

## RESEARCH ARTICLE

# Historical foundations and contemporary expressions of a right to health care in Circumpolar Indigenous contexts: A cross-national analysis

Josée G. Lavoie<sup>1,\*</sup>, Jon Petter Stoor<sup>2</sup>, Elizabeth Rink<sup>3</sup>, Katie Cueva<sup>4</sup>, Elena Gladun<sup>5</sup>, Christina Viskum Lytken Larsen<sup>6</sup>, Gwen Healey Akearok<sup>7</sup>, and Nicole Kanayurak<sup>8</sup>

Although numerous comparative Indigenous health policy analyses exist in the literature, to date, little attention has been paid to comparative analyses of Circumpolar health policy and the impact these policies may have on Indigenous peoples' rights to health. In this article, we ground our discussion of Indigenous peoples' right to access culturally appropriate and responsive health care within the context of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Under UNDRIP, signatory states are obligated to guarantee that Indigenous peoples have access to the same services accessible to all citizens without discrimination. Signatory states must also guarantee access to services that are grounded in Indigenous cultures, medicines, and practices and must address Indigenous peoples' determinants of health at least to the same extent as their national counterparts. Our analysis finds that the implementation of this declaration varies across the Circumpolar north. The United States recognizes an obligation to provide health care for American Indian and Alaska Native people in exchange for the land that was taken from them. Other countries provide Indigenous citizens access to care in the same health care systems as other citizens. Intercultural models of care exist in Alaska and to some extent across the Canadian territories. However, aside from Sámi Norwegian National Advisory Unit on Mental Health and Substance Use in northern Norway, intercultural models are absent in Nordic countries and in Greenland. While Russia has not ratified UNDRIP, Russian policy guarantees access to health care to all citizens, although access is particularly limited in rural and remote environments, including the Russian Arctic. We conclude that Circumpolar nations should begin and/or expand commitments to culturally appropriate, self-determined, access to health care in Circumpolar contexts to reduce health inequities and adhere to obligations outlined in UNDRIP.

**Keywords:** Aboriginal, Inuit, Alaska Native, American Indian, Human rights, Access to care, Health care

## Introduction

The Arctic region is the home of Indigenous peoples with recognized rights under international treaties and conventions (Toebes, 1999). As a result of climate change, and because it is increasingly framed globally as a resource-rich environment, the Arctic has become a globally embedded and contested space in dominant discourses. An increasing number of Arctic and non-Arctic states and non-state stakeholders are competing for a say in governance over economic and political interests in the Circumpolar north (Johannsdotir and Cook, 2017; Keil and Knecht, 2017).

At national and global levels, Circumpolar Indigenous peoples' pursuit of self-determination has largely focused on legitimizing Indigenous stewardship over sustainable resource development in their territories (Shadian, 2017). In the past decade, this focus has broadened to encompass climate change. The international movement toward recognizing Indigenous rights is often not present in these debates. When featured, the focus on rights centers on Indigenous peoples' stewardship over natural resources and their individual and collective resilience (Wexler, 2014; Teufel-Shone et al., 2016).

<sup>1</sup>Ongomiizwin Research, University of Manitoba, Winnipeg, Canada

<sup>2</sup>Sámi Norwegian National Advisory Unit on Mental Health and Substance Use (SANKS), Finnmark Hospital Trust, Karasjok, Norway

<sup>3</sup>University of Montana, Missoula, MT, USA

<sup>4</sup>Institute of Social and Economic Research (ISER), University of Alaska Anchorage, Anchorage, AK, USA

<sup>5</sup>University of Tyumen, Tyumen, Russia

<sup>6</sup>University of Southern Denmark, Odense, Denmark

<sup>7</sup>Qaujigiartiit Health Research Centre, Iqaluit, Nunavut, Canada

<sup>8</sup>North Slope Borough, Utqiagvik, AK, USA

\* Corresponding author:  
Email: [josee.lavoie@umanitoba.ca](mailto:josee.lavoie@umanitoba.ca)

Indigenous peoples' relationships to their nation-states can best be described as one of internal colonialism as a result of external intrusion (Canada, the United States, Greenland/Denmark) or internal colonial imposition (Nordic countries and Russia; Shadian, 2017, p. 45). Little attention has been paid to the past and continued contribution of colonialism in perpetuating Circumpolar Indigenous peoples' (apparent) vulnerabilities to the impacts of climate change (Cameron, 2012). These perceived vulnerabilities could also be attributed to displacement, the destruction or undermining of local traditional economies, and the marginalization and dismissal of local and Indigenous knowledge in policy decision-making (such as resource management, including hunting rights; Poppel, 2017).

At national levels, Indigenous engagement with these global debates operates in the context of severe health inequities when compared to their national counterparts (see Young, 2012, pp. 86–121, for a detailed discussion). These health inequities can be attributed in part to differential access to determinants of health such as appropriate housing, safe drinking water, economic opportunities, food security, and appropriate local infrastructure (Young et al., 2020). Providing access to health services cannot palliate social and economic marginalization, compensate for underinvestment in infrastructure, rectify racism and dismissal, nor address the imposition of national over local interests in public policy (Marmot and Wilkinson, 2006; Greenwood et al., 2015): Access to responsive and appropriate health care can at best expand life expectancy and improve quality of life. While partial, these objectives remain worthwhile, and their assurance is codified in international treaties and declarations.

This article discusses the international and national foundations of Indigenous rights to culturally appropriate health care in Circumpolar contexts. Although numerous comparative Indigenous health policy analyses exist in the literature (Lavoie, 2003, 2004; Lavoie et al., 2010a; Tenbensel et al., 2013; Lavoie, 2014; Lavoie and Dwyer, 2016; Kornelsen et al., 2017), to date, little attention has been paid to comparative analyses of Circumpolar health policy and the impact these policies may have on Indigenous peoples' rights to access culturally appropriate and responsive health care.

This work was undertaken in the context of the Fulbright Arctic Initiative program, which brought together Indigenous and non-Indigenous Arctic scholars from Canada, Denmark, Finland, Iceland, Sweden, Russia, and the United States. The authors are established scholars in their respective countries, actively engaged in Circumpolar health research in partnership with Indigenous communities and organizations. Our collective purpose is to highlight areas where Circumpolar health and policy developments hold promise for improving the health and well-being of Indigenous peoples.

The method we chose is to review published and gray literature, including legislation, policies, and government reports for each state under study, and related policy studies that might shed light on the implementation of such policy. Policy document analysis is a widely accepted method for tracking policy implementation (see e.g., Lavoie et al., 2013; Jones et al., 2017; Munthe-Kaas et al.,

2019; Steinmann et al., 2020). We searched for documents publicly available online. We based this choice on trends in governments' transparency and in their use of the internet as key vehicle for sharing policy documents.

Our chosen approach draws on obligations included in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which require states to be transparent in their actions. By definition, transparency requires the publication of findings. We admit that some policies and analyses may not be published but argue that in such cases, the lack of transparency is not in compliance with the principles expressed by UNDRIP.

We tried to assess the extent to which Indigenous nations were engaged in cocreating or were at least consulted in the drafting of the policies we reviewed. In all cases, however, we assume that the final document reflects a national policy position. We did not attempt to document whether a policy document reflects Indigenous perspectives. We instead assessed the policy's alignment with UNDRIP.

### The international foundation for a right to health

Although some authors trace the origin of the right to health to more recent documents (Tobin, 2012), the Constitution of the World Health Organization (1946) entrenched a list of inalienable rights, including,

*The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.*

Toebes has argued that the concept of a *right to health* is problematic, as health cannot be guaranteed. Accordingly, the right to health is at times conflated in the literature with the right to health care, that is, to medical care and/or to health protection (Toebes, 1999).

International covenants have tended to focus on health protection and access to care. For example, the United Nations' Universal Declaration of Human Rights reiterated a right to health, including well-being, stating:

*(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control (UN, 1948).*

For this article, we reviewed relevant international provisions on the right to health in international covenants and resolutions. A summary is provided in Appendix A. Key themes highlighted in these declarations include the following:

- The Universal Declaration of Human Rights (UN, 1948) and the International Covenant on Economic, Social and Cultural Rights (UN,

1966) establish a right to standards of living (determinants of health and well-being) necessary to achieve the highest attainable physical and mental health;

- The International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1965) establishes a right to public health, medical care, social security, and social services devoid of discrimination and racism;
- The International Labour Office's Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries (International Labour Office, 1991) establishes a right to participate individually and collectively in the planning and implementation of health care; and
- The Convention on the Elimination of All Forms of Discrimination Against Women (UN, 1979) establishes a right for women living in rural environment to access care.

States' obligation to realize a right to health requires the adoption of national health plans, effective accountability measures, the collection of appropriate data, the development and assessment of appropriate benchmarks, the facilitation of effective participatory strategies, multi-sectoral and interdisciplinary initiatives, and targeted policies for vulnerable populations (Tobin, 2012, p. 224). Oversight by human rights monitoring bodies further ensures some accountability.

International treaties and other instruments have emerged addressing Indigenous peoples' right to health, and several specifically address racism (see Appendix B for details). For Indigenous peoples, access to effective and responsive care has historically been challenged by ethnocentrism, prejudice, and racism (see, e.g., Bhopal, 1998; Hansen et al., 2010; Billie and Smylie, 2015; Gair et al., 2015; Leyland et al., 2016; Paradies, 2016; Browne, 2017). In addition, Circumpolar Indigenous communities often face challenges in access to care, such as the scarcity and attrition of professionals, inappropriate communications, and high costs associated with travel to specialized care (Young and Chatwood, 2011; Young, 2012). The UN Combat Racism Conference of 1983 explicitly recognized that Indigenous peoples are covered in existing international instruments (World Conference to Combat Racism and Racial Discrimination, 1983). However, of these, only UNDRIP explicitly recognizes Indigenous peoples' right to access "programmes for monitoring, maintaining and restoring the health of indigenous peoples" managed by Indigenous peoples (UN, 2007).

In this article, we recognize the importance of all international instruments cited above and chose to ground our discussion of Indigenous peoples' right to access culturally appropriate and responsive health care as articulated in UNDRIP (UN, 2007). UNDRIP has created an opportunity to define, legitimize, and advance a broader range of

Indigenous rights. In this article, we focus on UNDRIP's Articles 24 and 29, which are focused on the health of Indigenous nations:

24.1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. **Indigenous individuals also have the right to access, without any discrimination, to all social and health services.**

24.2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. **States shall take the necessary steps with a view to achieving progressively the full realization of this right.**

29.3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining, and restoring the health of indigenous peoples, **as developed and implemented by the peoples affected by such materials**, are duly implemented (UN, 2007, pp. 9, 21, emphasis added).

To date, seven of the eight<sup>1</sup> Circumpolar countries have endorsed UNDRIP, Russia being the exception.<sup>2</sup>

We recognize that national legislative and policy frameworks already exist in some Circumpolar countries to frame Indigenous rights in relation to health care. We also recognize that non-signatory countries may draw from UNDRIP to inform their own policy development. For example, Russia recognizes the rights of Indigenous peoples "in accordance with generally recognized principles and norms of international law" (Constituteproject.org, 2014, Article 69). However, this qualification lacks the guarantees we believe are warranted to fully operationalize the spirit of UNDRIP.

1. Circumpolar countries include Canada, Denmark, Finland, Greenland, Iceland, Norway, Russia, Sweden, and the United States. Our article focuses on eight of these countries since Iceland does not have an Indigenous population as defined by the United Nations (United Nations Permanent Forum on Indigenous Issues, n.d.).

2. Official versions of the declaration are available in Arabic, Chinese, English, French, Spanish, and Russian. In addition, unofficial versions have emerged in Danish, Finnish, Kalaallisut (Greenland), Innu (Labrador and northern Quebec), Karelian (Republic of Karelia, Russian Federation), Komi (northeastern European part of Russia), Livvi-Karelian (Republic of Karelia, Russian Federation, and part of Finland), Norwegian, some Sámi languages (North, Inari, Skolt, Finland), and Veps (Republic of Karelia, Leningrad, and Vologda regions of the Russian Federation). Absent from this list are Dené (Alaska), Deneh (Canada), Iñupiaq (Alaska), Yup'ik (Alaska), Inuktitut (Canada), Inuvialuktun (Canada), Sámi languages spoken in Norway and Sweden, and Swedish (United Nations Department of Economic and Social Affairs, 2008).

**Table 1.** United Nations Declaration on the Rights of Indigenous Peoples–informed framework for tracking progress in Circumpolar Indigenous Peoples’ Right to Health (United Nations, 2007). DOI: <https://doi.org/10.1525/elementa.2019.00079.t1>

Right	Indicators
24.1 Obligation to guarantee access to the same services accessible to all citizens without discrimination.	1. Access guaranteed in legislation/policies
29.3 Obligation of states to implement programs monitoring, maintaining, and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials.	2. Systematic monitoring of socioeconomic, education, health, and other inequities in the public domain
24.1 Obligation to guarantee access to traditional medicines and to maintaining their health practices, including the conservation of their vital medicinal plants, animals, and minerals.	3. Support for traditional practices in the form of enabling policies, funding, as appropriate to the national context
24.2 Obligation to address Indigenous peoples’ determinants of health at least to the same extent as national determinants of health.	4. Cocreation of programs to remedy inequities, with active engagement from Indigenous populations.

### Implementation of an indigenous right to health

The UNDRIP stipulates clear obligations for nations to operationalize Indigenous peoples’ rights in relation to health. These obligations provide a framework to assess nations’ progress on the implementation of UNDRIP, as shown in **Table 1**.

Interestingly, UNDRIP was adopted in 2007 by Denmark, Finland, Iceland, and Sweden. At the time, Canada and the United States voted against UNDRIP, and Russia abstained. The United States eventually adopted UNDRIP in 2011 and Canada in 2015. In the Circumpolar context, Russia remains the only country which has still not ratified UNDRIP.

### Circumpolar comparison

**Table 2** provides an overview of Circumpolar Indigenous nations and their access to health care, as provided by the nation-state. The table highlights two important contextual factors that impact how states can respond to the obligations stated under UNDRIP. To begin, Indigenous populations vary considerably in terms of their proportion to the overall population in the jurisdiction in which they live: Nunavik Inuit represent 0.1% of the population of Québec, whereas Inuit in Nunavut constitute 85.9% of the Nunavut population. Also important is the diversity of Indigenous nations within a single jurisdiction. Noteworthy are Alaska and Circumpolar Russia, which are home to multiple and diverse nations.<sup>3</sup> The second factor relates to national policies regarding access to health care. Of all countries under study, only the United States does not have a universal coverage health care system: Indigenous Alaskans however benefit from such a provision. Thus, expectations within these states are framed differently than in states where universal coverage is entrenched in policy. Further, cultural diversity, population density, and

national policies regarding state obligations toward citizens in relation to access to care, all shape opportunities available to nation-states in terms of compliance with UNDRIP provisions.

**Table 3** provides a comparative analysis of Circumpolar countries, based on indicators identified in **Table 1**, taking into consideration the contextual factors identified above. We discuss each country’s alignment with these requirements in two distinct sections. We first discuss Indigenous peoples’ access to health care and then explore the adaptation of services to Indigenous cultures, including access to traditional medicine.

### Equitable access to health care

In *Canada*, an Indigenous-specific right to health remains under discussion. Treaty 6, signed between the Crown and First Nations peoples in what is now Saskatchewan and eastern central Alberta, contains what is commonly referred to as the Medicine Chest Clause (Canada, 1876a), promising First Nations peoples access to a medicine chest located at the house of the Indian Agent, to be used at the discretion of that agent. Similar provisions were discussed in the negotiations of Treaties 8 and 11, but no provision was included in the final text of these Treaties (Lavoie et al., 2012). These historical treaties should be understood as limited colonial concessions made with First Nations in exchange for a peaceful settlement of land held by First Nations but needed by the colonial state to support an emerging agrarian economy. The implementation of the treaties was however haphazard. Canada has to date interpreted the Medicine Chest Clause to signify that access to medical care is to be provided at the discretion of the Crown (Canada, 1966).

Universal coverage for hospital-based care, family physician, and specialist care is guaranteed to all Canadians, including Indigenous peoples, through the Canada Health Act 1984 (Government of Canada, 1985; for a more detailed analysis, see Lavoie, 2017). In addition, First Nations and Inuit can access a complement of medication, dental care, eye care, and medical equipment funded

3. Canada recognizes 70+ different nations; Circumpolar Canada is far less diverse.

**Table 2.** Indigenous peoples and health care in Circumpolar countries. DOI: <https://doi.org/10.1525/elementa.2019.00079.t2>

Region/Country	Indigenous Population, Total Population (% of Total Population)	Indigenous Nations	Universal Health Care	Access to Care
Yukon (Canada)/Indigenous peoples	8,195; 35,111 (23.3%)	Kutchin, Hän, Kaska, Tagish, Tutchone, and Teslin	Yes	Access to health care for Indigenous peoples is currently viewed as a matter of policy, based on the Johnston appeal of 1966.
NWT (Canada)/Indigenous peoples	20,860; 41,135 (50.7%)	Deneh, Tłı̨ch̨o, Slavey, Innuvialuit, Gwich'in, Sahtu, and Métis		
Nunavut (Canada)/Inuit	30,550; 35,580 (85.9%)	Inuit		
Nunavik (QC, Canada)/Inuit	10,880; 7,965,450 (0.1%)	Although the overall province includes many nations, the Circumpolar portion of the province includes primarily Inuit.		
Labrador (Newfoundland and Labrador, Canada)/Innu and Inuit	1,285 (Innu) and 6,450 (Inuit)/512,250 (1.5%)	Nunatsiavut Inuit, Innu, Nunatukavut Inuit		
Denmark/Greenlanders	Estimate, 16,470; 5,581,190 (0.30%)	Greenlandic Inuit or Kalaallit	Yes	Universal, no specific Indigenous provision
Finland/Sámi	Estimate, 9,000; 5,517,830 (0.2%)	Sámi	Yes	
Greenland	50,171; 55,877 (89.8%)	Greenlandic Inuit or Kalaallit	Yes	
Norway/Sámi	Estimate, 55,544; 5,295,619 (1.0%)	Sámi	Yes	
Russia/north, Multiple tribes	Estimate, 270,000, based on small population rule;a 146,000,000 (0.2%)	Aleuts, Alyutors, Chelkans, Chukchis, Chulyms, Chuvans, Dolgans, Enets, Siberian Yupik, Inuit, Evenks, Evens, Itelmens, Kamchadals, Kereks, Khanty, Koryaks, Kumandins, Mansi, Nanai, Negidals, Nenets, Nganasans, Nivkhs, Oroks, Orochs, Sámi, Selkups, Shors, Soyots, Taz, Telengits, Teleuts, Tofalars or Tofa, Tubalars, Tozhu, Udege, Ulchs, Yukaghirs Yakuts, Buryat, Komi and Tuvans do not have Indigenous status under Russian legislation	No	Market-driven, no specific Indigenous provision

(continued)

TABLE 2. (continued)

Region/Country	Indigenous Population, Total Population (% of Total Population)	Indigenous Nations	Universal Coverage Health Care	Access to Care
Sweden/Sámi	Estimate, 20,000–40,000; 10,230,185 (0.2%–0.4%)	Sámi	Yes	Universal, no specific Indigenous provision
Alaska (USA)/Indigenous peoples	737,438; 112,828 (15.3%)	229 federally recognized tribes, including Inupiat, Yupik, Siberian Yupik, Sugpiaq, Unangax, Eyak, Tlingit, Haida, Tsimshian, and Athabaskan	No	Access to free health care is considered a right for Indigenous peoples as compensation for land taken.

Denmark and Sweden, 1751; United States of America, 1868, 1904a, 1904b, 1921, 1924, 1971, 1975, 1992; Canada, 1876a, 1876b, 1966, 1974, 1982b, 1985; Foighel, 1979; Health Canada, 1979; Government of Canada, 1985; Canada and Nunavut Tapariit Kanatami, 1993; Case and Voluck, 2002; Aaen-Larsen, 2004; Koivurova, 2008; Greenland, 2009; United States of American Office of the Legislative Counsel, 2010; Constituteproject.org, 2014; Statistics Canada, 2016a, 2016b; Statistics Denmark, 2018; Statistics Greenland, 2018; The Inuit of Labrador, Her Majesty the Queen in Right of Newfoundland and Labrador, Her Majesty the Queen in Right of Canada, 2018; U.S. Census Bureau, 2018; Arctic Council, 2019; Russian Federation Federal State Statistics Service, 2019; Statistics Finland, 2019; Statistics Sweden, 2019; Statistisk sentralbyrå, 2019; Sweden, 2019; United Nations Regional Information Centre for Western Europe, 2019; Det Gronlandske Hus, n.d.).

<sup>a</sup>Guarantees extend only to small-numbered Indigenous peoples with population of less than 50,000 members (Xanthaki, 2004).

through the noninsured health benefits program (Health Canada [FNIHB], 2013). These additional benefits are provided by the federal government on “humanitarian grounds” (Marchildon et al., 2017). In the fall of 2019, the governments of British Columbia, the Northwest Territories, and the federal government tabled legislation committing to the implementation of UNDRIP (CBC North, 2019; Government of British Columbia, 2019; Government of Canada, 2019).

As shown in **Table 3**, Canada already complies with key UNDRIP health care–related provisions, with the exception of providing substantial support to traditional healing practices. Although Indigenous ceremonies were banned for the better part of the 20th century, these bans have been rescinded (Mitchell et al., 2019), yet the displacement many Indigenous nations experienced as a result of colonial encroachment through farming and extractive activities undermines access to food security and medicine. These pressures are more readily felt by nations whose territory is south of the 60th parallel. Circumpolar Indigenous communities have experienced these pressures to a lesser extent, although pressures appear to be growing (Markowitz, 2020).

Of all countries under study, the *United States* is the only one that recognizes a right to health care for American Indian and Alaskan Native peoples, provided with no fee at the point of service (Pfefferbaum et al., 1995). This recognized right contrasts with provisions for all other U.S. citizens whose access to care varies with private insurance coverage. The Snyder Act (United States of America, 1921) provides a basic authorization for Indian health care in the United States by authorizing the federal government to deliver programs, including health, with responsibilities vested in the Bureau of Indian Affairs under the supervision of the Secretary of the Interior. The Act did not specify an entitlement to specific benefits or services. To date, this entitlement has been interpreted as access to the full continuum of care (family physicians, specialists, hospital, public health, etc.). In the continental United States, under-resourcing and structural issues (small dispersed populations, diseconomies of scale) have resulted in chronic staff shortages within the Indian Health Service, barriers to accessing quality care, and poorer outcomes for Indigenous peoples (Levinson, 2016). The Public Law 93–638 Indian Self-Determination and Education Assistance Act, enacted in 1975, and amended several times, authorizes tribes “to contract with the Federal government to operate programs serving their tribal members and other eligible persons” (Department of the Interior Bureau of Indian Affairs and Department of Health and Human Services Indian Health Service, 1996). Substantial 1988 amendments, refined by 1994 and 2000 legislation, further allowed tribal self-governance, which has resulted in over 50% of federal Indian programs governed by tribal entities instead of federal agencies (Strommer and Osborne, 2015). Examples of health care programs that have taken advantage of this law include the Southcentral Foundation and the Alaska Native Tribal Health Consortium, which are both Alaska Native governed. These

**Table 3.** Circumpolar countries' legislative and policy alignment with United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). DOI: <https://doi.org/10.1525/elementa.2019.00079.t3>

Region/Country	UNDRIP Provisions, Indicators			
	Access guaranteed in legislation/policies	Systematic monitoring of socioeconomic, education, health, and other inequities, in the public domain	Support for traditional practices in the form of enabling policies, funding	Cocreation of programs to remedy inequities
Yukon (Canada)/Indigenous peoples	✓	✓	Existing legislation to respect traditional healing	Some, limited
Northwest Territories (Canada)/Indigenous peoples	✓	✓	No <sup>a</sup>	✓
Nunavut (Canada)/Inuit	✓	✓	No <sup>a</sup>	✓
Nunavik (QC, Canada)/Cree and Inuit	✓	✓	Decisions on programming are at the discretion of the Nunavik and Cree health boards for community-based services only	Extensive, primary, and secondary health care
Labrador (Newfoundland and Labrador, Canada)/Innu and Inuit	✓	✓	Decisions on programming are at the discretion of Labrador Inuit Association for community-based services only	Extensive, primary prevention services only
Denmark/Greenlanders	✓	No	No	Limited to counseling services
Greenland	✓	No	No	No
Finland/Sámi	✓	No	No	Limited to Sámi-centric mental health services in northern Norway
Norway/Sámi	✓	Yearly Statistics Norway report on Sámi health using geographical proxy for identity.	No	
Sweden/Sámi	✓	No	No	
Russia/north, Multiple tribes	✓	No	No	No
Alaska (USA)/Indigenous peoples	✓	Yes	No barriers are entrenched in policies	Extensive, primary, secondary, and tertiary health care

^ Denmark and Sweden, 1751; United States of America, 1868, 1904a, 1904b, 1921, 1924, 1971, 1975, 1992; Canada, 1974, 1982a, 1985, 2004; Foighel, 1979; Health Canada, 1979; Government of Canada, 1985; Canada and Nunavut Tapariit Kanatami, 1993; Case and Voluck, 2002; Yukon, 2002; Aaen-Larsen, 2004; Koivurova, 2008; Greenland, 2009; United States of American Office of the Legislative Counsel, 2010; Lavoie et al., 2012; Constituteproject.org, 2014; Statistics Canada, 2016a, 2016b; Nunavik Board of Health and Social Services, 2018; Sonstebo, 2018; Statistics Denmark, 2018; Statistics Greenland, 2018; The Inuit of Labrador, Her Majesty the Queen in Right of Newfoundland and Labrador, Her Majesty the Queen in Right of Canada, 2018; U.S. Census Bureau, 2018; Arctic Council, 2019; Cree Board of Health and Social Services of the James Bay, 2019; Russian Federation Federal State Statistics Service, 2019; Statistics Finland, 2019; Statistics Sweden, 2019; Statistisk sentralbyra, 2019; Sweden, 2019; United Nations Regional Information Centre for Western Europe, 2019; Det Gronlandske Hus, n.d.

<sup>a</sup>The Northwest Territories and Nunavut do not have Indigenous-centric policies; however, since Indigenous populations constitute the majority of these territories' population, and since the territories' legislative assembly include a majority of seats held by Indigenous candidates, it is often assumed that policies represent the interest and wishes of Indigenous residents.

entities jointly own and operate the Alaska Native Medical Center, which offers comprehensive medical services, including specialty care, primary care, dental, behavioral health, and pharmacy services, using a framework that integrates key Indigenous values in program planning and everyday delivery of services (Alaska Native Medical Center, 2020).

*Nordic countries* have adopted universal coverage provisions for all citizens, including Indigenous Sámi, thereby guaranteeing a right to health care for all. Of all the countries under study, health inequities between Indigenous peoples and their national counterparts appear to be less pronounced in Sweden, Norway, and Finland, although credible research on disparities in these regions is scant.<sup>4</sup>

There are considerable disparities when comparing Greenlandic Indigenous peoples' (Kalaallit) health to that of Danes. The relationship between Kalaallit and Danes is arguably somewhat different than that between Sámi and their national counterparts: *Greenland* was colonized by, and remains a part of, The Kingdom of Denmark. Different from most other Indigenous populations in the Arctic, Kalaallit are a majority in their own country, with approximately 90% of Greenland residents being Indigenous to Greenland. Greenland acquired home rule in 1979 and self-rule in 2009. The elected Parliament has all Indigenous leaders and health care has been the responsibility of the Inuit Government of Greenland since 1992. Greenlandic movements toward self-governance and home rule (Foighel, 1979) have highlighted striking differences in power between Kalaallit and Danes living in Greenland (Gad, 2013), which remain today.

The *Russian* government guarantees access to health care and emergency medical treatment for unemployed and socially vulnerable categories of citizens (Popovich et al., 2011; Constituteproject.org, 2014). Like the United States, access depends on a mix of private insurance and personal resources (Popovich et al., 2011), although affordability of insurance is not addressed (Vorobyev et al., 2012). Barriers to accessing care are related to substantial inequities in the distribution of health workers and hospitals across the Russian Federation. Access is particularly limited for all Russians in rural and remote environments, including Indigenous peoples in the Russian Arctic.

### Access to culturally appropriate and adapted care

UNDRIP's Article 24 goes beyond a generic right to health, adding specific rights relevant to Indigenous peoples. Signatory states are thus obligated to guarantee that Indigenous peoples have access to the same services accessible to all citizens without discrimination. Signatory states must also guarantee access to services that are grounded in Indigenous cultures, medicines, and practices and must address determinants of health that negatively impact

Indigenous health, at least to the same extent as is possible at the national scale. These provisions, which are intended to progressively achieve "equal right to the enjoyment of the highest attainable standard of physical and mental health" (UN, 2007, p. 9), are supported by the literature. Considerable attention has been paid in recent years to cultural assumptions embedded in the delivery of biomedical health care. The deleterious impact of biomedical hegemony has resulted in a silencing of alternative knowledge (Flesch, 2007; Hardon and Pool, 2016). A vast literature has emerged to

- conceptualize culturally appropriate care (e.g., see Ramsden, 1990; McCormick, 1996; Anderson et al., 2003; Wilson, 2008; Baba, 2013; Kirmayer, 2013; Crawford, n.d.),
- document existing models (Johnson, 2006; Mignone et al., 2007; Salaverry, 2010; Scaiola, 2010; Wetterhall et al., 2011; Kirmayer and Ban, 2013; Haynes et al., 2014; Carrie et al., 2015; Marsh et al., 2015; Browne et al., 2016; Lavoie et al., 2016; Menendez, 2016; Pelcastre-Villafuerte et al., 2017; Sandes et al., 2018), and
- evaluate the impact of innovations on outcomes (Mignone et al., 2007; Lavoie et al., 2010b; Mignone et al., 2011; Mignone and Gómez Vargas, 2015; Browne et al., 2016; Browne et al., 2018; Cueva et al., 2018a, 2018b).

Intercultural models building on Indigenous peoples' health knowledge and practices have not emerged uniformly across Circumpolar countries (see **Table 3**). Intercultural models of care exist in Alaska: These emerged not only from legislative and policy commitments but also from Indigenous innovations in the development of these models (Gottlieb, 2013; Southcentral Foundation, 2019). Canada's territories have developed a single territorial health care system, supplemented by policies addressing key issues of relevance to Indigenous citizens. For example, the Yukon Health Act of 2002 acknowledges the importance of respecting traditional healing practices (2002): This policy commitment has however not necessarily resulted in access to these treatment modalities in territorial hospitals. Such access is being promoted by the research community (Redvers et al., 2019). Land-based healing and wellness programs exist across all territories as a result of community initiatives that have emerged ad hoc and are funded through a patchwork of largely short-term pathways (Redvers, 2016). These modalities exist largely in parallel to the main health care system, which remains largely informed by a biomedical paradigm. In Nunavut, there is substantial writing documenting Inuit health-promoting practices (Briggs et al., 2000; Ootoova et al., 2000; Bennet and Rowley, 2004; Pudlat, 2011; Tagalik, 2018); however, to date, although Nunavut has made some attempts to embed Inuit values into the health care system,

4. The SAMINOR survey remains, to date, the only reputable source of research documenting inequities between Sámi living in northern Norway and other Norwegians (SAMINOR, 2014; Broderstad et al., 2019).

discussions of embedding Indigenous practices have not yet emerged.

Evidence of intercultural care models in Nordic countries is scant: Such models exist only in Norway, and even then, only for mental health services (Lavoie, 2014; Dagsvold et al., 2015). The Greenlandic health care system remains primarily structured like the Danish health care system, with little adaptation to Greenlandic Indigenous cultures and values, beyond language. We are not aware of intercultural models of care in Arctic Russia, although certain regions (Yamal, for example) take efforts to make health care available and Indigenous-centered. What Indigenous-centered care means in this context, however, may or may not align with a North American concept of Indigenous-centered care (Markin and Silin, 2016). Further research is required to unpack the meaning of Indigenous-centered care in the Russian context.

## Discussion

In the celebrations that followed the adoption of UNDRIP in 2007, Victoria Tauli-Corpuz, then chairperson of the UN Permanent Forum on Indigenous Issues, noted in her remarks on the passage of the declaration, “This is a Declaration which sets the minimum international standards for the protection and promotion of the rights of Indigenous peoples. Therefore, existing and future laws, policies and programs on Indigenous peoples will have to be redesigned and shaped to be consistent with this standard” (UN Permanent Forum on Indigenous Issues, 2007).

The declaration nevertheless generated staunch criticisms: Speaking of Sweden and drawing on Brunsson (2006), Mörkenstam refers to UNDRIP as a system of “organised hypocrisy,” where “organization meets some demands by the way of talk, others by decisions, and yet others by action” (2019, p. 1719). Others have argued that UNDRIP focuses on deficits rather than strengths (Craft et al., 2018). A recurrent criticism is that key concepts embedded in UNDRIP are based on western epistemologies rather than Indigenous philosophies. We agree that UNDRIP has numerous and concerning limitations. The four provisions we focused on, however, provide a basic framework that can help track progress across Circumpolar states.

Our analysis suggests that countries with a history of colonialism from external intrusion (Canada, the United States, both notably late to ratify UNDRIP) are showing some progress in implementing UNDRIP-compliant policies and processes. Most of this progress occurred before Canada and the United States ratified UNDRIP. Both countries have sizable Indigenous populations living in the Arctic, and these nations/tribes have been actively engaged in the pursuit of self-determination for decades. Inequities have been painstakingly recorded, if not effectively addressed.

In contrast, Nordic countries adopted UNDRIP at the onset. Interestingly, these countries show little progress in implementing UNDRIP in the health care and delivery context. These countries’ relationship to Indigenous citizens is best qualified as internal colonial imposition. Across Nordic countries, Sámi populations are small, making the implementation of programs paralleling what the state offers difficult to operationalize. Still Nordic countries have, to

date, refused to monitor inequities in health outcomes for minority ethnic populations, including Sámi, on the individual level. We acknowledge that Norway reports on Sámi health inequities, yearly, using a geographical proxy (Sámi municipalities, i.e., comparing health outcomes from communities with a higher proportion of Sámi, vs. other communities). Whether these reports accurately reflect Sámi reality is questionable.

In this analysis, Greenland and Russia are outliers. As discussed, Greenland is an independent country colonized by Denmark. Its population is primarily Indigenous, although most professional positions remain held by Danes, and the health care systems itself was and remains modeled on the Danish system. Accommodations beyond language are not apparent. Any critique of this situation is however double-edged: The Greenlandic government, which is Indigenous-led, has been setting health policies for Greenland since 1992.

Russia is an entirely different case. For decades, the Arctic did not feature in Russian policy. Recent interest is centered on resource extraction and Indigenous rights. Mokhorov argues that the Constitution guarantees a complement of Indigenous rights. He also explains that “branch laws” of both federal and regional levels further secure certain rights of Indigenous peoples for traditional uses of natural resources and to engage in traditional economic activities (Mokhorov et al., 2019). We found no evidence of inequity monitoring. Admittedly, the Russian social contract is vastly different from that of other countries under study: Although the Constitution guarantees coverage of health care for Russians, the system remains fragmented and insufficiently funded. Access to care, therefore, depends largely on location rather than entitlement (Popovich et al., 2011). We took this into consideration in our analysis. It remains, however, that Russia’s definition of Indigenous peoples includes nations with less than 50,000 members only. Therefore, while guarantees exist, they selectively apply to some. Larger groups are assumed to be “Russian” rather than Indigenous. This distinction suggests a continued and unquestioned colonial agenda.

## Conclusions

We acknowledge that considerable challenges remain in ensuring adequate access to effective and culturally appropriate health care, especially in remote communities. We also acknowledge that no single solution exists for addressing health inequities across Circumpolar countries. However, we assert that Indigenous peoples must be fully engaged in the creation, implementation, and continual assessment and improvement of health care services for Indigenous peoples. As local communities and populations must be involved, the definition of culturally appropriate care will differ from one country to the next and between Indigenous nations. Nevertheless, it is our collective recommendation that Circumpolar nations begin and/or expand commitments to culturally appropriate, self-determined, access to health care in Circumpolar contexts to reduce health inequities and adhere to their obligations outlined in UNDRIP.

## Appendix A

**Table A1.** International covenants, conferences and their relevance to the right to health. DOI: <https://doi.org/10.1525/elementa.2019.00079.tA1>

Covenant	Document	Right to Health	# Countries	Ratified										
				Canada	Denmark	Finland	Greenland	Iceland	Norway	Russia	Sweden	United States		
Universal Declaration of Human Rights (United Nations, 1948)	Universal Declaration	(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age, or other lack of livelihood in circumstances beyond his control.	50	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
International Convention on the Elimination of All Forms of Racial Discrimination 1965 (United Nations, 1965)	UN Human Rights Treaty	<i>Article 5</i> In compliance with the fundamental obligations laid down in Article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, color, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:  (d) Other civil rights, in particular... (iv) The right to public health, medical care, social security, and social services	166	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
International Covenant on Economic, Social and Cultural Rights (United Nations, 1966)	UN Human Rights Treaty	1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.  2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:  (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;  (b) The improvement of all aspects of environmental and industrial hygiene;  (c) The prevention, treatment, and control of epidemic, endemic, occupational and other diseases;  (d) The creation of conditions that would assure to all medical service and medical attention in the event of sickness.	146	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Alma-Ata Declaration 1978 (World Health Organization, 1978)	Unilateral Declaration	<b>I</b> The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.  <b>II</b> The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.	N/A											UN Resolution, ratification not applicable.

**III** Economic and social development, based on a New International Economic Order, is of basic importance to the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries. The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life and to world peace.

**IV** The people have the right and duty to participate individually and collectively in the planning and implementation of their health care.

**V** Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations, and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.

**VI** Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.

**Article 10.** States Parties shall take all appropriate measures to eliminate discrimination against women in order to ensure to them equal rights with men in the field of education and in particular to ensure, on a basis of equality of men and women: Article 10(h): (h) Access to specific educational information to help to ensure the health and well-being of families, including information and advice on family planning.

Article 12.1.1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Convention on the Elimination of All Forms of Discrimination Against Women (United Nations, 1979)

UN Human Rights Treaty

50

✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

(continued)

TABLE A1. (continued)

Covenant	Document	Right to Health	# Countries	Ratified																
				Canada	Denmark	Finland	Greenland	Iceland	Norway	Russia	Sweden	United States								
		<p><b>Article 14</b> 1. States Parties shall take into account the particular problems faced by rural women and the significant roles that rural women play in the economic survival of their families, including their work in the non-monetized sectors of the economy, and shall take all appropriate measures to ensure the application of the provisions of the present Convention to women in rural areas.</p> <p>2. States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right: (b) To have access to adequate health care facilities, including information, counseling, and services in family planning;</p>																		



TABLE B1. (continued)

Covenant	Document	Relevance	Ratified										
			#	Countries	Canada	Denmark	Finland	Greenland	Iceland	Norway	Russia	Sweden	United States
UN Combat Racism Conference 1983 (World Conference to Combat Racism and Racial Discrimination, 1983)	Adopted by UN	Recognizes that indigenous peoples are covered in existing international instruments,  22. The rights of indigenous populations to maintain their traditional economic, social, and cultural structures, to pursue their own economic, social, and cultural development and to use and further develop their own language, their special relationship to their land and its natural resources should not be taken away from them;  35. Indigenous populations should be free to manage their own affairs to the fullest practicable extent and should be consulted in all matters concerning their interests and welfare, wherever possible through formal consultative arrangements. Special measures should be taken to remedy past dispossession, dispersal, and systematic discrimination.  36. Funds should be made available by the national authorities for investments, the uses of which are to be determined with the participation of the indigenous populations themselves, in the economic life of the areas concerned, as well as in all spheres of cultural activity.  37. Governments should allow indigenous populations within their territories to develop cultural and social links with related or similar populations, taking into account the important role of international organizations or associations of indigenous populations, and with due respect for the sovereignty, territorial integrity, and political independence of those countries in which indigenous populations live.  38. The Conference further urges States to facilitate and support the establishment of representative nongovernmental international organizations for indigenous populations through which they can share experiences and promote common interests. The Sub-Commission on Prevention of Discrimination and Protection of Minorities should ensure that the urgent work being carried out by its Working Group on Indigenous Populations is continued so that the complex issues involved can be analyzed and appropriate measures taken at the international and national levels.  39. In view of the vulnerability of Indigenous populations to discrimination and violations of their human rights, and of the gravity of the threat faced by Indigenous populations in some parts of the world, Governments should pay close attention to situations in which the rights of Indigenous populations may be violated or denied, in order to prevent such violations, which should be widely publicized as soon as they are detected.	N/A										
ILO Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries 1989 (International Labour Office, 1991)	Legally binding agreement for signatories	Article 25.2. Health services shall, to the extent possible, be community-based. These services shall be planned and administered in cooperation with the peoples concerned and take into account their economic, geographic, social, and	17		✓		✓			✓		✓	

cultural conditions as well as their traditional preventive care, healing practices, and medicines. 143 √/a √/b √/c

Declaration on the Rights of Indigenous Peoples Declaration 2007 Working Group on Indigenous Populations (United Nations, 2007) Article 21.1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health, and social security. √ √/b √/c

2. States shall take effective measures and, where appropriate, special measures to ensure continuous improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children, and persons with disabilities.

Article 23. Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have 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.

Article 29. 1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programs for indigenous peoples for such conservation and protection, without discrimination.

2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior, and informed consent.

3. States shall also take effective measures to ensure, as needed, that programs for monitoring, maintaining, and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

<sup>a</sup>Canada initially refused to ratify because of the Declaration's language over self-determination and the lack of clarity over the word Indigenous. Canada ratified the declaration in 2016.

<sup>b</sup>Finland signed the declaration despite long-standing disputes between Sami Reindeer owners and Forest Administration.

<sup>c</sup>The United States initially refused to ratify because of the Declaration's language over self-determination and the lack of clarity over the word Indigenous. The United States ratified the declaration in 2010.

## Data accessibility statement

All data are cited and contained in the article.

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## Author contributions

- Contributed to conception and design: JGL, JPS, ER.
- Contributed to acquisition of data: JGL, JPS, KC, EG.
- Contributed to analysis and interpretation of data: All.
- Drafted and/or revised the article: All.
- Approved the submitted version for publication: All.

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