Are there grounds for optimism for the future of global health?

Jeremy Shiffman

In the past decade, the field of global health has faced severe challenges and intense scrutiny concerning its legitimacy and effectiveness. A longer-term perspective—200 years rather than 10—offers grounds for guarded optimism about the future of global health. A review of the history of international health reveals that although the self-interested agendas of industrialised states have been the dominant driving forces in the field, these pursuits have been tempered by the gradual cross-national diffusion of cosmopolitan norms and initiatives concerning the right to health for all and government responsibility to improve population health. The grounds for hope are not that progress is inevitable. Rather, universalist commitments might have become sufficiently widespread and institutionalised to withstand periods of political backlash without reversing long-term expansion. The key to sustaining progress will be that actors who are committed to these norms persist in defending them.

Lancet Public Health 2026; 11: e930–33

Johns Hopkins University, Baltimore, MD, USA
(Prof J Shiffman PhD)

Correspondence to:
Prof Jeremy Shiffman, Johns Hopkins University, Baltimore, MD 21205, USA
jeremy.shiffman@jhu.edu

Introduction

In the past decade, the global health field has faced severe challenges and intense scrutiny concerning its legitimacy and effectiveness. Developments that have spurred these concerns include the world's inadequate response to the COVID-19 pandemic; the decline of multilateral cooperation for health spurred by the rise of nationalist-driven populism, especially from the second Trump administration in the USA; poorly addressed threats affecting health such as climate change, conflict, and wealth inequality; and persistent power imbalances in the field favouring actors from high-income countries over those from low-income countries. These developments have generated widespread pessimism about the future of global health, with some analysts questioning whether the field, in the absence of radical transformation, has any future.[1]

A longer-term perspective—looking back 200 years rather than 10—offers grounds for guarded optimism about the future of global health. A review of the history of international health, informed by international relations scholarship on interests and norms,[2–4] reveals that although the self-interested agendas of industrialised states have been the dominant driving forces in the field, these pursuits have been tempered by the gradual cross-national diffusion and institutionalisation of cosmopolitan norms and initiatives concerning the right to health for all and government responsibility to improve population health.

The past decade has been a clear setback for these norms. However, a focus only on the recent past obscures the slow but steady diffusion of universalist norms. Progress is not inevitable; however, universalist commitments might have become sufficiently widespread and institutionalised to withstand periods of political backlash without reversing long-term expansion. As long as actors who are committed to these norms persist in defending them, there are grounds for hope.

State interests and global health

The history of international health reveals that its driving forces have been the security, commercial, and population health interests of established (eg, USA) and rising powers (eg, China). When these interests have clashed with cosmopolitan aims, state interests have usually prevailed.

Self-interested motives instigated the establishment of the field of international health, which is one reason for widespread scepticism about the field's legitimacy and prospects. Early evidence of cross-state coordination to prevent disease transmission—and therefore of an emergent system of international health governance—occurred in the 1830s, as European states sought to prevent the spread of diseases originating in Asia without disrupting trade.[5] A primary coordinating mechanism that emerged subsequently was a series of 14 international sanitary conferences, the first held in Paris in 1851, with the last (also in Paris) held in 1938.[5,6]

Colonial interests shaped the field throughout the pre-World War 2 era,[7] and that legacy continues to underpin contemporary power imbalances in the field.[1] Historical examples abound. One is French military general Hubert Lyautey's use of medical missions as a supplement to force in subduing local populations in Indochina, Madagascar, and Algeria in the late 19th and early 20th centuries.[8] Another is US physician William Gorgas' innovations to curb mortality from malaria and yellow fever in the early 20th century, which had their roots, in part, in US efforts to ensure a healthy workforce able to build the Panama Canal, a waterway that facilitated the country's rise as an economic superpower.[9] The interests of colonial powers also shaped the early work of some major schools of public health, including the London School of Hygiene & Tropical Medicine.[10]

After World War 2, Cold War politics shaped the evolution of the field.[11] Interest in creating markets for goods through economic growth and in securing support in the battle against communism was a major reason for US support for efforts to eradicate malaria.[11,12] The Soviet Union's rivalry with the USA for influence in low-income countries shaped its decision to fund and host a conference in Alma-Ata (now Almaty, Kazakhstan) on primary health care in 1978.[11,13]

Since the 1990s, dominant states have pursued an agenda—health security—often depicted as a response to lethal dangers that affect humanity as a whole, but one more accurately understood as a reaction to the sudden onset of diseases that alarm elites and citizens in high-income countries.[14,15] For instance, WHO has declared public health emergencies of international concern in response to only a small number of disease outbreaks, placing legal obligations on states to respond. Nearly all these declarations have followed outbreaks that have incited considerable alarm among governments and populations of powerful countries. Meanwhile, outbreaks that have spread across borders in low-income countries (such as cholera and meningitis) that governments and populations of industrialised countries have not perceived as threatening to themselves have never received such a designation.

The dominance of state interests in global health is also reflected in the degree to which states and corporations collude to obstruct efforts to create barriers to market access for health-harming products, particularly tobacco, in low-income and middle-income countries. For example, the governments of the USA, China, Japan, and Germany—all with powerful domestic tobacco lobbies—opposed key provisions in the Framework Convention on Tobacco Control designed to restrain the tobacco industry.[16]

The global response to the COVID-19 pandemic is a more recent illustration of the dominance of national interests in global health. Industrialised states that were partners in COVID-19 Vaccines Global Access—an initiative to ensure vaccine access across the world—used advance purchase agreements to secure access to vaccines for their domestic populations, offering prices that low-income countries could not match.[17] Moreover, to gain geopolitical advantage, the US and Chinese Governments traded accusations on the pandemic's origins, each blaming one another and criticising the other's response to addressing COVID-19, with WHO caught in the middle.[18]

Most recently, nationalist-inspired populism has contributed to a dramatic drop in development assistance for health: 21% between 2024 and 2025, from US$49·6 billion to $39·1 billion.[19] Many countries have reduced support, including the UK, Germany, and France.[19] The effects have been most pronounced during the second Trump administration in the USA—historically the country that has been the largest funder of global health initiatives—which has decreased levels of support and enacted a transactional approach to development assistance.[20] Reduced aid has had major effects on health. A UNAIDS report, for instance, estimated that in 62 countries between 2024 and 2025 there was a 38% decline in the number of people who took pre-exposure prophylaxis at least once to avert HIV transmission.[21]

Cosmopolitan norms and global health

Although the self-interest of powerful states has been the primary force shaping the evolution of the field, this pursuit has been tempered by the gradual diffusion of norms regarding the right to health and the responsibility of governments to improve population health. These norms have underpinned the establishment of new international organisations (eg, WHO); spurred eradication campaigns (eg, smallpox); activated social movements (eg, HIV/AIDS); infused the content of treaties (eg, the Framework Convention on Tobacco Control); altered government behaviour (eg, increased budgets for the health sector); led to increased development assistance for health (bilateral, multilateral, and from foundations); and helped to spur the development and diffusion of new health technologies.[22] In doing so, these norms, alongside technological advances and other factors, have contributed to measurable improvements in population health, including a 60% decline in global mortality in children younger than 5 years between 1990 and 2024.[23]

At times these norms have reflected high-income country priorities and reproduced existing power imbalances.[24] However, their histories are more complex than a simple spread of liberal ideologies from high-income countries. Cosmopolitan norms have been shaped through struggle, reinterpretation, and promotion by a diverse array of actors from low-income and middle-income countries[4,25,26]—including advocates for antiretroviral therapy (ART) in South Africa, access to medicines in India, the right to health in Brazil, and primary health care across Latin America—who influenced the ideas that were advanced at the Alma-Ata conference.

Norms relating to the cross-national promotion of health first emerged in the early 1900s, when international organisations and private philanthropic foundations operating internationally to address health were established. The first was the Pan American Sanitary Bureau founded in 1902, with the primary aims of controlling epidemics and protecting national economies in the Americas region.[27] Another was the Rockefeller Foundation, founded in 1913 with an International Health Division, which aspired to use science to improve human wellbeing.[28] Scholars have debated whether the Foundation's stated universalist aims were genuine, or rather oriented towards protecting US interests and stymieing social change to preserve a capitalist status quo that benefited powerful countries.[28]

The creation of WHO in 1948 in the wake of World War 2 represented an unprecedented statement of intention by states to advance population health and to secure the right to health on a global basis—an injection of cosmopolitan norms in international health at a level never before seen. The 1946 preamble to the WHO constitution stated that "the enjoyment of the highest attainable standard of health is one of the fundamental

rights of every human being", and that governments had a responsibility for "the health of their peoples which can be fulfilled only by the provision of adequate health and social measures".[29]

These declarations influenced a series of WHO-led initiatives from the 1950s through the 1970s to improve population health for disadvantaged populations and to secure their right to health. In 1955, WHO began an effort at global malaria eradication, and in 1967, an initiative on smallpox that ultimately resulted in the eradication of that disease. A high point of the promotion of the right to health occurred at the 1978 conference in Alma-Ata, at that time part of the Soviet Union, which called for the universal provision of primary health care with the animating goal of "health for all for the year 2000" and which reaffirmed health as a human right.[30,31]

Principles of solidarity in health continued to spread through the end of the 20th and beginning of the 21st century. One of the major developments in global health was the rise of the AIDS movement beginning in the 1980s. Motivated to fight the stigmatisation of marginalised groups,[30] the movement was grounded in civil society activism in South Africa, Brazil, Thailand, the USA, and elsewhere, and emphasised the obligation of states to make ART available regardless of ability to pay.[32] Another major development was the establishment of the Bill & Melinda Gates Foundation in 2000, which by the fourth quarter of 2025 had provided around $90 billion in grant payments since its inception, much of that which was allocated to global health.[33] The foundation brought with it a technology-focused and private-sector orientation towards global health.[28]

From the 2000s on, a flurry of global initiatives appeared, aimed at securing health access for populations across the world. Health had a privileged position in the Millennium Development Goals, which emerged from a UN General Assembly Declaration adopted in 2000. The 2003 Framework Convention on Tobacco Control, negotiated under the auspices of WHO, drew on arguments related to rights and established legal obligations on states to regulate tobacco.[34] Launched in 2015, the Sustainable Development Goals included an expansive health goal that encompassed targets that went beyond conditions prioritised in the Millennium Development Goals. Building on a target in the Sustainable Development Goals, in 2019 UN member states adopted a political declaration on universal health coverage at a UN High-level Meeting.[35]

Most recently, over the past 5 years, in the wake of the world's response to COVID-19, the rise of populism, and the USA's retreat from global health, many countries have reacted by seeking to boost cross-national collaboration. For instance, building on preparedness efforts already underway, African states convened an emergency meeting in Ethiopia shortly after the appearance of the first case of COVID-19 in Africa, where they agreed to a joint continental strategy on the pandemic.[36] And the Accra Reset, spurred by Ghanaian President John Dramani Mahama,[37] seeks to move countries away from aid dependency and towards self-sufficiency, including on health systems development and procurement of medical goods.

The future of global health

Since World War 2, initiatives inspired by norms of global solidarity have operated alongside and challenged an international health governance system founded on colonialist impulses, infused with power imbalances, and driven by the interests of industrialised states. The universalist norms have never managed to eliminate power asymmetries nor to displace these interests, and whenever state interests and norms have come into conflict, interests usually have prevailed.

Nevertheless, over the past 200 years, these universalist norms have spread internationally, albeit slowly. In 1826, widely shared norms and initiatives to promote the health of populations across national borders were non-existent. In 1926, these norms and initiatives were emerging but remained nascent, as several international organisations and foundations committed to promoting health cross-nationally were established but had circumscribed power. In 2026, such norms and initiatives, although under threat, are widespread. These expanding norms and initiatives—in interaction with democratisation, economic development, technological advances, and the pursuit of state interests—have helped to spur many health gains, including the eradication of smallpox, the extension of ART coverage, the expansion of child immunisation, the development of new products to address global health conditions, and increases in government funding for health services.

We might now be witnessing a structural shift that constitutes a reversal in the historical trajectory. Current crises facing the field of global health, particularly the rise of autocracy, the spread of geopolitical conflict, and climate change, could be of a different order than past challenges to the field. Yet it would be premature to conclude that a permanent reversal is underway. The past two centuries show that cosmopolitan norms for health have survived periods of upheaval. Several mechanisms have underpinned their resilience: codification in international and national law; backing by international organisations and national bureaucracies; government acceptance of the legitimacy of these norms; concern among governments to protect their own international reputations; advocacy by transnational movements; and citizen demand that their governments act to protect health. Moreover, there are already signs of adaptation in the global health field. Collaboration among low-income and middle-income countries is growing; middle powers including Brazil, Canada, South Africa, and Nigeria are assuming more central roles; several low-income and middle-income countries are devoting greater domestic resources to health; and

domestic opposition to populist, nativist forces in the USA and other industrialised states appears to be mounting.

The past 200 years therefore offer grounds for optimism, as they point to the growing diffusion, institutionalisation, and resilience of universalist norms for health. The persistence of these norms is far from inevitable and will depend on actors in civil society movements, grassroots organisations, international organisations, national political systems, and foundations continuing to defend them at a moment when they are under severe threat. If these actors persevere, the present retreat could come to be understood as harmful, disruptive, and deeply unfortunate, but not as the demise of global health, nor the end of a long-term expansion of cosmopolitan commitments for health.

Declaration of interests

I declare no competing interests. During the preparation of this work, the author used ChatGPT-5.6 Luna to refine language, correct grammar, check references, identify additional relevant literature beyond that considered by the author himself, and consider critiques of the argument. The author reviewed and edited the output as needed and takes full responsibility for the content of the published article.

References

1 Abimbola S, Pai M. Will global health survive its decolonisation? *Lancet* 2020; **396:** 1627–28.

2 Mearsheimer JJ. The false promise of international institutions. *Int Secur* 1994–95; **19:** 5–49.

3 Finnemore M, Sikkink K. International norm dynamics and political change. *Int Organ* 1998; **52:** 887–917.

4 Acharya A. How ideas spread: whose norms matter? Norm localization and institutional change in Asian regionalism. *Int Organ* 2004; **58:** 239–75.

5 Ersoy N, Gungor Y, Akpinar A. International sanitary conferences from the Ottoman perspective (1851–1938). *Hygiea Int* 2011; **10:** 53–79.

6 Huber V. The unification of the globe by disease? The international sanitary conferences on cholera, 1851–1894. *Hist J* 2006; **49:** 453–76.

7 Hussain M, Sadigh Mi, Sadigh Ma, Rastegar A, Sewankambo N. Colonization and decolonization of global health: which way forward? *Glob Health Action* 2023; **16:** 2186575.

8 Paul J. Medicine and imperialism in Morocco. *MERIP Rep* 1977; **60:** 3–12.

9 Braunold J. How racism and "tropical medicine" built the Panama Canal. *AMA J Ethics* 2024; **26:** E179–83.

10 Hirsch LA, Martin R. LSHTM and colonialism: a report on the colonial history of the London School of Hygiene & Tropical Medicine (1899– c.1960). 2022. https://researchonline.lshtm.ac.uk/id/eprint/4666958/ (accessed Aug 21, 2026).

11 Brown TM, Cueto M, Fee E. The World Health Organization and the transition from "international" to "global" public health. *Am J Public Health* 2006; **96:** 62–72.

12 Packard RM. Malaria dreams: postwar visions of health and development in the third world. *Med Anthropol* 1997; **17:** 279–96.

13 Cueto M. The origins of primary health care and selective primary health care. *Am J Public Health* 2004; **94:** 1864–74.

14 Rushton S. Global health security: security for whom? Security from what? *Polit Stud* 2011; **59:** 779–96.

15 Weir L. Inventing global health security, 1994–2005. In: Rushton S, Youde J, eds. Routledge handbook of global health security. Oxford: Routledge, 2014: 18–31.

16 Mamudu HM, Glantz SA. Civil society and the negotiation of the Framework Convention on Tobacco Control. *Glob Public Health* 2009; **4:** 150–68.

17 Storeng KT, de Bengy Puyvallée A, Stein F. COVAX and the rise of the 'super public private partnership' for global health. *Glob Public Health* 2023; **18:** 1987502.

18 Fidler DP. The COVID-19 pandemic, geopolitics, and international law. *J Int Humanit Leg Stud* 2020; **11:** 237–48.

19 Institute for Health Metrics and Evaluation. Financing global health 2025: cuts in aid and future outlook. July 15, 2025. https://www.healthdata.org/research-analysis/library/financing-global-health-2025-cuts-aid-and-future-outlook (accessed June 28, 2026).

20 Yamey G. Trump and RFK Jr have a new approach to global health: holding vulnerable people to ransom. *BMJ* 2026; **393:** e387444.

21 UNAIDS. Global AIDS brief 2026: united to end AIDS. June 11, 2026. https://www.unaids.org/en/resources/documents/2026/20260612_Global_AIDS_brief (accessed Sept 16, 2026).

22 Ogbuoji O, Schäferhoff M, Zimmerman A, Fawole A, Yamey G. Health and economic benefits of improving efficiencies in product development for neglected diseases, emerging infectious diseases, and maternal health. The Center for Policy Impact in Global Health, in partnership with Open Consultants. 2024. https://centerforpolicyimpact.org/wp-content/uploads/sites/18/2024/07/health-and-economic-benefits-of-improving-efficiencies-in-product-development.pdf (accessed Aug 21, 2026).

23 Sharrow D, Hug L, Liu Y, Fell GW, You D. Global, regional, and national levels and trends in under 5, infant, and neonatal mortality during 1990-2024 with scenario based projections to 2030: modelling study. *BMJ* 2026; **393:** e088684.

24 Affun-Adegbulu C, Adegbulu O. Decolonising global (public) health: from western universalism to global pluriversalities. *BMJ Glob Health* 2020; **5:** e002947.

25 Robins S. From "rights" to "ritual": AIDS activism in South Africa. *Am Anthropol* 2006; **108:** 312–23.

26 Sikkink K. Evidence for hope: making human rights work in the 21st century. Princeton, NJ: Princeton University Press, 2017.

27 Pan American Health Organization. History of the Pan American Health Organization (PAHO). 2022. https://www.paho.org/en/who-we-are/history-paho (accessed June 24, 2026).

28 Youde J. The Rockefeller and Gates Foundations in global health governance. *Glob Soc* 2013; **27:** 139–58.

29 WHO. WHO constitution. World Health Organization, 2026. https://www.who.int/about/governance/constitution (accessed June 25, 2026).

30 Gostin LO, Meier BM, Thomas R, Magar V, Ghebreyesus TA. 70 years of human rights in global health: drawing on a contentious past to secure a hopeful future. *Lancet* 2018; **392:** 2731–35.

31 WHO. Declaration of Alma-Ata. World Health Organization. 1978. https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 (accessed June 24, 2026).

32 Kapstein EB, Busby JW. Making markets for merit goods: the political economy of antiretrovirals. *Glob Policy* 2010; **1:** 75–90.

33 Gates Foundation. Foundation fact sheet. 2025–26. https://www.gatesfoundation.org/about/foundation-fact-sheet (accessed June 24, 2026).

34 Reubi D. Making a human right to tobacco control: expert and advocacy networks, framing and the right to health. *Glob Public Health* 2012; **7** (suppl 2)**:** S176–90.

35 United Nations. Political declaration of the high-level meeting on universal health coverage "universal health coverage: moving together to build a healthier world". Sept 23, 2019. https://www.un.org/pga/wp-content/uploads/sites/53/2019/07/FINAL-draft-UHC-Political-Declaration.pdf (accessed June 24, 2026).

36 Happi CT, Nkengasong JN. Two years of COVID-19 in Africa: lessons for the world. *Nature* 2022; **601:** 22–25.

37 The Accra Reset. The Accra Reset. 2026. https://accrareset.org/the-accra-reset (accessed June 24, 2026).

Copyright © 2026 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY-NC 4.0 license.