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Indigenous Peoples' Self-determination and Long-term Care: Sápmi and Nunavut

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Abstract

This paper examines long-term care for the elderly as a point of departure for critically engaging with the debate on the self-determination of Indigenous peoples. By employing the case of the Arctic Indigenous peoples, the Sámi Parliament (Sámediggi) in Norway and Government of Nunavut in Canada, are utilised as central cases from which to explore the institutionalization and self-determination. The thrust of the paper calls for a critical re-investigation of the contingency of long-term care for the elderly in the context of claims of Indigenous sovereignty.

Specifically, I examine the landscape of population ageing and the organisation of care among the Sápmi and Nunavut populations, focusing on colonisation from a circumpolar perspective. The functions and practices of Sámediggi and Government of Nunavut are analysed to illustrate how self-determination is exercised and to what extent they safeguard the rights of elderly people. Sámediggi and Nunavut government as institutional arrangements that mark significant advancements in Indigenous peoples' reclamation of power and restoration of sovereign rights are discussed. Unfortunately, the political functions that would allow self-determination and self-government to be effective continue to be limited for the Inuit in Nunavut and the Sámi in Sápmi on the Norwegian side.

Key words: self-determination, self-government, Nunavut, Inuit, Norway, Sápmi, Sámi, long-term care

Introduction

Indigenous peoples of the circumpolar North are actively reclaiming autonomous power, from which two overarching socio-political trends can be discerned. First, approaches to accommodate the claims to self-determination of Indigenous peoples have developed in various ways. Over the past few decades, a trend in institutionalising self-determination has proven to be prominent in the circumpolar North, notably, manifesting in the Sámi Parliaments in the Nordic countries, and, the Home Rule of Greenland and the Government of Nunavut (see Figure 1). Second, claims to self-determination are evident when Indigenous peoples engage in stronger efforts to assert their autonomous authority. Based on these trends, common topics for discussion can be identified, including language, cultural autonomy, land rights, rights to natural resources, functions of self-determination institutions and financing schemes for these institutions (Anaya, 2011; Dahl, Hicks, & Jull, 2000; Kuokkanen, 2017; Stępień, Petrétei, & Koivurova, 2015). While there is rich literature in Canada on Indigenous peoples' jurisdiction over social policy and services, especially in child welfare (Blackstock 2016; Shewell 2016; Shewell and Spagnut 1995; Wien at al 2007;) there remains a paucity in the research linking Indigenous peoples' well-being and long-term care to their expressions of self-determination and decolonization. This study aims to address the gaps by conducting an institutional analysis of long-term care connecting the concept of self-determination to the practice of self-government. That is, assess the quality and character of long-term care as a barometer for determining the scope and scale of indigenous self-governance and extent to which successive colonial governments willingly cede power to, and control over indigenous resources.

Decolonisation is a focal emphasis in the institutional analysis of long-term care. This study locates its analytical focus within the transition from a newcomer-dominant society (or 'secondary society') to a society wherein Indigenous peoples have regained autonomous power (or 'tertiary society'). The study compares the Sámi and the Inuit, and aims to answer the following questions: (i) do the institutions of self-government for the Sámi in Norwegian Sápmi and the Inuit in Nunavut

allow them to determine their own system of long-term care? (ii) And, what localised measures have they taken toward advancing long-term care for the elderly? The Sámi Parliament in Norway (hereinafter Sámediggi) and the Government of Nunavut are each examined as concrete examples of the institutionalisations of self-government in the context of a localised devolution strategy.



Figure 1Demography of indigenous peoples of the Arctic based on linguistic groups. Hugo Ahlenius, UNEP/GRID-Arendal

Analytical framework

Indigenous peoples, colonisation and three categories for self-determination

Three sociological categories are delineated in order to illustrate pathways to the self-determination of Indigenous peoples across the Circumpolar North: (1) primary society, (2) secondary society, and (3) tertiary society (Andreyeva, Poelzer & Exner, 2010: 2-3). Primary society, or the indigenous phase, refers to the chronological time ranging from 40,000 BP to the 18th century. Secondary society, or the proto-colonial phase, refers to occupation of Lapland, Greenland, Canada, Siberia and Alaska by European settlers. It is during the 19th century period where European settlers imposed a market economy over existing economic arrangements from which arose an entirely new social, civil and political arrangement to support it. Tertiary society refers to a modern day nascent stage, where Indigenous peoples' inherent rights to self-determination are recognised by the states. It is characterised by decolonisation and the re-autonomisation of Indigenous sovereignty as enshrined in the UN Declaration on the Rights of Indigenous Peoples.

When focusing on the term *Indigenous peoples* as a political category - with emphasis on colonial contact - the term refers to an involuntary, or forced transition from a primary society to a secondary society. Martínez Cobo (see Frinchner, 2010) enumerates three main features linked to the political nature of the concept itself. First, Indigenous peoples are the geographic land inhabitants who had established their own societies before the invasion or arrival of colonisers. Second, Indigenous peoples are today not the dominant power holders, whether in terms of number or influence. Third, Indigenous peoples have their own unique languages, cultures and social, legal and political institutions, distinct from those of mainstream society (UN Commission on Human Rights, 1982). These characteristics are shared among Indigenous peoples, including the Sámi and Inuit.

Secondary society

The struggles and experiences of Indigenous peoples to survive oppressive colonial forces constitute commonality and consistency among Indigenous peoples worldwide. They are what Gray et al. (2013: 5) call a "shared experience of dispossession, discrimination, exploitation and marginalisation precipitated through the colonial projects". Colonial social policies create distinctive pathways at the stage of secondary society and this is no different for the Sámi and Inuit.

The Sámi people have had occupation claims in the circumpolar North region for centuries and their self-government system was usurped by European settlement during the 1700s. A religiously-initiated incursion into Sámi-held territory took place, precipitated by a further incursion spurred on by European colonial expansionism, justified by 19th century social Darwinism (Hicks, 2000). From 1851, Norwegianization was introduced as mandated policy by the school system to assimilate and control Sámi. Phrenology was used as a theoretical basis to correlate and validate claims of inferiority based on skull size and consequently decreased psychological aptitude and intelligence. As both phrenology and religiosity became more pronounced during the early part of the 20th century (1900-1940) the assimilation of the Sámi was consequently normalised and justified in the name of race and eugenics, and a caring paternalism, rendering Sámi people to the category of a dying race, and, according to Henriksen (2016) in need of an improved welfare system.

As with the Sámi, the Inuit of Canada inhabited the circumpolar North. Their encounters with colonial settlers from the south began with the whale traders and Judeo-Christian missionaries whose influence over time resulted in the usurpation of Inuit culture and their rights to self-determine. This settler arrival phenomenon disrupted traditional systems of child care by introducing paternalistic laws and ordinances that legitimated the forced separation and removal of Inuit children from their own homes (Sinha and Kozlowski, 2013). Indigenous children were subjected to abusive laws that were intended to 'civilize and Christianize' them in church-run residential facilities. It was enacted and enforced through child welfare measures such as the 'Sixties Scoop'— a term first coined by Patrick Johnston (1983). It referred to

a pervasively harmful practice that took place from 1960 to mid-1980 where Indigenous children were literally 'scooped' from their families and adopted into non-Indigenous homes; the rationale being Indigenous peoples were culturally and racially inferior and incapable of taking care of their children (Sinclair, 2007). This aligned to misplaced colonial ideologies, resulting in the ill-fated rise in Indian Residential Schools (IRS). Kuokkanen (2003) argued that institutional care for native children was in reality a pretext for separating them from their communities and families. The essence of this action was, and has fundamentally been, to assimilate, disempower and control of the Natives. This argument can be applied in the cases of both the Sámi in Norway and the Inuit in Canada, since both nation-states implemented residential school systems (Smith, 2009).

Social policies in modern states (tertiary societies), particularly those policies relating to child welfare and elderly care, are entrenched in a paternalistic charity of imperialism and a mindset of racial superiority. This system and its deeply embedded mindset perpetuates marginalisation through objectification and a learned sense of helplessness (see Greenwood & Schmidt, 2010 and Smith, 1999). Typically, a state provides one-size-fits-all approach to services as a way to promote a common sense of national membership and to consolidate a homogenous national identity. Such policies and services tend to have a catastrophic impact on indigenous communities. For example, native children in Canada suffer "disproportionately high rates of suicide, sexual abuse, incarceration, poverty, and unemployment and low rates of educational success" (Blackstock, Trocmé and Bennett, 2004: 904) and this is linked to cultural historic trauma and lose of identity. The suffering is also linked to a sense of disconnect from the land. Mohawk scholar Taiaiake Alfred offered a conceptualisation of colonialism applicable to wider Indigenous struggle against colonial oppression. According to Taiaiake Alfred (as cited in Corntassel, 2012), colonialism is "an irresistible outcome of a multigenerational and multifaceted process of forced dispossession and attempted acculturation—a disconnection from land, culture, and community—that has resulted in political chaos and social discord within First Nations communities and

the collective dependency of First Nations upon the state" (p:88). While there are important differences among those in the circumpolar North, we can agree that they "share significant symmetries that have evolved from the common experiences of European colonialism" (Gray et al., 2013:5) and a colonial patronage inherent in secondary societies. Collectively, disconnectedness, as understood by Taiaiake Alfred, reveals complicity and perplexing consequences related to indigenous well-being. It is crucial therefore that we examine the significance of disconnection to determine and unravel what well-being means in transition from a secondary society to a tertiary society.

The shift from secondary to tertiary societies

The past three decades have witnessed a shift in the circumpolar North from secondary to tertiary societies (Andreyeva, Poelzer & Exner, 2010). This shift signifies a normative goal in which self-government and self-determination are focal points in the decolonising process and the reconciliation of Indigenous peoples and the modern states. At the opening of the 15th United Nations Permanent Forum on Indigenous Issues (UNPFII) in 2016, Jody Wilson-Raybould, Minister of Justice and Attorney General of Canada and former British Columbia Assembly of First Nations (BCAFN) regional chief, stated that real reconciliation between Indigenous peoples and Canada can only be achieved when Canada establishes a nation-to-nation relationship with Indigenous peoples "based on the recognition of rights, respect, co-operation and partnership". She further emphasised that the legacy of colonialism will persist so long as Canada is unable to move beyond a system of imposed governance (Wilson-Raybould, 2016). Her statement clearly reflects the shift needed to transition from a secondary to a tertiary society in Canada.

Although Canada has made significant strides toward the implementation of Indigenous peoples' self-government, it requires further investigation whether this political gesture reflects in the Inuit self-determination through land claim in Nunavut. In Norway, the Sámediggi first convened in 1989 under both the Alta Case and Sámi claims to cultural and legal rights. The establishment of the Sámediggi signified a constitutional approach to self-government that was different

from the Canadian experience. No matter what the route however, the goal was to take lawful control over their resources and destinies. In spite of this common desire, the Sámi and the Inuit encountered Wilmer, referred to as "the unfinished business of decolonization" (1993: 5). Meaning, that is the processes by which Indigenous people leverage their claims in the transition from secondary to tertiary society are plagued by colonial institutional demands. This correlates with Harris-Short's binary analysis (2012: 288-289), in which she argues the core tenets of substantive self-government are established and weighed between reconciling efforts to decolonise and how one expresses sovereignty. Based on these points Norway and Canada are contentiously still in the early stages of decolonisation.

Worldwide, the histories of systematic colonisation has led to contemporaneously appalling well-being standards and an epidemiological profile that depicts Indigenous peoples as a sick and dying race (Cunningham, 2009). Structures built on colonialism and racism have further pathologized Indigenous peoples and negatively impacted their health, their state of mental and spiritual wellness and sense of identity (Adams et al., 2017). Cunningham (2009) affirms "Indigenous Peoples have experienced a collective history of genocide, dispossession and dislocation" (p. 167). The colonial impact inherent in secondary society includes Indigenous peoples suffering higher negative health disparities compared to their national population health figures. The Sámi are however an exception. Their epidemiological profile does not indicate any significant difference from the Nordic national population. However, disaggregated data on Sámi health with ethnic markers are still not measured, as such it is difficult to draw substantive conclusions about Sámi's true state of well-being.

Over the past decade indigenous social work scholars have questioned current social policies, in particular, child welfare and their links to colonisation and assimilation (Gray, Coates, Yellow Bird and Hetherington, 2013; Henriksen, 2016; Sinclair, 2007). These policies fail to acknowledge intergenerational trauma (Bombay et al., 2014; Menzies, 2010) among other things, the consequence of which, is to undermine the Indigenous healing practices (Bombay, Matheson, & Anisman,

2014). For this reason, social workers are reminded, when working with Indigenous peoples, that one needs foremost to understand the issues created by colonisation (Tamburro, 2013). Linking intergenerational trauma and social work practice, Indigenous scholar Michael Yellow Bird utilises "neurodecolonization" to demonstrate how trauma and stress negatively influence brain chemicals (Yellow Bird, 2013). He further argues that the restoration of cultural practices, beliefs and values that antedate colonisation are essential for the survival, resiliency and well-being of Indigenous peoples.

In this light, while Norway, Sweden, Finland and Russia continue to perpetuate efforts to assimilate the Sámi into their majority mainstream societies (Blix, 2013), the Sámi resolve to self-determine and decolonise remains strong. Similar patterns are observed among Indigenous peoples in Canada, as Abele (2013) suggests that intergovernmental systems are in place to keep Indigenous people in a state of limbo where access to social and healthcare service become entangled in federal—provincial—municipal bureaucracies and institutionalised practices, policies and assumptions that attempt to derail strategies that actively pursue the well-being of the Indigenous peoples. Scholars argue that these patterns can be nullified if we commit to sustained political and economic self-determination and self-governance (Durst, 2010; Harris-Short, 2012; Littlechild & Stamatopoulou, 2014; The Truth and Reconciliation Commission of Canada, 2015), education (Frideres and Gadacz, 2007; Smith, 1999) and empowerment (Andreyeva et al., 2010; Wilson, 2004). However, we have to ask what does this mean in the context of the well-being and overall health in terms of the long-term care systems of the elderly?

Self-determination in indigenous elderly care entails the autonomy to define and control the design, resource allocation and delivery of social and health services. The UN Declaration on the Rights of Indigenous Peoples recognises autonomy as "the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions" (Art. 23). Not only do Indigenous peoples have the right to their "traditional medicines and to

maintain their health practices … Indigenous individuals also have the right to access, without any discrimination, to all social and health services" (Art. 24). The role of the state is to "take effective measures to ensure" that programs are pertinent to the good health of Indigenous peoples by "monitoring, maintaining and restoring the health" (Art. 29). The premise of this paper as stated earlier is to assert the quality and character of long-term care as an effective barometer for assessing the scope of indigenous self-governance and the extent to which decolonisation and efforts of successive governments willingly cede power to, and control over indigenous resources.

The theoretical pillars of self-determination and self-government and operational strategies for conceptualising the comparison of the Sámi homeland (hereinafter Sápmi) and Nunavut are introduced in the following sections. Here, I will focus on the scope of the framework of self-government. Special attention is placed on how this converges with, and diverges from, self-determination.

Theoretical pillars of self-determination

Indigenous peoples in Sápmi and Nunavut have been exercising self-government long before the colonial settlers arrived, maintaining their own political, economic and legal institutions, the key markers of a primary society. In secondary society, colonisation dismantled their ability to fully practice self-government, disrupted their community connections and deprived the people of their aspiration to self-determine (see Corntassel, 2012; Gray, Coates, Yellow Bird and Hetherington, 2013). Tackling ongoing colonial policies is essential for the shift from secondary to tertiary society. Colonial policies manifest in how Indigenous peoples, including children and the elderly, are objectified just for being Indigenous. Self-determination is needed in healing the disconnect and intergenerational trauma resulted from such obfuscating treatment. In shifting to tertiary society, the right to self-determination intentionally asserts and assists Indigenous peoples to regain power. UN Special Rapporteur on the Rights of Indigenous Peoples James Anaya confirms by affirming Indigenous peoples' rights "to control and manage their own affairs and to participate effectively in all decisions affecting them" (UN Human Rights Council, 2011: 21).

This movement to recalibrate self-determination is evident in Canada and Norway. For the former, processes to achieve Indigenous peoples' self-government have taken place to facilitate power transitions from the federal government to the Indigenous people in Canada. An Inuit majority in Nunavut exercise their right to self-determine through public government. For the latter, autonomy is exercised in the form of the Sámi parliamentary system in Norway. The Sámi who registered in the census are eligible to vote or be elected - regardless of limited Sámi self-determination that is arguably reduced to that of a consultative role (Kuokkanen, 2017). Through these institutions, the Inuit and Sámi exercise long-term care policy decisions by deliberating and legislating on their own behalf to support their own social and health services.

To examine care institutions as a barometer of self-government and self-determination, the concepts of self-determination and self-government in relations to long-term care needs to be explicated. It is necessary because while they may seem synonymous, in practice they are distinct from one another. Drawing on Durst (2010)'s definition, self-determination "refers to the right and ability of a people or a group of peoples to determine their own destiny without external control or influence" (Durst 2010: 71). This right to self-determination is viewed as an inherent and collective right that is both a practice and a principle. He argues that self-government may entail diverse pathways/strategies in order to achieve self-determination. In order to achieve substantial self-determination, he identifies that the self-government body needs to fulfill the following:

> First, there must be the legal, political, or structural framework to be sovereign and operate as a supreme authority within a defined geographic area. Second, the self-determining body must have sufficient financial resources; and, third, the body must have an adequate social infrastructure, the knowledge, skills, and values (competencies) required to make self-determination happen. (Durst 2010: 71)

Using the case of the First Nations in Canada, Durst (2010: 71) compels us to accept that the Indigenous peoples of Turtle Island (the Americans) never ceded their rights to self-determination - including rights to

control affairs affecting children and families -- to colonial imperial forces. Normatively speaking, the right to self-determination is always present. The realisation of self-determination correlates directly to one's fulfillment of self-government in practice. To explain, the goals of self-government are three-fold: first, to strengthen control of local communities and increase local decision-making; second, to delineate specific local needs of Indigenous communities that are based in their distinctive cultures and historical context; third, to ensure the local people involved in the self-government structures are accountable (Frideres and Gadacz, 2007). The ultimate goal is to restore the inherent right to self-determination through pathways/strategies that are culturally appropriate and most suited to local conditions and circumstances. Self-government is a prerequisite to realising self-determination, which is a normative goal. High level of self-government, however, does not guarantee self-determination is present.

In elderly care and social welfare provisions, pathways to self-government are conceptualised as political processes through institutional arrangement; however, practicing self-government does not automatically mean self-determination is achieved. Using the First Nations in Canada as an example, Indian self-government of social services is at a high level because local band offices have direct administrative control over welfare programs within local communities. However, the contractual agreements between the Band Council and the federal Department of Indian and Northern Affairs (INAC) reveals a more ominous side: if local band offices violate federal procedures or regulations in any way they can be terminated without recourse. Local band offices are carefully circumscribed to be self-governing and making decisions on affairs that are only directed affecting themselves. They are not charged with any rights or responsibilities to self-determine on behalf of their people as they are contracted to fulfill federal obligations (Durst, 2010). From this example, we observe high level self-government does not equate to high level self-determination.[1] The

[1] It is worth noting that self-government and self-determination in the context of Indigenous peoples seldom necessitates a secession from the existing state. While asserting ancestral land rights and gaining higher level of territorial sovereignty are important for the Indigenous peoples, it does not necessarily entail separating from the states.

following section focuses on strategies of indigenous self-government in Norway and Canada as a way of examining the extent to which self-determination has been achieved.

Strategies of self-government

As stated above, high level self-government does not necessarily ensure high level self-determination. The political process underlying increasing legal recognition of indigenous self-government is nevertheless a prerequisite to self-determination. Discussion on Indigenous peoples' strategies of self-government are essential to create pathways in which care institutions are barometers of self-determination.

To begin, Rehof proposes a "legal *modi vivendi* between the State and the indigenous people" (1994: p.25) as concrete pathways for how secondary society shifts to tertiary society. In examining these legal arrangements, Rehof establishes six typologies to illustrate a spectrum pertaining Indigenous peoples' self-determination (Rehof 1994: 25-26). While Rehof suggests Norway belongs within the "Constitutional recognition of distinct status", we can extrapolate that Canada would fall between 'Treaty relationship (a State-to-Quasi-State relationship)'and 'Constitutional recognition of distinct status'. Based on Rehof's work, Canada and Norway share common grounds in the legal arrangements between the State and the Indigenous peoples.

To add further nuance, Kymlicka offers a multicultural perspective that recognises self-government rights as one of the nine indicators located on the Multiculturalism Policy Index (MPI) for Indigenous Peoples (Kymlicka, 2007). Based on the nine indicators, nine countries were placed on the Multicultural Policy Index to evaluate the extent to which Indigenous peoples' rights were accommodated (Coburn, 2011). The Index identified that, in Canada, while self-government rights are recognised they are "largely as a matter of policy rather than law" (Coburn, 2011: 18). Although Canada has recognised the distinct status of Indigenous peoples in its Constitution, it does not recognise the sovereignty of Indigenous peoples under international law (Shih 2005). Therefore, policies concerning land disputes, reserve systems, land-claims and self-government agreements are established for the purpose

of accommodating and appeasing Indigenous peoples' claims to self-determination. To contextualise the Canadian case, it is necessary to briefly explain the federal system and how it relates to the Inuit in Nunavut. Canadian federalism entails two orders of government: the federal government and provincial governments. Nunavut is a territory that uniquely emerged out of a land claim, therefore unlike provincial governments, Nunavut does not have jurisdiction over lands and resources (Rodon, 2014: 259). The issue of Inuit's right to self-government was impeded because Nunuvat as a territory does not have the same responsibilities and rights as the provinces. Utilising First Nations as an example, Shewell (2016) argues that the only solution for Indigenous peoples to be truly autonomous and control their cultural and social destinies is that "the current *de facto* jurisdictional arrangements must be terminated and full jurisdiction given to them" (p. 195).

On self-government rights in Norway, the MPI acknowledges its extent is "partial, but limited to matters of culture" (Coburn, 2011: 41). This means Sámi are recognised in the Nordic Constitutions but their self-determination is limited to matters of culture and language. Matters pertaining to land, natural resources, health and social care remain questionable. While acknowledging the existence of the Sámediggi and its separate electoral system with elections, the MPI project has deemed the Sámediggi as merely "an advisory body to the Norwegian legislature", which hardly constitutes "an order of government with jurisdiction over Sámi traditional territories" (Coburn, 2011: 41).

In summary, the dimension of self-government reveals that although both Canada and Norway acknowledge rights to self-govern and to accommodate the rights claims to be Indigenous, there is an egregious caveat: self-government rights in Canada are restricted to political rhetoric and in Norway are restricted to providing unbinding culturally-related advice. These dimensions of self-government serve as critical starting points for us to unravel the extent of self-determination in the long-term care of Inuit and Sámi elderly. We will take a closer look at the recognition difference between Norway and Canada in terms of long-term care systems.

Analysing long-term care and self-government: The Sámi

Ageing Population

Sápmi is the homeland for the Sámi people, stretching across the northern Artic embracing Norway, Sweden, Finland and the Kola Peninsula of Russia. As there is no census data available for the Sámi demographic, information is based largely on estimates. In a similar vein, as there is no official delimitation of the Sápmi area related to the ethnic origins of residents, there is no data by which to identify individual or group-based categories of ethnicity.

The case of the Sámi in Norway contains significant value for the studies of Sámi elderly care for three basic reasons. First, the population of the Sámi people in Sápmi Norway is estimated to be the highest between all regions. It is estimated the total number of Sámi people is 50,000–100,000 in all four countries. Within this, approximately 20,000 live in Sweden, making up less than 1.0% (0.22%) of Sweden's total population of ca. 9 million. On the Finnish side of Sápmi, the figure is ca. 8,000, or 0.16% of the Finnish total population of ca. 5 million and on the Russian side of Sápmi, the figure is ca. 2,000. In Norway, the number of Sámi is ca. 50,000–65,000, or between 1.06-1.38% of the Norwegian total population of ca. 4.7 million (IWGIA, 2011).

Second, Norway recognises the importance of culturally appropriate care for the Sámi. As Hassler, Kvernmo and Kozlov (2008) have noted:

> Norway is the only Nordic country that has a specific Sámi focus on public health for the Sámi population, acknowledging the need for culturally and linguistically adapted health services. Although health and social services for the Sámi had been established in the 1980s, the first national plan for health and social services for the Sámi population was made in 1995." (p. 166).

The shift towards ethnic-specific health service in Norway was rooted in the dedicated advocacy work among Sámi health and social services workers during the 1960-1970s.

Third, the elderly Sámi people in Norway are among those who suffered disproportionately from the official Norwegian assimilative policy of 'Norwegianization' (from 1850 to the end of the Second World War). Their lives are deeply influenced by the public narrative about Sámi inferiority and, therefore, an elderly care system that recognises their identities and culture is urgently needed (see Blix 2013). With the austere situation in mind, the resilience and resurgence of the Sámi people can be observed on various occasions, including through the movement against a hydro-electric dam on the Alta-Kautokeino River in 1971 and the establishment of the new Article 110a in the Constitution in 1988 (see Henriksen 2016: 592-593 and Rehof 1994: 30-31).

Today, the Sámi situation is, relatively speaking, the most progressive among the Nordic countries due in part to amendments made to the Norwegian constitution in 1988, calling upon public officials to protect the Sámi culture and traditional livelihoods, and an official apology made by the government. The 1987 Sámi Act, as a precursor to the Constitutional amendments, was established to enable the Sámi to safeguard and develop their heritage. The Act paved the way for the establishment of the Sámediggi to serve as the chief political body charged with administrative duties delegated by Norwegian law. Sámediggi, established in 1989 and opened in King Olav of Norway's presence, is deemed by the Special Rapporteur to the United Nations to constitute good practice with respect to state consultation with Indigenous peoples. The 2005 Finnmark Act was the government's landmark response to addressing the struggles of the Sámi, particularly in relation to the four decade's old, Alta-Kautokeino watercourse access rights (Anaya 2011). It is clear however, some scholars take different positions on the extent to which the 2005 Act succeeds in in recognising resource rights and ownership (Carstens, 2016; see e.g. Ravna, 2011).

Since there is little disaggregated census data regarding ethnic markers or demographic trends among the Sámi population, determining clear numbers remains speculative. This study estimates the number of elderly Sámi using Sámi Parliamentary subsidy scheme records (STN). The STN (figure 2) identifies the most concentrated Sámi settlement areas and accepted as statistical record. Use of STN areas for research is important as they include communities identified by Sámediggi as

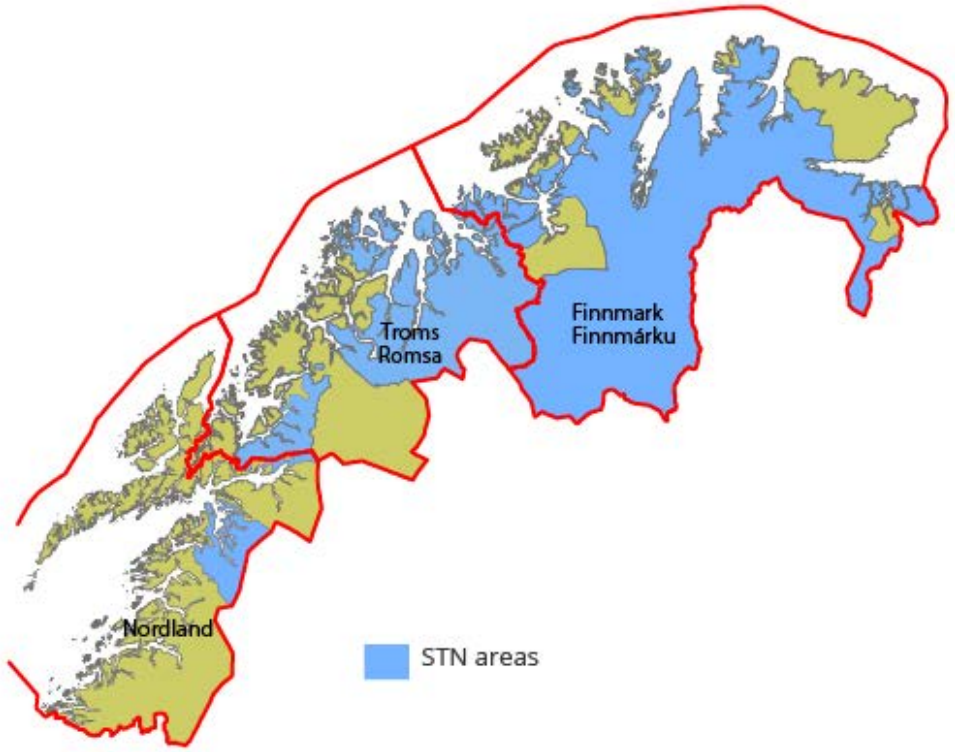


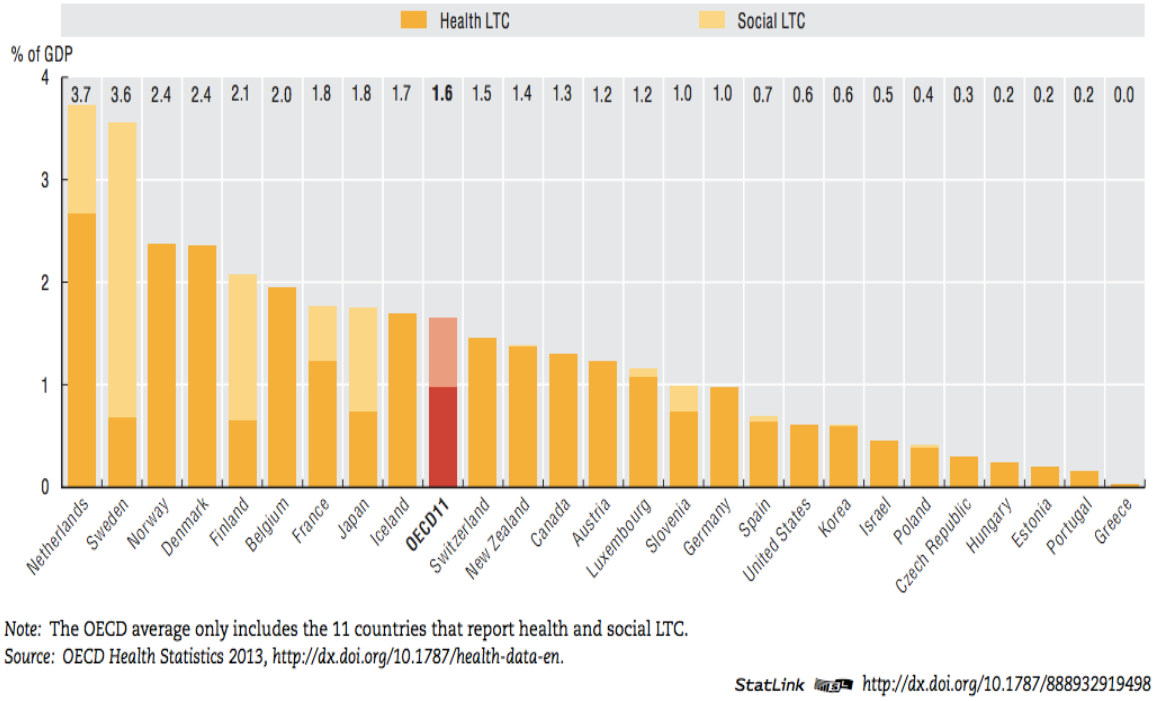
Figure 2 STN areas in Norway North of Saltfjellet. Statistics Norway.

cultural and industrial sites (Statistics Norway 2010). As the STN revealed life expectancy among Sámi for both men and women was lower than the national average, a need for better care is an important policy issue.

How is care organised?

Norway shares common features of welfare with Sweden, Finland and Denmark. These can be summarised as (i) stateness, (ii) universalism and (iii) equality (Kuhnle et al. 2010). Stateness refers to government's role in providing public services and taxation-based health and social

benefit schemes to all its citizens. In terms of universalism, Norway, like its Scandinavian neighbors, has a tax-based, public funded long-term care system consuming around two percent of their respective GDP (OECD / European Commission, 2013). Long-term care for the Sámi people in Norway comprises two parts: institutions (nursing homes and homes for the elderly) and community care (sheltered housing, domestic help and in-home care). Though funded by public taxes, care is carried out at the local level on a subsidised co-payments basis (OECD / European Commission, 2011). While the central government develops general policies, local municipal governments are responsible for the providing long-term care services.



Note: The OECD average only includes the 11 countries that report health and social LTC.
Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888932919498

Figure 3 Long-term care spending in GDP percentage among OECD countries. OECD Health Statistics 2013

In terms of equality, municipalities are charged with the task to execute long-term care services to ensure Norwegian citizens receive services in their own communities. There is, however, a caveat: elderly care belongs to municipalities' responsibilities so the distinctiveness of Sámi may be rendered less visible depending on the municipalities' local practice. For example, elderly people will move to nursing home when no longer able to care for themselves, but only half of those over the age of 90 live at a nursing home (Samfunnskunnskap, n.d.). Elderly people's preference

to live in their own homes could be extrapolated in one sense as a lack of social interaction and meaningful activities in nursing homes (Malmedal, 2014). It is even more pronounced for the Sámi, as they are culturally invisible, given nursing homes do not distinguish or recognise Sámi language, values, norms and mentality are different from Norwegian cultural norms (Minde, 2015). Minde (2017) reflects that Sámi elderly women prefer to live within the communities, as their wellbeing is greatly enriched and secured through participating in traditional reindeer herding, affirming their prominent place and roles as matriarchs and knowledge transmitters to their grandchildren.

Self-government systems of elderly care and challenge

How then do we render Sámi self-determination regarding long-term care within the Norwegian context? In Ragnhild Lydia Nystad's words, it could best be understood as the Sámi people's "right to make decisions about their own health and which services they want adapted to *their* [Sámi] culture and language, without necessarily having to administrate these services themselves" (Henriksen 2010: 45). In the following section, I explore legal considerations supporting Sámi rights and how Sámediggi achieves these as a function of its abilities to self-determine and self-govern.

The legal underpinnings of the rights to exercise self-determination in long-term care can be found at both international and national levels. Internationally, legal rights are outlined in the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights, the UN Declaration on the Rights of Indigenous Peoples, the ILO Convention No. 169 and the International Convention on the Elimination of All Forms of Racial Discrimination (Henriksen 2010: 49-51). Within the Norwegian context, legal rights of Sámi to self-determine as they transition to a tertiary society, are outlined in the Norwegian constitution (*Kongeriget Norges Grundlov*), the Sámi Act (1987) and the establishment of Sámediggi. Regarding long-term care, the constitution, the Sámi Act (1987) and a Ministry of Health and Social Affairs 1995 report clearly acknowledges these rights. Article 108 of the Norwegian constitution, for example, stipulates the responsibility of authorities to effect the conditions that would enable the Sámi people

to preserve and develop their language, culture and way of life. Article 110a sets the basis for the active role of the government to maintain and develop Sámi peoples' language, culture and lifestyle. In turn, the responsibility of Sámediggi is to develop a health and social policy for the Sámi community in collaboration with government authorities (Henriksen 2010: 45).

The Norwegian Constitution thus establishes the basis by which Sámediggi serves as a flagship for Sámi political expression. Thus, it rallies as the major platform for recognising self-determination among the Sámi. Sámediggi is a strategic arrangement for exercising the right to self-determination because direct participation of the Sámi in the national political system is limited due to its insignificant population (Stępień et al., 2015: 128). The Sámi Act (1987) states that Sámediggi can issue its sentiments through formal statements and proposals on all well-being matter so long as Sámediggi deems these to positively impact the lives of the Sámi.

The scope of influence of Sámediggi does however differ depending on the issue and the relevance towards long-term sustainability of Sámi interests. They have, for instance, significant power in areas of language and culture revitalisation, but have limited power in their ability to influence land and resource management matters (Stępień et al., 2015: 128). While Sámediggi can issue statements concerning prevailing social and health concerns, including inadequate funding for long term care, they are constrained by the politics and policies of mainstream government and to the provision of services in the Sámi language. Most importantly, Sámediggi establishes the right to delegate authorities to administer the national budget allocation granted for Sámi purposes (Stępień et al., 2015). The members are democratically elected every four years since 1989[2] and the parliament itself is an important conduit for Sámi opinions concerning their health and social needs (see Henriksen 2010). Linking back to the theoretical framework discussed earlier, these characteristics of Sámediggi demonstrate self-government in transition from a secondary to tertiary society. The extent of this self-

[2] Rather different from Finland and Sweden, the Sámi politicians in Norway cooperate with national political parties and align their names under major political parties.

determination manifests in the scope of influence and, as argued, is concentrated in substantive action to represent the Sámi way of life.

This being said, there are three key challenges the Sámi parliamentary system faces in regard to safeguarding the rights of an ageing constituency. First, the consultative process between the Norwegian government and Sámediggi has been criticised for its opaqueness and its inability to improve and impact outcomes on significant social and economic matters related to elderly care (see Stępień et al., 2015: 130). Second, the strength of Sámi non-governmental organisations has weakened over the years due to the establishment of Sámediggi (Stępień et al., 2015: 131). The authority of the Sámi parliamentary system has effectively usurped all other community-based non-government support services and positioned itself as the only legitimate channel that represents all Sámi people and interest. Third, the establishment of Sámediggi has exposed non-governmental organisations to the vagaries and pressures of partisan politics, forcing allegiances towards political parties that pledge to support them during election time (Stępień et al., 2015: 131). Hence, concerns about political transparency, competition and populism between Sámediggi and Sámi non-governmental organisations and efforts to secure sustainable funding are inherent challenges to autonomous Sámi self-government.

In spite of these challenges, the influence of Sámediggi over health and social care for the Sámi still remains largely marginalised and controlled by the state. Between provisions of health and social care, health care receives more legitimacy than social care (Henriksen 2016: 589), perhaps because health care is politically relevant as a human right. Discussion of health and social care often focuses on child and family care rather than elderly care. For this reason, it is essential to draw on the findings of Blix, Hamran and Normann (2013). Their research specifically focuses on health and social care in relation to the elderly Sámi and provides significance for understanding Norway's legislation on this matter.

Blix, Hamran and Normann (2013) identify four key reports as central to assessing the overall health care needs and social services of elderly Sámi (see Appendix A). On the one hand, two of these documents were

seminal in their understanding of health and care services for the elderly—i.e., the Norwegian Official Report (NOR): 1995:6 *Plan for the health and social services for the Sami population in Norway* (Ministry of Health and Social Affairs 1995) and Diversity and Equality (Ministry of Health and Social Affairs 2001). They argue that these two documents carry historical weight in establishing the norm for Sámi people's right to healthcare in Norway. NOR underlines the need to establish healthcare and social services for the Sámi population (Hansen, 2011: 150). On the other hand, the latter two documents are *Report no. 25: Care plan 2015* (2006) and *Report no. 47: The Coordination Reform* (2009). They conclude that the four documents shared two traits in the construction of Sámi through the new master paradigm and the process of Othering (p.93). The paradigm is based on *internal* pressure among the Sámi that there is only one way of being authentic Sámi while the Othering process is an *external* pressure that the Sámi culture and the Norwegian culture are essentially distinct. These two traits are criticised by the authors because such construction of authentic Sámi would render the needs of those elderly Sámi whose profiles do not fit the traits. The authors observed that, when concerning the training of health care professionals, policies need to look beyond visible cultural traits and language requirements that have been dominating the political discourse for more than a decade. Instead, policy makers should look beyond to make visible the everyday experiences of the current cohort of elderly Sámi (Blix, Hamran and Normann 2013: 96-97).

In conclusion, the legal underpinning to support Sámi self-determination through Sámediggi as the self-government strategy comes from both national and international level. The Sámediggi plays a main role in exercising self-determination in various issue areas, including developing health care and social services for the Sámi in Norway. Many elderly Sámi, however, express skepticism towards Sámediggi for it may be "a new public agency that will impose new rules on the people", not to mention it is subordinate to the Norwegian Parliament (Storting) (Minde 2017), which affirms the challenges faced by Sámediggi analysed above. The political discourse should include more elderly Sámi's diversified, life experiences; otherwise focusing only on the visible

cultural traits and the Sámi language may "make many elderly Sámi and their needs less visible" (Blix, Hamran & Normann 2013:96). There are many tasks at hand to create an advanced self-government system of care for the Sámi elderly. On the one hand, more awareness needs to be raised on reconstructing a renewed discursive continuity of who is Sámi. On the other hand, Sámediggi's equal partnership with central authority concerning health care and social service needs to be increased.

Analysing long-term care and self-government: The Inuit

Nunavut, the youngest population in Canada

The Inuit across the circumpolar North - Canada, Greenland, USA (Alaska) and Russia (Chukotka) - number approximately 160,000 (Inuit Circumpolar Council Canada, 2011). Nunavut, as a territory within Canada, number 37,500 of whom, 85% identify as Inuit (Hicks and White, 2000; Nunavut Bureau of Statistics, 2017) who speak the Inuktitut language and, though different dialects can be identified, as belonging to specific regions. Nunavut literally means 'our land'.

Census data indicates 31.7% of the population in Nunavut are under 15 years of age, a proportion almost double that of the national average (Government of Canada, 2015). Only 3.3% of its Nunavut were aged 65 and older. In 20 years, it is estimated that the elderly population will triple to 10.8% (Government of Canada, 2015). While the Inuit population is significantly younger than that of the non-Inuit (Hicks and White, 2000) this young demographic coupled with a rapidly ageing trend constitutes a need to devise a clear action plan for long-term care policies.

Care Services and the Entrenchment of Federalism

A long-term care plan of Nunavut entails that it is in principle and in practice *by and for* Nunavut self-determination.[3] In this section, long-term care in Nunavut is discussed by analysing the division of work

[3] Nunavut governance is influenced by a multilevel governance, namely Government of Nunavut (GN) and Nunavut Tunngavik Inc. (NTI). For more discussion on how land claim organisations played a part in the Nunavut governance, see Rodon (2014) and Alcantara & Wilson (2013).

between the Department of Family Services and the Department of Health, followed by a brief account of the types of services available to the elderly people in Nunavut. Long-term care is organised through two agencies within the Government of Nunavut: the Department of Family Services and the Department of Health. They can be distinguished by the different kinds of services they provide for the inhabitants of Nunavut, that is the *Nunavummiut*. While the Department of Health provides more specialised medical related services and benefits, the Department of Family Services is responsible for general services and benefits.

In addition to providing Extended Health Benefits (EHB), the Department of Health plays a more substantial role in providing Home and Community Care (HCC) program.[4] A well-functioning HCC is crucial for the Nunavummiut, as it helps to support the quality of life in remote communities. HCC is one of the three main types of long-term care offered and entirely subsidised by the Government of Nunavut. It is designed to assist people in remaining independent in their own home for as long as possible. Once a Nunavummiut makes a request for HCC, an assessment is done by a health professional in order to evaluate what level of support is necessary and appropriate. In remote communities, assisting people in need of long-term care maintains their sense of independence and is the most urgent priority.

Nunavut's health and care infrastructure is shaped by the political challenges of providing a wide range of care services to a small population dispersed across a vast territory with limited funds. Under the auspices of the Nunavut government, the Department of Family Services and Department of Health are in charge of long-term care for elderly people in Nunavut. Health facilities are spread across Nunavut, with most of the resources allocated in the capital Iqaluit area.[5] The fourth assembly of Nunavut government emphasised in the Sivumut Abluqta 2014–2018 that 'community-based solutions must be

[4] Home and Community Care (HCC) program includes the following services: homemaking, person care, nursing care, respite care and rehabilitation (Department of Health).
[5] The map of health facilities can be found in the Department of Health webpage http://www.gov.nu.ca/health/information/health-centres

supported to improve health, social well-being and local economies' (Government of Nunavut, 2014).

Despite Home and Community Care (HCC) providing important services in remote communities such as Nunavut, the quality of HCC is inconsistent across Nunavut (Government of Nunavut, 2015: 27). It is not uncommon to see communities encounter difficulties recruiting in-home care staff; therefore, no home care is available. Other problems include in-home care staff being unable to provide care in certain homes out of fear for their own safety. Some HCC programs, on the other hand, are highly regarded, as staff strive to care for community members and even organise lunch for the elderly in addition to providing service in the home (Government of Nunavut, 2015: 27-28).[6] As the analysis shows, care for the elderly in Nunavut may be at risk because Nunavut's long-term care facilities still lag in terms of fulfilling care needs and obligations. On the one hand, the elderly facilities in Nunavut are running at overcapacity and cannot cope with increasing needs. At the beginning of 2016, one Iqaluit boarding home reported it was facing "an explosion" of patients (CBC News, 2016). Currently, Nunavut has five facilities servicing the elders. All its inpatient beds are fully occupied, and a waiting list of up to 30 elders are queued up for residential long-term care (Government of Nunavut, 2015: 2)[7]. Tammaativvik Boarding Home, an elderly facility in Iqaluit, has eight beds with 40 elders on the wait list (Ducharme, 2016). On the other hand, an overhaul of elderly care with a focus on discriminatory practices is urgently needed as health care matters such as dementia rates and the ageing of the baby boomers is exponentially increasing (Van Dusen, 2016). Nunavut does not have its own database on healthcare and on the prevalence of illnesses like dementia; therefore, the data for dementia in Nunavut is a crude estimation based on Canadian national data (Government of Nunavut, 2015: 35). It is estimated, however, that

[6] In addition to HCC, two main types of long-term care are offered by the government: residential facilities and adult day programs (Sykes Assistance Services Corportation, 2015). The day programs are managed and operated by the Department of Health and Social Services.

[7] There were 44 beds for adults in the system (Government of Nunavut, 2015: 2). Kitikmeot Regional Health Centre was opened in March 22nd 2017 with additional eight beds (Government of Nunavut, 2017).

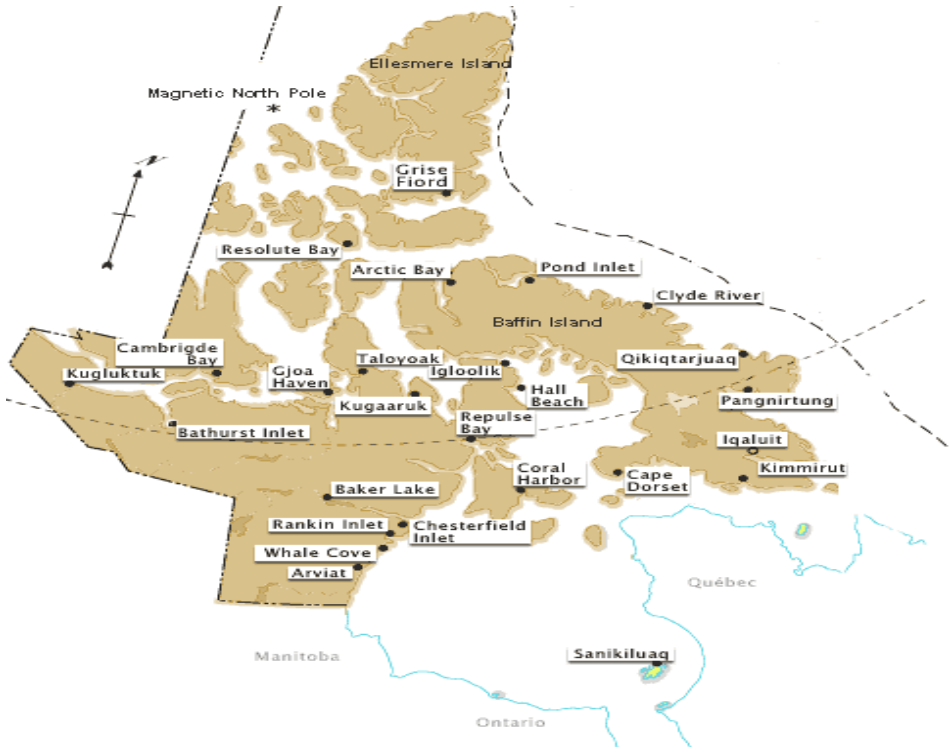


Figure 4 Nunavut's communities. Retrieved from Government of Nunavut

there are as many as 120 Nunavummiut living with dementia, which translated into a 600% increase in neuro-diseases such as dementia (ibid: 36).

The challenge ahead is how to provide adequate facilities and services to accommodate this rapidly increasing care need. As often happens, Nunavummiut living with dementia end up being sent out of the territory, since there is no coordinated assessment, case management or training standard for dementia care in the territory. Home and Community Care (HCC) are provided to prevent indigenous elderly being relocated away from the north. Once diagnosed and assessed as requiring higher levels of care, they are referred to assistive residential facilities and faced with the difficult dilemma of either leaving home or receiving no assistance. One anecdotal case, described how an Nunavut elder had to travel 2,000 kilometres, from Rankin Inlet to Ottawa, to secure a long-term care bed (Minogue & Konek, 2016). It is reported that at least 25 beds are needed to adequately address an equilibrium of current demand. However, it is further estimated that an additional 53 beds would be required by 2035 to substantively meet the needs of Inuit

when adding in the Manitoba ratios (Government of Nunavut, 2015: 32).

These accommodations and challenges clearly manifest in entrenchment federalism. Department of Health and Department of Family Services are Inuit's self-governing through public government in practice. Such governance structure of Nunavut is the most recent development of Canada's tri-lateral federalism (federal, provincial/territorial and regional). It is an attempt to build a more robust, progressive, autonomous political structure, grounded in both land-claims agreements and the federal structure of Canada (Alcantara & Wilson: 2013). To date, the fact that Nunavut are not totally independent from the federal government continues to proliferate how social services are economically controlled, politically affirmed and paternalistically delivered. Thus, attempts to self-determination are hampered by the lack of financial independence which I discuss in the following section.

Self-government systems of elderly care and economic challenges in self-determination

Before colonial contact the Inuit in Nunavut were self-governing people who enjoyed a 'flexible system of governance based on consensus and making decisions through discussion' (Loukacheva, 2007:17). The history and colonial legacy of the secondary society in Canada was oppressive and traumatising. The Canadian government actively conducted a policy of 'cultural genocide' against Indigenous peoples, and as the Truth and Reconciliation Commission of Canada concluded:

> For over a century, the central goals of Canada's Aboriginal policy were to eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and through process of assimilation, cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, religious, and racial entities in Canada. (Truth and Reconciliation Commission of Canada, 2015: 5)

Moving from the cultural genocide manifested in the form of residential school (see Truth and Reconciliation Commission of Canada, 2015: 82),

realising the right to self-determination in Nunavut is significant. Nunavut Land Claims Agreement (NLCA) was signed on May 25th, 1993 and the territory of Nunavut was officially created on April 1st 1999. The shift from a secondary society to a tertiary society took the pathway of formulating a public government model in which all residents of Nunavut can participate. The Government of Nunavut, a realisation of self-government by way of public government in transition to a tertiary society, reflects an enormous achievement for a small society like the Inuit.[8]

The tertiary society in which the Inuit's self-determination for health care is enacted results from the Land Claims Agreement and the Nunavut Act. According to the Nunavut Act, the government of Nunavut is structured in the same manner as the Northwest Territories (NWT), with decentralisation as its key feature. The Legislative Assembly of Nunavut has a consensus style of government, not the common party system. That is, all Members of the Legislative Assembly (MLAs) are elected as independent candidates in their constituencies without affiliation to political parties. This consensus style is deemed to be more compatible with the traditional Inuit style of making decisions. The Inuit's approach to self-government in Nunavut is, as detailed earlier, through the formation of a public government. Social and economic policies, including those promoting the well-being and health of the Inuit, and economic development can be understood as a common theme found throughout the Nunavut Act (Nowlan-Card, 1997: 52). Most Nunavummiut voted for Nunavut to separate from NWT, because this would have at least ensured an opportunity for Inuit autonomy (in Légaré 2008 cited in Shih, 2011). The establishment of Nunavut was intended to solve Nunavut's despairing social realities: soaring unemployment rate, low income rates, welfare dependency, and high suicide rates (Göcke, 2011). However, this intention to solve social and economic injustices has not come to fruition; the social and financial situation of the Inuit in Nunavut remains gloomy to this day (Göcke,

[8] On the role of indigenous peoples' struggle in transition from a secondary to a tertiary society, see, e.g., Glen Sean Coulthard's Red Skin, White Masks: Rejecting the Colonial Politics of Recognition (2014) to A. Simpson's Mohawk Interruptus and Land as Pedagogy.

2011: 88; Bernauer, 2015). De Bruin and Mataira (2003:169) argue "the capacity of indigenous communities to improve their state of health and wellbeing is largely dependent upon their abilities to foster and generate their own sources of revenue and sustainable economic wealth". Thus, they contend, alleviating poverty, reducing health disparities, improving educational achievements, and addressing cultural historic trauma are issues inextricably linked to the pervasive and often harsh economic realities faced by Indigenous people.

Nunavut heavily relies on the federal government for over 93% of its annual budget (Göcke, 2011: 91). The Nunavut government does not have the right to collect development fees or cash compensation. As a result it relies on the federal government's funding to maintain the operation of the government and to carry out medical service, education, welfare and employment and to maintain its infrastructure (Shih, 2011). The Canadian government funds a variety of health programs in Nunavut—e.g., the First Nations and Inuit Health and Community Care Program (FNIHCC), the single largest expenditure by the federal government. The program was intended to develop long-term care and in-home care in Inuit communities, ensuring that Inuit receive home and community care services comparable to other Canadians. In addition, it also aims to ensure that elderly Inuit are able to get sufficient aid to make relocation southward unnecessary (Marchildon & Torgerson, 2013).

Among all these challenges, such as the lack of long-term care facilities in Nunavut, the role of the Nunavut government has come under heavy criticism for its inability to cope with health and care demands and to adequately allocate appropriate and direct financial resources into this area (CBC News, 2016; Ducharme, 2016). The recurring explanation for the Nunavut government's passive role and ineffectiveness is tied to lack of revenue. The Nunavut government has been underfunded and therefore has not been able to fulfill its obligations towards the Nunavut people (Göcke, 2011; Shih, 2011) and arguably is in violation of its own federal obligations.

Nunavut dependence on the federal government treasury is tied to Canadian federalism under which powers are extended to the provinces

vis-à-vis the territories. To strengthen Nunavut's self-determination, revenues for social and health services must be ensured in a way that financial transfer to territories would be akin to the provinces (Göcke 2011: 91-93). There are two ways to achieve this end: (1) to attain proper implementation of the Nunavut Land Claims Agreement (NLCK) by court order, or (2) to achieve devolution (Göcke, 2011: 92). Whatever the strategy, financial realities present a critical test to achieving self-determination and honoring in long-term care responsibilities. Nunavut's fiscal dependence on the federal treasury impedes the level of self-determination it envisions to achieve (see Hicks and White, 2000). The case of Nunavut shows Inuit's limited right to self-determine in spite of Nunavut government's self-governing agencies. It suggests that the Inuit are suffering the consequences of Canada's rhetorical recognition and Nunavut self-determination is in name only.

Discussion and conclusion

This paper has critically engaged with two empirical cases concerning long-term care for the elderly through examining care institutions as a barometer for self-determination. The Indigenous peoples of the circumpolar North have come some way towards their self-government and self-determination. The Sámi and the Inuit share many similarities as peoples who have encountered colonial and assimilative policies under secondary societies. In their transitional efforts towards tertiary societies, consideration to self-determination must address devolution strategies to achieve reconciliation with their governing state(s). The cases examined - Sámediggi and the Government of Nunavut – speak to a shared consciousness and interrelated understanding of decolonisation, to a devolution of power, and to equitable access to resources. Linking the two cases to the theoretical framework in answering the questions posed in the beginning, three aspects can be summarized.

First, both cases illustrate the achievement in self-government, but the extent of self-determination remains limited. Inuit's right to self-determine their elderly care in Nunavut is impeded by the federal system, where current jurisdictional arrangements do not support Inuit in control of their resources. Nunavut as territory is destined to rely on

the federal treasury and cannot truly be autonomous. Therefore, the normative goal of self-determination for Indigenous peoples in Canada remains rhetorical rather than that of substantial devolution. The devolution process remains a key issue of whether or not Canada is willing to adjust the federal system that yields equitable jurisdiction to the Indigenous peoples. Norway, on the other hand, follows a social democratic tradition, and the infrastructure of long-term care is much more established than in Canada. The care needs of the Sámi, however, remain largely invisible under Norwegian care system because the influence of Sámediggi over health and social care remains marginalised.

Second, it is instructive to note, self-determination is distinct, complex and contextual. The Inuit constitute the majority of their territory, and the form of self-determination is realised through a public government. This public government model "controls health, education, social services, adult training, corrections, and much more, through a legislative assembly and cabinet that exercises most of the powers held elsewhere by provincial governments" (Bell, 2014). The strategy of self-government is an active compromise between the majority Inuit people and the federal government, which is reluctant to devolve any power to the Inuit. Such reluctance was noted in Canada's abstinence in the ratification of ILO Convention No. 169 and its votes against the UN Declaration on the Rights of Indigenous Peoples in 2007.[9] For the Sámi, Sámediggi has a mandate to raise and issue statements concerning constitutional guarantees of upholding Sámi language, culture and society. Although the Sámi population is small, Sámediggi gives them leverage in negotiating with the government. This strategy has worked well in Norway, a country that openly values its reputation as a key defender of international human rights. These international human rights instruments constitute a normative framework in international law for Sámediggi to promote Sámi's rights and needs in the sector of health and social services (see Henriksen 2010: 47). To exemplify, Norway ratified ILO Convention No. 169 in 1990 and has been engaged with follow-up consultations with the Sámi through Sámediggi.

[9] Canada announced in 2010 that it fully supported the UN Declaration on the Rights of Indigenous Peoples due to political pressure from indigenous peoples.

Third, the institutions of self-government that are meant to exercise self-determination have largely been hindered by financial constraints, since both the Government of Nunavut and Sámediggi rely heavily on state funding. The Government of Nunavut, with a consensus style of government deemed to be more compatible to the traditional Inuit style of decision-making, has been unable to tackle the rapidly increasing care demands. Sámediggi, with a democratic elected body, has been faced with skepticism for its impervious consultation process and limited jurisdiction over health and social care. This quagmire illustrates that the devolution process takes both the Indigenous peoples and the state to work as equal partners to produce an optimal solution that corresponds with the local circumstances.

Long-term care for the elderly is a barometer for self-determination as it is recurrent when shifting to tertiary society. While the institutions of self-government allow the Indigenous peoples to determine their care system, the devolution process remains entrenched in the national systems. The two cases have shown that their level of self-determination remain limited in spite of their systems of self-government having the potential to bring positive results in long-term care. In addition, the rapid increase of elderly indigenous people requires urgent arrangement and re-prioritisation of resources—financial, personnel, infrastructural. To think outside the box, the relationship between the State and Indigenous peoples shall benefit from conceptualising in a community-centered manner: as Corntassel and Bryce noted "the pursuit of self-determination should be reconceived as a responsibility-based movement centered on a sustainable self-determination process, not as a narrowly constructed, state-driven rights discourse" (2012: 160). Consequently, future research should focus on conceptualising long-term care outside the narrowly prescriptive, state-driven care to produce more accurate policy considerations.

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Appendix A: Table of official policy documents central to the healthcare and social services for elderly Sámi in Norway (Blix, Hamran & Normann, 2013: 81)

Document title in English	Year of publication	Responsible ministry	Comments
NOR 1995: 6 Plan for health and social services for the Sami population in Norway	1995	Ministry of Health and Social Affairs	First policy document in Norway addressing health and care service for the Sámi.
Action Plan for the health and social services for the Sami population in Norway, 2001–2005. Diversity and equality	2001	Ministry of Health and Social Affairs	A follow-up to the NOR (1995).
Report no. 25 (2005–2006) to the Parliament. Long-term care. Future challenges. Care plan 2015	2006	Ministry of Health and Care Services	Specify challenges in municipal health and care service. *Ch. 5.1.2.: The Sámi*
Report no. 47 (2008–2009) to the Parliament. The Coordination Reform. Proper treatment—at the right place and right time	2009	Ministry of Health and Care Services	Reforms to meet future challenges in health and care services. *Ch.11* concerns the Sámi.