

**Typologies and Logics of Welfare Bricolage in
Sweden: Uppsala case study**

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IRIS WORKING PAPER SERIES, NO. 21/2017

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Abstract

The Welfare Bricolage project (UPWEB) will reconceptualise welfare theory through responding to the question of how all residents living in superdiverse neighbourhoods put together their healthcare. Increasing population complexity, heterogeneity and pace of change under globalisation has provoked a need to rethink welfare design, alongside issues of engagement, approachability and effectiveness. This report focusses on the welfare bricolage of residents in two Swedish towns, highlighting how they access healthcare and the barriers they face within the healthcare system.

Keywords

Welfare bricolage, healthcare, migration, superdiversity, transcultural care, UPWEB

Citation

Bradby, H. & Hamed, S. (2017) 'Typologies and Logics of Welfare Bricolage in Sweden: Uppsala Case Study', *IRiS Working Paper Series*, No. 21/2017, Birmingham: Institute for Research into Superdiversity

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Funding

This research was funded by the NORFACE Welfare State Futures Programme – UK462-14-090

Contents

The welfare regime in Sweden	5
Migration to Sweden	6
The Swedish healthcare system	8
Migration and health in Sweden	11
Health outcomes	11
Transcultural care: Healthcare provider's perspective	11
Transcultural care: Healthcare receiver's perspective	12
The UPWEB project	14
Aim	14
Method	14
Table 1: Characteristics of interviewees in Gottsunda	14
Table 2: Characteristics of interviewees in Sävja	15
Neighbourhood profiles	15
Gottsunda	15
Sävja-Bergsbrunna	17
Preliminary findings	20
(Access) Barriers (Why do residents of superdiverse neighbourhoods bricolage?)	20
Residency status	21
Communication	21
Not taken seriously	23
Discrimination	24
Tactics (how they bricolage)	25
Insisting and persisting	25
Seeking emergency healthcare and private healthcare	26
Transitional healthcare	27
Navigation	27
Avoidance	28
Use of complimentary alternative medicine	28
Conclusion	28
Bibliography	29

The welfare regime in Sweden

Between 1870 and 1970, Sweden transformed itself from a poor nation to one of the world's richest countries with excellent economic growth, high taxes and a generous welfare state. In the 19th century various reforms were established and implemented such as compulsory elementary schooling for both boys and girls (1842), equal inheritance rights for men and women (1845), expansion of the railway network, establishing free trade as well as new public boards and agencies, land reforms and increased agricultural productivity (Valocchi, 1992). Swedish trade unions emerged at the end of the 19th century and became an important and integral part of the welfare regime and a reason for the emergence of class and gender equality in the Swedish society. In regards to healthcare, Sweden introduced the world's first universal public pension insurance system at the end of the 19th century (Landsorganisationen, 2003)

During the 20th century, Sweden became a progressive social democratic welfare state and is often celebrated as a successful combination of free market capitalism and social welfare, based on principles of universal access and solidarity, where a number of services and goods are publically provided (Esping-Andersen, 2013; Valocchi, 1992). The establishment of this welfare state is closely tied to the Social Democratic party, which continuously ruled Sweden from 1920 to 1976, as well as from 1982 to 1991, 1994 to 2006, and again from 2014 to the present time (Sunnemark, 2014). The concept of *folkhemmet*, which translates as "the home of the people", is a fundamental concept, which was used by the social democrats to institute their state model. The concept is based on the idea of a good home that is built through commonality and mutuality. The *folkhemmet* included Keynesian economics, structural welfare reforms as well as high and progressive taxes (Rojas, 2005). Sweden is therefore similar to many other European countries in the sense that it benefited from liberalization and functioning capitalist institutions and the inclusion of women in the workforce (Lavelle, 2015).

Sweden is a decentralized country and is governed at four levels: the national government, the regional level (21 County Councils or regions), the local level (290 municipalities) and lastly the European level which became part of the government level when Sweden entered the EU in 1995 (Regeringskansliet, 2015). Social services (health, and elderly care, schools etc.) are an important part of the Swedish welfare state and are almost fully tax-funded. They are considered to be a social right and are produced at the regional and local levels. The terms of provision of social welfare are regulated at the national level, with statutory control over the sector to oversee equality and diminish regional differences (Anell et al., 2012).

Sweden has a 'Bismarkian' social security system where payments are compulsory and administered through a social security system, which is state owned by the

Swedish Social Insurance Agency (Försäkringskassan). Social security in Sweden is a national system of 'income maintenance', founded on 'the loss of income principle' ('inkomstbortfallsprincipen'). A work ethic ('arbetslinjen' or 'the work-line'), is a fundamental part of the system. The work-line contributed to the very low unemployment rate in Sweden which was only 1.7% prior the great Swedish economic crisis of 1991 (Ervik and Kildal, 2016).

In the 1970s, real labour costs increased much more than labour productivity increases allowed. Taxes were the main reason why costs increased (the payroll tax increased from 12.5 percent of a salary in 1970 to 36.7 percent in 1979). Additionally, labour market regulation (e.g. protection against being fired on grounds of pregnancy, limitations on temporary employment, time off for trade union activity, permitting time off for education and training) and high nominal wage increases also contributed to the labour cost increase. The significant increase in taxes caused high levels of financial inefficiencies and tax avoidance. Numerous devaluations followed to deal with real labour cost, which led to more disruptions including an increase in the unemployment rate, culminating in the Swedish economic crisis in 1990. Subsequently, a revival of the Swedish economy followed the application of policies such as an increase in exports as a share of GDP from 28 to 42 percent (from 1980 to 2000) as well as a decrease in annual inflation from 10 to 1 percent. Moreover, major reforms in the tax system were executed, work incentives were increased as were economic openness, implementation of neoliberal policies, financial globalization and an increased reliance on private-public partnership for provision of services; policies which continues today (Bergh, 2014; Ryner, 1999).

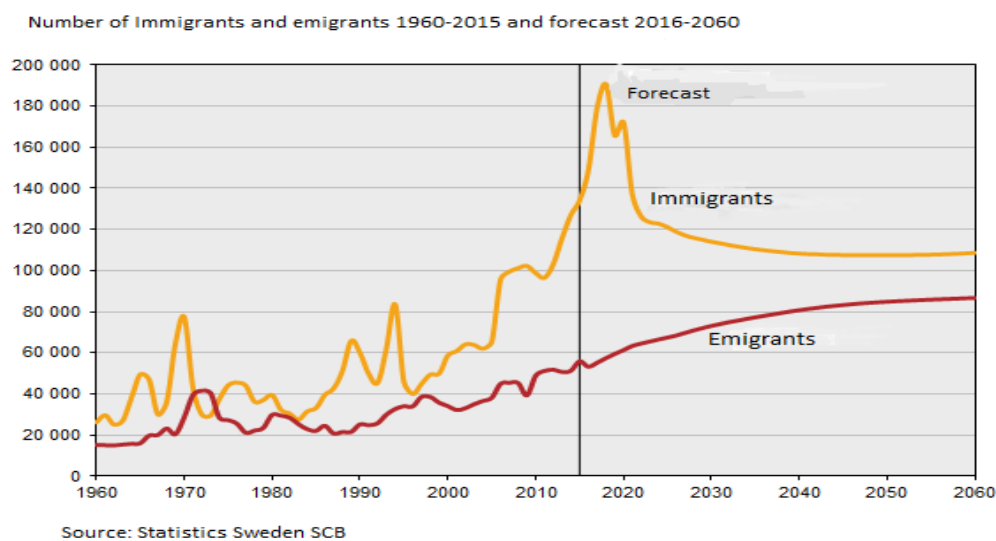
Since the economic crisis, inequalities have grown in Swedish society with an increase in inequality by one third between 1985 and the early 2010s to become the largest of all OECD countries (OECD, 2015). In 2012, the average income of the top 10% of earners was 6.3 times higher than that of the bottom 10%. Due to the introduction of reforms in the 1980s and 1990s as described above, the effectiveness of the redistribution of income weakened with time. The richest 1% of earners increased their share of total pre-tax income from 4% in 1980 to 7% in 2012. Furthermore, the top marginal income tax rate dropped from 87% in 1979 to 57% in 2013 (Nordin and Rooth, 2007; OECD, 2015). However, public social in-kind benefits, especially in the areas of education and care continue to be an important pillar of overall redistribution in Sweden, and more important than in most other European countries (Bergh, 2014).

Migration to Sweden

Migrants from neighbouring Nordic countries constituted most of the immigration to Sweden in the 1950s and 1960s with the largest numbers coming from Finland.

However, since the beginning of the 1970s migration has consisted mainly of refugees and family reunification from non-European countries in the Middle East and Latin America ("Sweden," 2006) . Immigration increased after the introduction of a new system aimed at receiving refugees in 1985 and the number of refugees from the Middle East and Africa began to rise. In the 1990s a large number of refugees from the former Yugoslavia came to Sweden after the war started in the Balkan area in 1991 (Migrationsverket, 2015).

The graph below illustrates the increase in the number of immigrants and emigrants from 1969 to 2015 (Statistiska Centralbyrån, 2015).



Statistiska Centralbyrån, 2015. Sveriges framtida befolkning 2015 - 2060

In 2016, foreign-born people constituted approximately 17.8% of the Swedish population, while the percentage of people with a foreign background (that is with one or more parents who were born abroad) was 22% in the same year. During the migration crisis of 2015, 163 000 people sought asylum in the country, almost double the number seeking asylum the previous year (Migrationsverket, 2016). Since then, 77% of the refugees who applied have been granted a residency permit. A new asylum law has been approved by the Swedish parliament entailing granting temporary (rather than permanent) residency and delimiting access to family reunification (Regeringskansliet, 2017).

Today most of the foreign-born population in Sweden (about 55%) is from Europe, with Finland being the most represented country of birth, followed by Iraq, former Yugoslavia, Poland and Iran. There has been an increase in the number of people from Africa mainly from Somalia, Ethiopia and Eritrea in recent years. In 2010, those born in Africa constituted 8% of the foreign-born population in Sweden (Statistiska centralbyrån, 2010). Sweden has become a multicultural and diverse nation, with a

varied group of people from a number of cultural and ethnic groups (Dellenborg et al., 2012).

In 1975, an immigrant policy was set out in Sweden. The over-riding goals of the policy were to ensure equality, freedom of choice and partnership. Equality is intended to ensure that everyone, both immigrants and native Swedes, have the same living standards. Freedom of choice means that immigrants should have the freedom to choose between their own cultural identities and or to assume a Swedish identity, while partnership refers to collaboration between the native Swedes and immigrants. Despite these values, a gap exists between the objectives of the policy and reality. There has been an increased geographical concentration of immigrants in certain areas, which have become both socially and politically marginalized (Bäärnhielm et al., 2005; Bäärnhielm and Ekblad, 2000). Foreign-born Africans and Asians have a lower employment and a higher unemployment rate than other groups. They are overrepresented in fixed-term employment and underrepresented in managerial positions. Furthermore, employment is particularly low among family-reunion and refugee immigrants. Educated people from these regions are more likely than others to have jobs requiring lower competencies than their educational level. A lack of human capital acquired in Sweden and a lack of access to networks as well as the prevalence of discrimination are some of the reasons why these inequalities exist (Lina Alden and Mats Hammarstedt, 2014).

The Swedish healthcare system

Sweden has a population of 9 938 648 people (August 2016) (“Befolkningsstatistik,” 2016) and has one of the world’s highest life expectancy (81 years for men and 84 for women) where non-communicable diseases, specifically circulatory diseases, are the leading cause of death in the country followed by Alzheimer’s disease and dementia (IHME, 2015). In general, the country performs well in disease-oriented indicators of health service outcomes as well as in measures of the quality of care (Anell et al., 2012).

The healthcare system in Sweden is largely financed by taxes. The total expenditure on health as a percent GDP is high in comparison with other European countries, standing at 11.9% in 2014. Private health expenditure as a percent of GDP is low (1.9% in 2014) although increasing (from 1.1% in 1995) (World Bank, 2016a, 2016b).

Swedish health care and national health registers are dependent on the operation of an individual identity number (‘personnummer’). The ten-digit number is maintained by the Swedish Tax Agency since 1947 for all individuals officially residing in Sweden and distributed to any individual who has a residency permit for more than one year (Ludvigsson et al., 2009). The identity number is necessary to access healthcare.

Without an identity number and without another form of health insurance (e.g. private insurance, EU health card), the individual is unable to access complete healthcare services and can only receive what is referred to as *vård som inte kan anstå* which is translated to “healthcare that cannot wait”. Healthcare that cannot wait is not a medical term but is formulated by The National Board of Health and Welfare (socialstyrelsen) and is determined by the healthcare provider on a case-by-case basis. Care that cannot wait is, in principle, available to undocumented immigrants, adult asylum seekers or anyone who does not have a Swedish personal identity number or a recognized form of health insurance (Socialstyrelse, 2016).

The healthcare system operates on the basis of three over-riding principles. The principle of human dignity means that all human beings have an equal entitlement to dignity and hence the same rights. The principle of need and solidarity means that those in greatest need should be prioritized in regards to healthcare and lastly the principle of cost effectiveness when it comes to healthcare options. There are eight government agencies which are involved in the healthcare system namely: the National Board of Health and Welfare (Socialstyrelsen); the Medical Responsibility Board (HSAN) (Hälsa- och sjukvårdens ansvarsnämnd); the Swedish Agency for Health Technology Assessment and Assessment of social services (SBU) (Statens beredning för medicinsk och social utvärdering); the Medical Products Agency (MPA) (Läkemedelsverket); the Dental and Pharmaceutical Benefits Agency (TLV) (Tandvårds- och läkemedelsförmånsverket); the Swedish Agency for Health and Care Services Analysis (Myndigheten för vård- och omsorgsanalys); the Swedish Social Insurance Agency (Försäkringskassan) and the Public Health Agency (Folkhälsomyndigheten) (Anell et al., 2012).

The Health and Medical Services Act of 1982 states that the county councils or regions and municipalities hold the responsibility for ensuring that everyone living in Sweden has access to good quality healthcare. Thus, the healthcare system in Sweden is decentralized and is managed and run by the county council, local authority or municipal authorities. The county councils are responsible for prioritizing their own healthcare resources, which results in significant variation in the availability of healthcare services by region (Anell et al., 2012; Socialstyrelsen, 2016a). Municipal authorities are responsible for meeting the needs of the elderly and people living with disability, including for their housing. County councils and municipal authorities generate income through state grants and user fees, with the latter set at levels determined by the councils and municipal authorities. However, the principles and guidelines for care are established by the Ministry of Health and Social Affairs (Socialdepartementet), which sets the political agenda for health policy and medical care (Anell et al., 2012).

There is a mix of publicly and privately owned healthcare facilities but they are almost entirely publicly funded. There are two types of private healthcare (Socialstyrelsen, 2016a):

- Healthcare services that are provided by a private company but under contract with the county council, local authority or municipality. The cost of private and public healthcare is the same.
- Healthcare services that are provided by a private company without any contract with the National Healthcare Services. Therefore, healthcare users must pay the full cost of any treatment and care that they receive.

There are three level of healthcare in the Swedish healthcare system (excluding dental care): Primary care, Specialized care and Highly specialized care. Primary healthcare provides basic health and medical care and is comprised of general healthcare professionals, who offer examinations, care and treatment of common conditions and illness. If necessary, a referral can be made from primary care to a medical specialist, although a referral is not necessary for access since patients can self-refer to specialist services. There is a range of healthcare professionals working at the primary healthcare units (vårdcentral) including nurses, midwives, physiotherapists, general and specialist physicians such as paediatricians, occupational therapists, nutritionists etc. Highly specialized care is only offered at one or two hospitals in Sweden and is commissioned by the National Board of Health and Welfare (Socialstyrelsen), which also determines the county in which the specialist care should be provided (Socialstyrelsen, 2016b).

Dental care is also a mixture of public and private provision in Sweden. Public dental care is found in every county and region and is referred to as the National Public Dental Services (Folktandvården). The cost of dental care is not regulated in the same way as the cost of healthcare and is left for the individual service provider to determine. However, the National Dental Public Services (Folktandvården) ensures that the cost of public dental care provided under its auspices, is similar across a single county/region. This is to ensure equality of cost at the regional level. Dental care that is part of another medical treatment is regarded as healthcare, which means that the rate is charged at the same rate as medical care which is regulated (Socialstyrelsen, 2016a).

Choice of primary care provider for the population, combined with freedom of establishment for providers who are deemed qualified by local county councils, became mandatory in Sweden in January 2010. A legal act made possible the establishment of more than 200 private primary care providers. Patients can register with any public or private primary care provider at the local level. In all county councils, except Stockholm county council, passive registration is practiced for individuals who do not make an active choice of primary care provider. Such passive

registration is based on the latest visit or shortest geographical distance to a provider (Anell et al., 2012).

Sweden does not have a specific law that regulates patients' rights. Various patient rights are incorporated in a range of legislations and are formulated in policy agreements between the state and the county councils through the Swedish Association of Local Authorities and Regions (SALAR) (Sveriges Kommuner och Landsting). However, these regulations mainly target the behaviour of personnel and are only indirectly targeting patients' rights. Counties and municipalities are obliged to provide patients with the necessary information for accessing appropriate care. Information, written by medically qualified staff, is available on the 1177.se website, which is a collaborative project between all county councils and regions in Sweden. People can also call the phone line 1177 for advice and quick answers. The phone line is available 24 hours a day (1177.se, 2016; Anell A et al., 2012).

Migration and health in Sweden

Health outcomes

In general, non-European immigrants in Sweden have a lower level of self-reported health, poorer health outcomes and lower health literacy as well as a higher prevalence of being overweight, as shown in a number of research reports (Hollander et al., 2011; Leão et al., 2009; Lecerof et al., 2011; Lindström et al., 2004; Martinez et al., 2013; Mohseni and Lindström, 2008; Wångdahl et al., 2014; Wiking et al., 2004). However, other factors, apart from being an immigrant, such as socioeconomic status, level of education and duration of stay in Sweden have been shown to have an impact on the health status of immigrants. A poorer level of self-reported health has been associated with a higher anticipation of discrimination by employers based on "race", skin color, religion or cultural background (Mohseni and Lindström, 2008).

Perinatal mortality is higher among infants born to women from Sub-Saharan Africa compared to Swedish women as well as women from other immigrant backgrounds. Women from Sub-Saharan Africa are also shown to more likely suffer from anemia, to have a higher Caesarean section rate, higher perinatal mortality and small for date infants at birth (Essén et al., 2000; Råssjö et al., 2013).

Transcultural care: Healthcare provider's perspective

Research into transcultural care in Sweden focuses on good communication as the most important facilitator to appropriate healthcare and thus its lack is a major barrier. The lack of a common language is the most common barrier, which can be further aggravated by a lack of trained interpreters and in some cases, the lack of an

interpreter who speaks a specific dialect associated with particular cultural groups. There is also a lack of so-called cultural sensitivity on the part of healthcare providers (Akhavan, 2012; Pergert et al., 2008).

Despite recognition that immigrants come from varying cultures, with individually specific histories, there is a generalized emphasis of cultural and religious differences between immigrants as one category/group and native Swedes as another category/group. Healthcare providers also report differences in emotional expression, where some immigrants are regarded as overly sensitive in comparison to how native Swedes would react. Furthermore, gender differences between native Swedes and immigrants are also highlighted with reference to the patriarchal cultures of some immigrants making it difficult and sensitive to deal with female immigrant patients, according to some healthcare providers (Caughy et al., 2003; Dellenborg et al., 2012; Kalengayi et al., 2012; Ozolins and Hjelm, 2003).

Organizational issues are also viewed as an important barrier (Hadziabdic et al., 2011; Ozolins and Hjelm, 2003; Pergert et al., 2008) for foreign-born patients' access to healthcare provision. Healthcare providers report working with immigrant patients to be more time-consuming than native Swedes (Pergert et al., 2007). Furthermore, healthcare providers report that appropriate transcultural training is needed but not available. Deficiencies in the availability of interpreters are also seen as an organizational barrier (Akhavan, 2012; Hadziabdic et al., 2011; Pergert et al., 2008, 2007). Where documentation concerning patients' language abilities is absent, it is difficult to book an interpreter before a consultation (Hadziabdic et al., 2011).

Other issues discussed by healthcare providers are the use of natural remedies by some patients (Ozolins and Hjelm, 2003); issues related to patients' own personal experiences of violence as well as potential racism and discrimination from care providers (Byrskog et al., 2015; Ozolins and Hjelm, 2003; Pergert et al., 2007). All these matters, as well as the barriers mentioned previously, can result in delays in care and a reduced quality of care given to immigrant care receivers.

Transcultural care: Healthcare receiver's perspective

Articles on the perspectives of recipients of healthcare who have a foreign background are few in the Swedish context. The available literature shows that healthcare recipients with a foreign-background see communication as a key issue and consider active participation in the process of healthcare as well as their own health as important (Brämberg et al., 2010; Pooremamali et al., 2011). Contrary to the "us" versus "them" construction of healthcare providers, care receivers discuss the importance of "sameness" and "union" as a way to gain affirmation and to be understood both verbally and non-verbally (Pooremamali et al., 2011). Language

proficiency is also seen as an important tool to facilitate communication (Pooremamali et al., 2011; Razavi et al., 2011).

Healthcare recipients report difficulties in navigating the healthcare system. They carry with them previous experiences, such as traumatic incidences from their past, causing difficulties in coping with their lives in Sweden (Hjern et al., 2001). The situation is further complicated when care receivers experience discrimination and racism in Sweden (Mohseni and Lindström, 2008). They also report receiving inadequate and contradictory information from healthcare providers and feel sometimes that they are being “tossed” around to various levels of care without receiving the necessary assistance. As a result some turn to alternative medicine such as acupuncture as well as natural remedies (herbs) when the health system fails to respond to their needs and requests (Binfa et al., 2010).

Superdiversity

The vocabulary of diversity in Sweden is politically fraught and the issue of racism is hard to discuss with existing vocabulary. Ethnicity has never been used as an official variable, so being foreign born or of foreign background or of non-European background are discussed instead. Estimates suggest that about 17.8% of the population was foreign born and about one fifth, i.e. 22% foreign background, defined as those who were born either abroad or born in Sweden to two immigrant parents. Despite these statistics, the image of Sweden as a homogenous Scandinavian population has persisted. The segregated nature of some neighbourhoods and the inequalities in terms of employment and earnings that describe populations of migrant background shows that the workline has not been an effective mean of integrating the refugees and asylum seekers who have arrived from outside Europe from the 1990s onwards. There is an urgent need to re-conceptualize the implications of migration-driven diversity for the whole population, particularly in the face of anti-immigrant populist parties’ ongoing electoral support.

The UPWEB project

Aim

The UPWEB project aims to develop the concept of welfare bricolage to understand how residents of superdiverse areas access healthcare. Specifically, the project aims to:

- Examine residents' experiences of accessing and communicating with providers and the approaches residents take to optimize their access to healthcare.
- Investigate the factors, which influence people's access to, and experiences of, healthcare including local and national welfare states, health and migration regimes.
- Explore the ways in which different types of providers identify need and investigate the roles they adopt, and challenges and opportunities they face.
- Use the experiential knowledge of providers and residents to develop new models of provision and test the applicability of these models to a wider population.
- Advance new methods capable of collecting data about welfare in highly complex spaces.

Method

A maximum diversity sample was used to recruit residents from two superdiverse neighborhoods in Uppsala, namely Gottsunda and Sävja. A total of 17 Sävja residents and 18 Gottsunda residents were recruited and interviewed. Due to the small size of the neighbourhoods and therefore a risk for jeopardizing confidentiality and anonymity of participants, a detailed table of participant characteristics will not be included. Below is a short description of some of these characteristic in each neighbourhood. Table 1 shows the characteristics of interviewees in Gottsunda, while Table 2 shows the characteristics of interviewees in Sävja

Table 1: Characteristics of interviewees in Gottsunda

Number of interviews	18
Gender	9 males and 9 females
Countries of Birth	Sweden, Ukraine, Chile, Indonesia, Iran, Iraq, Palestine, Syria, Sudan, Kenya and Somalia
Age range	24-80 yrs. Mean age: 50
Marital status	9 married, 3 divorced, 2 widows, 4 single
Religion	6 Muslims, 4 Christians, 4 'not relevant', 2 agnostics, 2 no religion
Languages spoken	Swedish, English, Russian, Ukrainian, Spanish, German, French,

	Greek, Italian, Indonesian, Hindi, Chinese, Arabic, Kurdish, Persian, Swahili, Tigrigna, Somali, Swahili, Kikuyu
Employment	10 employed, 2 retired, 2 housewives, 1 student, 2 unemployed, 1 on sick leave
Health concerns	Uterine Myoma, Diabetes, Hypertonia, Heart failure, Other heart problems, Mental illness, Missing tooth, Hand injury, Arthritis, Epilepsy, Hypothyroidism. Some reported symptoms: fatigue, dizziness, muscle pain, general body pain and stress

Table 2: Characteristics of interviewees in Sävja

Number of interviews	17
Gender	11 females and 6 males
Countries of Birth	Sweden, Inkerinmaa (Finland), Chile, Palestine, Lebanon, Syria, Sudan, and Somalia
Age range	20-93 yrs. Mean age: 54
Marital status	7 married, 1 divorced, 3 widows, 4 singles, 2 in a relationship
Religion	8 Muslims, 5 Christians, 2 'non relevant', 1 atheist, 1 no religion
Languages spoken	Swedish, Finnish, English, Russian, Spanish, German, French, Norwegian, Dutch, Arabic, Kurdish, Somali
Employment	7 employed, 4 retired, 1 housewife, 2 students, 2 unemployed, 1 on sick leave
Health concerns	Diabetes, Hypertonia, Heart problems, Mental illness, Missing tooth, Fibromyalgia, Chronic Obstructive Pulmonary disease, hemorrhoids, Asthma and dental caries. Some reported symptoms: Fatigue, muscle pain, general body pain, stress and tachycardia

Neighbourhood profiles

Gottsunda

Gottsunda is situated about 7 km southeast of Uppsala city center, between Norby in the north and Sunnersta in the south-east. There is evidence that people lived in Gottsunda as long ago as 2,500 years (Uppsala Kommun, 2013) .

Modern Gottsunda was built in the 1970s as part of the national 'million program residential areas' (miljonprogrammet bostäder) for the working class. A long and elaborate plan was put into action to make Gottsunda an idyllic living space, different from the other 'concrete towns' (betongstad) built around the same time in other parts of Sweden. However, the plan did not materialise due to reported vandalism and large turnover of residents as well as an influx of 'undesirables' (icke-önskvärda) to the area such as substance abusers (Molina, 1997). In 1982, a policy

decision was made by the Uppsala municipality to prioritize people with socio-economic problems when allocating housing. This policy was adopted in collaboration with the municipal social housing body 'Uppsala Hem', which is publically owned. This policy subsequently led to White Swedish families moving out of the area, leaving many houses empty. Since then, the area has accommodated new immigrants as well as people with social and economic problems (Mötesplats Gottsunda, 2016; Uppsala Kommun, 2013).

Gottsunda has a relatively large commercial center, which was established in two phases; the commercial section in 1974 and the cultural and leisure facilities in 1975. There is a mix of single-family homes and apartment buildings with all forms of tenure (see next paragraph for explanation) with renovation of the housing stock ongoing, as well as comprehensive renovation and expansion of the shopping center facility, which currently includes shops, cafes, a public library, a gym, an art exhibition space, a theatre, a library, continuing education premises (studiefrämjandet), pharmacies, hairdressers and other services (Mötesplats Gottsunda, 2016; Uppsala Kommun, 2013).

About 66% of the houses in Gottsunda are rented flats and only 10% are owner-occupied (bostadsrätt) compared to 30% home ownership in Uppsala as a whole (although this may change with the current building boom). Similarly, only 24% of the houses are bostadsrätt compared to 44% in Uppsala. The district has good access to public transport being served by a number of bus lines. There are many daycare centers both public and privately owned, two primary and middle schools as well as one secondary school (Uppsala Kommun, 2014a, 2013).

The population in Gottsunda in 2014 was 10,085 with 53% of having a foreign background which is more than double the proportion in Uppsala. There are 128 different countries of origin and 99 different nationalities represented in the district (Uppsalanyheter, 2013). Data on the specific languages spoken are not readily available, however there is an indication (from different project reports) that the major languages are; Finnish, Arabic, Somali, Turkish, Persian, Polish and Serbo-Croatian.

Gottsunda is one of the most deprived districts in Uppsala. In 2014, approximately 56% of the working age population (16-64 years old) was involved in some kind of income generating activity compared to 70% in the rest of Uppsala. The unemployment rate in 2014 was 42%, higher than Uppsala's. The median household income in 2014 was 213,000 Swedish Crowns, which is lower than that of the rest of Uppsala, which was 270,000 Crowns for the same year. Furthermore, the number of households receiving social support is four times higher in Gottsunda than in Uppsala. Additionally youth unemployment and gender differences in the rate of employment are wider in Gottsunda compared to that of Uppsala as a whole

(Uppsala Kommun, 2014a). The educational level is lower in Gottsunda, especially in the higher educational level (3 years or more) which was 24% in Gottsunda compared to 35% in Uppsala. There were more people with only a primary education in Gottsunda (19%) than in the rest of Uppsala (9%). A positive development in the education sector is that two of the top performing schools in the municipality are located in Gottsunda (Uppsala Kommun, 2013).

Gottsunda is regarded as an area with a high crime rate. Between 2009 and 2012, there were more reported crimes per 1,000 residents in Gottsunda than in Uppsala, with narcotic related crimes topping the list (Statistiska centralbyrån, 2011). However, the number of reported crimes in Gottsunda is not significantly higher than the national level as it ranks at number 27 out of the 38 areas examined across the country, according to the Swedish Central Statistical Bureau (Statistiska centralbyrån, 2011).

There are different health services available in Gottsunda including primary care for adults and children, midwifery care, dental care, psychiatric care, nutrition services, counseling, physiotherapy, a medical lab, youth clinic and occupational therapy as well as two pharmacies. These are all located inside or close to Gottsunda Shopping Centre (centrum). However, Gottsunda has a higher rate of sick leave days taken per year (34 in 2014), compared to the rest of Uppsala (20 days per year). The sick leave rate is defined as the number of paid days which are compensated with sickness benefit, employment injury benefit, and rehabilitation benefit or sickness registration from social insurance related to the number of registered insured population aged 16-64 years (4.7). Women's sick leave rate in 2014 was higher than men's in Gottsunda, 37 compared with 22 days (Uppsala Kommun, 2014a). There are no data on the disease burden for the area. However, the annual national public health report indicates that persons with low socio-economic status have a higher risk for non-communicable diseases such as cardiovascular diseases (Socialstyrelsen, 2013).

Gottsunda has acquired a negative reputation as an area that suffers crime and social unrest. In an effort to counter this, large investments in both the public and private sectors have been made. In 2013, Uppsala Municipality compiled a report entitled 'structural overview for Gottsunda and Valsätra'. This report is unique in Sweden as it contains information about the cultural projects and initiatives around the physical environment while highlighting social aspects, statistics and history. The aim of this report was to give the residents and actors in the area an insight into what is happening in the neighborhood and thereby increasing their participation in the decision making processes (Uppsala Kommun, 2013).

Savja-Bergsbrunna

Bergsbrunna, Nântuna, Vilan and Sävja make up the southeast districts of Uppsala municipality, which is, situated about 6 km from the city center. The district is divided into two municipal administrative areas; Sävja-Bergsbrunna and Nântuna-Vilan. The focus of this project is Sävja and Bergsbrunna.

Sävja is popularly referred to as the 'city of the woods' (staden i skogen), as it is located near a forest. Bergsbrunna is a much older villa style residential area that was built in the 1950s and 60s whereas Sävja is a newer residential area mainly of blocks of flats with the highest being 4-storeys. Sävja was built in 3 phases: Savja North (or Savja 1) and Savja South (or Savja 2 and 3). The houses were built between the 80s and early 90s (Uppsala Kommun, 2015). Sävja and Bergsbrunna's histories are not well documented as both were new expansion areas; Bergsbrunna and surrounding areas during the industrial expansions of the 1940s and 1950s and Sävja during the late 1980s and early 1990s in response to a housing shortage. Both residential areas were at the periphery of the city and did not attract much attention (Molina, 1997). In 2014, a new cultural center was opened in Sävja North after old library was burnt down in 2009 (Niklas Kihlberg, 2013). The center is at the heart of the residential district serving as a community center, after-school club, youth club, library, Swedish church and municipal offices. It aims to be a place for education, culture, information sharing, learning and meetings between different generations and cultures (Uppsala Kommun, 2014b). There is no commercial center to speak of in Sävja, with the area served by one shop, which is located near Bergsbrunna, two pizzerias (one in Sävja and the other in Bergsbrunna), a small supermarket and a kiosk, which sells sweets, milk and tobacco (Uppsala Kommun, 2015). For a small residential area, Sävja has a large number of nursing homes and nursery schools, five of each. There are two primary schools and two primary healthcare centers, which also offer child and maternity services. One health center is located in the same building as the dentist, pharmacy, day-care for the elderly and a halfway home for children who have been removed from their parents' care. Private provision dominates the health and elderly care sectors as well as the childcare sectors; all but one childcare center and one elderly home are operated by private companies (Capio vårdcentral, 2016).

Sävja is a typical dormitory residential area with few public meeting places beyond the cultural center. The streets are usually empty during the day, with more activity in the evening as people return from work. The population of Sävja-Bergsbrunna was 6,696 in 2014, about 30% of whom were under the age of 20. Most of the population is between the ages of 45 and 64, followed by the age group of 25-44 years (Uppsala Kommun, 2014a).

In 2014, there were about 3,000 households of which 1,257 included children. Sävja is a multi-cultural residential area with foreign-born persons making up 33% of the

population, which is higher than Uppsala's 17% (Uppsala Kommun, 2014a). By contrast, people who are not of foreign background (that is, the ethnic majority) almost exclusively inhabit Bergsbrunna. There is little information on the different ethnic groups living in Sävja, since these data are not gathered in Sweden. There is however, a nursery school and a nursing home that cater for native Finnish speakers. Recently, racist notices have been appearing in public places, accusing the Roma people of lying, stealing or trying to spread diseases (Bertzell, 2015; Metro, 2014). Despite a perception that there is a large population of Roma in Sävja, so far, there is no data to substantiate the claim. It is also unclear whether the perception is due to the arrival of new Roma from Romania and other European countries or the longer standing Finnish or Swedish Roma.

Housing in Sävja-Bergsbrunna consists of 27% rental apartments, 45% owner occupied apartments (bostadsrätt), which is similar to Uppsala as a whole. Home ownership in Sävja-Bergsbrunna (28%) is similar to Uppsala as a whole (30%). However, these statistics are influenced by Bergsbrunna's relative wealth, which not only raises the proportion of property owners but also the average income for the whole area (Uppsala Kommun, 2014a). The average income for Sävja-Bergsbrunna in 2014 was 272,000 Swedish Crowns, which is similar to the average income for Uppsala of 270,000 Swedish Crowns (Uppsala Kommun, 2014a; Uppsalanyatidning, 2009)

Sävja has pockets of deprivation for which it is hard to find data since all the reported data include Bergsbrunna, the more affluent residential area. Sixty-seven per-cent of people aged 16 to 64 years were economically active in Sävja-Bergsbrunna in 2014, which is similar to the figure for Uppsala as a whole (70%). Education levels are slightly lower than the average for the Uppsala municipality, with a higher educational level in Sävja (3 years or more in the age group 20-64 years) at about 28%, lower than the 35% for Uppsala. However, the percentage of people between the ages of 20 and 64 years with a higher education (less than 3 years and 3 years or more combined) is almost the same as in Uppsala at 55% (Uppsala Kommun, 2014a).

Sick-leave is one of the most reliable indicators for ill health in Sweden. Sävja-Bergsbrunna has a higher than average rate of sick leave compared to Uppsala as a whole, at 28 days per person per year compared with 20 in 2014. The figure was higher among women (33 days per person per year) compared to men (22) (Uppsala Kommun, 2014a).

Sävja has a higher income per household, lower unemployment and higher number of owner-occupied apartments and houses when compared with Gottsunda. However, the media discourse on Sävja is still negative and, just like Gottsunda in that conversations in social media discourage newcomers from seeking housing in

the area. Even though there are good prospects for the district, segregation between people with foreign backgrounds and long-standing Swedes is evident. The cultural center was built to enhance integration and provide a meeting ground. However, Sävja is nonetheless considered a problem area by the media (Vigström, 2015).

Preliminary findings

Bricolage is defined as the use of multiple resources in order to meet a health concern. Since Sweden has a decentralized healthcare system, with local primary health care centers offering universal access at neighborhood level for everyone with a personal identity number, the need to bricolage may be less marked than in other European settings, especially those with an insurance model (Collantes, 2011). Waiting time has been described as the 'Achilles' heel' of Swedish healthcare, which in other respects comes out as a good quality healthcare system when compared across countries (Anell et al., 2012).

Despite the relatively good access to care for all those with a personal identity number, there were hindrances to getting care that were identified in interviews, which we describe in the following section. Thereafter the different tactics used by these residents to circumnavigate barriers and enable healthcare access are considered.

(Access) Barriers (Why do residents of superdiverse neighbourhoods bricolage?)

The interviews revealed the existence of various barriers in the healthcare system. A barrier here is defined as any factor reported by the interviewees that may restrict the use and benefits of formal healthcare services (access to healthcare), when addressing a health concern. Although the sample included a diverse group of residents, foreign-born people with different lengths of stay, employment, gender and age reported most of the barriers. A native-born Swede, 31-year-old female with mental health concerns reported experiencing barriers in accessing mental healthcare. She experienced problems with having to wait a long time before receiving medications and before her problems were addressed. She was also dissatisfied with having to phone for an appointment and she reported that she would rather have booked an appointment physically instead of phoning. Another native Swede, a 60-year-old female, also reported facing problems with booking appointments at her primary healthcare centre via phone and having to wait for a long time although she had hip pain due to arthritis.

Below are some of the main barriers reported by the participants:

Residency status

Residency status was a barrier to accessing adequate healthcare in some cases. One participant described difficulties in accessing healthcare whilst he was an asylum seeker. He reported that he had pain but did not go to the primary healthcare center in the neighborhood because he did not have a permanent Swedish identity number. He did not go to the city hospital either for the same reason and was advised by some acquaintances to go a specific healthcare center that offered healthcare to refugees and undocumented immigrants.

“and so if something happens then we can go to (name of healthcare facility) and they will decide if it is a bigger problem, that it needs referral, they could do that but I couldn't go the primary healthcare center because I didn't have my numbers” 32yrs, M (Syria Kurd)

Issues arising when determining care that cannot wait (see section entitled The Swedish healthcare system) were also reported in this study. A young Syrian man reported having to seek medical care after a hand injury at the city hospital. Since he did not have a Swedish identity number nor any other health insurance, the healthcare providers evaluated his case and decided that he would only receive temporary treatment. After a series of events whereby the participant sought and received access to healthcare outside Sweden paid for by friends, the result was that his hand movement became restricted due to nerve damage which occurred as a result of the delay in receiving treatment.

“You can see, if you touch here (points to his hand), then you can feel that it is hard here. My hand is almost not functioning, I can't open it like this and it's all because of the treatment delay. It's not because the doctor didn't know what to do or didn't do a good treatment. It was because of their delay” 27yrs, M (Syria)

Communication

Foreign-born participants were most likely to report problematic communication as a barrier. Participants reported that language barriers were common in communicating with healthcare providers. This applies not only to newly arrived immigrants but also others who, despite having lived in Sweden for many years, were still unable to learn the language. There was a general lack of interpreters and in some cases, it was stated, that the interpreters did not have enough knowledge of medical terms or did not know the language well enough to do their job. Participants reported having to rely on family members or friends to help with communication.

“When I was at the doctor, I could understand what the doctor said and so I noticed that the interpreter didn't translate correctly...some Iraqi people who

have lived in Iran for some years, they say that they speak Persian but during the doctor visit, they don't know what a navel is called in Persian" 72yrs, F (Iran)

Even when there was a common language, interviewees described not being given enough information about their health condition or getting confusing and contradictory messages about their health concerns and their appointments. In the quote below, a participant explained that she was told by a doctor that she needed to rinse her ears due to an ear infection. She was given an appointment, only to be told by another doctor that the treatment was not necessary.

"When I took a day off from work (to go to the primary care center), I met another doctor who said to me 'who told you to come and rinse your ears? Who told you that?' I told him that this was the third appointment but he told me 'Your ears are clean!' So all of a sudden my ears have cleaned themselves or what!?" 51yrs, F (Iraq Kurd)

Confusing information from healthcare providers concerning medication and their usage was also described. A participant had difficulty communicating with the doctor regarding his son's asthma medication. The doctor prescribed a 5 mg pill when the participant's son is supposed to take only 2.5mg. The pill is too small to cut in half, so the participant, who works as a nurse, ends up giving his son the whole pill.

"He (the son) is supposed to get 2.5mg (of the medication) but they prescribe a 5mg tablet which we are supposed to split. But the tablets are too small so we can't really split them (...). It's weird and there is always an issue when we go to the pharmacy because they ask us why we are prescribed a 5mg tablet when we are supposed to get 2.5 mg, you have to split this..." 31yrs, M (Swedish-African)

Additionally, some participants reported difficulties booking appointments by phone. Since one could not book an appointment by physically going to the primary care center, one had to call to be able to book an appointment or to get advice on a health condition. Participants found it difficult to express themselves and their health needs via phone. A participant's wife who was present during the interview talked about this issue in the quote below:

"One thing is that when you call the primary healthcare center here, you call a certain number and you will get choice 1, 2, 3,4 and press here...OK and now this and you press this...he (the participant) has a problem with hearing and this and so I don't think that he can understand all of that...you put your personal number press this and this and that and then what happens is that OK you will be called at this time and you know and then it would be like if you call in the morning you will get time in this one and if you don't want this time,

change the time by pressing 1, pressing 2 blab blab blab. There are a lot of these things and then you never come in contact with someone. Sometimes I would like to go there and book the time but you can't, you have to book it through a telephone so I would rather that there is somebody there so I would personally contact" 80yrs, M (Indonesia)

Not taken seriously

Some interviewees of foreign background explained that their health concerns were not taken seriously or were ignored, especially in regards to mental health issues (13 participants). They explained how some healthcare providers did not give them enough time to speak about their health issues especially when it came to their mental health.

"I needed mental health support and more information. I wanted to communicate with the healthcare professionals better and that they would have had the time to take my problems seriously. I felt that they did not really care. It was disturbing for me that they did not have any time (...) But I felt that they didn't have time, it would only take 5 minutes. If I started to talk, to talk about something, then they would interrupt me and go to the next point. No time. So I couldn't talk. They were in a hurry" 51yrs, F (Iraq Kurd)

Some participants, especially those with a foreign background, reported having to spend a lot of time to convince healthcare professionals that their symptoms were real which in some cases resulted in a loss of trust and avoidance of healthcare services.

In one case, a participant's wife had tried, in vain, for a year to convince the doctor at the neighborhood's primary healthcare center that her husband had a serious seizure problem. It was only after the participant risked having a car accident when he got a seizure while crossing a highway, that the doctor started an investigation. The participant was later diagnosed with epilepsy.

More serious health outcomes were reported when participants were not taken seriously. In one case, an interviewee of foreign background explained how she lost her baby while pregnant since the healthcare professional did not take her pain seriously.

"Sometimes we are confident in the health system and sometimes it's just hard to get the services you need. Sometime back I was pregnant and I went to the hospital when I had severe pains and they sent me back to the hospital saying that I was not ready. The next day I stopped feeling the baby and the contractions stopped, so I was worried, my husband then took me for a walk but nothing happened, I still couldn't feel the baby. I went to the hospital that

evening again this time I had excruciating pains and they told me that the baby is asleep and you are 5 cms apart. They called the doctor and they checked me and told me that they think the baby is either dead in your stomach or the baby is sleeping. So we will check to confirm and then see what to do, either to operate you when the baby is sleeping or do a procedure if the baby is dead. I was very worried. In the end they told me that my child is dead, I was in shock, both my husband and I were devastated. He told them that you returned us home three times, how could you let this happen? So they gave me the medications, I gave birth to the child and it was dead. I used to go to the clinic, I was past my due date, and they kept sending me back home". 64yrs, F (Somalia)

Discrimination

Some participants reported that they encountered discrimination in the healthcare system at the primary healthcare level or at the hospital. They explained that they believed they did not receive adequate treatment, or that they had to wait for long periods at the emergency unit before getting treatment, because of their ethnic origin. One participant, who accompanied his mother to the emergency unit, described having to wait for a long time. He explained noting that despite arriving later and appearing not to have serious health issues, he perceived that "White" Swedes were prioritized and given treatment first. It was only after his mother fainted in the waiting room that they received treatment.

Participants also reported that patients with foreign background are treated differently by healthcare professionals due to their foreign background and in two cases treated in a "rude" manner.

"I thought that my nurse I don't know what to call her, a native or what I should call her; I felt that the way she treated me was not good... I didn't like it...some of the things that she could have done in the room, she would take me somewhere else without explaining why...sometimes I asked her if I could eat now and she would tell me no you can't this is not the time to eat. She treated me in a tough way, she wasn't nice at all. I actually felt sorry for her more than sorry for myself". 50yrs, F (Sudan)

One participant reported being mocked by a healthcare provider at the hospital, because of his Indian background. The participant lost his one of his eye lenses in the late 1980s after an eye operation in Sweden. He explained that he tried to contact some Indian surgeons in India, in order to get some consultation on how to substitute his lens. When talking to an eye doctor in Sweden and upon explaining his condition, he was mocked by the doctor who said sarcastically

“I am certain that your Indians most probably can repair it”. 80yrs, M (Indonesia)

Another participant said that a healthcare provider referred to her son, who is mixed race, as exotic. She also explained that the same healthcare provider thought that she was lying about a mole her daughter had. He thought that it was very dark and asked the daughter if she drew it herself.

“When the same doctor met my daughter (...) she had a small mole (...) he thought that she had a very dark mole so he asked if she had drawn it with pen...because for him it was too dark” Got10, 60yrs, F, Sweden

Tactics (how they bricolage)

Tactics refers to the various methods residents in superdiverse neighborhood use to meet their health needs or to resolve their health issue. Since access is relatively universal (apart from those without person numbers) and geographically evenly distributed, given the system of neighborhood primary healthcare centers, those describing delimited access are particularly interesting.

Insisting and persisting

Participants of foreign background (except one Native Swede participant) reported that they tried to put pressure on healthcare providers by insisting on getting an appointment or a certain treatment. Participants described using the internet and radio to acquire knowledge on their conditions in order to use this tactic. This was in many cases an effort made in response to not being taken seriously by healthcare providers, especially among interviewees with foreign backgrounds.

“I just want to say that we as foreigners when we try to meet a doctor, we need to make an extra effort to get help...I don't think Swedes need to make the same effort...because they get the help they need and they ask the doctor and the doctor asks them about many things...I always feel that we need to make more effort...so even though you are ill you need to be alert and focus so you don't miss anything...when you are ill, you may not be able to talk or focus but you have to...I don't think this happens anywhere else, that you you have to be sick and focused at the same time (...) could be one way in which you are discriminated”. Got01, 50yrs, F, Sudan

Another participant talked about how her medication caused dizziness and that she fell over a few times. Her daughter, who was present at the interview, explained that she searched the internet and found an alternative medication. She called the healthcare facility (hospital) a “thousand times” so that they could solve the issue.

She had to continue calling and insisting many time before the doctor finally listened and changed the medication, upon which her mother's dizziness got better.

"I called nearly a thousand times (...) So I have called and called and finally then ah, we got hold of someone who could help in anyway (...). In the beginning when I called, they said they would call back but didn't. Some other times, I would talk to a nurse and she would say ...eh...I cannot change the prescription, you have to speak to a doctor..." 55yrs, F (Somalia)

One participant, a native Swede, explained that she phoned and was given an appointment, but not until three months later. She had a lot of pain and expected to get an immediate appointment. The participant decided then to call the Patient Advisory Committee and file a complaint against the healthcare center. In the quote below, she explains what happened:

"I was angry so I wrote to the Patients' Advisory Committee ... I think a copy was sent to the head of the health center ... then the day after before eight just when I arrived at work they called and ... just like that... we were able to book a new appointment ...a week after" 60yrs, F, Sweden

Seeking emergency healthcare and private healthcare

Participants reported going directly to an emergency care unit at private healthcare unit, nära akuten, (which has a contract with the Municipality) instead of going to the primary healthcare center in the neighborhood. Participants thought it was easier to go to the emergency clinic in terms of getting an appointment even if the health condition was not serious. This is because it was difficult to get an appointment at the primary healthcare center.

"If they call you (the primary healthcare centre), they do not call until the day after and then it gets worse and worse. So when I get for example ear infection or urinary tract inflammation, then I usually to nära akuten and get an appointment". 51yrs, F (Iraq Kurd)

One participant reported seeking fully private healthcare when it came to her mental health issues but also other issues such as muscle pain. This was because they were not taken seriously but also due to long waiting times. The high cost was seen as a problem and so that particular participant was not able to continue these treatments even though she felt better when receiving them. Apart from that participant, all other participants used either public health care or private healthcare, which had a contract with the County.

Transitional healthcare

One participant had to seek medical private care in Turkey since he didn't receive complete treatment in Sweden. The participant relied on friends who helped him financially and was able to get an operation in Turkey five days after his injury. This delay caused permanent hand mobility limitations.

Another participant of foreign background, who had serious mental health issues, described how treatment in Sweden didn't work for him. He also had communication issues with his health providers whom he felt in some cases, did not take his problems seriously. Upon going back to his country of origin, he talked about receiving Quranic treatment from a Sheikh there and also receiving some treatment from one of the city's Imams upon returning to Sweden. He later stopped going to the psychiatric clinic and relied on his religion to get better. The participant describes this treatment in the quote below:

“No, to be honest I wasn't religious at that time...I didn't pray or fast regularly but I felt calm, my body I mean and I felt a serenity so he started reading as well...and he told me to try to feel comfortable so I could either open or close my eyes...so I laid down and closed my eyes to feel more comfortable and then after a while he told me to get up...are you awake...yes I am I said so I was not unconscious, I knew what was happening around me so I removed the ear plugs and he told me to lie on my back...because I had this fear and he wanted to “cut” the fear as we say here in my country...it's like a massage...they would do a special massage if one had fear and so he told me you are too afraid you need to be massaged at least two more times” 39yrs, M (Palestine)

Another participant stated that she was sent painkillers from abroad, prescribed for her by her daughter who works as a doctor in the USA. Another participant mentioned that he knew someone who went to his country of origin to receive dental prosthodontic care since the cost of this treatment was so high in Sweden.

Navigation

Significant know-how was necessary for people to access the health care they needed, even if they had full eligibility. It was not uncommon for people to use the advice of, for instance, a relative who was also skilled healthcare professional living abroad or in Sweden, to then leverage appropriate care for a condition that had not previously been diagnosed.

Cultural knowledge was also important, which people of foreign background might not have, even if they had good linguistic skills. A man who had long-standing mental health problems felt that his efforts to use treatment that was based on the Qu'ran was dismissed by his healthcare provider. This man's religion was a central aspect of

daily life and so a potential source of support in times of trouble. By contrast, mention of religion in secular public bodies in Sweden is widely seen as inappropriate, particularly after the split between the protestant Church of Sweden and the state in the year 2000.

Avoidance

Participants reported trying to avoid seeking healthcare altogether. Some participants stated that the waiting time was too long so it was better to avoid seeking healthcare. However, other participants avoided healthcare due to perceived discrimination or for fear of not being taken seriously.

“That makes you more angry and then I do not go to the doctor and I become more and more sick and stop caring since I get the same response anyway (from healthcare providers)” 51yrs, F (Iraq Kurd)

One participant even reported that she avoids going to the public healthcare center since as an immigrant, things are so good in Sweden compared to how it was in her country of origin, that she felt she should not complain.

Use of complimentary alternative medicine

Only four participants reported using herbs or home medications to address their health concern. A young Syrian reported using chamomile tea to address his stomach pain, which he often gets when under a lot of stress. As he is not able to access healthcare due to his residency status, he boils chamomile and other herbs and drinks them to soothe his pain. Two Somali participants interviewed together reported using black seeds, black pepper, ginger, honey and fenugreek to address their own symptoms such as fatigue, colds and constipation. They also shared the remedies with other people in the neighbourhood. A Palestinian woman talked about using ginger in everything she cooks as well as rinsing her mouth with salt water when she has toothache. However, with the exception of the Syrian man who was refused access, the three women mentioned here nonetheless relied on the formal healthcare system to address their health needs.

Conclusion

Municipal authorities in Sweden are responsible for service provision including the provision of healthcare services at neighborhood level. Each of the two neighborhoods in the study had a primary healthcare center (and one also had a dental healthcare center), employing a range of healthcare providers. Nevertheless, some participants reported facing barriers to receiving healthcare services. Most of the barriers concerned communication issues as well as not being taken seriously and discrimination. This was particularly evident in accessing mental healthcare

services. It is noteworthy that most of these barriers were experienced by participants of foreign background. Those who did not have a foreign background generally expressed satisfaction with healthcare services and did not report major challenges in navigating the healthcare system. However, there were also participants of foreign-background including two who were partially illiterate and could speak almost no Swedish, who did not report any challenges in accessing the healthcare system. But there were also people of foreign background who experienced significant problems. Some of these people had longstanding residence in Sweden and some spoke excellent Swedish, yet they nonetheless encountered unfriendly treatment or a lack of appropriate referral that made accessing treatment very difficult.

In general, Bricolage, defined as using multiple resources to address healthcare needs, was not as evident in Sweden. This could be attributed to the nature of the universal healthcare system in Sweden and the well-planned neighbourhoods, which all include public healthcare centres offering a range of treatments. As most of the healthcare system is publically funded, although the number of private healthcare centres is growing, issues related to cost are not present in the Swedish data. It was also observed in our data, that the level of trust towards the welfare system is high and that most of the participants, especially native Swedes, reported no major issues in accessing healthcare. The universal healthcare system, which is widely trusted, means that alternative provision of healthcare is limited and therefore there are limited options to turn to or lose trust or face other barriers to uptake. The small size of the neighbourhoods and the significant regulation of employment and service provision, means that small-scale private provision is scarce. Given the superdiverse nature of these neighbourhoods, we had anticipated finding some level of informal provision of services, but beyond the distribution of seeds and herbs described under 'Use of complementary or alternative medicine' there was no evidence.

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