

Everyone Has the Same Access to Healthcare? Health (In)equality in a Superdiverse City

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Abstract People experience different challenges impacting their health. Existing research shows that varying experiences of the healthcare system increases with demographic diversity, with gender, education, citizenship status, and many other factors determining outcomes. That has consequences also for peoples' trust levels in society. Conducting a pilot of the Diversity Survey in Malmö, as a superdiverse city in Southern Sweden, allowed us to build on this existing work. The results confirmed an association between unmet healthcare needs and key demographic factors but also whether people felt at home in the city. As seen elsewhere, people are more likely to seek help when they trust the healthcare system. Despite Malmö having a very international population, when seeking healthcare information people trust Swedish government websites, healthcare professionals, and friends and family over the foreign and/or Swedish media, as well as the internet. That indicates the importance of public authorities in connecting a diverse society towards improved healthcare access.

INTRODUCTION

Three questions in the Malmö Diversity survey in 2025 were specific to human health. However, as this paper discusses, the complexity of factors impacting how well we feel, whether we seek healthcare when needed, and what channels we trust for healthcare information means almost all the questions in the survey can be argued to relate to human health. Even with Sweden's comparatively strong free-at-point-of-use healthcare system, individuals have different experiences with respect to access, trust, and so on. For example, gender is known to be a significant variable determining health.¹ Likewise, the literature notes a clear link between an individual's education level and their health.² Research on the relationship between migration and health has shown a correlation between an individual's skills in the host country's language and their health.³ As other papers in this issue make clear, Malmö is a superdiverse city with much of its population foreign born. Existing research on the relationship between superdiverse cities and human health identifies the need to

acknowledge the varied ways individuals experience the healthcare system to ensure equal access and overcome potential inequities. For example, Pemberton et al.'s study of four superdiverse cities in Europe identified that people's level of trust and willingness to use healthcare services varied according to a wide variety of intersecting factors including not only migration status but also wealth, age, physical mobility, accommodation, and many others.⁴ In such diverse environments, how individuals are positioned but also their community connections could determine their health and well-being.

DIVERSITY AND HEALTHCARE IN SWEDEN

Socio-economic differences as well as differences in health and longevity constitute potential problems for sustainable development and long-term societal resilience, including trust.⁵ All public activities and institutions in Sweden have a common and constitutionally established responsibility and purpose to promote the right and security for housing, work, education, social service and promote health, which includes that the social service and healthcare should work towards promotion of equal health and social security for all in society.⁶

The public health policy in Sweden has the overall goal of good and equal health for all, and this also includes equal and health-promoting healthcare.⁷ The work within healthcare should focus on equality but also include equity, which means seeking to meet the needs and possibilities of the individual patient. This includes ensuring that the communication and information is understood by the individual patient as well as that the patient will

be provided a continuity of care within the healthcare system. Equal healthcare also means that it should be given on an equal basis, no matter of the patient's age, gender, education and socioeconomic or ethnic background.

Earlier research shows challenges for vulnerable groups such as migrants to access the healthcare that they need, including the existence of several barriers to effective health communication.⁸ Qualitative interviews and a quantitative survey among migrants in the county of Scania have revealed that cost and trust, as well as language differences, could be barriers for migrants to access the healthcare system.⁹ During the Covid 19 pandemic, challenges around healthcare access were more evident where the healthcare system relied extensively on digital services.¹⁰ Many of these challenges have been witnessed globally.

CHALLENGES TO HEALTH LITERACY AND TRUST

Research shows that there are barriers for migrants in order to seek healthcare, including their often limited knowledge of their rights or cultural and language barriers.¹¹ It has also been seen that in order for people to use health care services appropriately they need to be able to access and understand health-related information, which could be explained as health literacy.^{12;13} Today, information from the healthcare system has become more technical, advanced, and complex¹⁴ and medical jargon could make the information difficult to understand, especially if people are new in a country.¹⁵ Furthermore, eHealth is increasingly being integrated into the delivery of healthcare settings and has been highlighted by the World Health Organization as one potential solution for improving healthcare and moving towards an achievement of the sustainable development goals.¹⁶ Recent research shows that eHealth literacy is generally overlooked in developing eHealth interventions targeting socially disadvantaged groups, and this might lead to health disparities.¹⁷

We know from public health research that trust is an important factor impacting an individual's likelihood to seek healthcare when required,

contributing to improved health.¹⁸ Research on marginalized populations has shown distrust being a barrier to their healthcare.¹⁹ Healthcare programmes globally have consequently put substantial resources into building trust. During the pandemic, the WHO was particularly concerned that rising disinformation was preventing marginalized populations from accessing much-needed vaccines.^{20;21} There is also evidence of structural racism within healthcare settings that could be a contributor to ill-health for those exposed to it.²²

PRESENT SITUATION

At the time of writing, healthcare in Sweden is radically changing. Despite evidence that interpretation increases access to healthcare, Sweden's anti-migrant policy shift has seen a concerted effort from Stockholm to oppose the use of interpreters – whether physically present or via the phone – in health consultations.²³ The country is also undergoing a more significant shift to its traditionally region-based healthcare system. The increasing use of digitalization coupled with the roll-out of AI systems is effectively centralizing population healthcare management, undermining regional control of budgets as well as local heterogeneity. Both shifts are likely to particularly impact Malmö as a Sweden's third largest city with a population that is both superdiverse and with distinct needs to the rest of the country. Therefore, there is a need to investigate how healthcare access is meeting the needs of its inhabitants in a diverse city as Malmö and what factors around gender, educational level and language skills that are associated with healthcare access, which is the aim of the current paper.

RESULTS

Several statistically significant observations emerge from the diversity survey with relevance for health. For example, as described below, there was a clear correlation between key demographics (gender, language skills, education) and self-reported health. Whilst not providing new knowledge, such findings do support the survey as

a means of general validation of the survey's methodological design.

General health condition in relation to gender, spoken language and level of education

Grouping the information regarding general health condition into bad or good general health condition as well as putting this information in relation to gender resulted in 16.7% (458 out of 2745) males and 19.9% (540 out of 2720) females reporting bad general health condition. Among those reporting good spoken language skills 81.9% reported good general health condition and 18.1% bad general health condition. Among those reporting bad general health condition 86.5% reported good spoken Swedish language and 13.5% reported bad spoken Swedish language. A total number of 4077 out of 4541 (89.8%) reported good general health condition and good spoken Swedish language. Those having a post-secondary level of education 15.3% reported bad general health condition and 84.7% reported good general health condition. Among those having primary level of education 28.1% reported bad general health condition and 71.9% reported good general health condition. Those having an upper secondary level of education 73.4% (1300 out of 1659) reported good general health condition (Table 1).

Table 1. General health condition stratified by gender, spoken language skills and level of education.

	General health condition	
	Bad n (%)	Good n (%)
Gender		
Male	458 (16.7%)	2287 (83.3%)
Female	540 (19.9%)	2180 (80.1%)
Other	59 (36.9%)	101 (63.1%)
Spoken language skills		
Good spoken	899 (18.1%)	4077 (81.9%)
Bad spoken	140 (23.2%)	464 (66.8%)
Level of education		
Primary	203 (28.1%)	519 (71.9%)
Upper secondary	359 (21.6%)	1300 (73.4%)
Post secondary	473 (15.3%)	2623 (84.7%)
Feeling at home in Sweden		
No	37 (37.0%)	63 (63.0%)
Yes	992 (18.2%)	4472 (81.8%)

Unmet health care needs in relation to gender, spoken language and level of education

Among males that answered to the question focusing on unmet health care needs (2743) unmet health care needs was reported by 636 respondents (23.2%) compared with 815 female respondents (30.1%) that reported unmet health care needs out of 2710. Those that reported bad spoken language skills 194 reported (32.25%) unmet health care needs out of 603. Unmet health care needs were reported from 786 respondents (25.4%) with a post-secondary level of education (out of 3092) and 212 by respondents (29.7%) with a primary level of education (out of 715) (Table 2).

The proportion of those reporting a good general health condition was higher in respondents with high level of education (84.7%) than in respondents with a middle or low level of education (76.4%). Bad general health condition was reported to a larger proportion for those with a middle or low level of education (23.6%) as compared with those with a high level of education (15.3%). A larger proportion of respondents refraining from seeking health care when needed was observed in those respondents reporting middle or low level of education (29.2%) as compared to respondents reporting high levels of education (25.4%).

Table 2. Unmet health care needs stratified by gender, spoken language skills and level of education.

	Unmet health care needs	
	Yes	No
Gender		
Male	636 (30.2%)	2107 (76.9%)
Female	815 (30.1%)	1895 (69.9%)
Other	70 (44.0%)	89 (56.0%)
Spoken language skills		
Good spoken	1314 (26.5%)	3651 (73.6%)
Bad spoken	194 (32.2%)	409 (67.8%)
Level of education		
Primary	212 (29.7%)	503 (70.3%)
Upper secondary	480 (29.0%)	1177 (71.0%)
Post secondary	786 (25.0%)	2306 (75.0%)
Feeling at home in Sweden		
No	41 (41.0%)	59 (59.0%)
Yes	1463 (26.9%)	3988 (73.1%)

Reasons for refraining from seeking health care when needed

The five most common reasons for refraining from seeking health care were long waiting times (11.6%), lack of trust in health care system (8.6%), other reasons not prespecified (8.4%), lack of time (8.3%) and lack of affordability (3.0%) (Table 3).

Table 3. Reasons for refraining from seeking health care when needed

Reasons	N	%
Lack of affordability	170	3.0%
Lack of trust in healthcare system	483	8.6%
Long waiting time	657	11.6%
Difficulty in communicating	102	1.8%
Fear of discrimination	83	1.5%
Inability to meet caregivers in person	128	2.3%
Lack of time	453	8.3%
Lack of personal identification number	5	0.1%
Lack of understanding digital systems	55	1.0%
Due to another reasons	472	8.4%

Trust in the health care system and in health information channels

There is concern within the field that people increasingly look to the Internet and social media for health care information, exposing them to the risk of relying on incorrect recommendations.²⁴ Migrants are thought to be at particular risk as persons less likely to have access or trust traditional channels of healthcare communication.

Contrary to those expectations, the population sampled in the diversity survey reported, when seeking healthcare information, having higher trust in Swedish government websites, healthcare professionals, and then family and friends. They did not see the mass media, including foreign and Swedish, or the Internet as trustworthy sources for healthcare information. That suggests that being a diverse city does not reduce how the population of Malmö evaluate the trustworthiness of different channels for healthcare information.

Trust in the health care system

When comparing trust in the health care system with general health condition, good general health condition was reported by 86.2% (3015 out of 3497). Among those that did not trust the health care

system good general health condition was reported by (73.3%) (1453 out of 1983). Those that trust the health care system (3497) and reported good general health condition were 86.2%. Distrust in health care system was reported by 40.8% (809 out of 1981) that reported that they refrained from seeking health care when needed. Those who trust the health care system and refrained from seeking health care when needed were 19.3% (673 out of 3488). This supports linkage between growing societal polarization and alienation from public healthcare systems, with negative outcomes for individuals' health.

Trust in health information channels

Trust in health information channels was measured by reporting trust on a scale ranging from no trust at all to complete trust as well as by the alternative do not now or do not use. Six different information channels were included as alternative health information channels which were health professionals for health information, friends and family, Swedish media, foreign media, internet and Swedish government websites. The three most completely trusted health information channels were Swedish government websites (38.4%) followed by health professionals for health information (32.8%) and friends and family (26.6%). The three most common not at all trusted health information channels were the Internet (19.4%), foreign media (15.2%) and Swedish media (12.8%). With regard to the alternative do not know or do not use the most commonly answered option was media (foreign media 33.8% and Swedish media 10.1%) followed by internet (9.2%). Trust to some extent was mostly reported for the Internet (60.4%), Swedish media (44.5%) and foreign media (38.5%). Health professionals for health information were mostly trusted to a large extent (43.3%) followed by Swedish government websites (40.7%) and family and friends (35.9%) (Table 4).

Table 4: Trust in health information channels.

Health information channel	Not at all	To some extent	To a large extent	Completely	Do not know/ Do not use
Health professionals for health information	110 (2.0%)	1099 (19.6%)	2421 (43.3%)	1834 (32.8%)	132 (2.4%)
Friends and family	143 (2.6%)	1648 (29.6%)	2004 (35.9%)	1484 (26.6%)	297 (5.3%)
Swedish media	715 (12.8%)	2481 (44.5%)	1479 (26.6%)	330 (5.9%)	565 (10.1%)
Foreign media	847 (15.2%)	2144 (38.5%)	645 (11.6%)	52 (0.9%)	1881 (33.8%)
Internet	1082 (19.4%)	3364 (60.4%)	562 (10.1%)	51 (0.9%)	513 (9.2%)
Swedish government websites	97 (1.7%)	865 (15.4%)	2280 (40.7%)	2153 (38.4%)	206 (3.7%)

In line with several other papers in this collection, people's sense of belonging is often seen to be a key factor in how they live their lives and is a potentially interesting challenge when considering a superdiverse city such as Malmö. We follow the same approach to that taken in the paper by Schütze and Irastorza, utilizing the survey question asking people if they feel at home in Sweden.

Feeling at home in Sweden results in a higher percentage in relation to self-reported general health condition, with only 18.2% reporting 'bad' health compared to 81.8% stating 'good' health. For those who did not feel at home in Sweden a majority still reported 'good' health but at 63% 'good' and 37% 'bad' there is a clear indication that belonging is correlated with improved health.

A similar pattern is seen regarding the relationship between feeling at home and whether respondents had unmet healthcare needs. For those who felt at home in Sweden, only 26.8% had unmet healthcare needs compared to 73.2% who did not. Amongst respondents not feeling at home

in Sweden, 41% had unmet healthcare needs compared to 59% stating 'no'. Whilst these correlations might not be causal, the overall pattern between a sense of belonging and being able to meet one's healthcare needs is demonstrated in the data.

The same picture is repeated in the responses on trust in the healthcare system. Amongst those who feel at home in Sweden, 35.3% do not trust or trust to some extent the healthcare system compared to 64.7% who do to a large extent or completely. Of those who do not feel at home in Sweden, the comparative figures are 76% (do not trust or trust to some extent) and 24% (do trust to a large extent or completely). That trusting the healthcare system is important to whether one feels at home in a country shows the centrality of health within how we study diverse societies. In all the above identified relationships the findings are statistically significant.

DISCUSSION

The pilot version of the diversity survey focused on Malmö contained three questions specific to healthcare, covering self-reported health status, unmet healthcare needs, and which channels people trust for healthcare information. These are all standard healthcare questions and, as has been discussed, largely produced results in accordance with findings in established research. Yet we also know from Public Health research that many of the variables impacting human health are not limited to health-specific factors. The so-called 'Social Determinants of Health' tradition goes as far as empirically showing up to 90% of the factors impacting healthcare outcomes – that is, what occurs after an individual has been clinically diagnosed with a condition – have nothing to do with what occurs within the healthcare system itself but lie within broader society itself.²⁵ That becomes a very long list of factors but, in brief, can be summarized primarily in terms of an individual's education, the quality of their accommodation, and their labour conditions. There is also evidence that the effects of the social determinants of health

cross generations. For example, an individual's life expectancy correlates with their mother's education level.²⁶ That relationship remains true globally, from Sweden to Gambia regardless of development level or welfare system.²⁷

Malmö as a diverse city with comparatively high immigration and rising inequality has been the focus of numerous studies with analysis frequently concentrating on exclusions from housing, education, and job security. At the point of writing, we have not been able to expand the analysis but clearly there is potential in engaging more closely with the non-health variables covered in the survey.

None of the existing non-health questions directly address the social determinants of health in a way needed for analysis, but several do touch upon them. For example, respondents were asked to report whether they had experienced discrimination in education and the labour market. In further analysis we hope to reconstruct the variables in such a way we can look for any relationship between discrimination in education and the labour market with whether and why respondents have chosen not to seek needed healthcare. Several questions also ask whether people feel a part of Swedish society, which can be read as a proxy for exclusion. We would like to explore possible correlations between those questions and what we can see on health.

Research in the Social Determinants of Health tradition can be reversed – that is, just as human health is dependent on social factors like housing, education, and job security; human health serves as a measure of how well a society functions. It provides an indicator of how well people can grow (i.e. physically, intellectually, economically), to live well, and connect with others in a way that society remains resilient to external crises (e.g. global recession, war, etc). Whilst the health-specific questions are just a small part of the diversity survey, the broadness of health means the entire survey can be read as a health survey – but not just of individuals' but also society's health.

CONCLUSION

We know from existing research that communities are a key ingredient to both individuals' health and societal resilience, including supporting national and local economies.²⁸ In a revised Diversity survey, we hope to include questions that measure the level of community activity, such as how well individuals are able to collaborate with their neighbours. Those questions would need to be planned to think ahead to ensuring the data can be correlated with the health-specific questions. Community activity is known to be important in ameliorating the effects of poverty, which is associated with numerous health conditions such as type-2 diabetes.²⁹ The role of community activity impacts health in several ways, and often very simply such as through shared exercising, discussing nutrition, as well as how to access the healthcare system.³⁰

Overall, we see it as fair to evaluate the existing pilot as a success as well as demonstrating the need for its revised expansion to a larger population.

This article is accompanied by a [visualisation](#) that conveys its main message. The visualisation was created by Noel Grunander and Idun Lindblad, BA students in Visual Communication at Malmö University, in collaboration with the authors.

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