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Evolving health norms amid overlapping crises: (re)constructing global health security and universal health coverage

For the Global Health at LSE blog this week, doctoral candidate Arush Lal, Dr Clare Wenham and Dr Justin Parkhurst (all LSE Health Policy) provide an overview of their recent paper in International Affairs, '(Re)constructing global health security & universal health coverage: norm contestation & interaction'. They begin by asking:

As pandemics, climate disasters, economic instability, and geopolitical conflicts converge, how do we build health systems that are both crisis-ready and universally-accessible? Are we prepared to balance national security concerns with the fundamental right to health in a world where multilateralism is eroding and nationalism is rising?

Within the global health community there is now recognition of the need to align the goals and policies used to pursue global health security (GHS) and universal health coverage (UHC). Achieving this requires what some scholars refer to as 'norm integration.' Norms in this sense refer to shared values, organizing processes, and standardized procedures which ultimately direct policy action. Yet, these norms that guide thinking and action can evolve differently for issues over time.

In a recent paper published in *International Affairs*, (Re)constructing global health security & universal health coverage: norm contestation & interaction, we examine how GHS and UHC – long considered isolated priorities – have in fact evolved together through repeated contestation and interaction, reshaping each other into integrated norms. By understanding their interconnected normative histories and how both have adapted to political, economic, and health shocks, we can better anticipate how GHS and UHC will continue to evolve – and what this means for policy today.

A fresh perspective on two essential health norms

Global health initiatives have often struggled to reconcile two of their most influential, yet seemingly divergent, agendas. On one side, GHS focuses on protecting nations from health emergencies by preventing, detecting, and responding to epidemics and outbreaks. On the other, UHC champions the right of every individual to access essential health services without financial hardship. Their separation has been reinforced by inherently distinct principles and approaches – security and preparedness for GHS, equity and access for UHC.

Yet, our research challenges this view. Rather than independent goals, we argue GHS and UHC function as dynamic norms that have continuously influenced each other over time. Drawing on a previously developed 'norm life-cycle' framework (by Finnemore and Sikkink), we traced their development through major milestones – from the International Sanitary Conferences over 100 years ago, through the Alma-Ata Declaration on primary health care of 1978, to modern crises like Ebola, Zika, and COVID-19 – to uncover the oft-overlooked ways in which GHS and UHC have continuously (re)constructed themselves and each other through key moments of overlap.

Through this hidden history of GHS and UHC, we find that both norms have not only adapted in response to health emergencies but have also become increasingly interlinked through international agreements into a more cohesive global health framework.

Three overarching takeaways

We first argue that GHS & UHC norms are not static: they are constantly evolving processes, shaped by discursive shifts reflecting political and economic realities. For example, GHS, once focused narrowly on infectious disease control, expanded under post–Cold War and 9/11 security architectures to include biosecurity, epidemic threats, and national preparedness. Meanwhile, the trajectory of UHC evolved from broad rights-based commitments in the Universal Declaration of Human Rights and the UN Human Rights Commission's 'General Comment 14' (on the right to health) to feature financial protection measures as countries faced economic constraints. Much like how the framing of climate policy has shifted in response to environmental emergencies, health policies have had to remain adaptable.

Second, GHS & UHC norms are closely interlinked – influencing each other more often than previously thought. During the 2014 Ebola outbreak, urgent security responses led to a heavy emphasis on GHS, which in turn sidelined long-term investments in routine health services and ultimately renewing attention to gaps in UHC. More recently, as vaccine inequity and uneven recovery from COVID-19 dominated headlines, the push for UHC reshaped discussions on pandemic preparedness amid heightened GHS discourse. These shifts demonstrate that strengthening one norm inevitably impacts the other – and, in this case, often strengthens both.

Third, GHS & UHC norms are increasingly integrated and mutually reinforcing. Our research documents how UHC norms steadily diffused into documents once dominated solely by GHS

frameworks, with WHO health emergency reports now frequently referencing equitable access to care. Conversely, GHS norms increasingly appear in traditionally rights-based UHC debates, with references to pandemic threats in iterative drafts of the 2019 UHC political declaration. This convergence toward a hybrid norm of GHS and UHC is an opportunity: rather than treating them as competing priorities, global health stakeholders should embrace a synergistic approach that ensures health systems are both crisis-resilient and equitable.

Implications for global health policy and international relations

These findings could not be more timely. Amid this era of polycrisis – with the lingering effects of COVID-19, ongoing conflicts in Ukraine and Gaza, climate-induced emergencies, and dwindling international health assistance – maintaining hard-won progress in global health requires a strategic and integrated approach.

For policymakers and practitioners, this means moving beyond siloed investments. Governments should stop treating GHS and UHC as separate budget lines and instead invest in dual-purpose health systems – ones that can detect and respond to new threats while providing essential health services. Major organizations like WHO, World Bank, GFATM, and GAVI should institutionalize integrated frameworks between GHS and UHC, with joint funding mechanisms, coordinated policy reviews, and cross-sectoral strategies to strengthen both emergency preparedness and everyday health programs. Increased support for initiatives like the Lusaka Agenda (on the Future of Global Health Initiatives Process) can bolster institutional coherence, reflecting this approach of hybrid norms in an era of geopolitical fragmentation. For global health advocates, the integration of GHS and UHC offers a powerful narrative. Health security should not come at the expense of universal access—both are essential. By framing health as an emergency imperative and fundamental right, advocates can build broader bipartisan support for systemic reforms, even in politically divided landscapes.

Beyond global health, our research reconceptualizes how we think about norm development. Rather than seeing norms as ‘fixed’ once they are implemented, we show that they continue to evolve through contestation and interaction. Furthermore, we demonstrate a successful case of two major norm regimes building up, rather than tearing down, each other in a way that is strategic for both. This insight applies not only to health, but to other areas of multilateral diplomacy and governance where competing priorities must be reconciled to create durable policy solutions: nuclear security, trade agreements, and gender equality. The ongoing tension between securitization and rights-based approaches is not necessarily a barrier to progress – it can provide a mechanism to drive policy evolution in contested environments.

Conclusion

In a world of overlapping crises, integrating GHS and UHC is not just an academic exercise – it is a pragmatic necessity. Our research shows that these norms are constantly (re)constructed in response to global challenges. Embracing their dynamic, intertwined nature allows us to build health systems that are resilient in emergencies and equitable in routine care.

This is not a call for abstract idealism, but rather a politically salient strategy that speaks to the priorities of governments across the political spectrum while retaining core principles. As countries weigh national security interests alongside commitments to human rights, understanding how GHS and UHC have evolved together provides a critical roadmap for the future. If we are to sustain global health gains in an era of growing instability, we must rethink these norms – not as separate priorities, but as mutually-reinforcing goals on the road toward a healthier, more secure future for all.

About the author

Arush Lal

Arush Lal is a doctoral candidate at the London School of Economics and Political Science. His research explores the politics of norms shaping global health governance and diplomacy, focusing on the integration of global health security and universal health coverage. His work on equitable and resilient health systems has been published in peer-reviewed journals like The Lancet and International Affairs, featured on platforms including CNN and Devex, and cited by the United States and United Kingdom governments, WHO, World Bank, OECD and the G7 Pandemic Preparedness Partnership, among others. He has served as a Senior Technical Advisor on the USAID COVID–19 Response Team, Board Vice Chair for Women in Global Health, Fellow for Planetary Health Equity, and Commissioner on the Chatham House Commission for Universal Health.

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Dr Clare Wenham is an Associate Professor of Global Health Policy at the London School of Economics and Political Science. She specializes in global health security and the politics and policy of pandemic preparedness and outbreak response, through analysis of influenza, Ebola, Zika and COVID–19. Her work has been featured in The Lancet, BMJ, Security Dialogue, International Affairs, BMJ Global Health and Third World Quarterly.

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