Ibidem*, 152.
[43] C. Fernández, *op. cit.*, 220.
[44] D. Sainsbury, *op. cit.*, 54.
[45] *Ibidem.*
[46] D. Sainsbury, *op. cit.*, 55 and 214.

German system to stay only for a limited period of time, and then to leave again e.g. so as to return to their country of origin.[47] These different perceptions contribute to distinct normative bases of the respective integration policies. Namely, the Swedish system traditionally seeks to integrate those who arrived into the state and society (including into the concepts of *'folkhem'* and *'folkhälsa'*),[48] whereas the German system focuses first and foremost on helping those who deserve protection to deal with their current situation, while also seeking to enable them to return as soon as safely possible.

Such differing perceptions regarding the level of integration of asylum seekers and refugees in the respective country of arrival lead to equally differing perceptions regarding individual deservingness of social support. Namely, in the case of Germany, asylum seekers have an obligation to prove that they are not only *in need of* help, but that they are also *entitled to receive* help – for instance in the form of health care beyond emergency care, as discussed below. This question of asylum seekers' claim to be deserving arose repeatedly in the context of German legislation changes from the late 1970s. Especially the restriction of asylum seekers' right to work – and hence to contribute to the social insurance system – potentially "reinforced Germans' impressions that asylum seekers were fake refugees living on welfare at the expense of the taxpayers".[49] The debate about asylum seekers' eligibility to become part of the social system has been, and remains, a very controversial one, notably as regards the extent to which asylum seekers should be integrated into the welfare and health-care systems.[50] In this debate, the individual's deservingness of social support is measured not only with regard to their social or health needs, but also with an eye on the contribution this individual has already made to the system, and thus to the community. On this basis, it is judged whether the individual level of contribution justifies the expense arising through the coverage of the individual's declared need.

This normatively charged contribution-deservingness calculation is closely related to the question of how welfare and health care are financed, or – more simplified – who pays for whom. In congruence to the deservingness question, the German health-care system is largely based on contributions of the individual members to different health insurances. The level of these contributions is determined on the one hand by the individuals' income, and on the other hand by the respective insurance, which the insured can choose relatively freely.[51] In other words, in Germany, it is evident to individuals what they themselves paid into the

[47] J. Butenop et al., *Future Challenges for the Public and Curative Health Sector*, in A. Krämer, F. Fischer (eds), *op.cit.*, 125.
[48] This changed in the context of the recent increased influx of asylum seekers, following which the Swedish government introduced among other (initially temporary) measures "various changes in the migration laws to offer temporary rather than permanent residence permits" (H. Bradby, *op. cit.*, 186).
[49] D. Sainsbury, *op. cit.*, 202.
[50] See e.g. M. A. Eger, A. Bohman, *The political consequences of contemporary immigration*, in *Sociology Compass*, 10 (2016).
[51] M. Lisac et al., *Access and choice – competition under the roof of solidarity in German health care*, in 5 *Health Economics, Policy and Law* 1 (2010).

health system, and what they – and others, who possibly did not contribute anything (yet) – get out of it, largely limiting solidarity to members of the social insurance schemes.[52] This restricted solidarity is clearly visible in the legal stipulation of asylum seekers' access to social services and health care in German asylum and social law. As a general rule, the *Asylbewerberleistungsgesetz* (*AsylbLG*, law regulating asylum seekers' access to social welfare) provides for social services which are principally at a level below those services available to members of the German social system.[53]

The Swedish health-care system, in comparison, is financed largely by taxes, namely statutory and municipal taxes and social security contributions via the income tax, and to a limited extent through small patient fees.[54] The tax basis of the Swedish system implies that all individuals in the state contribute similarly to the latter's overall functioning, part of which is a properly running health-care system. Consistent with the concepts of *'folkhem'* and *'folkhälsa'*, the Swedish health-care system is consequently based on a fundamentally *collective* approach. As an important element thereof, the concept of *'folkhälsa'* assigns a certain level of responsibility to the individual for the entire societal body.[55] This collective responsibility, in turn, has taken shape for instance in state initiatives seeking to restrain unhealthy behaviour of the people, such as the consumption of alcohol (via the alcohol monopoly *Systembolaget*), and the tradition to eat sweets only on Saturdays (the so-called *lördagsgodis*, based on a state-commissioned study from the 1940s finding that eating sweets once a week would be healthier than smaller amounts in a more regular frequency).[56] In the German health-care system, state-initiated incentives and sanctions seeking to motivate individuals to lead a healthy life are in comparison very fragmented and rudimentary.[57]

The national value of collective responsibility underlying the Swedish welfare and health-care system traditionally includes immigrants, and among them asylum seekers and refugees. Given that they are considered future members of the Swedish society, they are expected to contribute to the common health-care and welfare system in the long run, and hence to pay back to the system over time their share of the costs caused by them shortly after their arrival. Thus, not the same deservingness conflict as in the German case arises.[58] Indeed, the long-term

[52] D. Sainsbury, *op. cit.*, 278.
[53] G. Kuhn-Zuber, *Sozialleistungsansprüche für Flüchtlinge und Unionsbürger*, Baden-Baden, 2018, 53; M. Lehnert, M. Pelzer, *Diskriminierendes Sondergesetz: Warum das Asylbewerberleistungsgesetz verfassungswidrig ist*, in 43 *Kritische Justiz* 4 (2010).
[54] H. Bradby, *op. cit.*, 187.
[55] Van Oorschot et al., *op.cit*, 9 speak of "mutual responsibility" as one of the main values underlying the Social Democratic welfare regime, of which Sweden is often named as the prototype, as discussed above.
[56] E. Bommenel, *Sockerförsöket. Kariesexperimenten 1943–1960 på Vipeholms sjukhus för sinnesslöa*, Lund, 2006.
[57] L. F. Neumann, K. Schaper, *Die Sozialordnung der Bundesrepublik*, Frankfurt/New York, 2008, 212.
[58] In the light of the recent "crisis", however, a similar debate on deservingness and exploitation of the social system through 'outsiders' has taken increasing space in the Swedish public and political discourse on immigration and integration. See e.g. P. Marx, E. Naumann,

integration of asylum seekers and refugees into the state, society, labour market and welfare system has been "presented and defended as a win-win, morally justifiable and self-serving at the same time",[59] and thus as contributing a significant share to Sweden's prosperity.

Such a normative framework of collective responsibility is not compatible with the German health-care regime, and consequently also with the regulation of asylum seekers' and refugees' access to health care in Germany. The main reason lies in the vast landscape of private and statutory health insurances in Germany – instead of a central state-organised structure – which cover health services to different extents. The resulting system of competition and choice contributes to individuals' perception of having to pursue their own health coverage in contact with the respective insurance, rather than of the state taking care collectively of those living within its remit of responsibility. The basic value underlying this system is to answer each person's individual needs, which implies a high level of freedom of choice and individual, rather than collective, responsibility.[60] Namely, it is up to the individuals within the health-care system to decide to what extent and through what measures they wish to improve their health – or put it at risk. This freedom of choice is visible not least in the wide range of services covered by health insurances, including for instance 'alternative' curing methods[61] such as homoeopathy, which is not covered in many other European health-care systems such as Sweden, and most recently France.[62]

The fundamental normative difference of responsibility attribution – in the German case of individuals first and foremost for themselves (and, through the principle of subsidiarity, to some extent for those closest to them, as explained below), and in Sweden for the preservation of *'folkhälsa'* – connects once more to the question of deservingness. If individuals make health decisions largely by and for themselves, there is a lower overall willingness of society to collectively share the costs of these individual decisions, which implies a stronger questioning of the individual's deservingness to receive certain aid measures/reimbursements. This

Do right-wing parties foster welfare chauvinistic attitudes? A longitudinal study of the 2015 'refugee crisis' in Germany, in 52 *Electoral Studies* (April 2018), for the case of Germany, and M. Dahlstedt, A. Neergaard, *Crisis of Solidarity? Changing Welfare and Migration Regimes in Sweden*, in 45 *Critical Sociology* 1 (2019), for the case of Sweden.

[59] C. Fernández, *op. cit.*, 224.

[60] M. Lisac et al., *op. cit.*; G. Hensen, P. Hensen, *Das Gesundheitswesen im Wandel sozialstaatlicher Wirklichkeiten*, in G. Hensen, P. Hensen (Eds), *Gesundheitswesen und Sozialstaat. Gesundheitsförderung zwischen Anspruch und Wirklichkeit*, Wiesbaden, 2008, 21-23.

[61] A list of such 'alternative' curing methods covered by many health insurances in Germany has been assembled by "Krankenkassen. Deutschland", an 'independent information portal' (self-description in the legal notice of the website) on health insurance companies and coverage in Germany: https://www.krankenkassen.de/krankenkassen-vergleich/gesetzliche-krankenkassen/alternative-medizin/ (last visit 17 September 2019).

[62] In the French health care system, coverage for homeopathic medicine will be progressively removed until 1 January 2021. See press statement by French Minister of Health Agnès Buzyn, 10 July 2019 (https://solidarites-sante.gouv.fr/actualites/presse/communiques-de-presse/article/medicaments-homeopathiques-agnes-buzyn-suivra-l-avis-de-deremboursement-rendu, last visit 17 September 2019).

becomes particularly visible when examining persons at the fringes of the health-care system: to the group of persons in the focus of this article, only part of the value of individual responsibility seems to apply. Namely, up to the point when asylum seekers receive a legal status allowing them to stay,[63] their freedom of choice and self-determination regarding health services is restricted in a number of ways. For instance, during their stay in reception centres, they have no free choice of the doctor treating them in case of medical needs, whereas members of the German health-care system can usually make this choice individually.[64] Moreover, and more significantly, in some *Bundesländer* asylum seekers have to obtain a certificate of medical treatment whenever they require such treatment. These certificates are not issued by medical personnel, but by administrative staff working at the respective authority responsible for asylum seekers.[65] In other words, asylum seekers have to demonstrate before the state that they are in need of, and have a claim to, health services. This procedure thus connects again to the above-mentioned values of individual responsibility and deservingness. It should be mentioned, however, that it is not applied nation-wide: in some *Bundesländer*, such certificates are issued for a determined time period (typically a quarter year), rather than for every single use of medical services; in yet others, asylum seekers receive a health card similar to those held by members of German health insurances, which grants them relatively free access to the catalogue of health services provided for asylum seekers under the *AsylbLG*.[66]

Generally, it would be too simplified to assume that the German health-care system would be devoid of solidarity – this solidarity is merely situated at another level than the collective societal solidarity in Sweden. Namely, a distinct value underlying the German system in this regard is the principle of subsidiarity, i.e. of dealing with arising issues at the most immediate level, whereas the next highest level only steps in if an objective cannot be sufficiently achieved by the previous one.[67] The principle of subsidiarity is thus perceived to facilitate and

[63] German asylum law distinguishes three main legal statuses allowing asylum seekers to stay, namely as refugee, as person under subsidiary protection, or as person entitled to political asylum (see *Asylgesetz*, §§ 2-4, https://www.gesetze-im-internet.de/asylvfg_1992/BJNR111260992.html - last visit 30 July 2020). In addition, asylum seekers may get a (temporary) residence permit if their deportation is suspended due to potential danger to their health, life and liberty, (see *Aufenthaltsgesetz*, § 60, https://www.gesetze-im-internet.de/aufenthg_2004/BJNR195010004.html - last visit 30 July 2020). The above-mentioned restrictions of asylum seekers' access to health care are also lifted if the asylum procedure takes longer than 18 months (see *AsylbLG*, § 2, https://www.gesetze-im-internet.de/asylblg/BJNR107410993.html - last visit 30 July 2020).
[64] G. Kuhn-Zuber, *op. cit.*, 49.
[65] *Ibidem*, 49 and 87 f.
[66] J. Wenner, Y. Namer, O. Razum, *Migrants, Refugees, Asylum Seekers: Use and Misuse of Labels in Public Health Research*, in A. Krämer, F. Fischer (Eds), *Refugee Migration and Health. Challenges for Germany and Europe*, Cham, 2019, 53-54.
[67] R. Reiter, *Normative Grundlagen, Strukturen und internationale Einordnung der Sozialpolitik in Deutschland*, in R. Reiter (Ed), *Sozialpolitik aus politikfeldanalytischer Perspektive. Eine Einführung*, Wiesbaden, 2017, 51-84.

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improve social and health care via non-centralisation and the principle of self-help in the German system.[68]

Subsidiarity is an inherent characteristic of the German federal system more generally, dividing responsibilities among the national level, the *Bundesländer*, and the communes. In the case of welfare and health-care provisions for asylum seekers and refugees, for instance, general standards are set in national-level legislation, but it is up to the *Bundesländer* to implement these often rather superficial or vague legal provisions.[69] Especially in the area of welfare and health care, however, the principle of subsidiarity reaches beyond the distribution of responsibility among state actors: responsibility is borne here not only by the state, but also – in fact, traditionally first and foremost – by the family as the 'nucleus' of society. This 'nucleus'-level solidarity is visible for instance in the fact that (unemployed) spouses and children are insured via the health insurance of the working spouse/parent, without having to pay contributions themselves.[70] Indeed, van Oorschot et al. name the understanding of "society as an organic whole cherishing hierarchical group relations and professional, communal and family bonds in particular"[71] as one of the main values underlying conservative-corporatist welfare states like Germany. Thus, the German social and health-care system is also built on a strong dimension of solidarity, albeit focussed at society's smallest entities, rather than invoking a responsibility for society as a whole, as implied in the Swedish '*folkhälsa*'.[72]

Table 1 provides an overview of the national values identified in this article. The following conclusion summarises and discusses the main normative differences between Germany and Sweden, but also their common ground.

Type of national value	Germany	Sweden
Normative fundaments of state, society & health-care system	• Distributed solidarity (subsidiarity principle) • Support based on individual needs and deservingness	• Collective solidarity (*folkhem, folkhälsa*) • Universality of welfare and health care

[68] L. F. Neumann, K. Schaper, *op. cit.*, 62.
[69] J. Butenop et al., *op. cit.*, 119.
[70] L. F. Neumann, K. Schaper, *op. cit.*, 213.
[71] W. van Oorschot et al., *op. cit.*, 9.
[72] R. Reiter, *op. cit.*; F. Rau, *Der Sozialstaat: Prinzipien, Konstituenten und Aufgaben im Gesundheitsbereich*, in G. Hensen, P. Hensen (Eds), *Gesundheitswesen und Sozialstaat. Gesundheitsförderung zwischen Anspruch und Wirklichkeit*, Wiesbaden, 2008, 44; J. Frerich, *Sozialpolitik. Das Sozialleistungssystem der Bundesrepublik Deutschland*, Munich/Vienna, 1996, 32.

Role and responsibilities of state actors	• Preservation of the individual's status; provision of health care according to individual needs • Provision of state aid for those who need and deserve help/support	• Ensure and finance all residents' equal access to health care • Guidelines, incentives and sanctions to uphold collective healthy lifestyle (preservation of '*folkhälsa*')
Role and responsibilities of individuals	• Demonstration of individual need of and claim to health care • Individual responsibility for one's own health; Family as 'nucleus' of society bears some responsibility in health care provision • Refugees and asylum seekers as temporary residents in need/search of help and protection	• Equal access to public health care via residency • Individual responsibility to contribute to collective '*folkhälsa*' • Refugees and asylum seekers as potentially permanent members of society

Table 1: National values underlying German and Swedish health-care provisions concerning asylum seekers and refugees

4. Conclusion.

Global political, economic, military and ecological developments fuel the assumption that migration movements, including of persons seeking asylum, will not decrease in the foreseeable future, rather to the contrary. Consequently, immigration and the mid- to long-term integration of those who arrive is unlikely to disappear from political agendas anytime soon. National legislation frameworks of immigrants' rights and their integration will have to be adapted accordingly, not only in the context of (perceived) crises like the recent increased influx of persons seeking asylum in Europe and beyond, but on a regular basis.

This article has shown within what normative framework policy makers are adapting legislation in Germany and Sweden, i.e. the two EU member states which most demonstratively opened their doors to asylum seekers during the 2015-17 'crisis', but both of which subsequently restricted incorporation policies and arriving persons' rights to a significant extent. Examining specifically the

regulation of asylum seekers' and refugees' access to health care as an important aspect of their mid- to long-term integration, the article identified different sets of national values which have a significant impact on related legislation. Namely, this article traced values concerning (1) the normative fundaments on which the respective state, society and health-care system are based; (2) the roles and responsibilities assigned to state actors in the provision of health care; and (3) the roles and responsibilities assigned in this context to individuals living on the state's territory. Table 1 above summarises the main findings for each of these three sets of values.

Across the three examined dimensions, certain values were shown in the analysis to constitute a particularly dominant element in the normative framework underlying the respective health-care and asylum policies. Namely, the Swedish health-care and incorporation regime traditionally builds on a strong notion of collective responsibility and universality, whereas its German counterpart puts an emphasis on individual responsibility, based on the subsidiarity principle and intertwined with the question of individual deservingness. Such fundamental differences in the values underlying the respective regimes are not so surprising, as they mirror fundamental systemic differences among Germany's and Sweden's health-care and incorporation regimes.

In addition to such differences, however, this article also shed light on a range of similarities, which may help explain the similar behaviour of policy makers in both countries in the context of the recent increased influx of asylum seekers. Namely, the health-care and incorporation regimes in both countries are based on a fundamental – albeit differently applied – principle of solidarity. In Germany, this solidarity is situated at various levels, namely, generally the most immediate level able to provide assistance (in accordance with the subsidiarity principle). In Sweden, the solidarity principle encompasses society as a whole, epitomised in the concepts of *folkhem* and *folkhälsa*.

Importantly, in both Germany and Sweden, this solidarity is generally limited to members of the social security and health-care system. In both countries, asylum seekers and refugees can become members of this system, albeit based on different prerequisites and with a varying scope of access to health care, resulting from the different fundamental normative perceptions of asylum seekers and refugees in both countries. Namely, in Sweden, they traditionally receive relatively comprehensive access to the health-care system with the objective of turning them into members of society, i.e. to improve their social status from persons depending on state aid and protection to contributors, both in an economic and ideational sense. In the German welfare system, which builds on the principle of preservation of the individual's status, asylum seekers are included in the system with the objective first and foremost to provide them with the help that they temporarily need, which does not necessarily imply a level of social security and health care equal to members of the German society. If seeking to become full members of this society and the German welfare system, asylum seekers and refugees are expected to lift their own status either by demonstrating their claim

and deservingness of permanent residence and the social rights coming with it, or by becoming themselves contributors to the system.

The common value of solidarity based on membership of the social system – be it temporary or permanent – may help explain the two examined countries' similar reactions to the recent increased influx of asylum seekers, despite the systemic differences among their health-care and incorporation regimes. Namely, assuming the role of moral superpower – in the sense of providing more help than demanded by legal conventions and international agreements, and more than other countries in Europe – both Germany and Sweden admitted high numbers of asylum seekers and refugees into their social systems. The fundamental value of solidarity with those in need of protection played a prominent role in this context. However, the notion of solidarity could also be invoked by policy-makers in the course of the political turn towards the restriction of access (traceable in both countries after 2015/2016), based on the argument that the members of the respective system would suffer if the system became overburdened, and hence membership would have to be restricted.

This article has shown in a comparative analysis that the examination of different sets of values underlying national health-care and asylum legislation allows to gain a better understanding of asylum seekers' and refugees' varying access to the examined health-care systems. Its findings may provide relevant insights with regard to our general – growing – understanding of the nexus of incorporation and health-care regimes. More specifically, this article may serve as a basis for further studies analysing what factors influence and determine legal change and state actors' behaviour in the context of incisive events, such as the increased influx of asylum seekers in Europe between 2015 and 2017.

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