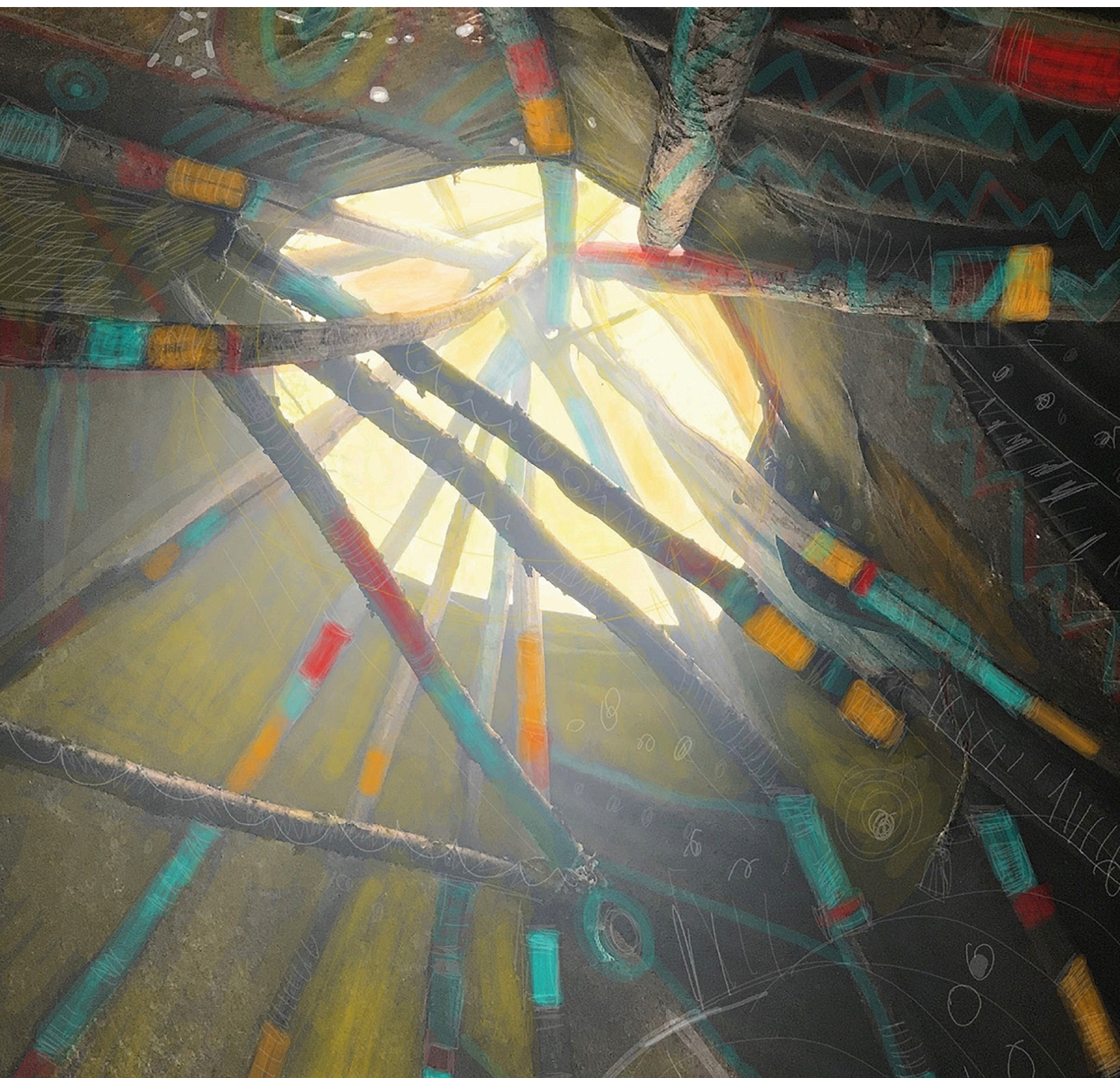




Equitable specialist health services for the Sámi people in Norway

Summary and recommendations





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Chapter 1 describes the Committee's terms of reference and its work.

Chapter 2 provides background information on the Sámi and Sámi health. The Sámi are the Indigenous People of Norway. The policy of Norwegianisation has had major consequences for language, culture, identity and trust in public services, and continues to affect health and quality of life. The knowledge base shows that, in many areas, the health of the Sámi is comparable to that of the rest of the population, but that challenges relating to mental health, discrimination, minority stress, violence and access to linguistically and culturally adapted services require particular attention. Equitable services require knowledge of Sámi language, culture, history and living conditions.

Chapter 3 reviews the State's obligations towards the Sámi with regard to the specialist health service. As an Indigenous People, the Sámi have the right to adequate health services that safeguard their language, culture and traditional medical practices. This right applies to the Sámi throughout Norway; however, there is scope for geographical variation in the services offered. As an Indigenous People, the Sámi have an extensive right to self-government and participation in decision-making, both in the design of Sámi health services and in their governance. It must be acknowledged that, in purely legal terms, the scope of this right within the specialist health service is not entirely clear. The Committee's interpretation of the body of legal sources as a whole is that the Sámi have the right to design their own specialist health services and to exercise control over them to the extent that they are able and wish to do so, and that the authorities are to cooperate with the Sámi to achieve this. The Sámi have the right to self-government over a dedicated Sámi specialist health service and the right to effective participation in decision-making on the linguistic and cultural adaptation of health services that are common to the Sámi and the majority society.

Chapter 4 describes the premises underlying the Committee's assessments. The Committee proceeds on the basis that the development of Sámi specialist health services must build on the rights of the Sámi as an Indigenous People, the experiences of Norwegianisation and the need for reconciliation. The services must be characterised by Sámi influence, high professional quality, language and cultural competence, equitable access and sustainable use of resources.

Chapter 5 describes the current organisation of Sámi specialist health services, key challenges associated with the current model and experiences from other countries in organising health services for Indigenous Peoples.

In Chapter 6, the Committee recommends establishing a national structure for Sámi specialist health services, comprising three mutually reinforcing main elements: a national unit for Sámi health, Sámi health teams and Sámi hospital programmes. The aim is to strengthen Sámi self-government and participation in decision-making, ensure more equitable access to linguistically and culturally adapted services, build up and disseminate Sámi health expertise, and enable more integrated patient pathways throughout the country.

The Committee recommends that responsibility for ensuring the provision of services should remain with the State and the regional health authorities, as it does for the rest of the population. The rationale for this is that Sámi patients should have access to the full capacity, infrastructure and medical expertise of the mainstream specialist health service; that responsibility must be determined by the geographical area to which patients belong; and that it is considered neither realistic nor desirable to establish a separate Sámi specialist health service with its own independent responsibility for ensuring the provision of services. Furthermore, a separate responsibility for ensuring the provision of services could weaken the regional health authorities' responsibility for Sámi patients in their own areas.

The Committee proceeds on the basis that Sámi language and cultural competence is to be strengthened in all the regional health authorities, that Sámi representation is to be ensured in the governing bodies of all regional health authorities and some local health trusts, and that it should be possible to include traditional Sámi medicine and culturally adapted forms of treatment as a supplement to standard treatment where the patient so wishes and this is professionally sound.

The Committee believes that earmarked funds and predictable funding are a fundamental prerequisite for the development of Sámi specialist health services. Earmarked funding allocated through items in the National Budget must cover the national unit, Sámi health teams, Sámi hospital programmes and specific measures for staffing and competence development.

Sámi health teams should be established in relevant areas to strengthen coordination between municipal services and the specialist health service, make Sámi language and cultural competence available closer to patients, and contribute to more coherent patient pathways. Sámi hospital programmes should be established at hospitals with a sufficient patient base to ensure that Sámi patients have access to language, cultural and support services during hospital stays.

The current Sámi klinihkka/SÁNÁG/SANKS should be further developed into a new national unit for Sámi health, with both clinical functions and an expanded national responsibility for research, professional development, dissemination of expertise, language and interpreting services, training for patients and relatives, and coordination of the Sámi health teams and Sámi hospital programmes. The Committee has assessed four options for organising the national unit: A national unit for Sámi health as a further development of the current structure, as a subsidiary, as a separate health trust, or as a new organisation/separate legal entity that is not an enterprise. All the options represent an improvement on the current organisation and are considered to have the potential to help safeguard the needs and rights of Sámi patients more effectively. The differences between the options mainly concern the degree of organisational autonomy, integration into the health trust system and administrative complexity. The Committee considers that the options within the health trust system provide stronger integration with existing structures and may be easier to implement, while option 4 provides the strongest institutional embedding of Sámi self-government. The Committee believes this to be the most important criterion of all. Option 4 is therefore the Committee's preferred option for organising a national unit for Sámi health.

The Committee emphasises that successful implementation requires earmarked funds, a strengthened knowledge base on Sámi health, increased Sámi representation in governing bodies, strengthened cooperation between municipal services and the specialist health service, and a new national action plan for Sámi health and care services.

In Chapter 7, the Committee responds to the questions in the terms of reference concerning staffing and recruitment. The Committee considers that a shortage of personnel with Sámi language and cultural competence is one of the greatest challenges to the development of equitable Sámi specialist health services. Access to such competence is a fundamental prerequisite for high-quality, culturally adapted services to Sámi patients.

The Committee recommends a comprehensive and long-term strategy for the recruitment, competence development and retention of personnel with Sámi language and cultural competence. Health trusts should work more actively and systematically on recruitment, assess the need for Sámi competence and request Sámi language and cultural competence when making appointments, where relevant. This work should include active recruitment strategies, financial incentives, upskilling, educational initiatives, flexible working arrangements and measures to retain personnel over time. The Committee also recommends strengthening the educational pathways for personnel with Sámi language and cultural competence, including interpreter training, study quota schemes, practical training placements and other measures that can secure future recruitment.

Chapter 8 deals with digitalisation, technology, infrastructure and coordination. The Committee considers that digitalisation and technology are important tools for ensuring accessible, equitable and culturally adapted specialist health services for Sámi patients. Technological solutions can reduce the impact of great geographical distances, make Sámi language and cultural competence available across municipalities and regions, and contribute to better coordination between levels of care.

The Committee recommends increased use of digital home follow-up, video consultations, Sámi interpreting services and Sámi-language digital health solutions, as well as investment in research, innovation and competence development in Sámi health technology.

Chapter 9 sets out the economic and administrative consequences. The Committee proceeds on the basis that the development of Sámi specialist health services requires long-term, earmarked funding. The proposals will necessitate long-term investment in personnel and expertise, but are expected, over time, to yield significant benefits through more equitable and accessible services, improved patient pathways, earlier diagnosis, reduced travel burdens, better resource utilisation and increased trust in the health service. In this way, the proposals can help to strengthen Sámi society in line with Article 108 of the Constitution.