The politics of evidence in health system crises: the case of Colombia

TINE HANRIEDER*

In 2022, Colombia's newly-elected government set out to fundamentally reform the country's health system. Although the new president, Gustavo Petro, had campaigned with the promise to do so and previous governments had dealt with health system crises by launching smaller or larger reform efforts, this initiative encountered instant, vocal pushback from domestic media and experts, who raised several key questions: Wasn't Colombia an exemplary country in terms of gradually extending health care coverage since the enactment of its new constitution in 1991? Wasn't the country a role model for achieving universal health care coverage and didn't it have a stellar record regarding the reduction of out-of-pocket expenditures for health care? Hadn't a historical World Health Organization (WHO) ranking of health systems placed Colombia among the top group of countries due to the financial fairness and equity of its system? This pushback and the equally forceful retorts from the government made health reform one of the 'most debated',[1] most salient issues in politics, media and society under the new government. The reform's opponents accused the government of risking both destroying health care and dismantling historical achievements, while supporters joined the government's accusations of the health care industry as predatory and pointed to segments of the population that did not have access to care.

This contentious process of sense-making provides an opportunity to study how politicians, experts and societies construct stories of success versus crisis in a health system. In a historical period termed by some the polycrisis, given intersecting phenomena including wars, cost-of-living crises and environmental crises,[2] the health sector is only one among many that is struggling with crisis. Health sector crises go far beyond acute outbreaks of diseases, such as the COVID-19 pandemic that exposed weaknesses of public health

* I would like to thank the *International Affairs* editors and the two anonymous reviewers for their helpful comments on an earlier version of this article.

[1] '"Este es el proyecto de ley más debatido en la historia del Congreso": Andrés Calle reconoce lento trámite de reforma a la salud', *Semana*, 21 Nov. 2023, https://www.semana.com/politica/articulo/este-es-el-proyecto-de-ley-mas-debatido-en-la-historia-del-congreso-andres-calle-reconoce-lento-tramite-de-reforma-a-la-salud/202339. (Unless otherwise noted at point of citation, all URLs cited in this article were accessible on 15 Dec. 2025.)

[2] Adam Tooze, 'Welcome to the world of the polycrisis', *Financial Times*, 28 Oct. 2022, https://www.ft.com/content/498398e7-11b1-494b-9cd3-6d669dc3de33.

International Affairs 000: 0 (2026) 000–000; DOI: 10.1093/ia/iiaf266

systems worldwide.[3] Exemplifying what International Political Economy (IPE) scholars call 'slow-burning crises',[4] health system crises build up slowly due to longer-term pressures such as economic slowdown, workforce shortages and epidemiological and demographic change. Recently, health system crises have moved up the political agenda in countries ranging from Chile to Spain and the United Kingdom.[5]

This article contributes to conceptualizing the politics of slow-burning crises in health systems. It aims to further our understanding of the process of active social construction of crisis interpretations in global health. I suggest that crisis sense-making in health systems, just as in global politics more generally, is a contentious process in which experts and policy-makers invoke different benchmarks, indicators and standards to make sense of a country's trajectory and its place in the world. In this process, they create meaning out of different pieces of evidence regarding a health system's performance that they embed in broader narratives of development. These narratives offer visions of history and a country's place in the world, as well as ideas of progress and possibility that shape expectations regarding health policy and social citizenship more generally. Like other international narratives, they entail a certain 'setting' or stage, different 'plots', and different 'actors/characterizations'.[6] The stage on which a country's health crisis narrative unfolds is international as well as domestic as health systems are compared with international peers and benchmarks. At the same time, a crisis is interpreted with reference to historical trajectories, which can be unique national ones but also broader historical trends in health and development. The main actors are usually public and private managers of the system, as health systems constantly renegotiate the role of state and market in service organization and provision. As I discuss in the case of Colombia, the country's international status as a recent member of the Organisation for Economic Co-operation and Development (OECD), the idea of progress and modernity amid social inequality, and the political legitimacy of state and private actors are all renegotiated through evidence about health system performance and crisis.

At the level of theory, the article builds on and contributes to three main literatures: International Relations (IR) theorizing on benchmarks and indicators, global health theorizing on the role of evidence in health policy and

[3] Lee Jones and Shahar Hameiri, 'Explaining the failure of global health governance during COVID-19', *International Affairs* 98: 6, 2022, pp. 2057–76, https://doi.org/10.1093/ia/iiac231.

[4] Leonard Seabrooke and Eleni Tsingou, 'Europe's fast- and slow-burning crises', *Journal of European Public Policy* 26: 3, 2019, pp. 468–81, https://doi.org/10.1080/13501763.2018.1446456.

[5] Thomas J. Bossert and Pablo Villalobo Dintrans, 'Health reform in the midst of a social and political crisis in Chile, 2019–2020', *Health Systems & Reform* 6: 1, 2020, https://doi.org/10.1080/23288604.2020.1789031; Euronews with AP, 'Hundreds of thousands march in Spain to demand better primary healthcare', Euronews, 12 Feb. 2023, https://www.euronews.com/2023/02/12/hundreds-of-thousands-march-in-spain-to-demand-better-primary-healthcare; Rachel Hall, 'Doctors warn of "massive" winter crisis in UK's overstretched A&E departments', *Guardian*, 18 Nov. 2024, https://www.theguardian.com/society/2024/nov/18/uk-doctors-winter-crisis-accident-and-emergency.

[6] Kai Oppermann and Alexander Spencer, 'Narrative analysis', in Patrick A. Mello and Falk Ostermann, eds, *Routledge handbook of foreign policy analysis methods* (Abingdon: Routledge, 2022), pp. 117–32.

IPE theorizing on slow-burning crises. Regarding the first, IR scholars have demonstrated that governments and societies care about how they compare to others, based on international rankings and status comparisons. Quantitative indicators of national performance are politically influential, even if contested in many domains, including education or security,[7] and they are mobilized to signify a country's place in the world. Regarding the second literature, the political role of evidence has been amply debated in global health scholarship. This literature explores the biases coming with quantification and the health metrics boom,[8] and it highlights the fundamentally underdetermined impact of health-related evidence. Evidence only becomes meaningful when combined with contextual considerations and norms,[9] or with underlying theories about demographic change and modernization.[10] Regarding the third literature, political economists have theorized how slow-burning crises lead to the renegotiation of social expectations around political issues.[11] I will build on these debates to conceptualize health system crises as renegotiations of development narratives.

Empirically, the article analyses the health reform debates in Colombia, where controversies and polarized interpretations of the health system have been a recurrent part of political life. Colombia underwent a sweeping reform of its health system in the late twentieth century. It is often mentioned as a case of exceptionally neo-liberal health sector restructuring led by international financial organizations and consultants, anchored in the *Ley Cien* (Law 100) of 1993.[12] Ever since, this restructuring has been contested and several reform attempts have been made.[13] Today, against the backdrop of continued social inequality and a rapidly ageing population, experts and politicians, civil society leaders and health sector stakeholders heatedly debate the nature of the health care crisis, and the question of who is the culprit and what is to be done. The latest round of mobilization of health reform expertise in Colombia thus sheds ample light on the contentious meaning of indicators and benchmarks, and on how these are embedded in ongoing re-evaluations of social ideals in times of rapid demographic change and social turbulence.

[7] André Broome and Joel Quirk, 'Governing the world at a distance: the practice of global benchmarking', *Review of International Studies* 41: 5, 2015, pp. 819–41, https://doi.org/10.1017/S0260210515000340; Paul David Beaumont, *The grammar of status competition: international hierarchies and domestic politics* (New York: Oxford University Press, 2024).

[8] Vincanne D. Adams, ed., *Metrics: what counts in global health* (Durham, NC: Duke University Press, 2016); Luis Aue, 'How do metrics shape polities? From analogue to digital measurement regimes in international health politics, *International Political Sociology* 15: 1, 2021, pp. 83–101, https://doi.org/10.1093/ips/olaa018.

[9] Justin Parkhurst, *The politics of evidence: from evidence-based policy to the good governance of evidence* (Abingdon and New York: Routledge, 2017).

[10] David Reubi, 'Modernisation, smoking and chronic disease: of temporality and spatiality in global health', *Health Place*, vol. 39, 2016, pp. 188–95, https://doi.org/10.1016/j.healthplace.2015.04.004.

[11] Seabrooke and Tsingou, 'Europe's fast- and slow-burning crises'.

[12] Carmelo Mesa-Lago, *Reassembling social security: a survey of pensions and health care reforms in Latin America* (Oxford: Oxford University Press, 2008); publ. online 15 March 2012, https://doi.org/10.1093/acprof:osobl/9780199644612.001.0001; Anne-Emanuelle Birn, Laura Nervi and Eduardo Siqueira, 'Neoliberalism redux: the global health policy agenda and the politics of cooptation in Latin America and beyond', *Development and Change* 47: 4, 2016, pp. 734–59, https://doi.org/10.1111/dech.12247.

[13] But see Mauricio Torres-Tovar, *Lucha social contra la privatización de la salud* (Bogotá: CINEP, 2013).

The rest of the article is divided into four sections and a conclusion. I first explain the relationship between crisis, evidence and change in health politics. Next, I introduce the health reform struggles in Colombia. Subsequently, I present my methods and data. I then discuss competing interpretations of Colombia's health system crisis and their underlying narratives. The conclusion summarizes the analysis, discusses its generalizability and limitations, and suggests avenues for future research.

Crisis, evidence and change in health politics

Crises are omnipresent in global politics and IR. In the health domain, pandemics are among the most acute crises, with potentially massive social and economic repercussions. Yet, as made plain by the COVID-19 catastrophe, pandemics and their impact on health systems and societies are conditioned by these systems' weaknesses, and their long-term consequences reach far beyond the acute pandemic phase.[14] 'Fast' health emergencies and 'slow' health system crises fuel each other. More generally, for many observers and communities, a condition of polycrisis now seems to be the new normal.[15] Violence and insecurity, ecological degradation and climate change, inflation, precarity and social conflicts shape the lives and worries of people around the globe. Many of these worries are not about acute emergencies but about the gradual buildup of concerning phenomena: widening inequality, global warming or unmet health care needs are often read not as events but as trends.[16] Evidently, the line between acute shocks and gradually unfolding crises is not always clear-cut and depends on interpretation.[17] And in any case, crises experienced as incremental are politically impactful, too: they erode the legitimacy of social orders and exert pressure on governments to adapt and respond.

Adjustments to crises engender material strategies of survival and resource reallocation as well as interpretive efforts to change 'cultural imaginaries'[18] or social expectations. As Leonard Seabrooke and Eleni Tsingou suggest, in the face of slow-burning crises such as health system ones, 'the issue for authorities is to develop narratives and frames via expert consensus, while social actors will change their expectations of what authorities and institutions can provide for them'.[19] Thus, expertise is mobilized to narrate crises. Yet, importantly, this happens in a context where evidence is contentious and open to varied interpretations. This article suggests that broader narratives of development

[14] Jones and Hameiri, 'Explaining the failure of global health governance'.
[15] Tooze, 'Welcome to the world of the polycrisis'.
[16] Danny Dorling, *The next crisis: what we think about the future* (London: Verso, 2025).
[17] Seabrooke and Tsingou, 'Europe's fast- and slow-burning crises'. Crises building up over time can also escalate into acute emergencies, as with the financial and social crisis following Greece's adjustment of its deficit in 2009. See Alexander E. Kentikelenis, 'The social aftermath of economic disaster: Karl Polanyi, countermovements in action, and the Greek crisis', *Socio-Economic Review* 16: 1, 2018, pp. 39–59, https://doi.org/10.1093/ser/mwx031.
[18] Kentikelenis, 'The social aftermath of economic disaster'.
[19] Seabrooke and Tsingou, 'Europe's fast- and slow-burning crises', pp. 476–7.

underpin how health system crises are interpreted and identifies the main elements of competing narratives.

This analysis can build on insights from IR and global health on the role of knowledge, narratives and evidence in global politics. Scholars of IR and of global health have amply demonstrated how evidence, which comes in many forms but is often quantified, helps to make policies and societies comparable as well as setting standards and expectations.[20] In the global health field, quantified metrics are central to policy-making, development efforts and advocacy practices. Yet, a rich literature on metrics and evidence in global health has also demonstrated that such metrics are not always locally relevant,[21] or that they can subtly displace social justice and long-term development goals with more instrumental and inequitable policy priorities.[22] In addition to highlighting such biases of quantification, IR and global health scholars' critical engagement with indicators also shows that these are contextually mobilized. Global health advocates strategically 'play the numbers game' when assembling information for their campaigns.[23] Governments draw on international status indicators in a selective and strategic manner to impress domestic audiences.[24] And underlying value judgements inform the policy conclusions drawn from medical or public health research.[25]

This article builds on these insights and proposes to understand sense-making about health system crises as an active alignment of evidence with political narratives in general, and narratives of development in particular. Health policy is deeply intertwined with ideas about development. Experts and global institutions keep relating ideas of economic development and health,[26] and they resort to visions of modernity and social and technological progress,[27] to decolonization[28] or to understandings of population trends and demographic change.[29] To identify the narrative elements of such sense-making, I draw on narrative analysis as deployed in IR and foreign policy analysis. As explained by Kai Oppermann and Alexander Spencer, narratives are made up of three interrelated components: the setting or stage on which a narration unfolds,

[20] Broome and Quirk, 'Governing the world at a distance'.
[21] Parkhurst, *The politics of evidence*; Adams, *Metrics*.
[22] For example, Sudhir Anand and Kara Hanson, 'Disability-adjusted life years: a critical review', *Journal of Health Economics* 16: 6, 1997, pp. 685–702, https://doi.org/10.1016/S0167-6296(97)00005-2.
[23] Katerini T. Storeng and Dominique P. Béhague, "'Playing the numbers game": evidence-based advocacy and the technocratic narrowing of the Safe Motherhood Initiative', *Medical Anthropology Quarterly* 28: 2, 2014, pp. 260–79, https://doi.org/10.1111/maq.12072.
[24] Beaumont, *The grammar of status competition*.
[25] Parkhurst, *The politics of evidence*.
[26] Global health discourse and institutions keep alternating between making a principled case for health and an instrumental case for health as wealth-enhancing. See Tine Hanrieder, 'Orders of worth and the moral conceptions of health in global politics', *International Theory* 8: 3, 2016, pp. 390–421, https://doi.org/10.1017/S1752971916000099; Nitsan Chorev, 'Restructuring neoliberalism at the World Health Organization', *Review of International Political Economy* 20: 4, 2013, pp. 627–66, https://doi.org/10.1080/09692290.2012.690774.
[27] Reubi, 'Modernisation, smoking and chronic disease'.
[28] Sunil S. Amrith, *Decolonizing international health: India and southeast Asia, 1930–65* (London: Palgrave Macmillan, 2006).
[29] Matthew Connelly, *Fatal misconception: the struggle to control world population* (Cambridge, MA: Harvard University Press, 2008).

the assemblage of events into plots and the characterizations of the main actors regarding their interests, abilities, choices and behaviours. As I develop in more depth in the case of Colombia, a main stage for narrating health systems' development is the international one. Health systems are usually organized by states, and plenty of evidence is collected about national health systems, health indicators and development indicators. Positive or negative comparison with, and benchmarking against, peers as well as international benchmarks and standards give meaning to a country's place in the world, its health system's likely evolution or those features to be proud or ashamed of. Colombia's case shows that the country's recent membership in the OECD as well as its broader development aspirations critically shape interpretive struggles over health care crises. In terms of employment, national historical trajectories, visions of modernity and progress, and the role of historical milestones (such as a new constitution) are major temporal references for narratives of health systems' development and crises. As regards characterization, a wide set of actors can potentially be part of narratives about health systems: health care professionals as the front-line workers can be narrated as national (revolutionary) heroes or as villains (e.g., when used as scapegoats), social movements can be main protagonists when fighting for health-related rights, and courts and judges can play central roles where health care is judicialized.

In this article, I focus on two main groups of actors and the way they are narrated in debates about health systems: public/governmental and private/market actors. This is because in debates about electoral politics and regime change as well as in debates about health care organization, the public–private divide is fundamental to discussions about legitimate and effective governance. For example, as Leslie Gates has demonstrated for periods of major political change—the election of far-right or far-left 'outsiders'—voters' decisions are shaped by perceptions of the relative performance of public officials and capitalists. She explains that attributions of corruption to public or private actors play an important part in shaping interpretations of competent and legitimate rule.[30] I argue that a similar dynamic is at play in Colombia, where polarized debates about health reform evolve to a significant extent around the question of whether public or private actors are more credible governors, and around what evidence is available to bolster either claim. More generally, health system crises are also sites of legitimacy struggle between public and private authority in social policy and the state. The narratives through which societies read such crises not only grapple with but also transcend the specific, sometimes technical, health policy issue for which evidence is debated. Narratives of development precede each individual experience of crisis and are there to be reached for in a society, but they are also remade and re-narrated through interpretive struggles over crises.

[30] Leslie C. Gates, *Capitalist outsiders: oil's legacies in Mexico and Venezuela* (Pittsburgh: University of Pittsburgh Press, 2023).

Contested health reform

Colombia fundamentally restructured its social security (above all pension and health) system in the wake of its economic and political troubles in the 1980s. This was the 'lost decade' in Latin America's development, but also part of a worldwide period of economic trouble, with debt crises shattering African, Asian and Latin American countries. These crises paved the way for the international financial institutions to guide the restructuring of welfare states through policy conditionality and expert advice. Each national reform combined the prescriptions of market-led social service provision with visions of social rights and public responsibility in its own, distinct way. Overall, there was a shift in the 1980s and early 1990s towards a 'transformed common sense'—austerity and privatization became necessary parameters for organizing the welfare state.[31]

Colombia has taken decisive turns towards neo-liberal governance since the 1990s, starting when the new constitution adopted in 1991 laid the basis for an overhaul of the social security system. Early on, neo-liberal governments shaped this into a mixed public–private system guided by market principles for service provision.[32] The main legislative move through which Colombia transitioned from a system of very limited state-provided social security to its current health system was the *Ley Cien* adopted in 1993. This installed a health system with a strong role for intermediary organizations termed *entidades promotoras de salud* (health-promoting entities—EPS). The state's role changed from that of service provider to that of subsidizer of demand through different health insurance packages for different parts of the population. This form of organizing health was named 'structured pluralism' in a World Bank paper by Juan-Luis Londoño and Julio Frenk, two central figures in the 1993 health reform.[33] 'Structured pluralism' meant entrusting intermediaries with mission-critical 'articulating' functions, including the enrolment of patients, the definition of competitive service packages, the organization of provider networks and thereby the structuration of consumer choices, and quality management.[34]

In this restructuring, Colombians mostly joined one of two groups: patients in the subsidized regime that was funded with public transfers and patients in the contributory regime, which are mostly persons in formal employment. The

[31] Celia Iriart, Emerson Elias Melhy and Howard Waitzkin, 'Managed care in Latin America: the new common sense in health policy reform', *Social Science and Medicine* 52: 8, 2001, pp. 1243–53 at p. 1250, https://doi.org/10.1016/S0277-9536(00)00243-4; Mesa-Lago, *Reassembling social security*; Alexander Kentikelenis and Thomas Stubbs, *A thousand cuts: social protection in the age of austerity* (Oxford: Oxford University Press, 2023).

[32] Karen Stocker, Howard Waitzkin and Celia Iriart, 'The exportation of managed care to Latin America', *New England Journal of Medicine* 340: 14, 1999, pp. 1131–6, https://doi.org/10.1056/NEJM199904083401425.

[33] Juan-Luis Londoño and Julio Frenk, 'Structured pluralism: towards an innovative model for health system reform in Latin America', *Health Policy* 41: 1, 1997, pp. 1–36, https://doi.org/10.1016/S0168-8510(97)00010-9. Londoño was World Bank chief economist for human resources in the 1990s and Colombia's minister of health from 1990 to 1992. He was instrumental in designing the *Ley Cien*. Frenk had leading roles in Mexican and global public health and served as an adviser to Colombia's 1993 health reform.

[34] Londoño and Frenk, 'Structured pluralism'.

baskets of services available in each regime initially diverged, and their convergence took much longer than anticipated. In 2008, a Constitutional Court ruling obliged the government to equalize the services in the two regimes, which the government began implementing five years later, bringing services to a roughly equal level.[35] The extension of coverage—the enrolment of all Colombians with one of the EPS—was slow. Still, over time, the share of those with health insurance rose from 25 per cent prior to 1993 to about half of the population in 2006,[36] and 'universal coverage' was reached in 2022 with an enrolment rate of over 99 per cent.[37]

Colombia's shift to a state-sponsored but privately managed health care system was politically contentious from the start. The extension of EPS enrolment notwithstanding, critics and an increasingly organized civil society decried the commodification of health and lobbied for health to be understood as a fundamental human right.[38] The 2008 Constitutional Court ruling responded to such pressure and declared health to be a fundamental human right.[39] Since the 2000s, consecutive governments have also been confronted with crises of the system's financial sustainability and have engaged in reform efforts and controversial EPS bailouts, while the public was shocked by corruption scandals at several intermediaries. The gap between formal enrolment and actual access to services, and waves of hospital closures, alongside the impressive record of achieving universal coverage regularly fuel public debate about the success or failure of the system.[40]

The reform attempt by the Petro government, started in 2022, is thus only the latest peak in a long history of crisis, critique and calls for reform. In the context of multiple development crises, economic slowdown and waves of social unrest and mobilization during the COVID-19 pandemic that ultimately led to the swing towards the left-leaning Petro government, health reform has again become a central point of political controversy. After the initial reform proposal—with the abolition of the EPS at its core—was defeated in the Senate, the upper legislative chamber, in April 2024, the government tried to get approval for a toned-down second reform attempt, which again was rejected in the Senate in December 2025. It has tried to gradually change the system through executive acts, but not achieved structural reforms such as curtailing the competencies of EPS.

[35] Everaldo Lamprea, 'The judicialization of health care: a global South perspective', *Annual Review of Law and Social Science*, vol. 13, 2017, pp. 431–49, https://doi.org/10.1146/annurev-lawsocsci-110316-113303.

[36] Everaldo Lamprea and Johnattan García, 'Closing the gap between formal and material health care coverage in Colombia', *Health and Human Rights* 18: 2, 2016, pp. 49–65 at p. 53, https://pmc.ncbi.nlm.nih.gov/articles/PMC5394995; Mesa-Lago, *Reassembling social security*, ch. 8.

[37] Ministry of Health and Social Protection, 'Colombia llegó al aseguramiento universal en salud al alcanzar el 99,6 %', 29 June 2022, https://www.minsalud.gov.co/Paginas/Colombia-llego-al-aseguramiento-universal-en-salud-al-alcanzar-el-99.6.aspx.

[38] Yadira Eugenia Borrero Ramírez, *Luchas por la salud en Colombia* (Cali, Colombia: Pontificia Universidad Javeriana and Sello Editorial Javeriano, 2014).

[39] Torres-Tovar, *Lucha social contra la privatización de la salud*.

[40] Borrero Ramírez, *Luchas por la salud en Colombia*.

Methods and data

The following sections unpack how proponents and opponents assemble evidence, theory and practice to make the case for or against health reform. I focus on the period from 2022, when the Pacto Histórico coalition led by Petro formed a new government, until early 2025, when its second attempt at reforming the health system was stalling in Congress and the government kept the debate alive through televised cabinet meetings about the health system crisis and through proposals for plebiscites on social reform issues. This period saw intense public controversies about the health system, renewed liquidity crises among insurers and providers, and legislative and judicial battles about reform proposals, funding decisions and governmental takeover of bankrupt or malfunctioning EPS. Throughout, a myriad of experts, civil society organization members and government and opposition figures weighed in to question each other's narratives, credibility and evidence regarding the condition and best way forward for the health system.

My analysis is based on a broad array of documents. For contextual understanding of Colombia's health system evolution and reform struggles since 1993, I rely on secondary sources. For evidence construction regarding the Petro government's reform initiative, I analyse professional media coverage of the reform and social media posts by contending actors on the platform X (formerly Twitter) and on Facebook. Additionally, I analyse documents produced by contending parties, such as competing legislation proposals by the government and opposition groups, whose substantive proposals and extensive background sections give distinct accounts of the health system performance and relevant evidence. I have also consulted public statements by civil society groups such as patient associations and trade unions and by professional associations, as well as background and watchdog reports on aspects of the health system, and conference and other event recordings. Finally, open letters by different interest groups including groups of former health ministers and other former members of government, published on these groups' websites and/or on X/Twitter and diffused through professional media, media interviews with members of the government and a live, televised 2.5-hour cabinet meeting in March 2025 discussing the health system and the reform initiative provided further insight on the government and opposition's positioning and claims.

I have complemented these documentary sources with 15 key informant interviews conducted between April 2024 and September 2024. I spoke with civil society leaders from trade unions, patient organizations, human rights groups, professional organizations and academia. The interviewees at one trade union and at one civil society organization brought colleagues to the interview, reflecting the high importance that health reform debates and the sharing of historical experience and insight has for them—altogether, 19 persons participated.

The interviews were conducted in person and online via video calls. Informal conversations with Colombian health experts and two first inter-

views took place in April 2024 in Mar del Plata, Argentina, during the Fifth People's Health Assembly—a major civil society summit held every few years, which that year brought together hundreds of health activists and experts, especially—due to the location—from Latin America. Most interviews were conducted during a trip to Bogotá in August 2024. Participants were recruited through a mix of targeted and snowball sampling. The interviews focused on the substance of the government's reform proposals, preceding ones and the constellation of political and civil society actors mobilizing for or against them.[41]

I analysed the material in several abductive steps. A first, information-oriented step consisted in tracing the process and main actors in Colombia's health reform struggles, as well as gathering information about power dynamics in the country's academic and media landscape to contextualize and triangulate information and claims. For my interpretation of the contested claims and expertise, I conducted a thematic analysis with a focus on claims about the nature of Colombia's health system crisis and about the reform. In a further theorization step, I distinguished between the main points of contention on the reform debate—whether there was a crisis or not, and whether the reform was feasible or not—and between the underlying narrative elements that emerged as giving meaning to evidence—international comparisons, visions of history and the legitimacy of public versus private governance.

Health crisis—identity crisis

The coalition government that took office in Colombia in 2022 launched a fundamental 'structural' health system reform as one of its priority projects. Its aims were to abolish intermediaries and return control of health care finances to the state, to strengthen public health capacity in remote regions and to improve the working conditions in the sector. This initiative was eagerly anticipated by reform proponents, but it also met massive criticism and public backlash even before the bill was published in February 2023. Where some saw a crisis and a need for urgent repair, others warned that major reform would plunge the country's—generally quite popular[42]—health system into disruption and further crisis. The reform initiative led to a major cabinet reshuffle and to the breakup of the coalition by mid-2023, because several ministers disagreed with the bill. After the defeat of that first bill in the legislature in April 2024, a revised one was presented in September which made some concessions, such as the continued existence of intermediaries, but with a reduced function and without control of health system finances. A myriad of experts and stakeholders

[41] All interviewees provided written consent. The study was granted ethics approval by the London School of Economics and Political Science, reference 352382.

[42] A survey conducted in 2023 found that 73 per cent of Colombians judged the health system excellent or acceptable. *Percepción de los colombianos sobre el sistema de salud* (Asociación Nacional de Empresarios de Colombia and Invamer, 2014), https://www.andi.com.co/Uploads/PPT%20Rueda%20de%20prensa%20salud%20-%20Resultados%20INVAMER%20-%20V4.pdf.

weighed in and debated the reform proposals—the central questions being whether the health system was in crisis and whether the proposed reform was financially and administratively feasible. Their answers to these questions also offer competing interpretations of Colombia's development trajectory.

Contentious indicators of success

'If you select carefully which indicators you use, your Colombian heath system can be great. Coverage is huge.'[43] This observation by a representative of a trade union association highlights recurrent debates about adequate indicators of success in Colombia's health system. Mainly, contention revolves around coverage and out-of-pocket payments.

Universal health care coverage The most impressive and frequently mentioned indicator regarding the quality of Colombia's health system is the rise of formal coverage from about a quarter of the population at the beginning of the 1990s to universal today. Almost every citizen is now enrolled with an EPS through either the contributory or subsidized insurance regime, with entitlements in the two mostly similar.[44] This is not only a story of progress; it places Colombia among the top-performing countries worldwide. Yet, using this indicator to promote a 'Viva Colombia' narrative about the health system, as one activist put it, was not accurate given actual problems of access.[45]

Critics of the system emphasize the gap between coverage and access. Especially vulnerable populations in remote urban territories and in rural spaces that are marked by poverty, violence and lack of infrastructure do not have access to primary, let alone specialist care.[46] Interviewees, regardless of being in favour of or against major reform, said that some 15 to 20 per cent of the population do not, de facto, have access. Even the formally employed, urban population, which in theory is taken care of by a close net of providers, is often affected by long waiting times for appointments, insurmountable hurdles in accessing care and lengthy bureaucratic marathons, phenomena described as the 'walk of death' (*paseo de la muerte*)[47] and EPS 'denial of care'.[48] Statistics on the vast amount of legal complaints by patients, mostly through *tutela* claims, against health care institutions, undergird this critique. *Tutelas* are low-barrier legal tools available to any citizen, who can submit them to denounce various rights violations. Over the past decades, there have been tens of thousands of

[43] Interview 3, Susana Barria, Public Services International official, video call, 3 June 2024.

[44] Quality and outcomes are still disparate between the regimes: for example, women in the subsidized regime have a much higher risk of dying from breast cancer than women in the contributory regime. See World Bank, *Colombia—program for improved access to effective health services for the vulnerable and enhanced health system resilience* (Washington DC: World Bank, 2024), https://documents.worldbank.org/en/publication/documents-reports/documentdetail/099012224124520218, p. 12.

[45] Interview 14, Vicente Calvo, founder of NGO Donde Está la Plata (Where is the Money), video call, 30 Aug. 2024.

[46] World Bank, *Colombia*, p. 17.

[47] Interview 4, Nancy Molina, Luz Dary Carmona and Ana Lucía Casallas, members of the human rights NGO Grupo Guillermo Fergusson, Bogotá, 13 Aug. 2024.

[48] Interview 3.

health-related *tutela* cases, reaching a peak of 207,734 in 2018 and, after a sharp decline during the COVID-19 pandemic, rising again to 197,767 in 2023.[49] Hence, the celebration of universal enrolment and health care uneasily coexists with crises of access.

Out-of-pocket expenditures The health system's financial fairness, another main indicator of success, is subject to intense contestation. Colombia was a top performer in the health system ranking in the WHO's *World health report* in 2000 (an exercise that was not repeated in the face of continued dissensus regarding adequate metrics). Nonetheless, the country's high rank (22nd) in 'overall health system performance' and its first rank in 'fairness of financial contribution to health' have been talking points ever since.[50]

The main criteria for financial fairness in the report was households paying for health care according to their ability to do so and being financially protected against catastrophic expenditure—which favoured Colombia, due to its subsidized insurance regime for the poor and its low rates of out-of-pocket (OOP) expenditure for health care. Colombia joined the OECD in 2020 and the government's reform proposal contains many references to the organization's benchmarks and evidence. With OOP expenditure accounting for 15 per cent of total health expenditure, Colombia is just behind the OECD average of 14 per cent and far below the Latin American average of around 33 per cent. One activist, when emphasizing how defenders of the system sought to distract from fraudulent financial practices by the intermediaries, said they embellished the system by 'looking to other countries' and 'regarding OOP payments we compare ourselves with Germany, with [the] United States, with Norway'.[51]

The interviews showed that the financial fairness of the system is a live and contentious issue. Especially interviewees affiliated with trade unions offered counter-metrics to underline that low OOP expenditure is an indicator that does not give an accurate picture. Several trade unionists presented extensive lists of payments that Colombians contribute to the health system—taxes, deductions from their salaries, co-pays, fees for supplementary health insurances necessary due to denial of care—and also, in the case of people living in remote areas, high transport and overnighting costs due to long, multi-day trips to the nearest health centre.[52]

Academics also problematized the OOP indicator with regard to varied reference points. One expert said that co-pays could be a massive burden for low-income families, but that by international standards OOP payments remained low. He suggested that the majority of Colombians were not aware

[49] *Informe de tutelas en salud 2023* (Bogotá: Ministry of Health and Social Protection, 2024), https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/CA/informe-tutelas-salud-2023-orden-trigesima-sentencia-T-760-2008.pdf.

[50] WHO, *The world health report 2000* (Geneva: WHO, 2000), https://www.who.int/publications/i/item/924156198X.

[51] Interview 14, translated from Spanish by author.

[52] For example, interview 2, Fabio Melo, president of the trade union Sindistritales, Mar del Plata, 10 April 2024 and Bogotá, 14 Aug. 2024.

of how good their health access was; only those who travelled abroad or who came back to Colombia from, say, the United States to seek treatment had this awareness.[53] Another academic closely aligned with the right-to-health movement highlighted that evidence was mixed regarding OOP and co-pays. Yet, he also pointed out that for those in the contributory pillar co-pays came on top of monthly contributions to the health system, which again points to a mismatch between the social expectations raised by the 1991 constitution and its promise of guaranteeing universal health services and OOP costs of additional insurance needed to secure services.[54]

International benchmarks of universal health care coverage and OOP expenditure are thus controversial. They are contested with competing visions of universality and financial fairness, but remain an integral part of the sense-making about Colombia's place in the world and its historical trajectory (its development plot). Obviously, these are not the only indicators by which to measure health system performance. The government's reform bills cite a plethora of WHO reports, OECD and World Bank figures, United Nations Development Goals and international comparisons to make the case that Colombia is punching below its weight as an OECD country. Again, the question of how far along the country is on the path to development informs such use of evidence. For example, the 2024 bill states that Colombia had one of the highest maternal mortality rates among OECD countries, only surpassed by India and South Africa, as well as the highest child mortality rate.[55] Maternal and child mortality have long served as central indicators of health justice and health system performance, and their high incidence, coupled with the enormous inequality in Colombia, not only counter stories of excellence, but also set a horizon of progress that the country must work towards.

Contentious indicators of feasibility

The second main point of contention has been whether the government's reform plan is feasible financially and administratively. Claims keep being exchanged regarding who has the right numbers, budget projections and adequate costing of services, and who has the capacity to administer the health system. Here again, seemingly technical debates and evidence are made sense of with recourse to broader narrative elements about which actors are competent and legitimate. Competing characterizations of public and private actors are put in the context of larger historical plots and interpretations of the pathway

[53] Interview 10, Giovanni Jiménez, professor at Universidad de Bogotá Jorge Tadeo Lozano, Bogotá, 26 Aug. 2024.

[54] Interview 5, Mauricio Torres, associate professor at Department of Public Health, Universidad Nacional, Bogotá, 14 Aug. 2024. Torres also highlighted that co-pays negatively affect early detection and treatment of illness and can end up being costly to the health system.

[55] *Hacia un sistema de salud garantista, universal, eficiente y solidario que privilegie la vida: proyecto de ley 'por medio del cual se transforma el Sistema de Salud en Colombia y se dictan otras disposiciones'* (Bogotá: Ministry of Health and Social Protection, 2024), https://www.minsalud.gov.co/CC/Documents/Proyecto-de-ley-radicado-con-anexos.pdf, pp. 87–9.

from the 1991 constitution and the direction of population and technological change.

How much does the reform cost? Many critics of the health reform proposals stated that they were not fully costed and thus not affordable.[56] The government and many reform proponents insisted, however, that the reform was soundly budgeted.[57] A major challenge is lack of financial transparency due to the complexity of the system, opaque EPS accounting and uncertainties regarding future and reform scenarios, all of which make these debates very hard to settle.

Several experts favouring the reform leaned towards the argument that cutting out EPS as intermediaries, or reducing their control over finances, would free up much of the needed resources.[58] This argument was often contextualized through a fuller discussion of the history of the public health system. Many interviewees who supported major reform insisted on going back in history and emphasized what they saw as the fatal downward path from the *Ley Cien*. Some of them underlined their points with political timelines to emphasize key laws and turning points. For them, the *Ley Cien* allowed the corporate capture of health, which had been 'turned into a business'.[59] Perverse incentives leading to the disappearance of public hospitals from poorer parts of the country and the precarization of working conditions are widely noted,[60] and EPS that managed to divert resources through their organizing power and vertical integration (the creation of health care providers to which they could contract services) are pointed out as both a cause and a symptom of harmful marketization.

The counter-vision to marketization, referenced by many supporters of reform, is the mobilization for health as a human right. This has long been a social counter-movement to the *Ley Cien*,[61] supported by Constitutional Court decisions obliging the government to strengthen health care provision. Since the 2008 Constitutional Court ruling, governments have been obliged to undertake further measures to ensure access to health care and equalization of services. While it did not alter the marketized architecture of the system, the ruling reinforced the mandatory funding of services. Stressing the 'progressive' nature of the right to health, the ruling made it almost impossible to exclude health services and technologies (except for a small number of services such

[56] For example, health economist Andres Vecino, opining on new expenses and a lack of cost control measures foreseen by the reform, in '¿Por qué la nueva reforma a la salud no es la reforma que necesitamos?, *La Silla Vacía*, 5 Nov. 2024, https://www.lasillavacia.com/red-de-expertos/red-social/por-que-la-nueva-reforma-a-la-salud-no-es-la-reforma-que-necesitamos.

[57] Interview 6, Ana Maria Soleibe, president of the Federación Médica de Colombia, video call, 15 Aug. 2024.

[58] Interview 11, Maria Doris Gonzalez, president of the trade union Sindess, Bogotá, 27 Aug. 2024.

[59] The point of health being 'turned into a business' (translated from Spanish by the author) was stressed, for example, in interview 7, Nancy Wilches, Miguel Ángel Feliciano and Jorge Peña, officials at the trade union CTC (Confederación de Trabajadores de Colombia), Bogotá, 16 Aug. 2024, as well as in interview 11.

[60] César Ernesto Abadía-Barrero, *Health in ruins: the capitalist destruction of medical care at a Colombian maternity hospital* (Durham, NC: Duke University Press, 2022).

[61] Borrero Ramírez, *Luchas por la salud en Colombia*.

as purely cosmetic ones) from the list of citizens' entitlements. As explained by the president of a medical association, the ruling has thereby exacerbated 'technological pressure' to pay for newly marketed health care technologies, which continuously increases costs.[62] Efforts to reprioritize health funding and to invest, for example, in peripheral zones and in public health infrastructure are hampered by the fact that individuals and well-organized patient groups can often win access to costly new treatments.[63] Beyond the 2008 ruling, reform critics also stressed that Colombia could not escape the cost pressure coming with development. Trends, such as population ageing, which create new care needs and costs mean that Colombia's health system faces similar challenges to, say, those of the UK, France or Spain—a point stressed vocally and publicly by a former minister of health and minister of education, who is an outspoken critic of the government's health reform agenda.[64]

The debate about cost became ever more acute and polarized after the first reform proposal was defeated in the Senate in April 2024. Attention began to shift to the ongoing costs of the health system. The government attempted to get control over EPS through take-overs of those in financial trouble (a practice of previous governments as well) and it contested claims that public funding of the sector was insufficient. By the end of 2024, the public debate focused on the sufficiency of the end-of-year increase to the per capita rate that the government pays to EPS.[65] In the contentious and publicly contested exercise of setting the rate, the government discarded the expenditure claims of most EPS, relying instead on an ever smaller number of EPS out of the existing 28 to calculate the costs of care.[66] All the other EPS were deemed unreliable bookkeepers, whose inconsistent payments, rule breaches such as the failure to build up their obligatory financial reserves,[67] lack of transparency of contracts with providers or instances of fraud rule them out of the calculation.[68] Furthermore, even statements by regulatory agencies such as the Office of the Inspector General of Colombia, when invoking EPS-backed numbers suggesting that the per capita rate is insufficient, were discarded by the govern-

[62] Interview 13, Clemencia Mayorga, president of the Colegio Médico de Cundinamarca y Bogotá, video call, 29 Aug. 2024, translated from Spanish by the author.

[63] Lamprea, *The judicialization of health care*. The near impossibility of excluding technologies from the basket of publicly covered services was also stressed by interviewee 10.

[64] Alejandro Gaviria (@agaviriau) via X, 'A manera de resumen, comparto en este hilo cuatro reflexiones sobre el sistema de salud de Colombia … ', thread, 22 Dec. 2024, https://x.com/agaviriau/status/1870881278498947145. Interviewee 13 also emphasized such cost pressures and further elaborated that the best way to deal with this technological pressure would be to make technology assessment subject to medico-professional peer regulation.

[65] Regarding the annual rate increase at the end of 2024, the EPS and their associations publicly argued for the need for at least a 15 percentage point Capitation Payment Unit [Unidad de pago por capitacion, UPC] increase, while the government stayed below six percentage points: see 'Minsalud aumenta la UPC para 2025 en 5,36 %, lejos de lo que esperaba el sector', *El Espectador*, 31 Dec. 2024, https://www.elespectador.com/salud/ministerio-de-salud-anuncio-aumento-de-la-upc-para-2025-sera-igual-que-la-inflacion.

[66] Interview 14.

[67] Juan Miguel Hernández Bonilla, 'Las reservas técnicas de las EPS: el debate que puede definir el futuro de la reforma a la salud', *El País*, 10 Nov. 2023, https://elpais.com/america-colombia/2023-11-10/las-reservas-tecnicas-de-las-eps-el-debate-que-puede-definir-el-futuro-de-la-reforma-a-la-salud.html.

[68] Interview 14.

ment—and there were accusations regarding who had the right numbers or the right to state numbers, and who owed what to whom.[69] As explained by the head of a medical association, between the allegations of the EPS and those of the government, 'we don't have a real figure' about the sufficiency of funding.[70]

With providers slowing down service provision, salary payments and care, or, in the worst case, declaring bankruptcy, the contest over numbers and debt manifests itself in ever more visible crises of access to health care.[71] Against this backdrop, a January 2025 Constitutional Court judgment obliged the government to recalculate and increase the per capita rate. The government countered with delays and the broadcasting of cabinet sessions, as noted above. In a televised cabinet meeting in March 2025, members of the government and regulatory bodies went far back in history to remind the public of EPS corruption scandals and of the health sector crises since the 1990s, including with footage of lorries with medicines to argue about the greedy hoarding of the latter.[72] In this polarized debate, evidence and counter-evidence are again aligned with competing narratives of the health system's history—as one of progress and technological change or as one of corporate capture.

Who has the capacity? To a significant extent, the health reform debate in Colombia is about the relative trustworthiness of public or private actors. Critics question the state's capacity to administer the health system without EPS after decades of outsourcing. Even cautious supporters of the reform warn that it is designed for an ideal country with a strong government living in peace.[73] In this context, the question of whether public-sector corruption is equally or more worrying than private-sector corruption is often discussed. One academic with professional experience in the health sector and in politics asserted that primary care centres in peripheral regions would be

[69] 'Procuraduría tacha de "irrespetuosa" respuesta de Minsalud sobre UPC y plata del sistema', *El Espectador*, 29 Dec. 2023, https://www.elespectador.com/salud/procuraduria-tacha-de-irrespetuosa-respuesta-de-minsalud-sobre-upc-y-plata-del-sistema; Juan Diego Quiceno, 'Los números rojos del sistema de salud, en medio de la reforma', *El Espectador*, 5 Nov. 2024, https://www.elespectador.com/salud/los-numeros-rojos-del-sistema-de-salud-en-medio-de-la-reforma.

[70] Interview 13, translated from Spanish by the author.

[71] Santiago Amaya Barrantes, 'Así impulsa el gobierno Petro la "crisis explícita del sistema de salud"', *La Silla Vacía*, 10 Nov. 2023, https://www.lasillavacia.com/silla-nacional/asi-impulsa-el-gobierno-petro-la-crisis-explicita-del-sistema-de-salud/. This is not the first such financing crisis. A prominent earlier iteration took place under the government of Alvaro Uribe, which in 2009 tried to fill financial gaps with emergency rule and a set of decrees; for example, by raising additional taxes on consumption. This led to massive social protests and counter-mobilizations; the Constitutional Court declared the state of emergency unlawful. See Borrero Ramírez, *Luchas por la salud en Colombia*.

[72] The meeting on 25 March was not broadcast until the next day by private channels, due to a clash with football World Cup elimination matches. See Nelson Álvarez, 'El gobierno retransmitiría el miércoles 26 de marzo el Consejo de Ministros sobre el sistema de salud', Infobae, 26 March 2025, https://www.infobae.com/colombia/2025/03/26/el-gobierno-retransmitiria-el-miercoles-26-de-marzo-el-consejo-de-ministros-sobre-el-sistema-de-salud/. Recording at Vicepresidencia de la República—Colombia, via YouTube, 'Consejo de Ministros—revive de manera detallada el estado de la salud en Colombia', 26 March 2025, https://www.youtube.com/watch?v=oIXLfYdoYQI.

[73] Interview 8, Gerardo Herrera Barbosa, former leader of the trade union Sintrasanignacio, Bogotá, 21 Aug. 2024.

better run as public–private partnerships, as local mayors and political elites would otherwise appropriate and politicize the additional funds.[74]

While such worries about public-sector corruption are shared among reform proponents as well, for them the need to establish a stronger presence of the state in the health system, and in particular in peripheral regions, tends to outweigh these concerns. For example, the leader of a citizen oversight organization near the border with Venezuela stressed the total abandonment of his community by the state and the need for access to basic services such as sanitation. His hope for the reform was that the state would at least 'reach the territories'.[75] This interviewee also stated that the pre-1990 health care system, even if it was one of charity-style public hospitals for the poor, at least had these public hospitals, which disappeared with the *Ley Cien*. Hence, in a partial return to the pre-1990 organization of social security, such public capacity lost through marketization should be rebuilt. Several interviewees made references to pre-1990 times, indicating an ongoing debate about the social security crisis of the 1980s. For some, this crisis was in part avoidable and due to specific governance decisions, but was then turned into a justification of neo-liberalization.[76] Yet for others, the 1980s were a time of unsophisticated government. They accuse current left-wing reformers of promoting a 'regression' to a 'primitive single payer' model that rolls back the modernizations of the *Ley Cien*.[77]

Ultimately, the relative trust in state and capitalist actors is crucial in informing which reform or crisis narrative experts and the public favour, how reform finances and capacities are evaluated, and how history is repeatedly evoked and reinterpreted. The always-contentious evidence about the health system is constantly re-narrated in the horizon of different narratives of development.

Conclusion

Health system crises are a priority concern of people in many countries, especially in high- and middle-income countries such as the UK, Canada and China, where universal health systems have become or are becoming a major social expectation and where failure to meet this expectation is fuelling

[74] Interview 10.

[75] Interview 9, Angel Solano, president of the public oversight committee for health for Guajira, video call, 23 Aug. 2024, translated from Spanish by the author.

[76] Interview 4 and interview 12, Fabio Serna, director of the human rights group Octava Papeleta, Bogotá, 28 Aug. 2024. On the controversial and politicized interpretation of Latin America's social security crises in the 1980s, see the contributions in Carmelo Mesa-Lago, ed., *The crisis of social security and health care: Latin American experiences and lessons*, Latin American Monograph & Document Series, no. 9 (Pittsburgh: Center for Latin American Studies, University Center for International Studies, University of Pittsburgh, 1985).

[77] This accusation of regression and primitivism (translated from Spanish by the author) was made by Augusto Galán, who was Minister of Health in the 1990s and now directs the health think tank Así Vamos en Salud (This is how we go in health). See Licsa Gómez, 'Exministro de salud lanzó fuerte advertencia tras la aprobación de la reforma en cámara: "Nos devuelve a un modelo primitivo"', Infobae, 8 March 2025, https://www.infobae.com/colombia/2025/03/08/exministro-de-salud-lanzo-fuerte-advertencia-tras-la-aprobacion-de-la-reforma-en-camara-nos-devuelve-a-un-modelo-primitivo.

a sense of crisis.[78] This article argues that societies and their elites reinterpret their social contract and development vision in dealing with these crises. They assemble and re-narrate evidence to adjust expectations and to justify political projects.

Focusing on the case of Colombia's sense-making of health crisis and reform, I have shown how global benchmarks and indicators about health systems become part of narratives of development. Experts from politics, the professions and civil society interpret health crises by assembling a version of the past and the future, characterizing the public and private actors entrusted with running the health system and invoking international comparisons that co-define a nation's place in the world and in history. In the health domain, where epidemiological models of modernization, law-like transitions and population trends are powerful imaginaries, expertise on trends and scenarios inform such crisis interpretations and should get more scholarly attention. This becomes even more relevant as the health agenda is increasingly linked to the global climate agenda, so that projections of the climate crisis' health impacts and mitigation scenarios will be central in global health debates and narratives.

As a single case-study, this article has limitations. It focuses on an exceptionally politicized and public debate about health crisis and reform. While this salience is analytically useful in bringing to the fore the underlying narratives that are used to make sense of crises, health systems often get much less public attention. For example, the candidates in the 2024 presidential election in the United States were relatively silent on health, since it seemed to be a losing issue.[79] Across the world, the salience of health politics ebbs and flows. When further removed from public debate, interpretation is more left to technocrats and epistemic communities, whose construction of interpretive lenses is an important field of study, given that these lenses become repertoires for public debate.[80]

Furthermore, Colombia's concern with international status as a new OECD member and its quest for comparative international insight is not always replicated across countries. For example, debates about the crisis of the UK's National Health Service are less outward-looking, given that political culture considers it a unique achievement integral to British identity.[81] Future research should explore further how a country's alliances and positioning *vis-à-vis* international peer groups influence its vision for health and development, especially in the context of a multipolar world order where western benchmarks and narratives are increasingly contested.

[78] Dorling, *The next crisis*.

[79] Andrew Yamakawa Elrod, 'Where Americans work: an interview with Gabriel Winant on the care economy in the 2024 election', *Phenomenal World*, 1 Nov. 2024, https://www.phenomenalworld.org/interviews/gabriel-winant.

[80] Annabelle Littoz-Monnet, 'Exclusivity and circularity in the production of global governance expertise: the making of "global mental health" knowledge', *International Political Sociology* 16: 2, 2022, https://doi.org/10.1093/ips/olab035.

[81] Clare Herrick, 'Medical futurology: the National Health Service and the politics of inevitable conclusions', *Antipode* 57: 2, 2025, pp. 559–77, https://doi.org/10.1111/anti.13130.

Finally, processes of populist backlash against medical science can play a stronger role in other countries' health policy debates. Yet, as evident in the case of the second Trump administration in the US, even the backlash against medical science is never all-out, and evidence and indicators are still selectively referred to. The development perspective allows us to consider how a broad variety of narrative repertoires—from nativism to (anti)feminism to climate politics—are mobilized or not in making sense of the current polycrisis.