Beyond Integration

Indigenous Health Sovereignty and Traditional Medicine Policy in the United States

Leslie Korn, PhD, MPH, Hailey Allen, Charlotte Berg

ABSTRACT

This policy paper examines Indigenous peoples' traditional medicine in the United States as a comprehensive, land-based system of health grounded in intergenerational knowledge, ecological relationships, and community governance. It analyzes tensions between Indigenous health self-determination and state-led health policy, with particular attention to federal frameworks and the evolving approach of the World Health Organization (WHO) toward traditional medicine—from the community-based recognition reflected in the 1978 Declaration of Alma-Ata to more recent approaches emphasizing integration through regulation, biomedical validation, and standardization. The paper argues that these frameworks often marginalize Indigenous epistemologies by removing healing practices from their cultural, spiritual, and ecological contexts while privileging external evidence systems and governance structures. Drawing on examples from Tribal Nations and urban Indigenous communities, including Indigenous-governed health systems and community-based interventions, the paper highlights documented contributions to physical health, behavioral health, and community well-being. It also identifies structural barriers, including funding inequities, restrictive reimbursement policies, and the exclusion of traditional healers from formal systems. Situating these dynamics within ongoing colonial policy structures, the paper advances policy recommendations that prioritize Indigenous health self-determination, Tribal sovereignty, epistemological pluralism, and support for autonomous land-based systems of care.

Keywords: Indigenous traditional medicine, Tribal sovereignty, health policy, land-based healing, Indigenous epistemologies, public health, United States

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Editor's Note: This policy analysis presents the central arguments of a forthcoming white paper examining Indigenous traditional medicine, sovereignty, and health governance in the United States. The full manuscript is available for download here centerfortraditionalmedicine.org/policy/

Introduction

Indigenous traditional medicine in the United States is a culturally grounded, land-based system of health rooted in Indigenous peoples' intergenerational knowledge, ecological relationships, and community governance. These systems of healing emerge from enduring relationships between Indigenous communities and their environments and are empirically grounded, adaptive, and place-based. Despite the steady practice of traditional medicine across Tribal Nations and Indigenous communities, including federally unrecognized and urban Indigenous communities, these practices remain inadequately recognized and supported within federal and state policy systems, where recognition is partial, inconsistent, and insufficient. Without dealing with these gaps and defining actionable, enforceable policies that support traditional medicine practice, the goals of "Healthy People 2030," the U.S. national program that sets measurable health goals to improve the health and well-being of people in the United States by 2030, will fail to yield meaningful health outcomes for Indigenous peoples.

This paper studies Indigenous traditional medicine across Tribal Nations, Indigenous communities, and urban Indigenous populations, identifying a central tension between Indigenous self-government in health and well-being and state-led systems of governance and economic control. Indigenous health systems represent comprehensive systems of knowledge, authority and care, rather than isolated practices. As culturally grounded, land-based, and place-based systems, they are rooted in relational worldviews in which health emerges from interconnected relationships between land, culture, spirituality, food systems, and community. Healing practices, including ceremony, plant medicine, body-based therapies, and community care, are inseparable from these contexts. Indigenous food systems also function as forms of medicine rather than simply sources of nutrition.

The evolution of attitudes and policies toward traditional medicine practice has been ongoing since global colonization, which most often resulted in the banning of traditional practices, including the use of ritual, medicinal, and sacred food substances. Not unique to the U.S. and Canada, many of those bans coincided with parallel colonial efforts of assimilation and cultural genocide, like the forced relocation of children to boarding schools, forced sterilization policies, the "Sixties Scoop," in which the Canadian government removed Indigenous children from their families and facilitated adoption by white families in the U.S and Canada. All of these remained in place, often until the 1960s in the United States and Canada. Some, though not all of this, was driven by the apparent incompatibility of the Catholic church with Indigenous medical practices.

Just prior to the 1978 Declaration of Alma-Ata, the World Health Organization had already begun advancing traditional medicine within global health policy. In 1977, WHO adopted Resolution WHA30.49, one of its first major resolutions specifically focused on the training, research, and appropriate integration of traditional medicine into national health systems. That same year, WHO convened a major meeting in Geneva titled “The Promotion and Development of Traditional Medicine,” which further emphasized the role of traditional healing systems and practitioners in expanding access to primary health care worldwide.

The 1978 Declaration of Alma-Ata recognized traditional medicine within community-based systems, and while granting some autonomy, it left them politically and institutionally marginalized. More recent World Health Organization approaches have shifted toward integration through evidence-based validation, standardization, and regulation. In practice, this often moves traditional medicine away from autonomy and toward incorporation into biomedical practice.

In the Western Hemisphere, although the Pan American Health Organization (PAHO)serves as the WHO Regional Office for the Americas and largely operates within the WHO’s traditional medicine frameworks, regional consultations and intercultural health programs also help shape broader WHO policy conversations. In comparison with WHO’s increasingly technocratic traditional, complementary, and integrative medicine frameworks, PAHO discourse has more explicitly emphasized intercultural health, Indigenous identity, Indigenous participation, ethnicity and health, and the relationship between culture, land, and community well-being. These regional initiatives have also influenced broader international discussions about epistemic justice, Indigenous participation, and the recognition of multiple medical knowledge systems within global health governance.

Although integrative models of care can play an important role, they often rely on secularization and the adaptation of traditional practices into forms legible to biomedical systems. Some intermediary models, such as naturopathic medicine, share structural similarities with Indigenous approaches—including whole-person care and non-pharmacological treatment—and may offer opportunities for collaboration when governed by tribal authority. However, they are not equivalent to traditional medicine systems.

In practice, integration frequently becomes assimilation. Indigenous and traditional knowledge systems are incorporated into biomedical institutions as supplementary techniques rather than engaged as distinct systems operating according to their own governance structures and epistemologies.

This transformation is not value-free. When traditional medicine is standardized, clinically abstracted, or institutionally integrated, it is separated from the land-based, cultural, and relational contexts that sustain its effectiveness and its meaning. This pattern appears in the medicalization of entheogenic healing and in the standardization of acupuncture, where awareness and training are reduced to protocols. These processes facilitate commodification, corporate expansion, and the homogenization of medicine. Traditional practices are stripped of cultural meaning while the risks of biopiracy, unauthorized appropriation, and intellectual property extraction remain.

Indigenous traditional medicine is supported by practice-based evidence developed through observation, application, and community validation over generations. These systems indicate positive outcomes in physical and mental health, substance abuse prevention, and community health. Evidence from tribal and urban Indigenous programs includes Indigenous-governed systems such as the Nuka System of Care of Southcentral Foundation, which has shown elevated patient satisfaction, reduced emergency utilization, and stronger chronic disease outcomes. Community-based interventions such as talking circles, traditional food programs, and ceremonial practices have also shown improvements in behavioral health, family functioning, and quality of life.

However, dominant evidence frameworks persist in marginalizing these systems by privileging standardized methods, which are poorly aligned with culturally grounded knowledge systems. Funding priorities reinforce this disproportion by favoring biomedical research over Indigenous evidence systems and by limiting the recognition of Indigenous epistemologies and evaluation approaches.

Structural disparities undermine Indigenous health systems. Specific federal policy constraints include limited Medicaid reimbursement for traditional healing services, “four walls” requirements that restrict coverage to clinical settings, and credentialing systems that exclude traditional healers from formal employment structures. These disparities are rooted in colonial policies that disrupted Indigenous health by severing relationships between people, land, ceremonies, and knowledge systems. Compulsory assimilation, land dispossession, boarding schools, and institutional restructuring weakened the intergenerational transmission of ecological knowledge and healing practices. The consequences remain visible in chronic disease disparities, intergenerational trauma, and disruptions of systems of knowledge transmission. Although later federal policies were pressured to introduce self-determination policies in response to tribal nations’ demands for government-to-government relationships and expanded funding mechanisms, Indigenous healthcare remained largely embedded in biomedical systems rather than organized around restored land-based systems of care.

This is not to suggest that sovereign nations and Indigenous communities should depend on the United States fulfilling its federal trust responsibility. The federal trust responsibility has not provided equitable access or outcomes. Indigenous systems, including the Indian Health Service, continue to face chronic underfunding, limited specialty care, workforce shortages, deficient infrastructure, and culturally incongruent care. Federal recognition policies exclude many Indigenous peoples entirely from services, while urban Indigenous populations are disproportionately affected by fragmented systems and underfunded programs. Urban Indigenous populations, who represent most Indigenous peoples in the United States, rely heavily on urban Indian organizations that face additional barriers to funding, reimbursement, and culturally appropriate service delivery, despite serving essential roles in community health infrastructure. The result is a fragmented health system that is structurally unaligned with the diverse needs of tribal nations.

Indeed, it is time for Indigenous nations and communities to assert full sovereignty over health care governance, delivery, and financing, free from dependence on inconsistent federal obligations. This includes the authority to design and sustain Indigenous-led systems of care grounded in community priorities, cultural knowledge, land-based healing practices, and self-determined models of funding and accountability. Rather than remaining constrained within colonial systems that have repeatedly failed to meet Indigenous health needs, Indigenous nations must be supported in reclaiming the power to define, govern, and deliver health care on their own terms.

The World Health Organization and Global Traditional Medicine Policy

The tensions shaping Indigenous traditional medicine policy in the United States also appear in larger global and institutional debates regarding traditional, complementary and integrative medicine.

For example, globally, WHO frameworks have increased recognition of traditional medicine through research, regulation, and inclusion into national systems. WHO has also increasingly recognized native knowledge systems, including traditional ecological knowledge and traditional medicine. Over time, however, WHO policy has progressively shifted toward privileging biomedical evaluation models, creating growing tensions with Indigenous and traditional systems of healing. Certain critics suggest that this shift reinforces epistemological bias, excludes traditional healers from governance processes, strips healing practices from their ceremonial and land-based contexts, and facilitates the commodification and extraction of intellectual property without meaningful community consent. Poorly designed integration efforts can subordinate local knowledge systems to dominant biomedical institutions, while reproducing colonial power structures within global health governance. These global frameworks provide important context, though the central focus here is U.S. federal policy, tribal sovereignty, and the structural conditions shaping Indigenous health systems domestically.

The World Health Organization's position on traditional medicine has undergone a major conceptual shift since the late twentieth century. In the period surrounding the Alma-Ata Declaration of 1978, WHO treated traditional medicine primarily as a socially embedded and culturally legitimate component of primary health care. Alma-Ata explicitly recognized the role of "traditional practitioners" within community-based health systems and framed primary care as relying on "health workers, including physicians, nurses, midwives, auxiliaries and community workers as applicable, as well as traditional practitioners as needed." This language reflected a pluralistic philosophy in which traditional medicine was valued for its ease of access, cultural tradition, and practical contribution to public health, especially in developing countries where biomedical infrastructure was limited. Instead of requiring traditional systems to conform to biomedical scientific standards, WHO's early framework emphasized inclusion, participation, and local self-reliance.

By the early 2000s, however, WHO policy had begun to shift toward a more regulatory, evidence-based approach. The WHO Traditional Medicine Strategy 2002–2005 still affirmed the importance of traditional medicine and argued that it could "play a far greater role in reducing excessive mortality and morbidity." Yet the strategy simultaneously reframed traditional medicine within the language of "safety," "efficacy," "quality," and "rational use." One of the document's central strategic objectives was to "integrate TM/CAM with national health-care systems, as appropriate, by developing and implementing national TM/CAM policies and programmes" (World Health Organization 2002, 5).

Another objective was to establish evidence concerning safety and efficacy through research and evaluation. WHO regional discussions accompanying the strategy argued that traditional medicine "too has to be assessed in a similar manner" to conventional medicine, referring specifically to biomedical standards of evidence and evaluation. This marked an important transition in WHO thinking. Traditional medicine was no longer promoted mainly because of its cultural legitimacy or traditional persistence, but increasingly because it could be confirmed by scientific and biomedical assessment.

This trend became even more pronounced in the WHO Traditional Medicine Strategy 2014-2023, which adopted a more technocratic vocabulary centered on regulation, quality assurance, evidence generation, and inclusion into national health systems. The strategy repeatedly emphasized the need to promote the "safe and effective use of traditional medicine through the regulation, research and integration of traditional medicine products, practitioners and practice into health systems" (World Health Organization 2013, 7). Compared with the more community-oriented language of Alma-Ata, the 2014 strategy reflects a substantially different institutional orientation. Traditional medicine is no longer discussed chiefly as an autonomous body of Indigenous or culturally grounded knowledge, but rather as a category of health practices that require benchmarking, evidence databases, uniform terminology, and governmental supervision. Although WHO continued to endorse traditional medicine, legitimacy became increasingly conditional upon conformity with evidence-based biomedical models and state regulatory systems.

An example of this broader institutional shift appears in the report I*ntegration of Traditional, Complementary, and Integrative Medicine in the Institutionalization of Evidence-Informed Decision-Making: The World Health Organization Meeting Report* (2025). Although the report acknowledges that traditional and indigenous healing systems possess distinct epistemologies and articulates concerns regarding "epistemic justice" and different forms of medical knowledge, its overall framework is based on the institutional language of evidence-based governance. The report repeatedly emphasizes “evidence-informed decision-making”, research infrastructure, policy systems, guideline development, and inclusion in formal health systems. The contradiction is hard to ignore. Traditional medicine is rhetorically recognized as a distinct knowledge system, yet institutional legitimacy increasingly depends upon conformity with biomedical standards of evaluation, regulation, and evidence production. While the report formally endorses medical pluralism, it also demonstrates the ongoing biomedicalization of traditional medicine within global health governance.

Naturopathic and Integrative Medicine

The institutional shift identified in WHO policy has important parallels in the evolution of naturopathic medicine in the United States and Canada. Early naturopathic traditions emphasized vitalism, constitutional treatment, hydrotherapy, botanical medicine, fasting, lifestyle reform, and holistic theories of health that often stood outside dominant biomedical paradigms. However, as naturopathic medicine pursued licensure and professional legitimacy during the late twentieth and early twenty-first centuries, curricular standards progressively adopted biomedical curricula modeled on conventional medical training. Contemporary naturopathic programs now devote extensive attention to pharmacology, laboratory diagnosis, pathology, and evidence-based clinical sciences to secure regulatory recognition and integration within mainstream health systems. Some clinicians even prescribe antibiotics as a first-line approach for infections that are manageable by other means. While this process expanded professional acceptance and legal authority (and some insurance companies now pay for Naturopathic medical care, thus arguing for its increased accessibility), critics within the field argue that it also narrowed naturopathy’s epistemological distinctiveness by subordinating traditional healing philosophies to biomedical norms and institutional expectations.

The rapid expansion of “integrative medicine” within conventional hospitals and academic medical centers shows a related phenomenon. Since the 1990s, major health institutions in North America have increasingly established integrative medicine clinics, wellness centers, and complementary therapies programs. Some of these projects genuinely incorporate non-biomedical modalities such as acupuncture, herbal medicine, mindfulness practices, psychedelic and entheogenic psychotherapy, or nutrition-based therapeutics. Critics, however, maintain that integrative medicine often functions primarily as a branding strategy within conventional biomedical systems. In many cases, the unification remains superficial. Minor supportive measures, such as meditation classes, aromatherapy, or herbal teas, are added alongside unchanged biomedical treatment protocols, allowing institutions to market themselves as “holistic” without substantially altering the underlying biomedical framework. The result is frequently an asymmetrical relationship in which traditional or complementary practices are selectively incorporated only insofar as they remain subordinate to conventional clinical authority.

This pattern parallels the wider trajectory seen in WHO policy. Mainstream bodies increasingly accept traditional practices, but usually only after they have been translated into biomedical categories and placed under biomedical regulatory and professional control. Practices derived from traditional medicine may be accepted when they can be converted into accessible clinical interventions while their original philosophical frameworks are marginalized or removed. The contemporary language of “integration” can therefore obscure a more unequal process of assimilation in which biomedicine remains the dominant epistemological authority while traditional practices are selectively incorporated for institutional legitimacy, patient demand, or market differentiation. Several scholars have described this process as the “medicalization” or “biomedicalization” of complementary and traditional medicine. Rather than creating a genuinely pluralistic medical system, integration may involve the absorption of selected therapies into biomedical institutions on biomedical terms. The growth of hospital integrative medicine programs does not only reflect changing therapeutic philosophies, but also economic and institutional incentives within increasingly competitive medical systems, where “holistic” branding appeals to patient demand for individualized, human-centered care.

The central policy question is not whether Indigenous health systems should be integrated into biomedical institutions, but whether Indigenous nations retain the sovereign authority to define the terms of engagement, coexistence, or nonparticipation.

The exercise of Indigenous health sovereignty does not require a single institutional model. Indigenous nations and communities differ substantially in geography, legal status, infrastructure, political priorities, relations with federal systems, and continuity of indigenous healing practices. As a result, future Indigenous health systems may develop along a spectrum of approaches, ranging from selective collaboration within existing biomedical institutions to completely autonomous, tribally governed systems operating outside standard frameworks. Some communities may pursue transitional or hybrid arrangements as part of longer-term efforts to restore land-based healing systems, workforce capacity, community governance, and intergenerational knowledge transmission. The central issue is therefore not whether Indigenous communities participate in federal or biomedical systems at all, but whether they retain meaningful authority to determine the terms, limits, and conditions of that participation.

Policy Recommendations

Meaningful reform in Indigenous health requires a substantial transfer of authority, funding, and governance from external institutions to Tribal Nations and Indigenous communities. Integration alone is inadequate and may further erode Indigenous health systems. Policy must instead organize around Tribal sovereignty and recognize Indigenous traditional medicine as an autonomous system rather than a supplemental set of therapies within biomedical institutions.

New policy tools, including Medicaid Section 1115 waivers, show promise for supporting Tribal governance, reimbursing traditional services, and enabling land-based care. These approaches are most effective when they preserve Indigenous authority and avoid standardizing care according to biomedical norms.

The following policy directions focus on governance, financing, epistemological integrity, data sovereignty, and long-term community knowledge transmission.

Tribal authority and governance:

- Tribal Nations must hold primary authority over the definition, practice, and governance of traditional medicine, including control over health system design and practitioner recognition.
- Federal and state policies involving Indigenous traditional medicine should require meaningful Tribal and Indigenous governance authority in the design, implementation, oversight, and evaluation of these policies.
- Integrative health programs involving Indigenous healing practices should operate according to protocols defined by Tribal Nations and should not subordinate Indigenous systems to biomedical authority structures.

Evidence frameworks and epistemological pluralism:

- Federal and state health policies should recognize Native knowledge systems as legitimate evidence systems that are not reducible to biomedical validation models alone.
- Research and appraisal frameworks should be Indigenous-led and grounded in community-defined indicators of well-being, cultural sustainability, and relational accountability.
- Federal funding structures should support Indigenous-led research methods and community-defined evaluation approaches, rather than require all evidence to conform to conventional biomedical research models.

Credentialing and workforce transformation:

- Biomedical licensure requirements should not regulate traditional healers. Authority to practice should instead be determined by Tribal communities through culturally grounded processes, with protections for existing practitioners.
- State licensure and credentialing systems should not impose standardized biomedical training requirements on traditional healers or ceremonial practitioners.

- Policies should protect traditional healing systems from institutional assimilation through externally imposed certification, standardization, or scope-of-practice frameworks.

Structural and financial reform:

- Funding for land-based and ceremonial care should be expanded through mechanisms such as Medicaid Section 1115 waivers. Restrictive policies such as “four walls” requirements should be eliminated, and dedicated funding streams should support Tribal governments, urban Indigenous communities, and urban Indian organizations. Control over funding must remain with Indigenous communities.
- Funding structures should support parallel Indigenous health systems functioning under Indigenous governance, cultural protocols, and land-based models of care, rather than require incorporation into existing biomedical institutions.
- Reimbursement mechanisms should recognize ceremonial, relational, land-based, and community healing practices as legitimate forms of care.

Data sovereignty and enforcement:

- Indigenous data sovereignty should be legally enforced by explicit protections against unauthorized use in research and artificial intelligence systems, including enforceable penalties and benefit-sharing requirements.
- Indigenous communities must retain authority over how traditional knowledge, ceremonial knowledge, and health-related data are collected, interpreted, stored, and used in research, commercial development, and artificial intelligence systems.

Protection of Indigenous knowledge and intellectual property:

- Legal protections should prevent biopiracy and unauthorized patenting of Indigenous knowledge and should include Tribal review authority and enforceable agreements.
- Policies should prohibit the unauthorized commercialization, extraction, secularization, or commodification of Indigenous ceremonial and healing knowledge.
- Legal protections should recognize that the effectiveness and integrity of traditional medicine are inseparable from cultural, spiritual, ecological, and land-based contexts.

Community knowledge transmission and land access:

- Investment in land-based education, traditional food systems, language revitalization, and access to ancestral lands

> is necessary to sustain intergenerational knowledge transmission and long-term community well-being.

Conclusion

Improving Indigenous health outcomes requires more than expanding access to existing systems. The fundamental framework for governance matters. Health systems rooted in land, ceremony, community relations, and Indigenous knowledge cannot survive if authority remains external or if biomedical institutions persist in defining legitimacy on their own terms.

Current policy systems continue to marginalize Indigenous health systems through standardization, underfunding, epistemological bias, and administrative exclusion. Integration alone does not solve these problems and may reproduce them in different forms.

Achieving equity in Indigenous health outcomes requires a different approach: replacing integration with sovereignty, shifting from standardized biomedical incorporation to locally grounded, land-based systems of care, and recognizing that multiple medical knowledge systems may exist without being subordinated to a single institutional framework.

Long-term system change depends on accepting the authority of Tribal nations and Indigenous communities while supporting locally governed health systems rooted in land, knowledge transmission, ceremony, and community well-being. Distinct Indigenous knowledge frameworks may only survive when Indigenous communities retain control over governance, funding, and the conditions under which healing practices are sustained and transmitted.

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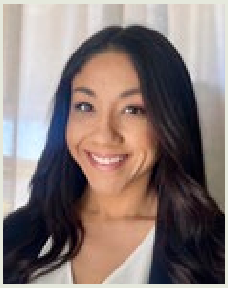

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Hailey Allen (Thx̱) is Yakama and Umatilla whose path was shaped by her great-uncle, the late Yakama elder Russell Jim, a longhouse leader and environmental protector, whose commitment to community deeply influenced her approach to research and public health.

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