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# The Invisible Sami Population

Regional Public Healthcare in  
Northern Sweden 1863–1950

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**ABSTRACT** Medicine and public health provision have often been used as instruments of power that have shaped relations between the colonizer and the colonized. The county councils, established in 1862 as regional self-governing authorities, became (and have remained) the main architects of Swedish public healthcare services. In this paper, we investigate the political praxis in regional public healthcare development in the three northernmost counties of Sweden, during 1863–1950. Our study finds that the “Lapp shall remain Lapp” policy, which dominated Swedish Sami policy at the time, had little if any influence on regional public healthcare politics. During the focal period, there were no public healthcare facilities and virtually no *specific* policies or directives aimed at improving access to healthcare for the Sami population.

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**KEYWORDS** colonization, Sami, history, county councils, Jämtland, Västerbotten, Norrbotten, Sápmi

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## Introduction

In his periodical report to the Swedish King, the County Governor of Norrbotten wrote in 1823 that he was witnessing the decline of the Sami people. According to the governor, this was due to Swedish colonization and the negative impacts that civilization and culture were having upon “wild and nomadic people all over the world” (County Governor of Norrbotten 1823: 36). This was one of several reports from the nineteenth century onward, where Swedish state officials acknowledged that Sami had worse general health (manifested by a population decline, lower life expectancy and higher rates of both child mortality and vaccination) than the non-Sami people in northern Sweden (for examples, see County Governor of Norrbotten 1823; County Governor of Jämtland 1852; Hellstenius 1884; Chief Medical Supervisor of Norrbotten 1894).

In other settings, such as Canada, New Zealand and Australia, the ill-health and apparent decline of Indigenous peoples strongly influenced the formation of both colonial relations and public healthcare provisions. From the late nineteenth century onwards, state public healthcare policies often included the establishment of separate health administration systems for Indigenous and non-Indigenous peoples.

The Swedish state began, during the latter part of the nineteenth century, to develop what has come to be known as the “Lapp shall remain Lapp” policy. According to Lantto (2000) and Mörkenstam (1999) this policy strongly influenced the Swedish state’s views and actions related to the Swedish Sami until after the Second World War. Nonetheless, the Swedish state never set out to incorporate responsibility for all Sami affairs under one single administrative branch, such as the Canadian Department of Indian Affairs or Native Department of New Zealand. Instead, throughout many sectors of the state, national Sami policy came to influence the formation of separate systems for Sami and non-Sami. The intention was often to protect the Sami from the negative effects of “modernization,” but would instead subordinate the Sami in relation to the Swedish state (Lantto 2012). On a regional level, from 1863 onwards, the newly instated county councils (Swedish *landsting*) of Jämtland, Västerbotten and Norrbotten initiated efforts to combat poor health. These counties were and are still located in the traditional Sami area in Sweden, that today is recognized as the Swedish part of Sápmi.<sup>1</sup>

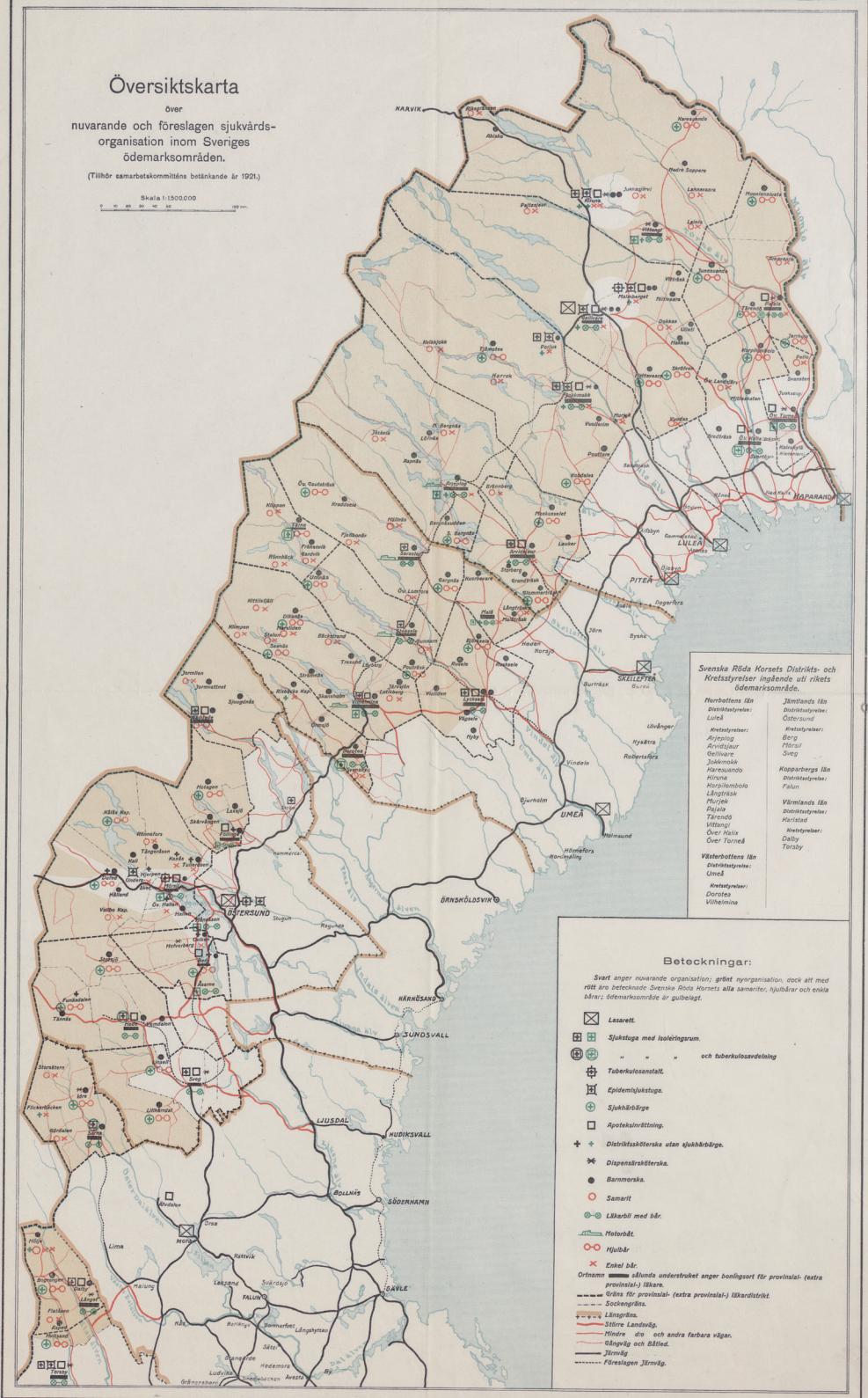
Fig 1. Public healthcare facilities in Jämtland, Västerbotten and Norrbotten at the start of the 1920s. The map, found in the collaborate committee of the Royal Medical Board and the Swedish Red Cross (1920–1923), displays existing public healthcare facilities administered by the county councils as well as new facilities proposed by the committee. Source: Riksarkivet, Svenska Röda korset, Kungl. Medicinalstyrelsens och Svenska Röda korsets samarbetskommitté 1920–1923.

### Översiktskarta

Över  
nuvarande och föreslagna sjukvårds-  
organisation inom Sveriges  
ödemarksområden.

(Tillhör samarbetskommitténs betänktande år 1921)

Skala 1:1500000



Svenska Rida Korsets Distrikts- och Kretsstyrelser ingående uti rikets ödemarksområde.

- |                                                                                |                                                                                                                                            |                                                                                                                                                        |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Distriktsstyrelser:<br>Luleå<br>Östersund<br>Åre<br>Umeå<br>Skellefteå<br>Umeå | Kretsstyrelser:<br>Berg<br>Mårås<br>Song<br>Kopperberg<br>Falun<br>Västerås<br>Gäddede<br>Karlstad<br>Överkalix<br>Övertorneå<br>Torshärad | Jämtlands län:<br>Gäddede<br>Östersund<br>Åre<br>Umeå<br>Skellefteå<br>Umeå<br>Västerås<br>Gäddede<br>Karlstad<br>Överkalix<br>Övertorneå<br>Torshärad |
|--------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|

#### Beteckningar:

Svart anger nuvarande organisation; grön nyorganisation, dock att med rött åro betecknade Svenska Rida Korsets alla samerter, hjälpar och enska båar; ödemarksområde är gulbetiget.

- ☒ Lasarett.
- ⊕ Sjukstuga med isoleringrum.
- ⊕ " " " " och tuberkulosavdelning.
- ⊕ Tuberkulosanstalt.
- ⊕ Epilepsisjukstuga.
- ⊕ Sjukhållörge.
- ⊕ Apoteksinrättning.
- + Distriktsläkare utan sjukhållörge.
- ⊕ Dispensarläkare.
- Barmorska.
- Samarit.
- ⊕ L&B-bil med bår.
- ⊕ Motorbåt.
- ⊕ Hjulbår.
- ⊕ Enkel bår.
- ⊕ Örtann omösa allönds underbrukel anger bonhörsort för provinzial- (extra provinzial-) läare.
- Gröna för provinzial- (extra provinzial-) läardistrikt.
- Södersgröna.
- Länggröna.
- Större Landväg.
- Mindre äta och andra farbara vägar.
- Gångväg och ållväg.
- Järnväg.
- Föreslagna Järnväg.

As it has not been previously addressed we want to understand the ways in which Sami people and Sami health were administered by these three county councils. We scrutinize the processes influencing decision-making at the county councils of Jämtland (CCJ), Västerbotten (CCV) and Norrbotten (CCN) based on records of their extensive archives from 1862 to 1950. We investigate how the county councils interacted with other regional and local authorities in the decision-making process regarding when and where public healthcare facilities should be established. Thus, the aim of this paper is to examine the establishment of regional public healthcare and how Sami health and healthcare needs were managed in the three counties during the period 1863–1950. We pose the following questions. Was the poor health among Sami, and their healthcare needs, formulated as part of “the Indigenous problem” and, if so, handled as a matter of separate interest? More specifically, did the “Lapp shall remain Lapp” policy influence political decision-making in the county councils during the establishment and development of public healthcare facilities in their regions?

When we end our study the county councils were the primary organizers and providers of healthcare in the evolving Swedish welfare state (Nilsson & Forsell 2013: 453–465). Moreover, a comprehensive epidemiological study concluded that, by the 1960s, the health of the Sami people in Sweden were on par with the majority population (Hassler *et al.* 2005). This means that this study covers the period when the Sami health transition took place as well as the active years of The State Institute of Racial Biology.

#### *Previous Research*

Previous research has shown that the “Lapp shall remain Lapp” policy profoundly influenced the development of welfare services in traditional Sami areas. Often, but not always, welfare services for Sami nomadic reindeer herders were to be separate from those provided for other citizens, including elderly care (Andersson 1996; Gaunt 1996; Karlsson & Liliequist 2016; Liliequist & Karlsson 2011; Lundström 2015), poverty care (SOU 1924) and education (Lantto 2005). Therefore, elderly care and education facilities provided for Sami were physically separated from those for the rest of the population through establishment of a system of residential homes for elderly Sami (Swedish *lappålderdomshem*) and schools (Swedish *nomadskolor*) throughout the Swedish part of Sápmi. These were specially designed to meet requirements for what the Swedish authorities defined as special needs of the Sami. According to Lantto (2005: 103), schools for Sami children were not to be too “comfortable” or “modern,” as this would pose a threat to “the nomadic character of the Sami, and in the long term the entire Sami culture.” Residential homes for the elderly Sami were, according to Liliequist

& Karlsson (2011), “designed to resemble a [Sami] settlement,” and located “in surroundings designed to incorporate Sami culture and tradition” (Liljequist & Karlsson 2011: 19).

The tendency to formulate separate systems for Sami and non-Sami can also be seen in poverty relief and poverty care provisions. The costs of Sami poverty care were covered by the Swedish government rather than the local communities and municipalities where Sami people lived, although the national Poverty Care Act of 1918 stated that the municipalities were responsible for poverty care of “the entire population, without consideration to nationality” (SOU 1924: 1).

In contrast to the segregative Swedish Sami policy, Norwegian policies aimed to promote assimilation of all Sami. For example, early twentieth-century campaigns against tuberculosis in the Finnmark of Norway (largely cooperative efforts by the Norwegian state and NGOs such as the Christian missionaries of Norsk Finnemission), were influenced by perceptions of the Sami people and culture as less civilized and more primitive than the majority population (Ryymin 2007: 146). According to the Norwegian National Association against Tuberculosis, the Sami were less resistant to the disease than the majority population, due to social and cultural rather than biological factors. Therefore, actions taken to combat tuberculosis included culturally uplifting and “civilizing” the Sami (Ryymin 2007).

In Sweden, the formation of public healthcare policies in relation to the country’s Indigenous people during the late nineteenth and early twentieth centuries has received little attention. In the 1960s Sixten Haraldson, a physician in Norrbotten since the 1940s, stressed that Sweden had done nothing to understand the health of the Sami people (Axelsson 2006). Prior to that, the only studies in the twentieth century connected to the “well-being” of Sami people were carried out with an eugenic agenda. The Swedish state Institute of Racial Biology examined in the 1920s and 1930s “when the Sami would die out.” It was not until the 1980s, when the Chernobyl nuclear power plant accident occurred, that the health of the Sami population, especially the reindeer herders, became matter of any greater a concern for health research and medical authorities (Axelsson 2015).

In countries such as Australia, Canada, New Zealand and the United States, Indigenous peoples’ healthcare needs were often identified and handled as part of an “Indigenous problem.” As stated by Shewell (2004), in Canada, the measures of the Indian welfare policy were “enough to keep them alive,” but forced First Nations into a colonial system created by the colonizers for the colonizers. In British Columbia, Canada, “notions of racial superiority and the ‘white man’s burden,’ assimilative goals, and the fear

of interracial pathological contagion merged to set the parameters of federal Indian health policy” (Kelm 1998: 100).

During the nineteenth and the majority of the twentieth century, the state of Victoria in Australia created reserves, officially intended to protect Aboriginal people from the abuse of settlers. Even if doctors assisted the reserves’ inhabitants, the Australian health system was still oriented towards providing superior medical care and services for the white population, and minor support for the Aboriginal peoples until they “faded away” (Smith *et al.* 2008; McCalman *et al.* 2009). In the United States, public health provisions for Indigenous people were, until 1955, under the jurisdiction of the Bureau of Indian Affairs rather than the Public Health Service that provided healthcare for the non-indigenous population (Kunitz 1990: 654). Similarly in New Zealand, Māori health has often been identified and handled as a separate matter from health of the Pakeha (those of European descent). From the establishment of Native Medical Officers in 1850 and the Native Department in 1863 to care for health of the Māori, administration of Māori health was generally characterized by ad hoc solutions and a lack of national-level coordination (Dow 1999: 68–69).

#### *Theoretical Concepts, Methods and Sources*

In this study we examine regional political praxis as manifested in records of the decision-making processes of the county councils, and their outcomes, regarding the development of public healthcare facilities in the three northernmost counties in Sweden. We also study how this process was shaped by interaction with other regional and local actors. We use a qualitative directed content analysis (Hsieh & Shannon 2005: 1281–1283). In order to examine the voluminous material, comprising of the printed records from the council assemblies of the different counties, spanning over 86 years and almost 100,000 pages, we used key concepts identified by previous research relating to Sami history and society. One of these key concepts is encapsulated in the maxim “Lapp shall remain Lapp” (Swedish *lapp skall vara lapp*), introduced by Reverend Vitalis Karnell (1906). His ideas were founded on the conclusion (based on essentialist, racist and hierarchical cultural ideas about the Sami) that to “protect” the nomadic reindeer-herding Sami from the “superior” Swedish culture and negative effects of modern society, they should be excluded from Swedish society as much as possible. Those that were of Sami descent but not reindeer herders should assimilate into the majority society. Researchers such as Lantto and Mörkenstam (2008) and Lantto (2005) have asserted that the “Lapp shall remain Lapp” notion strongly influenced Swedish Sami policy due to its harmony with prevailing images of the Sami in Swedish society at the time. The cit-

ed authors attribute some of their argumentation to the strong theoretical connections between images, identity and formulation of policy proposed by Kooiman (2003). According to Kooiman (2003: 29), the way in which a group is identified and framed profoundly influences the governing process and policy formation. Congruently, Lantto states that:

The native policies are based on how the indigenous groups are viewed, and these views limit the scope of possible political measures and actions; they define the boundaries of the policy area, and decide what the policy can contain and what it cannot. In a sense, these views also define the group, by stipulating who belongs to the group and who does not. (Lantto 2005: 98)

This theoretically explains the profound impact of the “Lapp shall remain Lapp” policy on the development and provision of welfare in Swedish Sápmi (Karlsson & Liliequist 2016; Lundström 2015; SOU 1924; Lantto 2005) and the industrial colonization of Sami lands in the nineteenth and twentieth centuries (Össbo 2014; Össbo & Lantto 2011). However, to what extent this view also came to influence the formation of public healthcare policy in the core Sami areas of Sweden, the focus of this study, has not been previously examined.

### Archive Material

The primary sources for this study are records from the County Councils of Jämtland, Västerbotten and Norrbotten from 1862 to 1950. These records were created within Swedish administrative bodies for purposes defined by the Swedish state. Thus, they do not enable us to articulate Sami people’s own experiences, a common limitation in analyses of archival material that tends to reduce Indigenous people to passive subjects rather than historical actors. We acknowledge this shortcoming. Nevertheless, the sources still illuminate colonial dimensions in Swedish policy-making and its effects on the formation of the regional public healthcare system.

Archives from the county council assemblies are, as noted by Nilsson and Forsell (2013: 416), rather brief and formal. Records of long speeches that may have been given, or extended discussions that may have been held in council arenas, are virtually non-existent in this material. Thus, it is not ideal for small sample analysis of a specific political debate. However, the printed records from the county councils include substantial numbers of proposals submitted by council members, petitions from central and local authorities or county governors, and reports from provincial doctors, infirmary boards and NGOs such as the Swedish Red Cross. They also include information about, and reports from, a vast number of investigations con-

ducted by the council. Thus, overall the material provides diverse insights into regional political processes that came to shape development of public healthcare in the three county councils located in Swedish Sápmi.

It is also important to acknowledge that the state and the church repeatedly changed their definitions of Sami identification during the period of our investigation (Axelsson 2010). It is also very likely that Sami identification locally or regionally differed from understandings at state level, although to examine these variances is beyond the scope of this paper. However, as we know that the interpretation of who was “Sami” changed over time, the terminology used in this paper is based on contemporary use in the county councils.

### Background to the County Councils

Since the 1860s, the county councils have been central institutions in the Swedish public healthcare system. During the first decades of the twentieth century, the councils evolved into monolithic healthcare providers of the Swedish welfare state. The county councils were instituted through the County Council Act of 1862 (Swedish *1862 års Landstingsreform*). The act was highly influenced by liberal ideas that had gained increasing support in large parts of Western Europe after the turn of the nineteenth century (Nilsson & Forsell 2013; Gustavsson 1989). The Swedish government envisioned the county councils as forums that would represent the will of the people and exercise authority over matters within their regional jurisdiction accordingly. Through popular elections, the people of each county selected representatives who attended annual assemblies in the county capital and debated matters of common concern specified in the County Council Act. They were designed to cover the whole country, both geographically and administratively. Healthcare was initially handled as a subordinate issue at the councils, which primarily attended to improving communications, agriculture and (to some extent) education. According to Nilsson and Forsell (2013) the county councils began to emerge as the main organizers of public healthcare during the 1920s, as increasing parts of the public healthcare sector were officially placed under the councils' authority (Nilsson & Forsell 2013: 410–413, 433–434).

The counties were divided into electoral districts that were allocated numbers of council seats. A weighted voting system was used in the county council elections, in which the number of votes was decided by taxation on income and capital. In contrast to the parliamentary elections, unmarried women of legal age (25 years) and companies registered and taxed in the county had the right to vote. The weighted electoral system was abandoned in 1918/1919 and replaced by a proportional voting system that reduced the



dominance of high officials, and owners of large estates or companies. From the 1930s onwards, the county councils have mostly been governed by social democrats and left-wing parties (Nyström 1987).

The Swedish public healthcare system slowly started to expand in the north of Sweden during the eighteenth century. In the middle of this century, medical authorities submitted a report to the Swedish parliament stating that the lack of healthcare services posed a serious threat to population growth in northern Sweden. They called for publicly funded provincial doctors and midwives to be stationed throughout the area. This idea was met with great enthusiasm by the parliament, as it strongly resonated with the mercantilist ideology of the time. However, due to economic constraints of the Swedish state, most of the ideas were never implemented (Sandblad 1979: 22–27). The only result in practice was that a few provincial doctors, who were supposed to monitor health development and public vaccination programs in addition to providing medical services, were sent to northern Sweden.

At the end of the eighteenth century, the state built several hospitals throughout the country, including one in Umeå in 1785, which became the northernmost hospital in Sweden. Half a century later, hospitals opened in Piteå (1827) and Östersund (1836) (Sandblad 1979: 99–101; County Governor of Jämtland 1840). In areas of northern Sweden distant from the regional capitals, the provision of public healthcare was limited to sporadic visits by provincial doctors from the coast and services provided by church personnel. The most prominent elements of state public health provisions introduced during the eighteenth century were large-scale vaccination programmes, which were administered by local church personnel (Johannisson 1994; Sandblad 1979).

One important difference between Jämtland and the other two counties is that the Sami population were registered separately from the non-Sami population. Föllinge Lappförsamling [‘Föllinge Sami parish’] established in 1746 was not an ordinary Swedish parish, in the sense that it was without exact geographical boundaries. It served more as an administrative unit loosely covering Kopparberg and Jämtland county, recording only Sami. The priest in charge of the parish was named *pastor lapponum* [‘The pastor for the Sami’]. The Föllinge parish was later divided into smaller non-territorial parishes, with this system in place until 1942. This system also came to have an impact on taxes as Lars Thomasson (2016) has pointed out. Well into the twentieth century the Sami in Jämtland and Härjedalen were not registered for poll tax (Swedish *mantalsskrivning*) but paid for certain areas, called tax mountains (Swedish *skattefjäll*).

## Results

At the beginning of the year 1863 there were five hospitals in the focal counties: three in Norrbotten (Piteå, Luleå and Haparanda), one in Västerbotten (Umeå) and one in Jämtland (Östersund). Although the Council Act of 1862 stated that the county councils were to be responsible for public healthcare, regulations initially stated that this only encompassed hospital care. The first national Health Act (1874) stated that healthcare was mainly a responsibility for the municipalities, while supervision of health and healthcare was a matter for the Royal Medical Board (Swedish *Kungl. Medicinalstyrelsen*). The Health Act of 1919 transferred more responsibility for public healthcare into the hands of the councils, but until the early twentieth century, the provision and development of healthcare was largely a responsibility of the municipal councils. Consequently, most elements of public healthcare—including rural healthcare, provincial doctors, maternity care, vaccination programs, control of epidemics and tuberculosis care—were not under the county councils' jurisdiction. However, a general understanding seems to have emerged during the late nineteenth century, that the county councils were the natural bodies for discussing and administering matters regarding public healthcare. Therefore, the councils adopted a more active role in public healthcare development than regulations stipulated. As the county councils did not have a mandate to singlehandedly administer or develop public healthcare, they assumed numerous roles (depending on the issues concerned and time), ranging from mandating, developing, planning, organizing and financing healthcare to assisting or working in cooperation with local or national healthcare institutions and companies. Unsurprisingly, therefore, public healthcare came to develop along rather different lines in the three focal counties, as outlined below.

### *Västerbotten*

In the autumn of 1863, the county council of Västerbotten held its first assembly, and concluded that the region was inadequately served with public health institutions as there was only one (in an area of 15,000 km<sup>2</sup>): the hospital in Umeå (which also had a small annex for venereal patients). Thus, in 1864, the council decided to build a second hospital in the city of Skellefteå, in the north-eastern part of the county, and to split the county into two separate hospital districts (southern and northern). The hospitals were to be funded separately through the collection of healthcare tax from the people of each district. However, the Lappmark<sup>2</sup> of Västerbotten was not included in either of the districts. Instead, it was decided that the people of the Lappmark would be granted access to the hospitals if a higher fee was paid, and that residents from the coastal areas were to be given higher priority

(CCV 1864). Thus, the people of the Lappmark, who accounted for about 20 per cent (16,205) of the county's population (81,478) at the time, were not included in the first major regional healthcare reform.

In the 1870s and 1880s, the council became increasingly involved in cooperating with the municipalities in developing rural healthcare provisions. The council decided to give economic support to municipalities willing to invest in infirmaries. These facilities, which came to form the backbone of rural public healthcare, were to be owned and maintained by the municipalities, but administered by the county council as integrated parts of the regional healthcare system.

This cooperation proved to be rather successful, and by the end of the nineteenth century a number of rural healthcare facilities had been built. However, they were predominantly located in the eastern part of the county, along the coast of the Gulf of Bothnia (Burträsk, Bygdeå, Byske, Degerfors, Norsjö, Nysätra). In the Lappmark only two infirmaries had been built (at Lycksele and Åsele). Several passages in the council archives highlight the poor state of infrastructure and communications in this sparsely populated area as factors holding back the expansion of healthcare services (CCV 1892, 1902, 1912–1918). The council tried to address the paucity of provisions in the Lappmark, which was considered in a number of investigations during 1870–1920. The reluctance of the Lappmark municipalities to participate in any large-scale healthcare project, such as establishment of an infirmary, was another obstacle highlighted in one of these investigations (CCV 1873). However, the peculiar administrative and fiscal status of the Lappmark, dating back to the seventeenth-century colonial policies of the Swedish Crown, seems to have been one of the most substantial problems. Due to these policies inhabitants of the Lappmark area were only liable for certain forms of national and local taxation. They did not pay regional taxes, such as the healthcare tax. This was a recurring issue in the council assemblies, and on several occasions their exemption was noted as a factor holding back development of public healthcare facilities in the Lappmark. Therefore, the lack of participation in funding public healthcare, together with the low population density, and poor state of communications and infrastructure, separated people of the Lappmark (both Sami and non-Sami) from the rest of the county. The following quote—from the summary of an investigation into the state of public healthcare in the Lappmark of Västerbotten—illustrates the nature of discussion at the beginning of the twentieth century.

Those municipalities in the Lappmark, yet to erect an infirmary, still need to have their entitled access to healthcare provided. Even if population density increases, and the state of communications improves,

which would allow the construction of a hospital, the services provided at infirmaries will still be needed. (CCV 1901)

Although access to public healthcare institutions was prescribed as a public right, the council members considered that the overall state of development and lack of economic resources among municipalities in the Lappmark were holding back its expansion. Hence, the county council continued to focus on expanding public healthcare provisions in eastern parts of the county. After 1874, the fiscal status of the Lappmark cleared somewhat, as some of the special regulations were lifted. However, the expansion still stalled for several decades until the aftermath of the Spanish flu epidemics (1918–1920), which struck the population in northern Sweden most severely (Åman 1990). From then, a combination of extensive financial support from the Swedish government and initiatives by the Swedish Red Cross resulted in a rapid expansion of healthcare institutions in the Lappmark of Västerbotten. Starting in the early 1920s, a number of infirmaries were built at sites throughout the Lappmark, including Malå (1923), Tärna (1925), Dorotea (1927) and Vilhelmina (1928), and the Swedish Red Cross built small healthcare shelters in Dikanäs and Saxnäs.

Although this expansion clearly signalled a shift of focus regarding the development of public healthcare facilities, the healthcare needs of the area's indigenous population, which according to official statistics of the time composed 1.5 per cent of the county's total population and 8 per cent of the Lappmark's population (County Governor of Västerbotten 1862), were not regarded as separate concerns for the county council. Furthermore, there is no evidence that the council created or discussed separate health facilities or healthcare policies for reindeer-herding Sami or other Sami. The few times Sami peoples or matters are mentioned in the material, it is together with Swedes in the same area.

#### *Norrbotten*

In Norrbotten, public healthcare provisions were more extensive, but in some ways similar to those of Västerbotten. The public healthcare institutions present in 1863 were all located in the eastern part of the county along the Gulf of Bothnia. In 1863, two hospitals were in operation (in Piteå and Luleå). In addition, a third hospital was under construction in the city of Haparanda by the Swedish-Finnish border. As in Västerbotten, the council decided to establish separate districts for each hospital. However, in contrast to Västerbotten, the Lappmark of Norrbotten was included in the hospital districts.

During the early 1880s, the council began discussing the obvious lack of

progress in the expansion of public healthcare in rural areas. One member suggested that the council should consider adopting the model developed in Västerbotten. Initially, the council seemed rather reluctant to shoulder responsibility for any additional healthcare institutions, and thus voted against the proposal, stating that infirmaries in rural areas were to remain the responsibility of the municipalities (CCN 1882). The following year, the subject was debated again. This time, the council rescinded its previous opposition, and decided to provide financial support for efforts by the municipality of Överkalix to build a local infirmary. They also initiated an investigation into the public healthcare conditions in the county, which led the council to develop a model of cooperation with the municipal councils in establishing infirmaries (CCN 1884). This became the foundation for expanding public healthcare facilities and, during the following decades, several infirmaries were built. Up until the 1920s, the county council and municipal councils combined forces to build infirmaries in Överkalix (1883), Nederkalix (1885), Pajala (1909) and Öjebyn (1916–1917). In the Lappmark, the cooperation resulted in infirmaries being built in the municipalities of Jokkmokk (1897) and Arvidsjaur (1908). Besides being among the most populous municipalities in the Lappmark of Norrbotten, these were, according to reports of the County Governor, municipalities where those of “Swedish nationality” had formed a clear majority for several decades (County Governor of Norrbotten 1887).

Thus, public healthcare institutions were starting to be built in the Lappmark of Norrbotten through cooperation between county and municipal councils at this time. However, stronger driving forces (especially in areas where Swedes were still in a minority) until the last years of the nineteenth century were the mining industry and large-scale infrastructure projects. For instance, the first infirmary in the Lappmark of Norrbotten was built to provide healthcare services for the labour force during construction of the Luleå–Narvik railroad in 1882–1903. The infirmary was located in Gällivare, an area mostly inhabited by Sami up until 1876, when the area quickly developed into the largest mining district in Sweden (Sköld & Axelsson 2008). After an agreement was reached between the company and the municipal council of Gällivare, the infirmary became a privately owned but partly publicly financed healthcare institution that was also intended to provide services to the general public (CCN 1892).

As the first phase of the railroad project came to an end in 1892, the infirmary was shut down, but a year later the municipal council and county council agreed to reopen it, this time as the first publicly owned healthcare facility in the Lappmark of Norrbotten. As the railroad had connected the iron ore-rich lands in Gällivare and Kiruna to shipping docks on the

Swedish and Norwegian coasts, the mining industry boomed, leading to a large inflow of settlers to the area, accompanied by increased demand for healthcare. In less than two decades, several healthcare facilities were built in the districts, including an infirmary in Kiruna and a second infirmary in Gällivare intended for tuberculosis patients. However, the county council neither initiated nor participated in this development. Instead, the mining companies emerged as the main organizers of healthcare development and provision. The county council eventually became involved in healthcare in the mining districts in the early twentieth century, following an investigation into the state of healthcare in northern Norrbotten initiated in 1908:

The population growth in the area and the fact that it is expected that mining will increase further due to the parliamentary decision in 1907 on the enlarged ore shipment, and that the mining industry is plagued by numerous accidents, will lead to an increased demand for care in the area. As it is now, there is only one hospital in Gällivare operated by the municipality with the contribution of the county council and also an infirmary in Kiruna operated by Luossavaara-Kirunavaara companies. The latter only company employees have access to. (CCN 1908)

The archives reveal how the manager of the mining company LKAB, a mine foreman, the county governor, and the chief medical supervisor, alongside a wholesaler from Piteå, were some of the minds behind the expansion of the healthcare system in the county. Although the hospital had been one of the original responsibilities of the county council, the discussions during assemblies in 1910 and 1911, as well as statements issued by county council committees, show that the opinions of the mining industry, as well as its financial support, played a major role in the eventual decision to build the new hospital, and its location within the mining district (CCN 1910; CCN 1911).

Just as in Västerbotten, the state of public healthcare in the Lappmark became an increasingly prioritized concern in Norrbotten after 1920. In the most northern part of the county, a number of healthcare facilities were established. However, just as in the previous development of healthcare in the mining district, this did not involve the county council. In this area, where Swedish settlers were a minority well into the twentieth century, the Swedish Red Cross became the major contributor to the development of healthcare facilities. During 1920–1923, this charity constructed small healthcare shelters in Tärendö, Muodoslompolo, Korpilombolo and Junosuando, as well as a combined healthcare shelter and Sami old age home in Karesuando. These were subsequently handed over to the county council and added to the regional public healthcare system in the 1940s (CCN 1942).

Thus, the development of public healthcare provisions in the Lappmark of Norrbotten followed a different pattern from that of the county's coastal areas. The model developed in the 1880s, based on joint development of healthcare facilities in rural areas by the county and municipal councils, does not seem to have delivered the same results in the Lappmark of Norrbotten, where expansion largely resulted from actions by mining and infrastructure corporations as well as NGOs. Following construction, these facilities often received public grants to deliver healthcare services to the general population, were subsequently taken over by the county council, and were thus formally incorporated into the regional public healthcare system. As in Västerbotten, the health of the Sami was not generally discussed as a separate matter from that of the general population when the development of public healthcare facilities was considered.

However, in 1946, the county council in Norrbotten drafted a new plan for maternity care where it was stated that an additional 200 maternity lots were needed “at institutions to enable that all pregnant women in the County, *including* [sic] the Sami population, can be given institutionalized childbirth” (CCN 1946). During our period of investigation, this is the only document that explicitly includes the Sami population in a general public healthcare plan.

The following year, 1947, the county council of Norrbotten received a proposition that the council, because of the severe isolation of the population north of Torneträsk, should appoint a nurse in the area. The lack of roads meant that the population of this area—estimated to be 300–400 individuals by the Sami Bailiff assistant (Swedish *lapptillsyningsmannen*)—was almost completely isolated for months at a time when water transportation was made unavailable due to weather conditions. The disastrous consequences this situation could have for women during pregnancy or labor was especially emphasized. The council gave its approval to the employment (CCN 1947).

### *Jämtland*

In 1863, the hospital in Östersund was the only public healthcare institution in Jämtland, and until the later part of the 1880s, the county council's sole public healthcare priority was to develop and modernize this hospital. As there was only one hospital in Jämtland, the county was not divided into different hospital districts. However, as in Västerbotten and Norrbotten, the lack of public healthcare institutions in rural areas became a matter of concern for the council during the last decades of the nineteenth century. This dearth was raised in 1887, when council members from Hamnerdal and Ström submitted a motion recommending that the council should fol-

low the example set by other county councils, and initiate the development of rural healthcare services. Just as in Västerbotten and Norrbotten, the Jämtland county council formulated a policy to extend provisions cooperatively with the municipal councils, through granting economic support to establish infirmaries in rural areas. Results of these initiatives seem to have been limited at best, as the county council concluded in 1895 that no infirmaries had been built. Furthermore, they decided that the county council should take control of rural healthcare development, due to the municipal councils' negligence of public health. They also concluded that infirmaries should be treated as facilities of common interest for the entire county, and thus under the responsibility of the county council rather than the municipalities (CCJ 1895–1897). As this policy was being developed, the council initiated investigations into the state of rural healthcare and began negotiating with potential partners who could participate in financing rural healthcare facilities. The council decided that infirmaries were to be built in Sveg, Hede and Ström. Besides the municipal councils, several private companies opted to participate in building these infirmaries. Consequently, the first rural healthcare facilities in the counties (infirmaries in Sveg, Hede, and Ström) were built by 1902. The county subsequently built an infirmary in Gäddede (1910). There were discussions in the 1910s of building a second hospital as they recognised that healthcare “was not sufficiently organised in Härjedalen” and that it was very possible that in the future it will be necessary to build a hospital in the southern part of the county. However, the new railway (*inlandsbanan*) was expected to be able to transport patients to the hospital in Östersund. At first the council argued that instead of setting up a hospital, priority should be given to complete the railway. However, eventually, a second hospital was built in Sveg in 1924, to serve the population in the southern part of the county.

Just as in Norrbotten and Västerbotten, the Swedish Red Cross was to play an important part in the development of rural healthcare services in Jämtland. In the early 1920s, the Swedish Red Cross began to set up health shelters in areas where public healthcare services were still particularly scarce, such as Hotagen and Storsjö. These were later handed over to be administered by the county council, and subsequently included in the regional public healthcare system; a system that had grown from a single hospital in 1863 to two hospitals, six rural infirmaries and two health shelters by the 1950s.

During our period of investigation, we find that the county council-led negotiations regarding rural healthcare development did not involve any Sami representatives. The Sami parishes, for instance, did not participate in any deliberations. The Sami population in Jämtland—according to the



County Governor of Jämtland (1862) numbering around 800 (less than 1.5 per cent) of the county's total population of 61,218—were referred to as nomads, and were not considered an integrated part of the municipalities (Thomasson 2016).

This is reflected in the way that Sami are discussed in regional public healthcare policy. For example, in the late 1930s during a discussion of how to improve the maternity care in the county, it was concluded “some wasteland areas with no or only nomadic populations should not be considered” (CCJ 1939).

In another example, the county council received an official state report in 1927 on the need to improve tuberculosis care and the accessibility to dispensaries in the three northern counties. The report identified the Sami population as one of several vulnerable groups requiring special support: “special measures must be taken to combat tuberculosis among the Lapps, who during their wanderings, when they stay at someone's house constitute an infection hazard” (CCJ 1927).

Nevertheless, in the following discussions concerning the implementation of the national directives, the Sami population were neither highlighted nor mentioned as a vulnerable group. In fact, during our period of investigation we are unable to find that the county council of Jämtland instituted any form of special measures for the Sami population regarding dispensaries or tuberculosis care.

Thus, we find evidence that the historical division of Sami and non-Sami in Jämtland was also apparently implemented in the political process of regional public healthcare development. Furthermore, we can conclude that the records show very little evidence that the Sami people or their health and wellbeing were discussed at all.

## Discussion

The role of the county councils in the development of public healthcare in northern Sweden varied greatly over time and space. From a strong focus on hospital-based healthcare in towns in the 1860s and 1870s, the county councils gradually came to influence rural public healthcare from the early 1880s. Initially, this consisted mainly of assisting municipal authorities in establishing rural healthcare clinics. By the turn of the twentieth century, the councils had emerged as a platform for general discussions of public health. These findings thereby challenge previous research, which states that county councils were not involved in the development of public healthcare until the 1920s.

The increased involvement of the county councils seems to have initiated a rapid expansion of public healthcare institutions throughout the

counties. However, our findings show that the councils paid most attention to developing healthcare facilities in the urban areas along the east coast of Norrbotten and Västerbotten and in central, densely populated parts of Jämtland. In Norrbotten and Västerbotten, increasing the number of public healthcare facilities in the Lappmark seem to have been a low priority. The same can be said for the sparsely populated areas in Jämtland, especially places only inhabited by nomadic people. This neglect seems to have resulted from the unclear fiscal status and lack of clarity regarding the respective rights and responsibilities of the Lappmark inhabitants and the Sami population of Jämtland. Therefore, establishing rural healthcare facilities in these regions often required extensive financial backing by the state or private companies, and/or initial establishment by the Swedish Red Cross. Especially in Norrbotten, private companies and state enterprises involved in mining or large infrastructural projects heavily influenced the development of healthcare in the county.

We also find that, as the regional public healthcare system in northern Sweden developed in the late nineteenth and early twentieth centuries, Sami people's health and health needs were not a matter of special concern for the county councils. In fact, the Sami people were seldom mentioned at all. In Norrbotten at the very end of our period of investigation, a maternity care plan in 1946 stated that Sami women should also to be included. Seven years prior a similar maternity plan was formulated and discussed in Jämtland, where the council explicitly excluded areas only inhabited by Sami people. Throughout the nearly 90 years this study covers, proceedings from the county council of Västerbotten reveal no mentions of either including or excluding Sami people.

This means that the county councils did not discuss or frame either Sami or reindeer-herding Sami health as an "issue," clearly defined and separated from that of the non-Sami. The councils did not develop or discuss the need to provide Sami people with public healthcare through a separate system of healthcare services. These results clearly deviate from findings on the formation of public healthcare provisions in other countries (including Canada, the United States, Australia and New Zealand), where Indigenous people's health has been identified as part of the "Indigenous problem" and thus handled separately from healthcare of the non-Indigenous population.

Furthermore, our results also differ from findings regarding the development of other Swedish welfare sectors in northern Sweden at the time such as education, poverty relief and old-age care. In these sectors, the Sami, and especially the reindeer-herding Sami, tended to be identified as a group in need of special consideration. The Swedish state invented separate systems for administrating Sami people that were designed to separate and "protect"

the nomadic reindeer-herding Sami from the “threats of modern society and the more developed Swedish culture” (Lantto 2005: 101). Towards the end of the nineteenth century there were also distinct facilities for the provision of welfare services for Sami people, and these were active up until the Second World War. Thus, it seems as if the “Lapp shall remain Lapp” policy, as well as the eugenic and cultural hierarchical arguments which influenced and legitimized the formation of separate systems for Sami and non-Sami in other welfare sectors, neither framed nor severely limited the councils’ political praxis and had little impact on the development of regional public healthcare.

## Conclusion

In this article we address the development of public healthcare provision in Swedish Sápmi and the way in which the county councils, as the main organizers of public healthcare, handled the health of the Sami population. By investigating the records from the county councils of Jämtland, Västerbotten and Norrbotten, 1863–1950, we show that the councils did not manage the health of the Sami people as a matter of separate interest. Few actions were taken specifically to administer healthcare of the Sami population. These results show that the impact of the Swedish image of the Sami, as encapsulated by the “Lapp shall remain Lapp” maxim, was limited, at least in comparison to its influence on the development of other welfare sectors during the late nineteenth and early twentieth centuries. Moreover, this clearly deviates from reported findings regarding the development of healthcare provisions in other colonial powers such as Canada, New Zealand, Australia, the United States and Norway.

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## NOTES

<sup>1</sup> In this paper, we refer to the part of Sápmi that was administered by the Swedish state during the period covered in the study. In this article, we use the contemporary terminology, thus referring to the area in terms of *län* [‘counties’]. The term *Lappmark* (which today would translate into ‘The Sami land’ or ‘Land of the Sami’) is the historical term used by the Swedish state referring to the north-western part of present-day Sweden (Lindmark 2013: 131).

- <sup>2</sup> Before the term *Sápmi* came in use during the late twentieth century, the Swedish state referred to the western parts of Norrbotten and Västerbotten as *Lappmark*, meaning 'Sami land.'

## REFERENCES

### Archives

- CCJ = Region Jämtland-Härjedalens Arkiv, Östersund ['Regional archives of Jämtland-Härjedalen'], Jämtlands läns landstings handlingar 1863–1950 ['Records of the County Council of Jämtland 1863–1950'].
- CCN = Länsarkivet i Norrbotten, Luleå ['County archive of Norrbotten'], Norrbottens läns landstings handlingar 1863–1950 ['Records of the County Council of Norrbotten 1863–1950'].
- CCV = Västerbottens Läns Landstings Arkiv, Umeå ['County Council archive of Västerbotten'], Västerbottens läns landstings handlingar 1863–1950 ['Records of the County Council of Västerbotten 1863–1950'].
- Riksarkivet ['The Swedish National Archives'], Svenska Röda korsets, Kungl. Medicinalstyrelsens och Svenska Röda korsets samarbetskommitté 1920–1923 ['The Swedish Red Cross' and The Royal Medical Boards' Joint Committee 1920–1923].

### Literature

- Åman, M. (1990). *Spanska sjukan. Den svenska epidemin 1918–1920 och dess internationella bakgrund* ['The Spanish influenza. The Swedish epidemic, 1918–1920, and its international background'], Uppsala: Uppsala University.
- Andersson, L. (1996). "Lapphemmen i Norrbotten" ['The Lapp old-age homes in Norrbotten'], *Socialmedicinsk tidskrift*, 73:7–8, pp. 417–424.
- Axelsson, P. (2006). "Science and Sami during the 20<sup>th</sup> century," in *Minority Policies, Culture & Science. The Use and Abuse of History in the Barents Region*, ed. L. Elenius, Luleå: Luleå University of Technology, pp. 113–123.
- Axelsson, P. (2010). "Abandoning 'the other.' Statistical enumeration of Swedish Sami, 1700 to 1945 and beyond," *Berichte zur Wissenschaftsgeschichte*, 33:3, pp. 263–279.
- Axelsson, P. (2015) "Urfolkshälsa. Utmanande och svårfångad" ['Indigenous health. Challenging and elusive'], *Socialmedicinsk Tidskrift*, 6, pp. 726–735.
- Chief Medical Supervisor of Norrbotten (1894). Norrbottens läns landstings handlingar. *Förste provinsialläkarens årsberättelse över Hälso- och sjukvården inom Norrbottens län år 1894* ['County council of Norrbotten. Chief Medical Supervisor's report 1894'], Luleå.
- County Governor of Jämtland (1840). Kongl. Maj:ts befallningshafvanden i Jämtlands län. *Kongl. Maj:ts Befallningshafvandes Jemtlands Län till Kongl. Maj:t i underdånighet afgifne Femårs-Berättelse för åren 1832, 1833, 1834, 1835 och 1836* ['County Governor of Jämtland, 5-year report 1832–1836'], Stockholm.
- County Governor of Jämtland (1852). Kongl. Maj:ts befallningshafvanden i Jämtlands län. *Kongl. Maj:ts Befallningshafvandes Jemtlands Län till Kongl. Maj:t i underdånighet afgifne Embets-Berättelse för åren 1848, 1849 och 1850* ['County Governor of Jämtland, report 1848–1850'], Stockholm.
- County Governor of Jämtland (1862). Kongl. Maj:ts befallningshafvande i Jämtlands län. *Landshöfdinge-embetets uti Jemtlands län underdåniga Berättelse för åren 1856–1860* ['County Governor of Jämtland, 5-year report 1856–1860'], Stockholm.

- County Governor of Norrbotten (1823). Kongl. Maj:ts befallningshafvanden i Norrbottens län. *Kongl. Maj:ts Befallningshafvande i Norrbottens Län, till Kongl. Maj:t afgifne Fem-års Berättelse år 1822* ['County Governor of Norrbotten, 5-year report 1822'], Stockholm.
- County Governor of Norrbotten (1887). Kongl. Maj:ts befallningshafvanden i Norrbottens län. *Kongl. Maj:ts Befallningshafvandes femårsberättelser för åren 1881–1885* ['County Governor of Norrbotten, 5-year report 1881–1885'], Stockholm.
- County Governor of Västerbotten (1862). Kongl. Maj:ts Befallningshafvande i Västerbotten. *Landshöfdinge-Embetets uti Westerbottens Län Underdåniga Berättelse För Åren 1856–1860* ['County Governor of Västerbotten, 5-year report 1856–1860'], Stockholm.
- Dow, D.A. (1999). *Maori Health and Government Policy 1840–1940*, Wellington: Victoria University Press.
- Gaunt, D. (1996). "Etnicitet, åldrande och hälsa. Introduktion till ett nytt forskningsfält" ['Ethnicity, aging and health. An introduction to a new research field], *Socialmedicinsk tidskrift*, 73:7–8, pp. 339–346.
- Gustavsson, H. (1989). *Sockenstugans politiska kultur. Lokal självstyrelse på 1800-talets landsbygd* ['Local self-government in rural areas during the nineteenth century'], Stockholm: Stadshistoriska institutet.
- Hassler, S., Johansson, R., Sjölander, P., Grönberg, H. & Damber, L. (2005). "Causes of death in the Sami population of Sweden, 1961–2000," *International Journal of Epidemiology*, 34:3, pp. 623–629.
- Hellstenius, J. (1884). "Barnadödligheten i Vesternorrlands och Jemtlands län" ['Child mortality in Västernorrland and Jämtland'], *Statistisk tidskrift*, 73, pp. 154–168.
- Hsieh, H.F. & Shannon, S.E. (2005). "Three approaches to qualitative content analysis," *Qualitative Health Research*, 15:9, pp. 1277–1288.
- Johannisson, K. (1994). "Public health policies in Sweden," in *The History of Public Health and the Modern State*, ed. D. Porter, Amsterdam: Rodopi, pp. 165–180.
- Karlsson, L. & Liliequist, M. (2016). "Fattigauctioner och samiska ålderdomshem. Synen på äldre samer i samband med åldringsvården" ['Poverty auctions and Sami old-age homes. Views on elderly Sami in relation to old-age care'], in *De historiska relationerna mellan Svenska kyrkan och samerna. En vetenskaplig antologi 2*, eds. D. Lindmark, & O. Sundström, Skellefteå: Artos & Norma, pp. 885–914.
- Karnell, V. (1906). "Lapparna och civilisationen" ['The Lapps and civilisation'], *Dagny*, 9:2, pp. 46–51.
- Kelm, M.-E. (1998). *Colonizing Bodies. Aboriginal Health and Healing in British Columbia 1900–50*, Vancouver: ProQuest Dissertations Publishing.
- Kooiman, J. (2003), *Governing as Governance*, London: SAGE.
- Kunitz, S.J. (1990). "Public policy and mortality among indigenous populations of northern America and Australasia," *Population and Development Review*, 16:4, pp. 647–672.
- Lantto, P. (2000). *Tiden börjar på nytt. En analys av samernas etnopolitiska mobilisering i Sverige 1900–1950* ['Time begins anew. An analysis of the ethnopolitical mobilization among the Sami in Sweden 1900–1950'], Umeå: Umeå University.
- Lantto, P. (2005). "The promise and threat of civilization. Native school policies in Canada and Sweden in the 20<sup>th</sup> century," in *Canadian Environments. Essays in Culture, Politics and History*, eds. R.C. Thomsen & N.L. Hale, Brussels: P.I.E.-Peter Lang, pp. 97–117.
- Lantto, P. (2012). *Lappväsendet. Tillämpningen av svensk samepolitik 1885–1971* ['Guardian of

- the Lapps. The modern Lapp administration in Sweden 1885–1971], Umeå: Umeå University.
- Lantto, P. & Mörkenstam, U. (2008). "Sami rights and Sami challenges. The modernization process and the Swedish Sami movement, 1886–2006," *Scandinavian Journal of History*, 33:1, pp. 26–51.
- Liliequist, M. & Karlsson, L. (2011). "Elderly Sami as the 'Other.' Discourses on the elderly care of the Sami, 1850–1930," *Journal of Northern Studies*, 5:2, pp 9–28.
- Lindmark, D. (2013). "Colonial encounter in early modern Sápmi," in *Scandinavian Colonialism and the Rise of Modernity*, eds. M. Naum & J.M. Nordin, New York: Springer, pp. 131–146.
- Lundström, C. (2015). *Den goda viljan. Kvinnliga missionärer och koloniala möten i Tunisien och västra Jämtland* ['The good will. Female missionaries and colonial encounters in Tunisia and western Jämtland'], Lund: Nordic Academic Press.
- McCalman, J., Smith, L., Anderson, I., Morley, R. & Mishra, G. (2009). "Colonialism and the health transition. Aboriginal Australians and poor whites compared, Victoria, 1850–1985," *The History of the Family*, 14:3, pp. 253–265.
- Mörkenstam, U. (1999). *Om "Lapparnes privilegier." Föreställningar om samiskhet i svensk samepolitik 1883–1997* ['On "The privileges of the Swedish Lapps." Conceptions of Saminess in Swedish Sami politics 1883–1997'], Stockholm: Stockholm University.
- Nilsson, L. & Forsell, H. (2013). *150 år av självstyrelse. Kommuner och landsting i förändring* ['150 years of self-governing. Municipalities and county councils in transformation'], Stockholm: Sveriges kommuner och landsting.
- Nyström, M. (1987). *Välfärdsbyggare i Norrbotten. NLL 125 år* ['Welfare builders in Norrbotten. NLL 125 years'], Luleå: Norrbottens museum.
- Össbo, Å. (2014). *Nya vatten, dunkla speglingar. Industriell kolonialism genom svensk vattenkraftutbyggnad i renkötselområdet 1910–1968* ['New waters, reflections of obscurity. Industrial colonialism through the Swedish hydropower development in the reindeer herding areas 1910–1968'], Umeå: Umeå University.
- Össbo, Å. & Lantto, P. (2011). "Colonial tutelage and industrial colonialism. Reindeer husbandry and early 20<sup>th</sup>-century hydroelectric development in Sweden," *Scandinavian Journal of History*, 36:3, pp. 324–348.
- Ryymin, T. (2007). "Civilizing the 'uncivilized.' The fight against tuberculosis in northern Norway at the beginning of the twentieth century," *Acta Borealia*, 24:2, pp. 143–161.
- Sandblad, H. (1979). *Världens nordligaste läkare. Medicinalväsendets första insteg i Nordskandinavien 1750–1810* ['The northernmost doctors in the world. The beginnings of public medical care in Northern Scandinavia 1750–1810], Stockholm: Almqvist & Wiksell.
- Shewell, H. (2004). *Enough to Keep Them Alive. Indian Welfare in Canada, 1873–1965*, Toronto: University of Toronto Press.
- Sköld, P. & Axelsson, P. (2008). "The northern population development. Colonization and mortality in Swedish Sapmi 1776–1895," *International Journal of Circumpolar Health*, 67:1, pp. 29–44.
- Smith, L., McCalman, J., Anderson, I., Smith, S., Evans, J., McCarthy, G. & Beer, J. (2008). "Fractional identities. The political arithmetic of Aboriginal Victorians," *Journal of Interdisciplinary History*, 38:4, pp. 533–551.
- SOU (1924). *Fattigvården bland lapparna. Utredning 1* ['Swedish Government Official Report 1924:58. Poor relief among the Lapps. Report 1'], SOU 1924:58, Stockholm.

Thomasson, L. (2016). "Lappförsamlingarna i Jämtland-Härjedalen 1746–1941. Gemenskap eller segregering?" ['The Sami congregations in Jämtland-Härjedalen 1746–1941'], in *De historiska relationerna mellan Svenska kyrkan och samerna. En vetenskaplig antologi 2*, eds. D. Lindmark, & O. Sundström, Skellefteå: Artos & Norma, pp. 855–884.

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