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Health in Swedish integration policies – a discourse analysis

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ABSTRACT

Previous research has indicated that migrants risk facing inequities both internationally and in Sweden; integration policies are therefore important to study. How health is described in policies affects how health interventions are approached. Discourse analysis offers a way of understanding how health is framed within the integration policies affecting newly arrived migrants in Sweden. The aim was to analyse the health discourses used in Swedish and European Union (EU) integration policies. A discourse analysis, inspired by Fairclough, was performed on integration policies related to Sweden, at local, regional, national and EU levels. The policies of the Establishment Program, which focuses on newly arrived migrants (refugees, persons of subsidiary protection and their relatives who arrived through family reunification), were chosen for the analysis, and 17 documents were analysed in total. The analysis of the documents showed how the health discourses were expressed in the form of the medicalisation of health, the individualisation of health and the risk of ill health. A pathogenic approach to health was visible in the policies and individual disease prevention or rehabilitation was the main health focus. The results showed similarities to previous research highlighting how a particular understanding of health in a neoliberal context is formed.

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Introduction

Health is a complex construction and can be viewed as a broad concept including physical, mental and social wellbeing, which follows the definition provided by the World Health Organization [1]. For health promotion, a salutogenic view of health, as developed by Antonovsky, has been suggested as a good foundation. The salutogenic model includes a view of health ease/dis-ease as a continuum, meaning health is not viewed as a binary state (either completely healthy or completely ill), but rather as a continuum – a spectrum that ranges from "ease" (complete health or well-being) to "dis-ease" (illness or lack of well-being). This perspective emphasises that individuals can move along this continuum depending on various factors. Instead, the emphasis is on the entire person (or collective) rather than the disease [2]. The salutogenic perspective concentrates on the "*process of enabling individuals, groups, organizations and societies to emphasize on abilities, resources, capacities, competencies, strengths and forces in order to create a sense of coherence and thus perceived life as comprehensible, manageable and meaningful*", which is a contributing aspect to good health [3]. Policies can be interpreted as salutogenic or pathogenic in their approach [4]. How health is defined and understood in policy contexts has shown to be important for how health is approached and improved [5,6].

According to this broader definition, health is mostly affected by factors determined outside of the healthcare sector [7,8]; therefore, approaches focusing on health policies outside of the healthcare sector are important. There are several different international initiatives, such as "health in all policies" [9] and "healthy public policy" [10], which aim to broaden the responsibility of other sectors regarding promoting health [8–10]. Health is particularly important in migration policies since integration policies are connected with the level of health inequities in a country [11]. Previous research has shown that migrants have an increased risk of ill health, which stems from both the migration process itself and from how they are received in their new country of residence [12–16]. Factors such as unfavourable outcomes in employment, housing, language skills and discrimination affect migrants' health long after migration itself is over [16,17]. A focus on health perspectives in relation

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to migration and integration is therefore important [16,18].

Swedish context

The Swedish Commission for Equity in Health [19] shows that immigrants face unfavourable outcomes in regard to health inequities in Sweden. Research indicate that the so-called healthy migrant effect does not seem to be relevant to non-western migrants in Sweden, who seem to have higher rates of ill health and health risks compared to western migrants and the Swedish population [20]. Since the 1970s, Sweden has had integration policies focusing on the immigrants' rights to welfare services. Initially, the focus was on labour migrants but also included refugees as they became more common in Sweden [21]. Between 2010 and 2018 the integration model was the so-called Establishment Program, which was a two-year long (full-time, 40 hours a week) civic orientation program focused on employability. It was a national program, but local actors, such as the municipalities and the Public Employment Services, had major responsibilities. Activities in the program included language training, civic orientation and other courses and activities to promote employability. Refugees, persons of subsidiary protection as well as their family members who have arrived through family reunification (together called "newly arrived migrants") had the right, but no obligation, to participate in the program [22]. After the first of January 2018 the establishment program was harmonised with other labour market policy activities. The content available for newly arrived migrants remains largely the same (an individual study plan being the main difference); however, the mandatory measures that the Public Employment Service can impose to facilitate employment for newly arrived individuals (such as prescribing specific educational interventions if deemed likely to lead to employment) are becoming more aligned with those applied to other unemployed individuals in Sweden [23]. As a member of the European Union (EU), Sweden is affected by EU policies as well, which over the last five years has increased its activities in regard to migration policies. Few of these policies are legally binding but aim to affect the behaviour of member states [24].

Critical policy research

Critical policy research offers a deeper understanding of the policy process [25]. Policies are not passive constructs; they are both shaped by how their content is interpreted within society and, in turn, influence how that content is manifested in social contexts [25]. The societal perception of health is crucial for understanding both the mechanisms of health promotion and the stakeholders involved [5,6]. The language used in policies is not neutral; instead, it creates and reproduces social meanings. Discourse analysis can reveal these meanings and provide an understanding of its effects [26]. Moreover, a discourse analysis of how health is constructed in integration policies can illustrate how governing actors understand and articulate health and how that understanding affects the approaches taken to promote the health of newly arrived migrants.

Aim

The aim was to analyse health discourses in Swedish and EU integration policies.

Method

The frame set for the study was the integration process for newly arrived migrants, which includes the activities from the so-called establishment program and other related policies. To study the discourses of health within this frame, a discourse analysis inspired by Fairclough's [27] critical perspectives and its description by Winther Jørgensen and Phillips [28] was used. A critical perspective has previously been used to analyse health-related policies [25,29].

Data collection and material

This study was interested in public policies related to integration. The aim was not to present a representative overview of every account of the phenomenon but to understand the particular view of health that is shaped, reproduced and legitimised through Swedish integration policies [26,28].

In line with Bernier and Clavier [30], this study defined public policies as aspects of what, for example, public authorities choose to do, or not choose to do, in the form of regulations or programs [30]. The policies were located by using a maximum variation sampling [31,32] focusing on all relevant actors in the integration of newly arrived migrants. The material of interest for the study was the current integration policies for newly arrived migrants in Sweden.

The relevant actors in the integration process were identified from the ordinance regulating the involved actors' responsibility [33]. The Public Employment Services as well as the County Administrative Boards were identified as major actors. Municipalities as well as

the Social Insurance Agency and the Delegation for the Employment of Young People and Newly Arrived Migrants (DUA) were also pointed out as partners in the integration process of newly arrived migrants in Sweden.

Data collection took place in May 2019. Two focuses were used in the searches: the above-mentioned organisations' 1) assigned responsibility and 2) their reported actions related to integration activities. To collect documents, each organisation's website was searched for policies focused on integration activities using the key terms "newly arrived migrants", "integration" and "establishment program".

For organisations with regional or local actors (municipalities, region, county administrative boards and DUA), the County of Västernorrland was used as a sample, including its seven municipalities. The municipalities had no public integration policies that could be identified; their role was examined through the local DUA documents. To add an international context, a manual search for policies on integration by the EU was performed, using the same search strategy as well as inclusion and exclusion criteria.

Inclusion criteria

- Official and public reports describing the organisations' work in integration activities
- Reports published by the identified relevant authorities – the Government Office of Sweden, the Public Employment Services, the Social Insurance Agency, the County Administrative Board and the DUA
- Current documents – valid from 2014–2019
- Reports containing information about integration activities and newly arrived migrants

Exclusion criteria

- Budgets and economical directives to and by the authorities
- Reports only focused on labour migrants

In total, 17 documents from six different actors were included in the analysis, see Table 1.

Analysis

To understand the health discourses in the included documents, a critical discourse analysis was applied. The analysis was influenced by Fairclough's [27] approach to critical discourse analysis and the structure of the analysis followed Tonkiss's [26] methodological approach to discourse analysis. The documents were initially reviewed, and any data related to health, illness, well-being or the social determinants of health were extracted for further examination, while other parts of the documents were excluded at this stage. During the review process, emphasis was placed on identifying recurring themes or key terms to categorise the data and gain insights into how health was represented [26].

Fairclough's framework for critical discourse analysis divides the analysis into three interrelated levels: the text, discursive practice and social practice [28]. In the current analysis, the focus was on text and discursive practice. According to Fairclough, the analysis can be

Table 1. Policies included in the analysis.

Actor	Title	Doc
European Union	The European Agenda on Migration	1
	Action plan on the integration of third country nationals	2
Swedish Government	Ordinance (2017:819) on financial compensation to participants in labour market activities	3
	Ordinance (2017:820) on establishment contributions for newly arrived immigrants	4
	The government's proposition 2016/17:175 A new ordinance for newly arrived immigrants' establishment in the labour market and social life	5
	Additional directive to The Delegation for the Employment of Young People and Newly Arrived Migrants (A 2014:06)	6
	Ordinance (2016:1363) on the County Administrative Boards' assignment in regard to activities for asylum seekers and newly arrived immigrants	7
	Appropriation directions Public Employment Agency	8
	Appropriation directions Swedish Social Insurance Agency	9
	Directive on simplified and more efficient processes for newly arrived immigrants	10
Public Employment Agency	Public Employment Agency's report: yearly report on activities in the Establishment program 2018	11
	Progression in the Establishment program	12
Social Insurance Agency	Report on Appropriation directions on meeting places and information	13
County Administrative Board	The County Administrative Boards' report on Appropriation directions on inspection of the civic orientation for newly arrived immigrants	14
	To do: course of action on integration and establishment	15
Delegation for the Employment of Young People and Newly arrived Migrants	Assignment collaboration 2018 Many challenges remains – interim report SOU 2018:12	16
	Agreement on collaboration about newly arrived immigrants (including appendix) Västernorrlands' respective municipality	17

Doc = identification number for the quotes in the results..

aided by studying aspects such as which assumptions are made and what is taken for granted as "common ground", as well as what was present and what was absent in the text. Other aspects of the language studied included whether it was "undialogized" and how modality and nominalisation were handled [27]. In the current study, this approach was applied by the data being read through several times, using the mentioned strategies to interpret what the text said about health. The data were analysed to identify recurrent themes or terms to organise the data into key categories of interest. To facilitate the reading, the texts were colour-coded, and notes based on interpreted meaning from the different aspects, both individually and collectively, were taken in the margins. Throughout the analysis, comparisons were made back and forth between individual parts of the text and the text as a whole. The focus was on understanding what these themes revealed about how health is presented in the data [26,28], i.e. how health is understood within the integration of newly arrived migrants in Sweden. The primary focus of the analysis was on the text and discursive practice. Social practice, according to Fairclough's framework is the broader social context in which discourses are embedded and take place [28]. The policies are one part of the social practice of health discourses. The context of social practices is explored further in comparison to previous research and theories in the discussion section.

In the analysis of the policies, three different aspects of health were identified. The different aspects were summarised and described, and particularly illustrative quotes were selected for inclusion in the results. The selected quotes and the document titles were translated into English by the first author.

Results

No explicit definition of health was presented in any of the policies, indicating that there was no need for defining health. This undialogized language combined with leaving out subjects created an illusion of an objective and purely fact-based text. However, an underlying assumption of a common understanding of health was shown to be non-existent when studying the content of the integration policies, both in how health was understood or defined by the involved organisations, but also what aspects of health were incorporated into the policies and activities. A County Administrative Board described how the content of health activities within the program could vary in form:

> In many cases, it consists of practical information and discussions about questions regarding the healthcare system, self-care, nutrition and physical activity [. . .] In other cases, it's rather defined as a health-promoting perspective integrated into all aspects of the program. (Doc. 14, p. 9)

The policies often referred to each other or were discussed in correlation or contrast to each other. In the included documents, three underlying aspects of the health discourse were identified: the medicalisation of health, the individualisation of health and the risk of ill health.

The medicalization of health

The medicalisation of health was visible in all the policies. Meaning a narrow view of health, focused on disease rather than health was present throughout the policies. This was seen through for example the explicit terminology, what was present and what was absent in the policies and what actors were pointed out as responsible.

The most explicit sign of the medicalisation of health was the terminology used in the policies. The main health-related aspects were portrayed in terms of diseases, healthcare and disabilities. The Swedish word for health promotion *"hälsofrämjande"* was continuously used, regardless of whether the content was focused on health promotion, disease prevention or rehabilitation, which indicates an underlying assumption of there being no differences between these three words. An illustration of this was how health promotion was mentioned in terms of prevention and rehabilitation:

> Health-promoting activities are to be done in an organized form with a clear aim and goal. They can be preventive or rehabilitating activities. (Doc. 11, p. 27)

Another example was how ill health was connected to official disability codes and diagnoses. One municipality did talk about the overrepresentation of newly arrived migrants in terms of ill health, and then went on to say:

> It is only a low number of individuals in the Establishment Program that have a disability code at the Public Employment Office. (Doc. 17, p. 18)

The document then discusses whether newly arrived migrants are underdiagnosed. Such a viewpoint indicates that ill health must be diagnosed and coded,

which is a purely medicalised view of health. It then discusses the need to involve healthcare personnel:

> Officials have the possibility to seek advice from psychologists, social consultants and occupational therapists. (Doc. 17, p. 18)

This also illustrated another aspect of the medicalisation of health – the involvement of the healthcare sector. The healthcare services, not having an active, continuous role in the integration activities, were addressed in the policies as having major responsibility for health-related activities. This corresponds to a narrow view of how health was approached in the document, regarding that what can be done and who should do it. Since the healthcare system does not collaborate with other organisations in the program, it risks leaving no one feeling responsible to promote health.

In the regional development plan for integration, the only aspect of health present was the chapter titled "*Health and Rehabilitation"*. The healthcare services were pointed out as responsible for the actions in the chapter and the only focus was on the healthcare, illustrated by the following goal:

> Goal 2020: newly arrived migrants have access to relevant healthcare and rehabilitation in the region. Activities during the establishment time proceed from abilities and health. (Doc. 15, p. 7)

Even though the second part of the goal focuses on abilities and health as a starting point, this is not mirrored in the activities presented in the plan, which is mainly focused on securing healthcare for asylum seekers and newly arrived migrants. The only other aspect presented is to facilitate collaboration between organisations, but the aim or reason behind this is not presented.

At the EU level, the same patterns were visible. In a document focusing on the EU's recommendation on integration activities, a sub-section called *"Access to Basic Services"* discusses the health of migrants and focuses on healthcare:

> Create competence networks of health experts, for example, on mental health — especially on post-traumatic stress — of refugees, in close collaboration among health authorities, NGOs and health professionals' organisations for prevention and early detection of problems and provision of support and treatment. (Doc. 2, p. 12)

Another way that the medicalised view of health was manifested in the policies was how many of the social determinants of health were present in the policies but ignored in regard to their connection to health. Some of the determinants that were addressed throughout the policies were work, education and language skills. In this aspect, the Establishment Program could be viewed as promoting health itself; however, this realisation was missing.

The individualization of health

Although the included policies focused on newly arrived migrants as a group, their individualism was highlighted throughout the policies, specifically through the terminology used. All the actors referred to health as an individual quality, also while discussing migrants as a group. One example of this is the expression of needs-based interventions:

> Increase the possibility of, when needed, being able to receive health-promoting activities within the establishment program. (Doc. 15, p. 7)

Providing something "when needed" indicates that specific individuals might need specific interventions. This was mainly raised in regards to participation in the program or being employable. Furthermore, the word "receive" provides an interesting aspect of how health was promoted. Receiving something indicated a passive role for the newly arrived migrants in how it was the authorities promoting their health. This idea was further connected with the main health-promoting activity – education about healthy living. With reference to the increased risk of ill health that newly arrived migrants face, a municipality wrote the following:

> We have prolonged the civic orientation with an additional health module. This will provide knowledge and tools for improved health early in the individual's establishment time. (Doc, 17, p. 18)

The assumption that only "knowledge" and "tools" are needed for improved health strengthens the idea that it is individuals who are responsible for their own health. It also creates a power dynamic in how the authorities have this knowledge and the migrants do not. Migrants become passive subjects in the policies.

In line with this, in the policies, health was described as something that could be received, by the passive subjects. Health could be provided and it could be invested in. Health is thus described as a commodity:

> Health-promoting activities can give good payoffs for both individuals and society. (Doc. 15, p. 7)

The risk of ill health

In the included policies health, or rather ill health, was understood as a risk factor. This aspect of health is

influenced by both previously described discourses, namely the medicalisation of health and the individualisation of health. The consequence of ill health was often sick leave, and it was focused on causing problems for individuals, often in them missing integration activities or their integration time being prolonged or them not being able to benefit from the program:

> Ill health is often a reason for a delayed/long establishment period. (Doc. 15, p. 7)

The effects are more broadly described in the EU policy, which is not only focused on a specific program, as the other policies in the analysis are. There are, however, similarities in how health as a resource is missing, but the risk of ill health is described in the EU-level policies:

> Evidence shows that ill health and lack of access to health services can be a fundamental and ongoing obstacle to integration, with an impact on virtually all areas of life and shaping the ability to enter employment, education, learn the host country's language and interact with public institutions. (Doc 2, p. 11)

The opposite of understanding ill health as a risk would be understanding health as a resource for participation and good results in the program, but this perspective was not present in the policies. The direction of assumed causality was also telling; ill health was seen as the reason for people not participating in the program, with health being the determining factor for participation. A different interpretation would be whether participation in the program affected migrants' health.

Discussion

The analysis of EU and Swedish integration policies showed that few policies contain explicit aspects of health. The visible ones included the medicalisation of health, the individualisation of health and the risk of ill health. The structural determinants of health were made invisible, and health was framed as an individual problem and responsibility. Health was simply an individual characteristic or quality that could affect a migrant's participation in the integration process.

Through studying the discourses of health in the present study, it became clear that the policies had a pathogenic perspective on health [4], which focuses on preventing ill health as well as eliminating diseases and risk factors [34]. This is a medicalised individual view of health. The pathogenic perspective focuses on risks [4], which was also evident in the policies. In contrast, a salutogenic approach focuses on enabling the individual (or collective), by focusing on their strengths and capacities, to promote a sense of coherence, which is contributing aspect to good health [3]. Also, the active participation of the participants is important so that they are not reduced to objects but are rather empowered [3,35]. These aspects have shown to be important in regard to migrants since the migration and integration processes have an increased risk of negatively affecting the migrants' sense of coherence and as well as their health [35]. The Establishment Program could be seen to help in these matters since it focuses on employability, language skills and knowledge of Swedish society. However, such a purpose is lacking in its policies. Furthermore, newly arrived migrants are reduced to passive recipients of health-promoting activities within the policy documents.

In the analysed policies, the Swedish word for health promotion (*hälsofrämjande*) was used even when describing disease prevention interventions or rehabilitation activities. Tengland [36] describes one of the differences between promotion and prevention. He describes that prevention is often seen as coming from a "medical model" (pathogenic), whereas promotion provides a more holistic and positive view of health (salutogenic). Even though the difference may be small between the two approaches in practice [36], in the current analysis, it was clear that even though the word "*hälsofrämjande*" was used in the documents, the policies advocated a more preventive approach.

These findings are in line with research showing how the view of health has been shaped by the current neoliberal context [37]. Generally speaking, neoliberalism prioritises the market and individual autonomy over state intervention [38]. Ayo [37] points out five important ways how health is understood in neoliberalism: minimal government intervention, market fundamentalism, risk management, individual responsibility and inevitable inequality as a consequence of choice. These aspects are all visible in a medicalised and individualised understanding of health that focuses on risks, and the unavoidable negative effects on health in a neoliberal context are inequities [37], which are also present in Sweden. The Swedish Commission for Equity in Health [19] confirmed that inequities in health exist in Sweden and that newly arrived migrants face negative consequences as a result. Although the Swedish public health goals, with its proposition, indicate a will of public ownership of health and that all actors that affect health take active responsibility for this [39]. Such perspective is lacking in the integration policies. This is in line with how De Leeuw and Clavier [40] describe a failure to implement healthy public policies because of poor implementation procedures.

The findings concerning the neoliberal view of health are consistent with previous studies, shown for

example in the evolution of the WHO charters "*from socially proactive to biomedically defensive health promotion*" [6] or how the target of health promotion has changed from the society to the individual [41].

The view of health in a society is often dependent on the political context [42]. In the current Swedish case, the neoliberal context has limited how health is formulated in the policies. The integration process presents a good opportunity for health promotion, as it addresses many social determinants of health, such as education, work, and social networks [7]. Previous studies have shown that authority officials in the establishment program recognise that they work with promoting health [18], even though they describe uncertainties concerning their roles and responsibilities [43]. However, included actors in the integration process in Sweden still has a limited understanding of health, and its potential has not been realised. Instead, the problem of structural health inequity is put on the individual [41]. Non-health-target policies for migrants are connected to health outcomes [44] and it is therefore important to illuminate this connection to ensure that no decisions or policy changes that negatively affect health are made without the explicit purpose of doing so.

For future policy changes, health is an important perspective that should be actively incorporated throughout the entire process. Additionally, it is crucial to include health competencies in policymaking, even in areas beyond healthcare policies. This would ensure that potential health-promoting aspects are utilised, appropriate distinctions between health promotion, disease prevention, and rehabilitation are made, and potential health risks are avoided.

Methodological considerations

For the regional and local context, Västernorrland and its municipalities were chosen as a sample county due to Västernorrland having received a relatively high number of asylum seekers in relation to the number of inhabitants in the area during the period [45]. The region also contains towns and municipalities of different sizes [46] which offers varied opportunities for integration and health promotion, making it a fitting sample county in the north of Sweden. The sample is in no way comprehensive. When performing discourse analysis, researchers must bear in mind that the goal is not to achieve an objective overview of policy content, but instead to form a deeper understanding of the concept of study [26]. The results therefore should only be generalised with caution.

The analysis took its departure from Fairclough's critical discourse analysis and although the method couldn't be followed in detail (social practices were only partly addressed) it offered analytical tools to focus on the text and the discursive practice [27,28], which was the aim of the study, making it a fitting method for the analysis. For a further understanding of the health discourses in integration policies, a broader view of the production of meaning can be applied in future research. Fairclough describes that both the production of the texts, the text itself and the reception of the texts are of interest in a broader understanding of discourses [27,28]. In the current study the aim was to understand health discourses in the polices as they exist in the world, but for future studies the interpretation of the policies in the social practices could be included.

Conclusion

This analysis of policies forming Swedish integration showed that discourses concerning health were expressed through the medicalisation of health, the individualisation of health and the risk of ill health. Health was thus understood as an individual characteristic in the integration process, and the risk of ill health, usually in the form of a disease, was mainly seen only as a threat to not being able to participate in the activities or not being able to enter the labour market. Such an understanding makes invisible the structural aspects of health and leaves no room for systematic health promotion. The results showed similarities to previous policy analyses and can be explained by a pathogenic understanding of health that is influenced by neoliberalism.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Data availability statement

All data material (policies) included in the analysis are publicly available information.

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