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Letter to the Editor

Narratives, evidence, and the material reality of Colombia's current health system crisis

Relatos, datos y la realidad concreta de la actual crisis del sistema de salud colombiano

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Abstract

This document argues that Colombia's health system crisis is not merely a discursive construction but a verifiable structural reality. It presents evidence of worsening access and financial instability, including a sharp rise in *tutelas* and complaints, adverse effects of government interventions in insurers, growth in private insurance uptake, and increasing out-of-pocket expenditure. The authors conclude that, beyond the politics of evidence, the current situation demands urgent, technically sound responses focused on equity and the effective protection of the right to health.

Keywords: Colombia. Health system crisis. Access to healthcare. Governance.

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Resumen

Este documento sostiene que la crisis del sistema de salud en Colombia no es meramente una construcción discursiva, sino una realidad estructural verificable. Presenta evidencia de un deterioro en el acceso y de inestabilidad financiera, incluyendo un aumento pronunciado de las tutelas y las quejas, efectos adversos de las intervenciones gubernamentales en las aseguradoras, crecimiento en la adquisición de seguros privados y un incremento del gasto de bolsillo. Los autores concluyen que, más allá de la política de la evidencia, la situación actual exige respuestas urgentes, técnicamente sólidas y centradas en la equidad y en la protección efectiva del derecho a la salud.

Palabras clave: Colombia. Crisis del sistema de salud. Acceso a la atención en salud. Gobernanza.

We read with great interest the article "The politics of evidence in health system crises: the case of Colombia" by Tine Hanrieder[1], published in *International Affairs*. The paper constitutes a timely contribution to understanding how indicators, international benchmarks, and development narratives are mobilized by different actors to interpret and contest the meaning of a "crisis" in health systems. We concur that the interpretation of evidence is embedded in political, historical, and symbolic processes.

Nevertheless, we introduce a critical distinction in the Colombian context today: while narratives and their interpretive disputes are analytically relevant, they are fundamentally different from the material reality currently experienced by patients, health workers, and households. Although the article rightly notes that the government framed the reform debate as a confrontation between public and private authority, it is essential to clarify that Colombia's managed competition model has historically combined public financing with an important participation of public hospitals and mixed or public insurers. By consolidating the crisis narrative around a simplified public–private dichotomy, the government capitalized on a politically powerful but analytically reductive framing that obscured the system's institutional hybridity. From an epistemological standpoint, while the article effectively critiques the selective political use of data, it could more clearly specify whether the crisis is treated solely as a discursive construction or also as a potentially verifiable structural condition beyond narrative contestation.

First, the sustained and recent increase in health-related *tutelas—legal* complaints filed to secure access to healthcare services—constitutes an unequivocal signal of structural failures in access to care. The article notes that *tutelas* reached a peak of 207,734 in 2018 and also reports the figure for 2023[1]. However, the current situation has deteriorated even further. Between 2022 and 2025, the number of *tutelas* grew by 104%, more than doubling from 156,274 to 318,981, underscoring the magnitude and acceleration of this trend[2]. The author misses another key indicator of declining access: complaints to the Health Superintendency grew by 64%, from 1,247,137 in 2022 to 2,048,435 in 2025[3,4]. Beyond rhetoric, *tutelas* reflect unmet needs, persistent barriers, and denials of care that directly affect people's health and lives. Since the beginning of the current administration, the gap between formal coverage and real access has widened rather than narrowed.

Second, the recent government interventions in multiple Health Promoting Entities (EPS, by its Spanish acronym), regardless of political or legal justification, have had observable adverse effects on financial stability and access to healthcare. These effects have been documented by the Office of the Inspector General[5]. Liquidity shortages, payment delays to providers, workforce precarity, and medicine supply disruptions are not discursive constructs; they translate into cancelled appointments, service closures, and therapeutic discontinuity for millions, including patients with chronic conditions. The case of *Nueva EPS—the* largest insurer in the country, covering

approximately 11 million enrollees, now under direct government intervention for nearly two years—is particularly illustrative: to date, no updated financial statements have been publicly disclosed[6], depriving providers, oversight bodies, and the public of information essential for assessing systemic risk.

Third, the rapid growth in the purchase of private health insurance policies and prepaid medical plans represents a critical indicator of declining trust in the health system. Between 2023 and 2024 alone, private health insurance coverage increased by 37%, reaching 1.66 million beneficiaries[7]. This trend deepens access segmentation and imposes an additional financial burden on households, many of which resort to these mechanisms defensively in response to uncertainty and service denial rather than by choice.

Importantly, these developments are neither isolated nor anecdotal. Consistent with the above, independent academic centers and oversight institutions, such as the Office of the Ombudsman of Colombia, have documented a sustained increase in out-of-pocket health expenditure[8,9]. For large segments of the population, healthcare spending is becoming an increasingly significant source of economic vulnerability, forcing households to forgo other essential goods.

It is crucial to emphasize that these warnings do not emanate from a single political or ideological position. On the contrary, they have been repeatedly articulated by scientific societies, patient associations, academic organizations, health sector guilds, oversight bodies, and other stakeholders. Moreover, in early 2025, the Colombian Constitutional Court determined non-compliance with the financial sufficiency component of the health insurance premium set by the Ministry of Health and Social Protection—resources transferred to EPS to manage population health risks—and urged the establishment of criteria for ex post adjustments, a mandate that remains unfulfilled[10]. This convergence of diagnoses suggests that Colombia is facing a real-time humanitarian crisis in health, rather than a merely interpretive dispute over indicators and development narratives.

Our observation is not intended to dismiss the article's valuable analytical framework, but rather to caution against the risk that an excessive focus on the politics of evidence may relativize the urgency of the current situation. Acknowledging that indicators are politically mobilized should not lead to inaction in the face of compelling empirical signals of suffering, exclusion, and deteriorating access to essential services.

While qualitative research offers distinct analytical approaches, it also requires transparency and rigor. In its current form, the manuscript does not provide sufficient transparency to assess the trustworthiness of its findings. The documentary corpus lacks a defensible sampling strategy and reproducible selection procedures, rendering it non-auditable and vulnerable to selection bias. The analytic process remains opaque, with no clear account of coding, iteration, discrepant cases, or audit trail, and the interview component is underspecified, including ethics, participant balance, and researcher positionality.

Although triangulation is implied, it is not explicit, and the boundary between analyzing contested discourse and advancing inference is insufficiently safeguarded. These limitations undermine dependability and confirmability and suggest the findings should be read as interpretive commentary rather than robust qualitative evidence, given the partial representation of actors and the limited inclusion of frontline health workers, distressed providers, rural or conflict-affected patients, and communities facing structural access barriers.

Greater transparency regarding ethical safeguards would also strengthen the analysis: in a highly polarized political environment, were anonymity protections sufficient to prevent indirect identification of participants or unintended exposure of institutional affiliations? Also, the media analysis lacks clearly defined selection criteria, temporal boundaries, and a transparent coding protocol, which reduces its methodological rigor and limits replicability. Finally, a more robust engagement with current epidemiological,

service delivery, and mortality data and a technical assessment of fiscal sustainability, cost structures, or actuarial dynamics would situate the debate beyond the realm of narrative contestation. Framing the crisis predominantly as a dispute over the politics of evidence risks obscuring the material reality that preventable deaths, delayed diagnoses, treatment interruptions, and geographic barriers to care continue to affect thousands of Colombians daily. The health system crisis is not merely discursive; it is measurable, cumulative, and life-threatening.

Conclusion

Beyond political and discursive debates, Colombia's health system today requires immediate, technically sound, evidence-based responses centered on the protection of people and the promotion of equity. The most important challenge is not to analyze the narrative of the crisis, but how it is urgently addressed to prevent its consequences from further deepening a social and humanitarian emergency.

We are fully aware that the Colombian health system is far from perfect and faces multiple and profound opportunities for improvement. However, we also recognize that perfectibility is an inherent condition of all health systems, even in the most consolidated contexts. For this very reason, academic and political debate should not be oriented towards denying existing deficiencies or idealising improvised models (as evidenced by the failed implementation of the teachers' health system model, documented by the Office of the Comptroller General of Colombia[11]), but rather towards responsibly correcting identified shortcomings, strengthening institutional capacities, and ensuring timely, people-centred responses that advance health equity and the guarantee of the right to health.

List of abbreviations

EPS - Health Promoting Entities (by its Spanish acronym)

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Conflicts of interest

The authors declare no commercial or financial conflicts of interest regarding this research.

Use of artificial intelligence tools

The authors declare that no artificial intelligence tools (such as ChatGPT, Copilot, Gemini, or others) were used in the writing, analysis, or review of this article.

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