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Authors: Tuomisto Karolina, Tiittala Paula, Keskimäki Ilmo, Helve Otto

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Refugee crisis in Finland: Challenges to safeguarding the right to health for asylum seekers

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Authors: Tuomisto K, Tiittala P, Keskimäki I, Helve O

Full names and affiliations:

Tuomisto, Karolina
- Department of Public Health, University of Helsinki, Finland
- Department of Health Security, National Institute for Health and Welfare, Finland

Tiittala, Paula
- Doctoral Programme in Population Health, University of Helsinki, Finland

Keskimäki, Ilmo
- Department of Health and Social Care Systems, National Institute for Health and Welfare, Finland
- Faculty of Social Sciences, Tampere University, Finland

Helve, Otto
- Children's Hospital, Pediatric Research Center, University of Helsinki and Helsinki University Hospital, Finland

Corresponding author and address:

Karolina Tuomisto
National Institute for Health and Welfare
P.O.Box 30
00271 Helsinki
Finland
Tel. +358407158283
Email. karolina.tuomisto@thl.fi

Highlights
- Finland has a partly parallel system for providing health services for asylum-seekers
- Large-scale implementation of existing policies exposed weaknesses in the legal framework
- Extreme decentralisation impeded adequate national coordination and supervision
- Integration of asylum seekers to the national public health care system recommended

Abstract

In 2015 Finland received an unprecedented number of asylum seekers, ten times more than in any previous year. This surge took place at a time the Finnish Government was busily undergoing a wide-

range health and social care reform amid growing nationalist and populist sentiments. Our aim is to explore the governance of a parallel health system for asylum seekers with a right-to-health approach.

We concentrated on three right to health features most related to the governance of asylum seeker health care, namely Formal recognition of the right to health, Standards and Coordination mechanisms. Through our qualitative review, we identified three major hurdles in the governance of the system for asylum seekers: 1) Ineffectual and reactive national level coordination and stewardship; 2) Inadequate legislative and supervisory frameworks leading to ineffective governance; 3) Discrepancies between constitutional rights to health, legal entitlements to services and guidance available.

This first-time large-scale implementation of the policies exposed weaknesses in the legal framework and the parallel health system. We recommend the removal of the parallel system and the integration of asylum seekers' health services to the national public health care system.

Introduction

Over 1.2 million first time asylum seeker applications were registered in the member states of the European Union in 2015.(1) The United Nations High Commissioner for Refugees defines an asylum-seeker as "[…] an individual who is seeking international protection [… and] whose claim has not yet been finally decided on by the country in which he or she has submitted it. "(2) In 2015, Finland received 32 476 asylum applications – an unprecedented number of applications ten times higher than any of the previous 30 years. This number meant that Finland received the 4th highest number of refugees per capita during the 2015 mass migration to Europe, behind Hungary, Austria and Sweden.(1)

Most asylum seekers to Finland arrived during August-December with a peak in arrivals in September. As in many other receiving countries, the rapid surge of asylum seekers caused strain for the reception system. However, in general, adjustments for growing numbers could be implemented quite rapidly, although a major part of asylum seekers crossed the border in the Northern part of Finland, which is sparsely populated.

In Finland, asylum seekers are not granted the same entitlements for health services as the Finnish residents (3,4,5,6,7,8,9), but in general the Finnish legislation provides to asylum seekers a level of access to services comparable to most Western European countries.(10) The system for delivering these services is separate from the general public health care and organised and funded by migration authorities. Its service level has also been designed primarily to receive low numbers of asylum seekers.

In 2015, the increasing demand led to several challenges in ensuring asylum seekers' access to health care. In addition, it took some time before these challenges became obvious at higher levels of governance, which resulted in a delay in addressing them.

With a right-to-health approach, this article explores the governance of the parallel health system for asylum seekers in Finland in 2015-2016. We aim to describe the process of the first-time large-

scale implementation of Finnish policies regarding health services for asylum seekers, to identify challenges related to the governance of the system and to make recommendations for the future.

Methods

Framework for analysis: governance of asylum seekers' right to health

Backman et al (2008) state that "the right to the highest attainable standard of health is the cornerstone of […] an effective health system".(11) It has been established that leadership and governance are cross-cutting components of a health system that serve as "a basis for the overall policy and regulation of all the other […] building blocks".(12) Therefore, we chose to evaluate the effectiveness of the health system in ensuring the right to health for asylum seekers by inspecting its leadership and governance component. WHO defines this component to "[involve] ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system-design and accountability."(12)

A preliminary model on the Right to health features of a health system underpinned by legal obligation, based on the General Comment 14 of the Committee on Economic and Social Rights (CESCR) has been published in the Lancet. (11) We concentrated on the model features that most related to the leadership and governance of the asylum seeker health care: Formal recognition of the right to health, Standards and Coordination mechanisms (Figure 1).

Qualitative review

Three authors of this paper (KT, PT and OH) worked as medical specialists on refugee health at different periods in the years 2015-2018 at the National Institute for Health and Welfare (Finland). They served as physician members of the Reception Unit's health team within the Finnish Immigration Service. One author (PT) also worked briefly as a chief physician at the Ministry of Social Affairs and Health (Finland).

The sources included in this study were gathered by the three authors in 2015-2019. Our qualitative review is based on the sources presented as references in this article as well as recollections of events and communications by the authors during their mandates as medical specialists on refugee health.

Parallel health systems for residents and asylum seekers in Finland

The Finnish health care system is mainly based on public financing derived from taxation and public provision organised by municipalities (Figure 2A). Most funds are collected and pooled at the municipal level. The municipalities also organise primary health services either alone or together with neighbouring municipalities. Specialised health services are organised by federations of municipalities in the form of hospital districts. With the exception of emergency and urgent services, the municipal authorities are legally obliged to provide services primarily for their own residents.

The Ministry of Social Affairs and Health (MSAH) is responsible for planning, steering and enforcing the Government's health and social policies. In practice, national and regional agencies under the MSAH provide policy support and supervision. The health care system is considered in major parts

to be extremely decentralised and the municipalities enjoy a high degree of autonomy when it comes to the planning, organisation, purchasing and provision of health care services.(13) There is a comprehensive legal framework covering, among other things, primary and specialised care, infectious disease prevention and control as well as school health.

The health care system for asylum seekers includes a wide range of stakeholders. The Finnish Immigration Service (Migri, https://www.migri.fi), an agency under the Ministry of the Interior, implements the Finnish immigration policy and oversees the asylum process, including the organisation and monitoring of health care (Figure 2B).

Migri contracts out reception centres that are run by private for-profit and not-for-profit organisations. Each asylum seeker is assigned to a reception centre, which is responsible for ensuring that the asylum seeker has access to basic services, such as housing, boarding, and health and social services. Some asylum seekers may live in private housing, but they also have a designated reception centre for receiving health and social services.

Once assigned to a reception centre, nurses working there offer asylum seekers a voluntary health examination that includes a risk assessment for certain infectious diseases, based on which blood tests and x-rays are ordered. These tests are done at private clinics and laboratories as part of a contract between Migri and private providers who have been selected through a tender process. The nurses also evaluate, on a case-to-case basis, the need for further medical services, such as in the case of acute illness, pregnancy or follow-up of a chronic condition.

Migri covers the cost of health services for asylum seekers. (4) The reception centres can purchase these services – apart from the screenings – from either private or public providers and get reimbursed by Migri.

The supervision of health services differs between the reception centres and general health care. Migri is in charge of overall supervision of reception centre activities, which includes health services. Despite the fact that these reception centres provide some health services, they are not officially considered health care facilities and therefore do not fall under the supervision of the regional state administrative authorities and the National Supervisory Authority for Health and Welfare (Valvira) which otherwise supervise health services (Figure 2).

Governance of asylum seekers' health care

Formal recognition of the right to health for asylum seekers

The right to health is founded on the Universal Declaration of Human Rights from 1948 and derives from the International Covenant on Economic, Social, and Cultural Rights and the Convention on the Rights of the Child.(14,15,16) Finland has ratified these latter treaties in 1975 and 1991, respectively.(17)

According to the Finnish constitution 731/1999, everyone has a subjective right to necessary livelihood and care.(3) However, the Public Health Act and the Act on Municipality of Residency determine the population groups entitled to access municipal services. Thus, individuals without a

residency permit, such as asylum seekers, do not have access to the full range of public health services.

The legislative framework regarding health care for asylum seekers in 2015 consisted of the Act on the Reception of Persons Applying for International Protection 746/2011, Health Care Act 1326/2010, Act on Specialized Medical Care 1062/1989, Communicable Disease Act 583/1986 and later 1227/2016, Act on Health Care Professionals 559/1994 and the Basic Education Act 628/1998.(4,5,6,7,8,9) These laws and policies stipulate that adult asylum seekers are entitled to 'essential and urgent health care'.(4,5,6,7,8)

Urgent health care is defined in the Health Care Act, section 50, as: "[cases] involving an injury, a sudden onset of an illness, an exacerbation of a long-term illness, or a deterioration of functional ability where immediate intervention is required and where treatment cannot be postponed without risking the worsening of the condition or further injury." (5) However, legislation is vague on what is essential health care. The Act of Health Care Professionals, section 22 states that: "A licensed physician [dentist] shall decide on the medical [dental] examination, diagnosis and appropriate treatment of a patient." (8) This indirectly leaves the interpretation of what is essential care to the licensed physicians and dentists caring asylum seekers.

Furthermore, the Act on the Reception of Persons Applying for International Protection defines a possible vulnerable status of asylum seekers depending on age, physical or mental states. However, it only stipulates that this vulnerability will "be considered throughout the asylum process" (4), with no further detail on how this may impact for example the entitlement of vulnerable groups, other than children, to more complete basket of health services.

The situation is different for asylum seekers under the age of 18 years. They are entitled to the same health services, including school health care, as children resident in a Finnish municipality.(4,7,9) This is in line with the basic human rights principle of non-discrimination which is aligned with the Convention of the Rights of the Child.

The role of the municipalities in the organisation of health care for asylum seekers remains unclear within the legislation. Although the Act on the Reception of Persons Applying for International Protection stipulates that the reception centres contracted by Migri organise health care for asylum seekers, it also states, for example, that children seeking asylum should receive the same care as children resident to the municipality.(4) This implies that the municipalities have a role to play in providing health services for asylum seekers. The municipality's role in the organisation and provision of health services is also implied in the preamble and bill to the Act.(18)

Also, the Communicable Disease and Basic Education Acts clearly identify the role of the municipalities in prevention and control of infectious diseases and in provision of school health care within their area, irrespective of the residency status of the people involved.(7,9) In addition, some health services are in practice only provided by the municipal facilities, such as preventive child and maternal health care, immunisations using vaccines from the national vaccination programme as well as other infectious disease control measures.

All in all, the right to health of asylum-seeking children is formally and fully recognised in the legislation. For adult asylum seekers, access to health services is more restricted by law. However,

the legislation remains open to interpretation on what might be considered essential care. Furthermore, which institution is effectively responsible for the organisation and provision of health services remains unclear within the legal framework.

Standards for asylum seeker health care

In terms of health care standards, a policy document on the prevention of infectious diseases among refugees and asylum seekers has been issued by MSAH.(19) Apart from these issued recommendations, MSAH has played a relatively small role in the health care for asylum seekers. MSAH and agencies under it have mainly provided guidance for the structures already present in the overall health system. Migri and the Ministry of the Interior have had more or less full responsibility for the asylum seekers' services. Migri monitored, guided, supervised and paid for the health services.

Before 2015, Migri had only a limited capacity of health care expertise. Previously, health care issues were under the responsibility of one non-medical civil servant in Migri's Reception Unit. However, soon after the rapid increase in the numbers of asylum seekers, a health team was set up. Migri collaborated with the National Institute for Health and Welfare (THL) to recruit experienced nurses and doctors to the team working at the national level. (20,21) Subsequently, the team was able to develop and update guidance, supervisory and monitoring frameworks. THL published this guidance on its website and Migri also disseminated all available guidelines to the health professionals at the Reception Centres.

Toward the end of 2015, MSAH issued a letter confirming the usage of national vaccination programme vaccines to vaccinate asylum seekers. (22) This was the first significant contribution to the stewardship of asylum seeker health care by MSAH. The role of MSAH became more visible as after this important policy decision.

Despite improvements in available guidance from the Migri health team and existing legislation, some municipalities initially failed to assist with prevention and control measures regarding infectious disease epidemics involving asylum seekers. Other municipalities blatantly refused to provide public preventive health services to children irrespective of the fact that children applying for asylum had a right to the same services as the children resident in municipalities.(23,24) The Association of Finnish Local and Regional Authorities (Kuntaliitto) representing municipalities later realigned their stance to the national guidance with regards to school children, but remained ambiguous in their view and guidance on services to children under school age, which is seven years in Finland.(25)

Finland has a strong public system of antenatal, postnatal and well-baby care services, which includes among others free immunisations. However, in the case of asylum seekers, the law seemed ambiguous with regards to who should provide these services. Even the preamble of the bill of the Act on the Reception of Persons Applying for International Protection did not explicitly indicate the public sector to be responsible for providing these services.(18)

To make the issue more complicated, in some cities and regions of the country, the reception centres had purchased some child health and maternal health services for years from private providers. However, these services were not comparable to the services provided by municipal

health centres partly due to a national license required for supplying the full range of services. Although in some municipalities private providers had acquired the required licenses, they were not for example able to provide mothers and children with free vaccines from the national vaccination programme.

In 2016, MSAH attempted to clarify what was meant, for instance, with the 'right to essential and urgent care services', the rights of children to the same care as resident children and what was expected from the municipalities in facilitating access to the services. For example, MSAH identified pregnant women as a special group who should have access to a wider range of services. MSAH issued guidance letters to the municipalities that defined essential care to include among others antenatal care and treatment of chronic diseases. However, the message still remained ambiguous and it had but little impact.

In spite of the guidance letters, reception centre nurses kept contacting the Migri health team with the message that, in some cases, asylum seekers had been denied essential and urgent care. A notable example were asylum seekers who had attempted suicide and who in some areas of the country were not being provided any follow-up or psychiatric assessments after the emergency care received. There were several reports of situations where asylum seekers had to endure long waiting periods to access treatment for mental health conditions including attempted suicide.(26,27) As a result, the health team was in constant contact with these public health facilities to provide them with further guidance on asylum seekers rights to the given services.

At a later stage, due to continuing poor access to preventive services among children seeking asylum in some municipalities, the issue was brought up to the Parliamentary Ombudsman. Migri health team members gave interviews to the media regarding some of these access problems and the professional organisations of paediatricians and gynaecologists issued statements regarding rights of children and pregnant women to health services irrespective of their immigration status.

Coordination mechanisms for asylum seeker health care

In December 2015, due to worrying messages in relation to screening guidance given by some of the regional authorities, MSAH organised a meeting for a large group of stakeholders, including a selection of regional state administrative authorities, hospital districts and municipalities. During the meeting it became clear that there were some very different views regarding how the asylum seeker health care policies should be implemented. For instance, the Hospital District of Helsinki and Uusimaa and the Southern Finland state administrative authority had circulated a mutual guideline to the reception centres in their catchment areas, which recommended a reduced scope and scale of screening and immunisation compared to the national guidance.

As a result, at the initiative of MSAH, a national level coordination group was set up, and it included representatives from MSAH, Migri, THL and the Association of Finnish Local and Regional Authorities. However, the coordination meetings were only used for sharing information and clear action points were seldom drawn from the meetings and situation assessments were not systematically compiled. A key MSAH official working on health and social affairs in relation to asylum seekers was placed in the cabinet of the Minister of Social Affairs and Health. Apart from the coordination group, MSAH stewardship seemed to be reacting rather than taking proactive measures.

After the December 2015 meeting, it was clear that some regional as well as municipal authorities had decided to deviate from national guidance provided by Migri in the face of the sudden influx of asylum seekers. For different reasons, some cities, hospital districts and regional state administrative agencies as well as the Association of Finnish Local and Regional Authorities were opposed to the national guidance regarding the scope and scale of the health examinations, screenings and immunisations for asylum seekers.

Migri as well as other central government officials took several measures to gradually address the inadequacies of asylum seekers' health services. The Migri health team organised negotiations with municipalities that were not following the national level guidance in order to discuss the underlying issues as well as to find solutions to the growing problems of asylum seekers' poor access to health services. The general guidance letters to the municipalities that had been issued in early 2016 by MSAH, and while not so effective by mere post, proved useful as a negotiation tool. (28)

In retrospect, what probably made the most substantial impact, with respect to the municipal health services and public hospitals, was the involvement of the National Supervisory Authority for Welfare and Health (Valvira), although only at a later stage. Valvira operates under MSAH and has an overall supervisory role in the Finnish health and social service system (Figure 2A). The steering and supervisory abilities of MSAH were therefore indirectly strengthened, as Valvira was able to bypass the regional state administrative agencies, which had differing positions on the extent of providing health services for asylum seekers.

A lack of accurate and specific data on health among asylum seekers prompted Migri and MSAH to request THL to launch the monitoring of asylum seekers' health examinations, with a particular emphasis on the implementation of screenings. In the spring of 2016, a first nation-wide survey was sent to the nurses and directors of the reception centres. The results were clear: in the areas of the two regional state agencies that had individual civil servants opposing to the policy, guidance regarding screening had not been followed. Reinforced negotiations with specific problematic municipalities were conducted and further training for the nurses was organised. Six months later, a second survey showed much improved results and it was estimated that a vast majority of asylum seekers had finally been screened according to the guidelines.(29) Analysis of national level procurement data for 2015-2016 revealed however that coverage of pulmonary TB screening was 71.6% and that of hepatitis B, HIV or syphilis screenings 60.6%.(30)

Discussion

Prior to the refugee crisis, Finland had been considered to have a relatively functional system for delivering health services for asylum seekers. However, in 2015-2016 this parallel system was tested for the first time in a situation requiring a larger scale implementation of the existing policies. This invariably revealed several weaknesses in the governance of the system, especially in safeguarding the right to health of asylum seekers.

Three major hurdles were identified in our review: 1) national level coordination and stewardship over the implementation was not adept nor proactive enough; 2) the parallel healthcare system for asylum seekers is not based on adequate legislative and supervisory frameworks and therefore lacks

resources and expertise for effective governance; and 3) discrepancies exist between constitutional rights to health, legal entitlements to municipal health services and national, regional and local guidance available to reception centres, and public and private health facilities.

1) Ineffectual and reactive national level coordination and stewardship

Migri acknowledged early its insufficient expertise with regards to infection prevention and control but also medical services in general, and sought collaboration with MSAH and THL. Migri agreed with MSAH and THL on recommendations and worked closely together to achieve the common goal of ensuring the access to health care of asylum seekers. However, MSAH and THL contributions took place on an ad hoc basis and the official system and regulations do not acknowledge that cooperation between immigration and health authorities is crucial in ensuring appropriate access to services.

Migri only had direct power over the reception centres and their activities, but not over municipalities, hospital districts or regional authorities. If the centre was located in an area where the regional and municipal authorities were inclined to restrict health services for asylum seekers, negotiating with these authorities was the only option for Migri to influence the situation. In some cases, the negotiations did bring some positive results, but altogether it was unfortunate that the central government did not have more leverage over regional and local decisions.

2) Inadequate legislative and supervisory frameworks leading to ineffective governance

Operating under the Ministry of the Interior, Migri lacked the capacities required to organize parallel health care for a population with specific vulnerabilities and needs. Moreover, stewardship by MSAH was weak and this was, on one hand, due to the practice of organising asylum seekers' health care through the reception centres, which are not considered health care facilities and therefore not supervised by the regular health care supervisory agencies. On the other hand, the autonomy of the municipalities and relative independent position of regional state administrative agencies enabled them to choose to deviate from national guidance without repercussions.

Recent evidence from Canada suggests that institutions may have a strong impact on provision of health care to asylum seekers (31). As the health sector is small in Finland, the impact of a few well-placed professionals with different ideas at the supervisory level on others closer to health service delivery may be significant. In the light of this, MSAH stewardship over any delegated supervisory agencies would need reinforcement to prevent deviations from national guidance.

A notable exception in the lack of power of MSAH in Finland is the Communicable Disease Act, which was actually updated around the same time. This act provides MSAH with a solid steering function in special situations regarding health care. In fact, the existing preparedness and contingency plans took into consideration large influxes of migrants and the number of migrants reached the predefined minimum threshold for a special situation. However, the Government in power at the time did not consider this particular influx of migrants to be comparable to a special situation or a state of emergency and thus MSAH stewardship by law remained weak.

In addition to hurdles due to governance structures, political factors may have influenced MSAH's reactions on difficulties in health service delivery for asylum seekers. The Government that started

in office in spring 2015 resumed the preparations of a wide-ranging health and social care and local government reform, which substantially occupied MSAH civil servants particularly due to the complex preparation process.(32) Another factor may have been that the government coalition of the time included the populistic Finns party, which has been strongly critical towards Finnish refugee policies. While during the crisis the Minister of Social Affairs and Health came from the Finns party, MSAH may have been hesitant to effectively address the challenges on organising asylum seekers' health care.

3) Discrepancies between constitutional rights to health, legal entitlements to services and guidance available

There was a legal framework, including the Finnish constitution and laws on health care and the reception of asylum seekers that outlines the right to health for asylum seekers. Some guidance existed and more was developed along the way to serve national, regional and local stakeholders. In addition, there were existing processes for health service delivery. However, issues with access to services arose for both adult and child asylum seekers, as legislation seemed open to interpretation and the roles in health service delivery remained unclear.

Recommendations for Finland and other countries

A) Carry out an evaluation of the processes during the crisis and a health system capacity assessment using the WHO-EURO Toolkit

A review commissioned by the Ministry of the Interior released in 2017 concluded that collaboration between the national level and different regional and local actors was a major issue across the board with regards to the response to the migrant crisis in Finland.(33) While the review did not analyse thoroughly the experiences on organising health services, it would be important to carry out a broad evaluation addressing all relevant actors involved in health care for asylum seekers in 2015-2016 and appraising the responses to the large influx of migrants. In addition, Finland, as well as other countries in Europe, should consider assessing its health system capacity to manage large influxes of asylum-seekers using the WHO-EURO Toolkit to better prepare and adapt for future challenges.(34)

B) Define clear roles and tasks for the institutions involved in asylum seekers' health care

Initially, drawing on the experiences and on the discussion above, it seems obvious that there is a need to reconsider how health service delivery for asylum seekers is organised in Finland. While Migri's role and responsibilities with regards to organising health care for asylum seekers need to be re-evaluated, the general supervisory authority for health and social services, Valvira, under the auspices of MSAH, should assume more responsibility in supervising the activities of the reception centres and health services procured by them. The cooperation mechanisms should be rendered more effective by defining clear and synergistic roles for different institutions and especially by narrowing down the divides between MSAH and the Ministry of Interior and the institutions they delegate power to.

C) Strengthen the legal framework by identifying vulnerable groups and their needs and provide clearer guidance on implementing the policies to all health professionals

In spite of the right to health for asylum seekers being formally recognised, there is a need to strengthen the legal framework to safeguard this. Identifying vulnerable groups and their needs should be a priority in order to improve their access to needed services. The legislation should also clarify the roles of different stakeholder within the process of health service delivery. Similarly, although standards and guidelines for implementing policy are available, they should provide clearer guidance to all health professionals and be more widely disseminated.

D) Move away from emergency response to an individualised and integrated care

Finland approached the refugee crisis and health needs of asylum seekers in a reactive way: an emergency response. This may not be the most effective way to provide health care to asylum seekers and therefore it would be important to reconsider health service delivery to asylum seekers as a whole. Puchner et al. (2018) concluded that European countries have failed to address important issues in relation to asylum seeker health care, including vulnerable groups and their specific needs. Moving away from an emergency response to more planned and individualised care is the direction European countries should take (35).

E) Consider alternatives to the parallel health system to improve continuity of care and integration to the national health system

An option for Finland could be to abolish the current parallel system and provide health services for asylum seekers within regular public sector health care. Some European countries such as Austria run a similar parallel system, while others including the UK allow asylum seekers to access to the National Health Service.(36,37) This can be especially important when it comes to preventive services, as the public sector has the knowhow and experience in providing them. It would facilitate the continuum of care as well as integration of asylum seekers into the health system, as a large part of them eventually become Finnish residents.

Conclusions

Before the migrant crisis, Finland had existing policy and preparedness plans at national level as well as a basic overall structure to provide health services to asylum seekers. The structure however faced challenges in the context of a large influx of migrants over the course of just a few weeks. Policies and roles of the different actors were not clear. This first-time large-scale implementation of the policies exposed weaknesses in the legal framework and the health system as a whole.

In summary, a lack of will and means to cooperate, inadequate coordination and supervisory structures at different levels and the reactive leadership approach exposed worrying aspects of the extreme decentralisation and weak stewardship of health care in Finland. Our review of the right to health of asylum seekers from a governance perspective during the migrant crisis in Finland, prompts a proposal to abolish any parallel system of asylum seekers' health services, and to integrate them to the national public health care system and its supervisory framework.

Conflict of interest

KT, PT, OH have all worked as medical experts on refugee health at the National Institute for Health and Welfare and as part of the Finnish Immigration Service health team.

IK is asked to advise the Finnish Ministry of Health and Social Affairs from time to time regarding issues related to health and health care policies.

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Fig 1

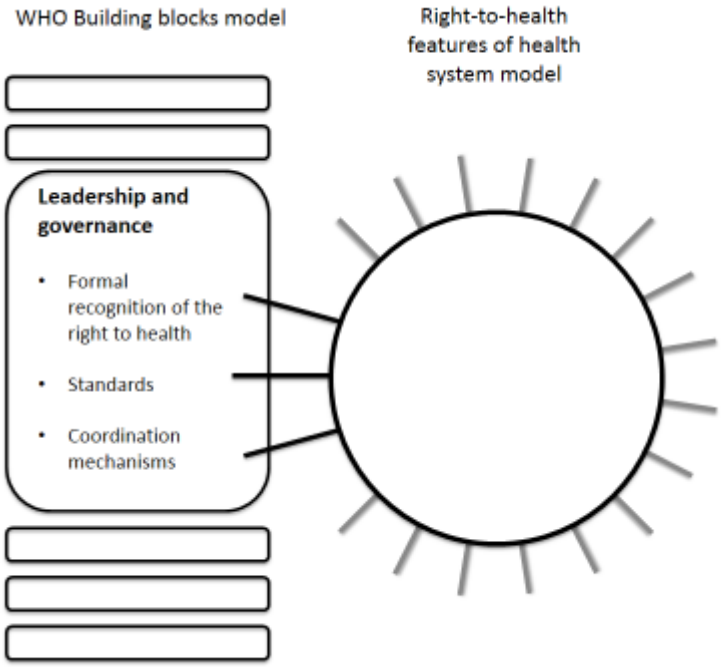

Fig 2a

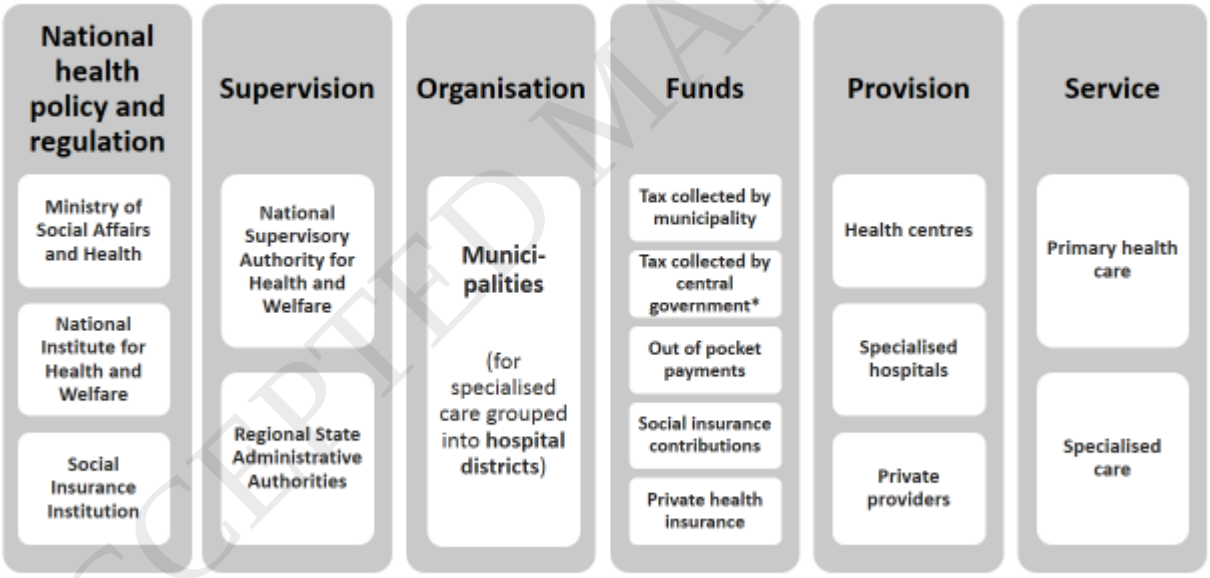

Fig 2b