COUNTRY REPORT

FINLAND

MIPEX HEALTH STRAND

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EUROPEAN COOPERATION IN SCIENCE AND TECHNOLOGY

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MIGRATION POLICY GROUP

MIGRANT INTEGRATION POLICY INDEX

HEALTH STRAND

Country Report Finland

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READER'S GUIDE TO THE REPORT

This report was produced within the framework of the IOM's EQUI-HEALTH project, in collaboration with Cost Action IS1103 ADAPT and the Migrant Policy Group (MPG). Full details of the research and its methodology are contained in Sections I and II of the Summary Report, which can be downloaded from the IOM website at http://bit.ly/2g0GlRd. It is recommended to consult this report for clarification of the exact meaning of the concepts used.

Sections 5–8 are based on data from the MIPEX Health strand questionnaire, which covers 23 topics, in 10 of which multiple indicators are averaged. Each indicator is rated on a 3-point Likert scale as follows:

0 no policies to achieve equity
50 policies at a specified intermediate level of equity
100 equitable or near-equitable policies.

'Equity' between migrants and nationals means that migrants are not disadvantaged with respect to nationals. This usually requires equal treatment, but where migrants have different needs it means that special measures should be taken for them. Scores relate to policies adopted (though not necessarily implemented) by 31st December 2014. However, some later developments may be mentioned in the text.

To generate the symbols indicating a country's ranking within the whole sample, the countries were first ranked and then divided into five roughly equal groups (low score – below average – average – above average – high). It should be remembered that these are relative, not absolute scores.

The background information in sections 1-4 was compiled with the help of the following sources. Where additional sources have been used, they are mentioned in footnotes or references. It should be noted that the information in WHO and Eurostat databases is subject to revision from time to time, and may also differ slightly from that given by national sources.

Section	Key indicators	Text
1. Country data	Eurostat	CIA World Factbooks, BBC News (http://news.bbc.co.uk), national sources
2. Migration background	Eurostat, Eurobarometer (http://bit.ly/2grTjIF)	Eurostat, national sources
3. Health system	WHO Global Health Expenditure Database[1] (http://bit.ly/1zZWnuN)	Health in Transition (HiT) country reports (http://bit.ly/2ePh3VJ), WHO Global Health Expenditure database
4. Use of detention		National sources, Global Detention Project (http://bit.ly/29lXgf0), Asylum Information Database (http://bit.ly/1EpevVN)

These reports are being written for the 34 countries in the EQUI-HEALTH sample, i.e. all EU28 countries, the European Free Trade Area (EFTA) countries Iceland, Norway and Switzerland, and three 'neighbour' countries – Bosnia-Herzegovina, FYR Macedonia and Turkey.

All internet links were working at the time of publication.

[1] For the definition of these indicators please see p. 21 of the WHO document *General statistical procedures* at http://bit.ly/2lXd8JS

1. COUNTRY DATA

KEY INDICATORS		RANKING
Population (2014)	5.451.270	●●●○○
GDP per capita (2014) [EU mean = 100]	110	●●●●○
Accession to the European Union	1995	

Geography: Finland is located in Northern Europe and borders the Baltic Sea, the Gulf of Bothnia, the Gulf of Finland, Sweden and Russia. Around two-thirds of the country is covered in forest and about a tenth by water (60.000 lakes). In the far north, the sun does not set for around ten weeks during the summer, while in winter it does not rise above the horizon for nearly eight weeks. The largest city is the capital Helsinki (population 620.715). The Helsinki Metropolitan Area (Greater Helsinki) consists of the cities of Helsinki Capital Region and ten surrounding municipalities: about a quarter of the total population of Finland lives there.

Historical background: Finland was a province and then a grand duchy under Sweden from the 12th to the 19th centuries, and an autonomous grand duchy of Russia after 1809. It gained full independence in 1917. During World War II, Finland successfully defended its sovereignty through a working alliance with Germany and resisted subsequent invasions by the Soviet Union – albeit with some loss of territory.

Political background: Finland is a parliamentary republic divided into 19 regions. The country joined the EU in 1995 and is currently the only Nordic EU member to use the euro as its national currency.

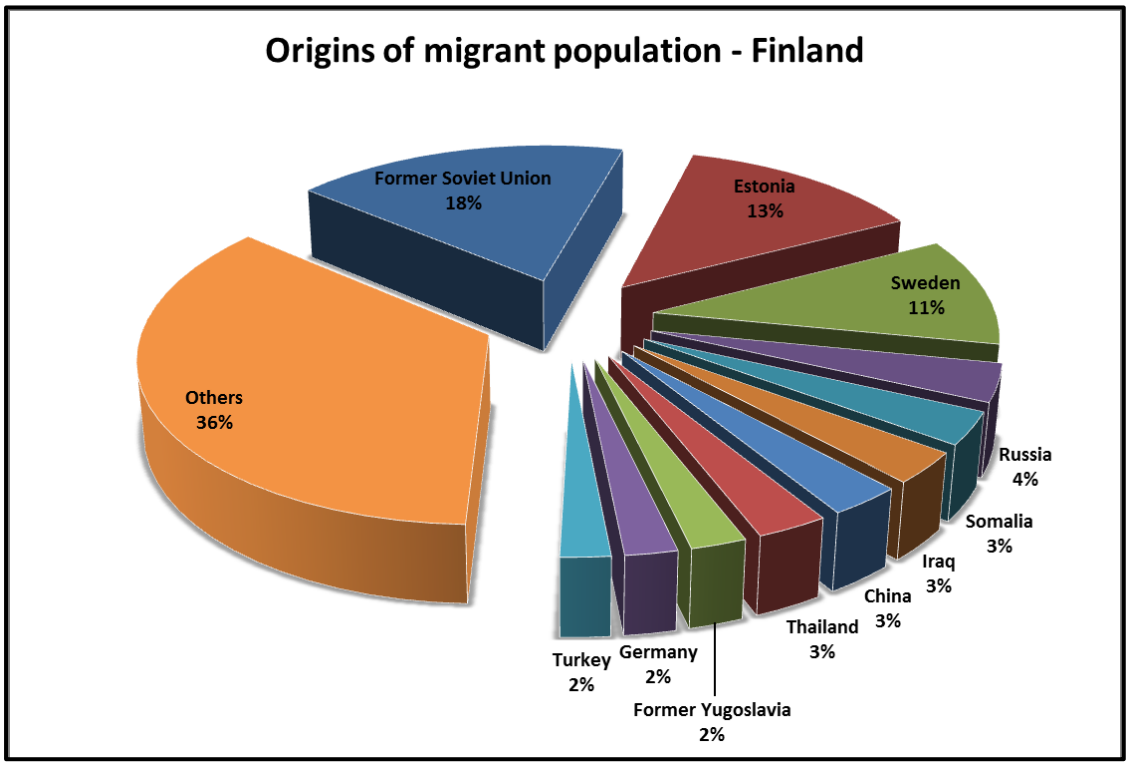
Economic background: Finland has a highly industrialized economy. Trade is important, with exports accounting for over one-third of GDP in recent years. The world economic slowdown hit exports and domestic demand hard in 2009, with Finland experiencing one of the deepest contractions in the euro zone. The country spends heavily on education, training and research – investment which pays dividends by delivering one of the best-qualified workforces in the world. In the longer term, the country will have to address a rapidly aging population and decreasing productivity in traditional industries.

2. MIGRATION BACKGROUND

KEY INDICATORS (2014)		RANKING
Foreign-born population as percentage of total population	5,5	●●○○○
Percentage non-EU/EFTA migrants among foreign-born population	62	●●●○○
Foreigners as percentage of total population	3,8	●●○○○
Non-EU/EFTA citizens as percentage of non-national population	58	●●●○○
Inhabitants per asylum applicant (more = lower ranking)	1.504	●●●○○
Percentage of positive asylum decisions at first instance	54	●●●●○
Positive attitude towards immigration of people from outside the EU (Question QA11.2, Eurobarometer)	47	●●●●○
Average MIPEX Score for other strands (MIPEX, 2015)	71	●●●●●

Until 1980, emigration from Finland exceeded immigration: during the 1950s and 1960s in particular, large numbers of Finns emigrated to the country's richer neighbour Sweden. In 1990 only 0,8% of the population was of foreign origin,[2] but in 2013 this proportion had risen to 5,5%. Nevertheless, the proportion of migrants is still low compared to most European countries.

Figure 1 Foreign-born population in 2014 by country of origin (Eurostat)



[2] Statistics Finland 2014, http://pxnet2.stat.fi/PXWeb/pxweb/fi/StatFin

Figure 1 shows that most migrants originate from the former Soviet Union and the neighbouring countries Estonia, Sweden and Russia. As in the Baltic States, the Russian-speaking minority contains many older migrants.

More than half of all migrants live in the Helsinki Metropolitan Area. Because only about a quarter of the total population lives there, this implies that the percentage of migrants in this area is about twice as high as in the country as a whole. In the major cities of Helsinki, Espoo and Vantaa the figures are 13,4%, 12,4% and 13,6% respectively. The questionnaire data for the MIPEX Health strand mainly reflect the situation in the region where most migrants live, the Helsinki Metropolitan Area.

The most common grounds for migrating to Finland from third countries have been family reasons in connection with the granting of asylum, and from the EU, work. Other important reasons have been return migration after the collapse of the Soviet Union, asylum and study. Labour migration grew in importance in the 2000s, but the recent recession has reduced the number of residence permit applications based on employment.

Finnish integration policies can be described as being labour-market oriented (Saukkonen 2016). The primary responsibility for integration issues lies with the Ministry of Employment and the Economy. In practice, integration training primarily targets unemployed immigrants and recently arrived refugees, but it is available to all in need of it. The guiding rationale seems to be that when a migrant can successfully enter the labour market, other aspects of integration (such as social and cultural) will follow on their own. Language skills are also emphasised specifically with employability in mind. According to MIPEX (2015), Finnish integration policies are among the best in the 34 countries studied in EQUI-HEALTH, and the Eurobarometer shows that tolerance of third-country migrants is higher than average. However, particularly since the 2015 ‘refugee crisis’, anti-migrant politicians and policies have enjoyed increasing support.

3. HEALTH SYSTEM

KEY INDICATORS (2013)		RANKING
Total health expenditure per person (adjusted for purchasing power, in euros)	2.591	●●●●○
Health expenditure as percentage of GDP	9,5	●●●●○
Percentage of health financing from government National health system (NHS) / social health insurance (SHI)	62	NHS
Percentage of health financing from out-of-pocket payments (higher percentage = lower ranking)	18	●●●○○
Score on Euro Health Consumer Index (ECHI, 2014)	846	●●●●●
Overall score on MIPEX Health strand (2015)	53	●●●●○

Introduction: All permanent Finnish residents are entitled to adequate social and health services as set out in Finland's Constitution. Broadly speaking, municipal social welfare and health care services, implemented with government support, form the basis of the Finnish social welfare and health care system. Municipalities are responsible for organising and funding a substantial amount of health care; they can provide basic social welfare and health care services alone, or form joint authorities with other municipalities. Municipalities may also purchase services from other municipalities and organizations, including private service providers.

Health services are divided into primary health care and specialized medical care. Primary health care includes the municipally organized monitoring of the health of the population, health promotion, and health care services provided at municipal health centres. Specialized medical care refers to specialist health examinations and treatment. Most specialized medical care is given in hospitals. Municipalities have joined into 20 hospital districts which organize this care. Some specialized medical care services are organized on the basis of special responsibility areas of university hospitals. The status and rights of patients, as well as timeframes for access to care, are set out in legislation. Additionally, there is a wide range of social welfare and health care organizations, providing services both free of charge and for a fee. It is notable that the ECHI score obtained by the Finnish health system is in the highest category, while health expenditure is only higher than average.

As far as the general population is concerned, private health care providers play a relatively minor role, but are nonetheless essential in the provision and promotion of occupational health. Employers are legally responsible for arranging occupational health care for their workers, which is funded by the employer and the Social Security Institute, Kela. This policy gives them a direct interest in providing safe and healthy working conditions.

Concerning the sources of health care financing, in 2013 municipal and State funding accounted for 62% of total health expenditure, about two-thirds of this amount being provided by the municipalities. The uncommonly high level of municipal contributions gives them an important stake in policy-making. A further 13% of total health expenditure was covered by the Social Security Institute (Kela). Out-of-pocket expenses accounted for 18% and private insurance 2%. (Private health insurance is rare among the adult population, but growing in popularity for children). The remaining 4% comes from employers and relief funds.

The key actor in health policies affecting ethnic minorities or migrants is the *Ministry of Social Affairs and Health* (MSAH). This ministry governs policies related to the basic social security of migrants, essential social and health services and other forms of support. On a governmental level, MSAH promotes people's health and welfare by increasing and maintaining their social welfare, security and social engagement, and by reducing poverty and social exclusion.[3]

As of 1st January 2015, MSAH strategy for social and health policy stressed:

a) the inclusion of the special needs of immigrants in the development of social and health care services, and
b) social and health care as a means of supporting the integration of immigrants and their families into Finnish society, in order to improve their chances of securing employment and continuing their education.

The *Ministry of the Interior* (MI) is responsible for the administration of immigration procedures, immigration policy, and related legislation and processes in Finland. Within this ministry, the Finnish Immigration Service deals with matters related to individual immigration cases, residence, deportation, refugees, and citizenship. The Immigration Service also provides relevant information to Finnish authorities and international organizations, and maintains a register of foreigners in Finland.

Besides the ministries mentioned above, the *Ministry of Employment and the Economy* (MEE) is responsible for the integration of migrants, implementation of integration measures, and the National Integration Programme since 2012. Under its supervision are the immigration units of the 15 regional Centres for Economic Development, Transport and the Environment (ELY). Together with municipalities, they share responsibility for the integration of immigrants.

Health policy: Since the 1970s, national health policy has aimed at narrowing the health gaps between different population groups. The main national health policies have been

- *Health for All by the year 2000* (MSAH 1986, in English 1987)
- *Health of All by the year 2000* (revised, MSAH 1993, see Sihto & Keskimäki 2000)
- *Health 2015 programme* (2001-2015)[4]
- *National Action Plan to Reduce Health Inequalities* 2008-2011 (MSAH 2008)
- *National Development Program for Social Welfare and Health Care (Kaste I)* for 2008-2011
- *National Development Program for Social Welfare and Health Care (Kaste II)* for 2012-2015.[5]

[3] See http://bit.ly/2gbakDo
[4] See http://bit.ly/2fR5pqh
[5] See http://stm.fi/en/kaste-progamme

By reducing health inequalities, these programmes have aimed to make good health undifferentiated among different sections of the population and in different parts of the country. By promoting changes in lifestyle it has been possible, for example, to reduce cardiovascular diseases, though inequalities in health and mortality still remain substantial. Unfortunately, after 2015 there is no separate national public health programme. The recent government programme (*Finland a land of solutions,* 2015, p. 20)[6] states that promotion of health and welfare and the reduction of health inequalities continue to be on the agenda, as in all previous government programmes since 2003, but no detailed plans have been adopted (Sihto & Palosuo 2016).

The *Health 2015 programme,* started in 2001, is a long-term health policy based on the *Health For All* programme of the World Health Organization. The programme seeks to promote health and wellbeing, not only in health care but in all areas of society. Health must be taken into account in all areas of decision making and policy: the health status of the population is to be improved by reducing inequality and increasing the welfare and relative status of the most disadvantaged population groups. The objective is to reduce mortality differences between different occupational groups and groups of different educational background by a fifth by 2015. The *Health 2015 programme* outlines eight targets, further specified by action statements. These action statements apply to various actors and environments in everyday life, including homes, schools and workplaces (Melkas 2013).

Implementation actions to reduce health inequalities are based on the 'Health in All Policies' (HiAP) approach, which emphasizes that public policies and decisions made concerning policy areas other than health (e.g. transport, agriculture, education, employment) have the most impact on citizens' health, on health determinants, and on the capacity of health systems to respond to health needs.[7] Moreover, health inequalities cannot be sufficiently reduced if the focus is only on the most disadvantaged members of society. Therefore, actions must be universal, preventive and health promoting, but with a scale and intensity proportionate to the level of disadvantage. Additionally, national policies need effective local delivery systems focused on health equity in all policies. This requires effective participatory decision-making at a local level.[8]

The *National Action Plan to Reduce Health Inequalities* (2008-2011) mainly operated in the following areas:

1) social policy measures: improving income security and education, and decreasing unemployment and poor housing;
2) strengthening the prerequisites for healthy lifestyles: measures to promote healthy behaviour of the whole population with special attention to disadvantaged groups where unhealthy behaviour is common;
3) Improving the availability and quality of social and health care services for everyone.

One main target out of 15 targets in the action plan concerning migrants was "to develop and enforce social and health care services for migrant origin population". A pioneering health study of immigrants was carried out, the first results of which were published in 2012 (Castaneda et al. 2012). In 2013, the impact of the study on health policy, health care strategies and practices in the city of Espoo was

[6] http://vnk.fi/en/publication?pubid=6407
[7] See http://bit.ly/2fHKI2x
[8] See http://bit.ly/2fd1t1v

evaluated. Following the study, public servants and care providers in Espoo gave more emphasis in their strategy and practical work to the questions of the migrant population's mental health issues, their children's health issues at schools, and financial problems of migrant families. The health monitoring of adults with migrant background continues as part of the national *Health and Wellbeing for Residents* (ATH) study.[9] The largest nationally representative survey for the foreign-origin working age population was carried out 2014 to investigate their work, health, welfare, functional capacity and living conditions (Nieminen et al. 2015.)

Finally, we will consider the *National Development Program for Social Welfare and Health Care (Kaste II)* (2012-2015), which aimed to reduce health and welfare inequalities and to ensure that social and health care structures and services are client-centred and financially sustainable. Kaste helped national, regional and local actors to work together in implementing reforms necessary for reducing health inequalities. The implementation process was carried out through nominated developmental projects, conducted in local co-operation with municipalities or areas, which were funded by Kaste and by participating municipalities. Municipalities and joint municipal boards for social welfare and health care could apply for discretionary government subsidies for creating and implementing good practices.

Health Policy Implementation: The Ministry of Social Affairs and Health (MSAH) coordinates all development work conducted by different actors like municipalities, joint municipalities, local research centres like the Centres of Expertise on Social Welfare,[10] associations, private care providers, non-profit NGOs, etc. Implementation of national policies and development of innovative new practices has been done by municipalities, largely through limited-term projects such as the Kaste programmes which have their own funding. Social and health care innovations and improvements developed during the course of local projects are not guaranteed to continue as best practices afterwards, due to lack of stable financing and personnel. Therefore, the development and implementation work of the national policy tends to be short-lived, fragmented, superficial, locally-based and liable to change following parliamentary elections every four years.

Each municipality has developed its own strategy to improve services to meet the needs of the population, including specific programmes for targeted populations like people of migrant background. The Health Care Act (1326/2010) § 12[11] requires municipalities to monitor the health of their inhabitants by population subgroup. The objectives of this important law are:

1) to promote and maintain the population's health and welfare, work ability and functional capacity, and social security;
2) to reduce health inequalities between different population groups;
3) to ensure universal access to the services required by the population and improve quality and patient safety;
4) to promote client-orientation in the provision of health care services; and
5) to improve the operating conditions of primary health care and strengthen cooperation between health care providers, local authority departments, and other parties in health and welfare promotion and the provision of social services and health care.

[9] http://bit.ly/2fhP13J
[10] http://www.socca.fi/in_english
[11] http://bit.ly/2iYBP3w

Monitoring of progress is carried out by municipal councils, which report annually on the health and welfare of their residents.[12] Municipalities can commission public, private, non-profit and for-profit NGOs as providers of health and social care services on their behalf. The length of contracts varies, as does the level of competence to contract private services: for this reason the quality of monitoring varies between municipalities. Increasing privatization of health and social care services in Finland has attracted much criticism, particularly in the care of the most vulnerable, elderly people in need of care. It is unclear what the effect of privatization is on service delivery to ethnic minorities and migrant populations.

In spite of many health policy initiatives and efforts to implement them, studies still show that people with a migrant background have worse health and wellbeing than the Finnish host population on many indicators (e.g. chronic illnesses, self-perceived health, obesity, dental health: see Koskinen et al. 2012a-b, Laatikainen et al. 2012, Suominen & Suontausta 2012, Castaneda et al. 2012; Nieminen et al. 2015). Compared to the host population and migrants from OECD countries, migrants from non-OECD countries are more likely to live in relative poverty. This is due to higher unemployment rates, lower-income occupations and lower educational attainment, ultimately leading to greater dependence on social welfare (Malin et al. 2011, Martelin et al. 2012, Kauppinen & Castaneda 2012). Indeed, health inequalities among the Finnish population have not been noticeably reduced during the Action Plan period 2008-2011 (MHSA 2009); if anything, they have increased (Sihto & Palosuo 2016). It should of course be borne in mind that the Finnish economy experienced a drastic contraction after 2007 and that GDP is still substantially below the level of that year.

[12] See http://bit.ly/2fIDgE3

4. USE OF DETENTION

The information below refers to the situation at 1st January 2015. As a reaction to the unexpectedly large influx of migrants in 2015, stricter measures have come into force since that year, but they will not be described in detail here.

A foreign national will be removed from Finland if they are present in the country illegally or have not been issued a residence permit. Foreign nationals who acquire and/or use visas or residence permits obtained on false grounds, for example by withholding information or providing false information, are also subject to removal. A foreign national may be held in detention if there are grounds to believe that he or she will, for example, hide in order to avoid refusal of entry or deportation. An asylum seeker can be held in detention if it is necessary to establish his or her identity.[13] Every effort is made to carry out removals from the country voluntarily within the time limit set.

A negative asylum decision will usually be accompanied by a refusal-of-entry decision, when the applicant has not been granted a residence permit on any grounds. The decision on refusal of entry or deportation may allow a period of grace (normally 30 days) during which a person must leave Finland. If they leave within this period, a refusal of entry to the Schengen area will not be imposed. If a person wishes to return to their home country voluntarily, they can apply for support for assisted voluntary return.

In other cases, the police enforce removal from Finland. The refusal of entry cannot be enforced until the decision of the Finnish Immigration Service becomes legally valid. In the event that a third country national without a residence permit appeals against the decision to the Administrative Court of Helsinki, the authorities are required to wait first for the court ruling. An application for leave to appeal to the Supreme Administrative Court does not prevent the implementation of the decision, unless expressly ordered otherwise by the Supreme Administrative Court.[14]

Finland has two detention centres with a capacity of 70 people (30 and 40 respectively); the maximum length of detention is 6 months (12 months in specific circumstances). Detention centres are required to provide adequate housing and food as well as essential health care services for the duration of a migrant's custody (see Kmak and Seilonen, 2015).

[13] See http://bit.ly/2gyVFp9
[14] See http://bit.ly/2feeSX2)

5. ENTITLEMENT TO HEALTH SERVICES

Score 56 **Ranking** ●●●○○

A. Legal Migrants

Inclusion in health system and services covered

The health care rights of a migrant depend on the type of residence permit and on whether they have a registered municipality of residence in Finland. Migrants who are registered as residents in municipalities have the same right to services as nationals. Registration as a resident in turn depends (with some exceptions) on a) the person's country of origin, b) the type of residence permit – fixed-term, which can be continuous [A] and temporary [B], or permanent [p]. The right to national universal health insurance in Finland thus depends on the type of residence permit (continuous/permanent or temporary) a person has. Citizens of EU/EAA countries and permanent residents have the right to receive health care according to the rules and regulations of EU agreements. Third country nationals legally staying a year or more in the country get a continuous residence permit (A) and are registered as municipal residents. The procedure is as follows:

First, the Finnish Immigration Service (MIGRI) determines whether a third-country migrant is eligible for a residence permit**,** and if so what kind. The first residence permit granted to a migrant is always issued for a fixed term; temporary residence permits are usually extended for one year at a time. Residence is considered as temporary if a migrant has arrived in Finland as a student or has a work contract for less than a year, or if an asylum seeker cannot be returned to the country of origin due to ill health or practical reasons.[15]

In 2013, out of all new residence permit decisions (n=17.503), 78% were positive and 22% negative. Of the new positive residence permits, approximately 68% were for temporary legal migrants.[16] In 2013 a third of first registrations or first residence permits of foreigners in Finland were based on family ties, 40% on work contracts, 20% on student enrolment, and 6% on humanitarian grounds.[17]

Second, foreign nationals have to register as residents in municipalities. The Municipality of Residence Act determines whether a person is to be granted health care services by the public health system in Finland. A migrant has to have a home address first in order to register as a resident at a local registry office, where they obtain a personal identity code needed at Kela (the Finnish National Social Security Institute), in health care centres, when opening a bank account, etc. When one moves into a municipality, one has to report one one's own initiative one's accommodation in the municipality to the Local Register Office (Maistraatti).[18] The office saves the migrant's personal data, permanent address, and municipality of residence in the Population Information System. A Finnish municipality of residence is registered for a foreigner who has moved to Finland if he or she plans on staying permanently and has a residence permit for at least one year. Those with a residence permit on grounds of international

[15] See http://bit.ly/2gyVFp9; http://bit.ly/2fvb9Wb
[16] http://bit.ly/2fvd5hi
[17] http://bit.ly/2gbVWKO
[18] http://bit.ly/1d5dSxX

protection may try to find their own accommodation a) with the help of the reception centre, which also pays the necessary rental deposit; or b) with the help of the regional Centre for Economic Development, Transport and the Environment (ELY Centre), which also pays the needed rental deposit; or c) by themselves wherever they want.[19] Personnel in reception centres as well as in ELY centres help the client to register with the Local Register Office and other authorities. Those with a temporary residence permit are frequently not registered as residents of a municipality.

Third, health insurance coverage is regulated by the Finnish Health Insurance Act. Kela issues a decision on one's eligibility for universal health care reimbursement and social security benefits. This decision is made on the basis of the Act on the Implementation of the Social Security Legislation (1573/1993). (Health care rights are part of the social security system in Finland.) Kela automatically sends out personal health insurance cards, which have individual personal identity codes, to eligible persons with continuous or permanent residence permits and registered home municipalities in Finland.

Temporary residence permits: Migrants with B type temporary residence permits (32% of all new permits in 2013), unless they have private health insurance, have to cover treatment costs themselves; their primary care is available only in private clinics. If they need specialised care that is only available in public hospitals, the hospitals charge them or their insurance company. In case of life-threating medical conditions, B type permit holders have the right to treatment in public hospitals but the treatment costs remain their own responsibility. However, in cases of indigence their expenses are covered by Kela. Third country nationals who do not satisfy the conditions for a continuous or permanent residence permit are required to have private health insurance as a precondition for obtaining a residence permit.

Other groups receiving only a temporary residence permit are students and those with short-term labour contracts. University students' health care situation is helped by the fact that they are also entitled to students' primary health care.

Among labour migrants, those employed for longer than four months but possessing a temporary residence permit receive some basic social insurance benefits related to health care, although they are not covered by the public health care system apart from urgent care. Employers are required to ensure occupational health care for their employees by law. The majority of employers provide primary health care as part of occupational health, although this is not mandatory. All employees are entitled to the range of occupational health services provided by the employer. After two years of temporary work-based residence permit and uninterrupted stay (holidays are allowed), migrants are typically granted continuous residence permits.

To sum up, the most vulnerable groups of legal migrants in terms of entitlement to health care coverage are:

- any migrant without a permanent address;
- temporary residence permit holders who arrived as asylum seekers;
- temporary residence permit holders who do not have an employer who provides primary health care as part of occupational health; and
- students from third countries, who are required to have valid private health insurance. If the estimated duration of the studies in Finland is less than two years, the student is usually not

[19] http://www.kotouttaminen.fi

assigned a municipality of residence. In this case, the student must obtain private health insurance covering treatment and drug costs up to EUR 100.000. If the studies in Finland are estimated to last at least two years, the student is usually granted a municipality of residence. In this case, the student must have private health insurance covering drug costs up to EUR 30.000.

Special Exemptions

Victims of torture or psychological trauma with permanent or continuous Finnish residence permits have the right to use the rehabilitation centre for torture survivors run by the Helsinki Deaconess Institute. The Centre for Torture Survivors[20] operates nationwide, but its clinical work focuses on Southern Finland. Therapy sessions are provided free of charge.

Sex workers have special primary health services at the *Pro-tukipiste* NGO in Helsinki and Tampere. Human trafficking is a crime in Finland. Crimes associated with human trafficking are investigated by the police and border control authorities. Victims of human trafficking are entitled to assistance and a residence permit. They have to co-operate with police and immigration authorities in order to be enrolled in a protection program.

Barriers to obtaining entitlement

For legal migrants, no documents are required that are difficult for migrants to produce and no decisions are subject to administrative discretion. (Requirements concerning registration of residence have already been dealt with above).

B. Asylum Seekers

Inclusion in health system and services covered

Asylum seekers are entitled to primary care services provided in the reception centres for asylum seekers**.** Asylum seekers have the right to get reception services which safeguard their necessary financial support and care**.** The reception services include accommodation, reception allowance or spending allowance, any necessary social and health services, interpretation and translation services as well as work and training activities. Meals can also be provided as part of the reception services. The reception centres are responsible for asylum seekers' social and health services. In practice, the social welfare and health care services are purchased from municipalities and private enterprises**.** There are reception centres throughout Finland. They all have an open-door policy and asylum seekers staying there are not obliged to report their whereabouts to the centre's personnel.[21]

[20] http://bit.ly/2g7UEPD
[21] http://bit.ly/2iMp64v

Most asylum seekers stay at reception centres while their asylum applications are being processed. However, many also make their own accommodation arrangements. Group homes and supported housing are provided for unaccompanied minor asylum seekers.[22]

Specialised care referrals are made by a physician at the reception centre if the medical condition of the asylum seeker is life-threatening or if specialized care is necessary to maintain stable health status. Maternity care and chronic disease treatment (including serious mental health problems and dental care) are regarded as necessary care.

All asylum seekers undergo a basic health examination and screening for infectious diseases at reception centres. An asylum seeker has the right to receive the social welfare services that a social welfare professional judges to be necessary (e.g. advice, guidance, dealing with social problems). Adult asylum seekers are entitled to urgent health care services, as well as the services that a health care professional judges to be necessary. Services provided by primary care nurses and doctors are free of charge in reception centres and in specialised care if the referral is made by the doctor at the centre (as long as the specialised care is medically necessary). If an asylum seeker has an income, they have to cover their own health care costs for the same fees charged to Finnish nationals. Additionally, if the doctor determines a given course of treatment not to be medically necessary, the patient is responsible for its cost. There are patients' fees in primary and in specialized care, which the patients have to pay themselves.

Asylum seekers can obtain a work permit after three months of arrival. As employees, they are entitled to the range of occupational health services provided by the employer.

Special exemptions

Pregnant women who are seeking asylum are entitled to antenatal care in the reception centre where they live, or in the nearest community health centre. **Mothers and infants** who are asylum seekers are entitled to childbirth and post-natal care, as well as care in well-baby clinics in primary care.

Asylum seekers under 18 have the same health rights and pay the same costs as nationals. Children under 7 years receive health and development screening at Child Health Clinics, and all children are vaccinated. The government pays all of their health care expenses, including the cost of medication. Children have also the right but not the obligation to attend preschool and basic education while in the reception centre. Furthermore, children have the right to child welfare interventions whenever needed.

Asylum seekers who are **victims of torture or psychological trauma** have the right to use the rehabilitation centre for torture survivors (see under Legal Migrants). Other vulnerable persons (older persons, persons with disability, persons with long-term illnesses, traumatised persons) receive the health services they need.

Barriers to obtaining entitlement

Decisions about whether a condition is 'life-threatening' or 'necessary to maintain stable health status' are subject to administrative discretion.

[22] see http://bit.ly/2fIPehj

C. Undocumented Migrants

The health care entitlements of UDMs are not clearly defined in law, but they are stated in several official documents. UDMs have access to health care in cases of emergency, but they have to pay for it. 'Urgent and necessary' care may also be provided, but it too must be paid for. The cost is the same as that charged for the same treatment in the public health care system (which is not the full cost). If the care provider is unable to receive payment, Kela will pay it on behalf of the client. In all these cases payment is handled after the urgent care is administered.[23]

However, Helsinki City Council permits pregnant women and UDMs under 18 to use all needed health care services without a patient fee in primary care. For ambulatory care and urgent dental care, the same patient fee as asked for as for citizens living in Helsinki. The city of Turku has adopted the same policy in 2015.

UDMs usually pay more for health care services than nationals when using private medical services, because nationals receive a small reimbursement from Kela.

The *Helsinki Global Clinic* NGO[24] has been providing anonymous, free primary health care to UDMs in Helsinki since 2011. Over a period of three years it treated over 500 UDMs; about 5% of the patients were referred to specialised care, while 70% of them were ethnic Roma from Bulgaria and Romania, who do not have documentation proving European social security which would enable them to receive unplanned health care in primary and specialised services in the host country during the first three months of stay. Global Clinics have been opened in Turku, Joensuu, Oulu and Tampere.[25] There are also interpreters, lawyers and social workers at the Clinics. The services are primarily meant for clients who are not entitled to public health care in Finland: Global Clinic is open to everyone, regardless of nationality or migration status. Help is given for free, anonymously and in strict confidence. All staff members have pledged full professional confidentiality.

Special exemptions

Victims of human trafficking are entitled to assistance and a residence permit. They have to co-operate with police and immigration authorities in order to be enrolled in a protection program.

[23] http://bit.ly/2i0Q1uK
[24] http://www.globalclinic.fi/en/etusivu
[25] http://www.globalclinic.fi/en

Barriers to obtaining entitlement

Discretionary judgements have to be made about whether a situation is an emergency and whether care is 'necessary and urgent'. According to the Health Care Act, public health care must always provide urgent treatment to all that need it. Urgent care has been defined and it refers to: sudden illness, injury, worsening of a long-term condition or decrease in ability to function that requires immediate assessment and treatment. In these cases, treatment cannot be delayed without the sickness or injury worsening. Furthermore, urgent care also concerns oral care, mental health care, substance abuse care and psychological care.[21]

6. POLICIES TO FACILITATE ACCESS

Score 73 Ranking ●●●●●

Information for service providers about migrants' entitlements

The Finnish Immigration Service (MIGRI), together with the Ministry of Employment and Economy (MEE), organises information sessions for the municipalities, briefing them about the arriving refugee groups. Municipalities receiving refugees for the first time, or receiving refugees of a different nationality than before, may ask the ELY Centre to organise an information session for those who will be working with the refugees. It is also recommended that the municipality inform residents about the arrival of the refugees, through publications or by organising public information sessions. Experts from MIGRI have also taken part in these information session, to inform the municipality or the public on the situation and background of a certain refugee group (EMN 2016).

Similar information is available from MSAH and the Ministry of the Interior. There is also a new organisation within the MEE, the Centre of Excellence on Integration,[26] which informs local authorities on how to implement the integration of different migrants, about best practices, etc. In addition, Kela has published two guidebooks for service providers in primary and specialised care and for municipal authorities, aimed at clarifying who is entitled to health services in Finland and how municipalities can apply for reimbursement from the state when patients do not have a municipality of residence. In each municipality, health care authorities and senior health care staff pass on information on eligibility to care providers.

Information for migrants concerning entitlements and use of health services

Every person receiving their first residence permit and moving to Finland receives a booklet *Welcome to Finland*[27] to help with their transition and adjustment in the country. The booklet contains information on services and practices, including health care services, and is available in 12 languages. In reception centres information is also delivered with help of interpreters and health care professionals in face-to-face meetings.

Irregular migrants can receive information on the different aspects of settling down, including health care in Finland, from NGOs like the Refugee Advice Centre and *Väestöliitto* (the Family Federation of Finland) or the Red Cross. *PRO-tukipiste* offers sex workers support, information, and help including information about health issues. It has two health and support services in Helsinki and Tampere: the services are for women, men and transgender people working in the sex and erotic industry.

In the capital city region (covering Espoo, Helsinki and Vantaa), municipal information services for migrants are available. *Virka Info*[28] is a public information service located in the Helsinki City Hall lobby, in Vantaa in Citizen's Office (Yhteispalvelutoimisto), Silkinportti Activity Centre, and in the Jeesi Youth Information and Counselling Service. Furthermore, there is the *Infochat* service for immigrants in Helsinki (a joint development project with the cities Espoo, Vantaa and Kauniainen). *Infochat* is an on-

[26] http://www.kotouttaminen.fi
[27] http://bit.ly/2eWuUK1
[28] http://www.hel.fi/www/kanslia/virka-en

line information service; *Infobank*[29] is a web page offering migrants information about Finland, rights to services, and general information about immigration in 12 languages. General information on public services is also provided at *suomi.fi* (the single access point to public services in Finland),[30] Public Service Info,[31] Kela,[32] and in the joint service portal of Kela and the Tax Office for foreign employees in Finland.[33]

Although most websites offer information in English, and some in many more languages, information is not otherwise adapted (i.e. 'targeted') to improve communication with migrants. According to the Finnish Constitution, everybody's cultural background must be respected and taken into account when delivering public services, and nobody is to be discriminated against because of his or her cultural background. In the same vein, the Act on the Status and Rights of Patients 785/1992[34] states that medical patients and clients of social services (Act of Social Welfare 2014) have the right to appropriate, non-discriminatory, and high-quality service from social and health care services. Options for treatment or medical measures to be taken must be explained openly and in an understandable manner to patients. Patients and clients of social services must be treated in a manner that does not infringe on their human dignity, convictions, or privacy. Additionally, the laws state that the mother language of the patient/client, their personal needs and culture, should be taken into account as far as possible in providing patient care and treatment. Furthermore, the laws state that whenever possible, interpreter services should be used. Nevertheless, no studies have been carried out on how these aims are to be achieved in practice. Patients do have the right to lodge formal complaints for discrimination, but the process is complicated and needs written statements in Finnish that require the help of the Patients' or Social Ombudsman. This is somewhat contradictory in an era when patients' security issues are highly stressed nationwide.

Health education and health promotion for migrants

Again, such services may be offered in different languages, but basically the same health education and health promotion is provided as for the general population. Information concerning certain illnesses like depression, PTSD, other mental health problems and HIV has been translated into different languages, mainly thanks to third sector initiatives. NGOs provide web-based information from their own field of expertise, such as the HIV Foundation,[35] *Filha* (Finnish Lung Health Association) about tuberculosis[36] and the Finnish Mental Health Association.[37] Some municipalities provide information in foreign languages, e.g. the city of Tampere on mental health. There is also an increasing amount of video education available, for example a video in different languages about sexuality for asylum seekers.[38]

Provision of 'cultural mediators' or 'patient navigators' to facilitate access for migrants

There are no provisions of this kind anywhere in the country. There have been some local cultural mediator projects.

[29] http://www.infopankki.fi
[30] http://www.suomi.fi/suomifi/english/index.html
[31] http://www.publicserviceinfo.fi/en-US
[32] http://www.kela.fi/web/en
[33] http://www.intofinland.fi
[34] http://bit.ly/2hYJD3U
[35] http://www.hivtukikeskus.fi/en
[36] http://tuberkuloosi.fi/materiaali/animaatiot/
[37] http://www.mielenterveysseura.fi/en
[38] http://bit.ly/2hYhuic

Is there an obligation to report undocumented migrants?

Care providers may not report undocumented migrants to police or other authorities.

Are there any sanctions against helping undocumented migrants?

There is no sanction or law against helping undocumented migrants.

7. RESPONSIVE HEALTH SERVICES

Score 50 **Ranking** ●●●●○

Interpretation services

Qualified interpretation services for patients with inadequate proficiency in the official language(s) are available. Interpreters are provided free of charge to patients – mainly to those with refugee backgrounds and Ingrian returnees whose expenses are covered by the central government. EU citizens also have the right to an interpreter if needed. Some municipalities hire interpreters when needed, but there is no direct legal obligation to do so. Nevertheless, failure to provide an interpreter when one is needed contravenes the Act on the Status and Rights of Patients (785/1992),[39] which states that "Health care professionals should try to give the information in such a way that the patient can understand it. If the health care professional does not know the language used by the patient or if the patient because of a sensory handicap or speech defect cannot be understood, interpretation should be provided if possible." Doctors and nurses of (for example) Russian and Estonian origin who work in health services can function as interpreters when providing treatment to patients from these areas.

Requirement for 'culturally competent' or 'diversity-sensitive' services

Standards or guidelines require that health services take into account individual and family characteristics, experiences and situation, respect for different beliefs, religion, culture and competence in intercultural communication. The Act on the Status and Rights of Patients (see above) states that "the mother tongue, individual needs and culture of the patient have to be taken into account as far as possible in his/her care and other treatment".

Training and education of health service staff

There is no systematic or obligatory training and education of health service staff concerning patients from other cultures. There are no policies to support training of staff in providing services responsive to the needs of migrants. However there are various refresher courses for professionals and trainees on migrant health and other social issues.

Involvement of migrants

There have been some local projects where migrants have been involved in service delivery (e.g. through employment as 'cultural mediators'). As far as we know, non-professional migrants have rarely been involved in the development and dissemination of health care information. Migrant patients or ex-patients or migrant organizations have not been involved in the evaluation, planning, designing or delivery of services. However, migrants have been involved in research (not only as respondents, but also as knowledgeable interviewers and health examiners in various recent studies on the living conditions and general wellbeing of migrants). Additionally, there are growing number of educated second-generation migrant-origin professionals who are working in various migrant-related projects in NGOs, universities and government institutes.

[39] http://bit.ly/2fx8tHm

Encouraging diversity in the health service workforce

There is no national programme or recruiting policy encouraging diversity in the health service workforce. Targeted programmes have been established in the largest cities in Russia, Spain, and the Philippines to recruit care providers such as nurses and doctors into Finland, but not with service delivery to migrants in mind. There are no specific recruitment measures (e.g. campaigns, incentives, support) to encourage the employment of people with a migrant background in the Finnish health care service workforce. However, there are special health care education programmes for migrant origin citizens to train as primary nurses in Finland.

Development of capacity and methods

A targeted national health programme and information for primary care providers about female genital mutilation (FGM), as well a national action plan to reduce this harmful traditional practice, has been launched.[40] Information has been made available in Finnish, Swedish, English, and Somali on the web pages of the Ministry of Social Affairs and Health.[41] Furthermore, there is extensive information in different forms about health and welfare issues affecting people of migrant origin, differentiated by their reason for migration, on the websites of the National Institute for Health and the Welfare and Family Federation of Finland.

[40] see http://bit.ly/2guuqv1
[41] see http://bit.ly/2fju5JQ

8. MEASURES TO ACHIEVE CHANGE

Score 33 **Ranking** ●●●○○

Data collection

In national health registers there are individual identification numbers through which census data on a person's country of origin or mother tongue can be linked to national surveys or medical records containing information on health and utilisation of health services.

Support for research

In recent years, there has been a fair amount of financial support for migrant health research (Castaneda et al. 2012, Nieminen et al. 2015). Funding bodies have in the past five years supported research on the occurrence of health problems among migrant or ethnic minority groups, social determinants of migrant and ethnic minority health, and issues concerning service provision for migrants or ethnic minorities.

A population based survey study concerning migrants' health was carried out in 2010-2012 in six larger cities (the Maamu study). This was followed up in the much larger national *Health and Wellbeing for Residents* (ATH) study (2012-2014).[42] Also, the *School Health Promotion Study* includes identifying questions about the pupil's mother language and her/his parents' countries of birth. In 2014 different national key actors conducted a nationally representative survey of the adult population of migrant origin investigating their work, health and living conditions (Nieminen et al. 2015).

In addition to the aforementioned studies, the Finnish Ministry of the Interior is funding and conducting a *Migrant Integration Barometer* on a regular basis (self-evaluation surveys of service providers, indicators from statistics, and a survey for people of migrant origin). Furthermore, the Academy of Finland has funded some large research projects concerning migrants and their health, e.g. R.-L. Punamäki's project on child development in refugee families and the effects of trauma on parenthood[43] and Pirkko Pitkänen's various collaborative studies concerning multicultural staff in social and health care.[44]

"Health in all policies" approach

As we have seen, "health in all policies" is a well-developed approach in Finland, and there is much research on the social determinants of health (e.g. the Kaste project). However, the emphasis is more on socio-economic factors than the influence of migrant status or ethnicity.

Whole organisation approach

There is no whole organisation approach locally or nationally concerning migrant or ethnic minority health as a priority throughout service provider organisations and health agencies ("integrated" versus "categorical" approach). On the contrary, the predominant approach is based on a "same services for

[42] http://bit.ly/2eXeLnD

[43] http://www.raijapunamaki.com

[44] http://www.uta.fi/edu/yhteystiedot/henkilokunta/pitkanen.html

all" model. There have been only a couple of local experiments like the Migrant Friendly Hospital in Turku and the application of the TF-MFCCH Equity Standards at Turku University Hospital.

Leadership by government

As discussed in Section 3 under 'health policy', many initiatives are taken by municipalities rather than central government, while the emphasis lies more on socio-economic health differences than questions of migrant status or ethnicity.

Involvement of stakeholders

There is no policy to involve stakeholders in the design of (national or regional) migrant health policies. There is no advisory body or centre of expertise promoting cooperation amongst stakeholders on migrant health policy. There is only one national stakeholder, ETNO (the Advisory Board for Ethnic Relations under the Ministry of Justice),[45] whose main aim is to promote a good and a decent culture of conversation. It engages in dialogue with ethnic, cultural and religious minorities, immigrants, public authorities, political parties and NGOs. Through cooperation and discussion, the aim is to build trust and an open Finland. The Board brings together migration experts from national, regional and local levels, ranging from public officials to civil society representatives. It also forms a network of experts on migration, integration and equality which promotes dialogue between different population groups. However, with respect to migrant health research as well as migrant related health and social projects, professionals and communities of migrant origin have been involved as workers and in implementing the results in projects carried out by NGOs such as the Family Federation of Finland.

[45] http://bit.ly/2ijQh5L

CONCLUSIONS

Finland has a well-developed welfare state with evidence-based policies promoting equity and inclusiveness for its citizens. Although the percentage of migrants among its residents is below the average for the EQUI-HEALTH sample, many multi-sectoral policies have been developed to promote migrant integration. Policies for migrant health, however, are not as 'migrant-friendly' as in other sectors of integration.

Finland's health system offers high quality and has several unique features, such as the fact that municipalities make a larger financial contribution than the State, employers are responsible for occupational health, and health care and social services are administered by the same organization (Kela). Whereas in most countries entitlements to care are determined at the level of national government, Finland shows variations between municipalities (for example in the entitlements of mothers, children and undocumented migrants). The country has energetically championed the WHO principle of 'Health in all policies' and much research and policy focuses on protecting the health of the population. However, doubts have been expressed about the implementation and sustainability of some of these policies, including those related to migrants.

Entitlements for migrants are only average for the 34 EQUI-HEALTH countries. New migrants with a temporary residence permit (about one-third of the total) have to insure themselves privately. Asylum seekers are entitled to a smaller range of services than national citizens, while undocumented migrants are entitled to even fewer – and are expected to pay for them.

By contrast, great efforts are made to ensure effective dissemination of information about entitlements, the use of the health system, and health itself. Information is available in many languages. However, little account is taken of cultural differences: for example, 'cultural mediators' are not used. Service provision, too, responds to linguistic differences but only incidentally to cultural ones. As in many health systems, 'equity' is mainly regarded as a matter of ensuring that everyone gets the same, rather than adapting services to different needs. This focus is also seen in relation to measures to achieve change. Data collection and research on migrant health are well under way, but there is little involvement of migrants and their organisations in policy-making. Policy initiatives are more likely to come from municipalities than from central government.

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