THEMES AND DEBATES

Health Equity: Conceptual Models, Essential Aspects, and the Perspective of Collective Health

Nivaldo Linares-Pérez[a], *& Oliva López-Arellano*[b]

Abstract

This paper analyzes the concept of health equity, drawing on ideas of social justice, of rights and values, and of the social and economic determinants which define living conditions and power relations among social groups. Differing schools of thought concerning health inequality and inequity in health are considered, highlighting contemporary approaches and the conceptual and operational diversity of definitions. We adopt the viewpoint of collective health and outline the elements which are essential to the understanding of inequity: the role of social, economic, political, cultural and ideological determinants on the equity of health outcomes, access to services and quality of care. We conclude that theoretical/conceptual frameworks must be formally spelled out before we can advance our understanding of health equity. The use and interpretation of terminology is made problematic by the abundance of definitions, although there appears to be a consensus on the need to further explore - in a varied, complementary and integrated manner - aspects of health care itself and of its environment. From a collective health perspective, we need to move beyond traditional approaches, a challenge which will enable better understanding of the social dynamics which, when expressed as inequalities in health, constitute social inequity.

[a] Nivaldo Linares-Péreza MD, MSc, PhD, Physician, Maestro en Ciencias de la Salud. Doctor en Ciencias en Salud Colectiva.Centro de Estudios en Salud, Universidad del Valle de Guatemala. 16 Avenida 10-50, Zona 15, Vista Hermosa III. Anexo CDC/CAP-UVG/CES
C.P. 01015. Guatemala City, Guatemala.
Telephone: (502) 2364-0734
Fax (502) 2364-3228
nlinares@gt.cdc.gov
[b] Oliva López-Arellano, MD, MSc PhD
Physician. Maestra en Medicina Social. Doctora en Ciencias en Salud Pública. Investigadora y Profesora del Programa de Doctorado en Ciencias en Salud Colectiva, Universidad Autónoma Metropolitana Unidad Xochimilco. Calzada del Hueso 1100, Col. Villa Quietud, Delegación Coyoacán, C.P. 04960, D.F. México.
Telephone: (52-55) 5483-7000
Email: oli@correo.xoc.uam.mx

Key words: health equity, health inequalities, collective health

Introduction

The greatest degree of social inequity in the world is to be found in Latin America and the Caribbean[1] where serious inequalities in health conditions and access to health services persist despite the development of programs designed to reverse them[2]. Inequality, expressed simply in differing health status between individuals and social groups – both within and between countries – constitutes a significant issue for health care systems. The growing global disparities in living and health conditions among social groups and between

geographic regions has given rise to increasing concern that they constitute an emergency situation which compromises the future of humankind[3].

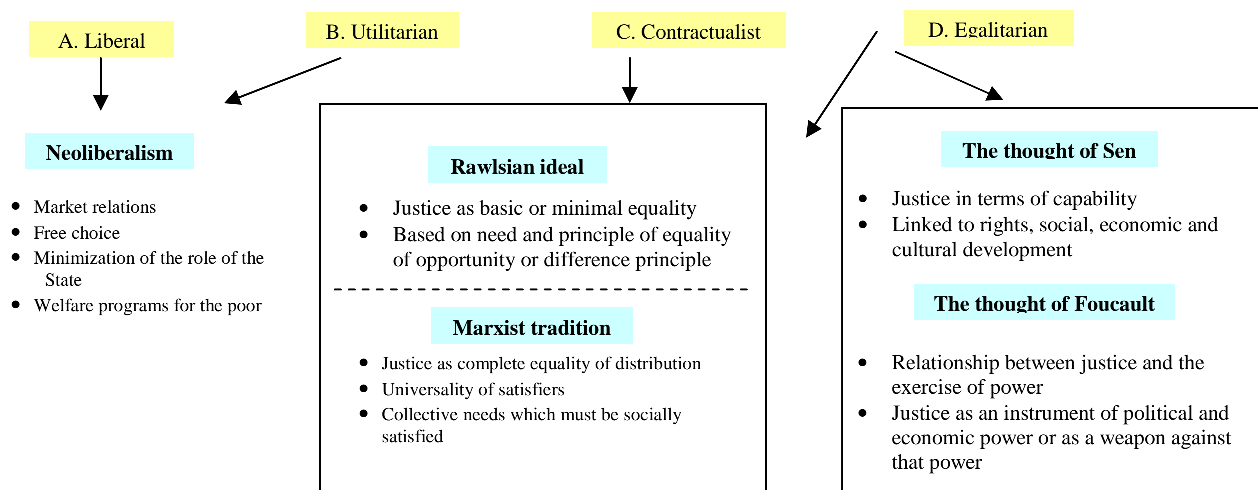
Health inequalities were a key issue in the 1970s and mid 80s. However, this interest was displaced by a concern over the efficiency and sustainability of health care systems and health policy reform began to reflect this new orientation[4]. A paradox resulted. Faced with increasing health inequality, most governments in the Americas developed strategies favoring efficiency and financial sustainability, creating health systems controlled by market forces, despite their negative impact on equity.

This paper discusses the concepts of inequality and inequity from the vantage point of social justice and examines contemporary approaches to health equity. Modern concepts of justice are reviewed, looking at liberal, utilitarian, contractualist and egalitarian approaches. Mention is also made of positions on social health equity derived from the Rawlsian approach, the viewpoint of A. Sen relating health justice and health equity, and the thinking of Foucault linking justice and power. Explanatory frameworks supporting these approaches are identified. Finally, we examine the approach taken by collective health, highlighting social, economic, political and cultural determinants in the explanation of unequal distribution of health outcomes, access to services, quality of medical and health care, and the very configuration of health care systems.

The Concept of Health Justice and Approaches to Health Equity

The very complexity of the subject of equity and the variety of disciplines studying it suggest that there may be various different approaches to it based on different philosophical and ethical-evaluative conceptions. To understand the general framework for understanding health equity, we need to start from the concepts behind the theory of social justice in general and health justice in particular (Figure 1). According to Vega-Romero[5] there are four recognized modern concepts of justice in the field of health: a) liberal, b) utilitarian, c) contractualist, and d) egalitarian. Together they make up, to a greater or lesser extent, the bases on which health care systems have been built and the intellectual foundation for current thinking on health equity.

Figure 1. Frame of reference: the idea of social justice and health equity



Liberals hold that health is a private matter and that the election and distribution of medical care must occur primarily through market mechanisms based on free choice. The role of the State is limited to basic programs of care for the poorest. *Utilitarians* base their distributive criteria on the principle of utility, i.e. the maximization of the sum of individual utilities, preferences and values. *Contractualists* base their position on the principle of a contract agreed upon following a specified procedure. Lastly, *egalitarians* hold that the principles of health justice should flow from a just social contract, or as the outcome of models of society such as those proposed by Marxism[5].

Peter and Evans[6] discuss four philosophical/moral approaches to health equity: the *utilitarian approach*, which advocates maximization of the sum of individual well-being, assuming that all people are equally capable of enjoying good health; the *egalitarian approach*, centering on distributive considerations without valuing the total health of the population; the *prioritarian approach* which sees itself as counter-balancing the principle of utilitarianism, giving preference to allocating health benefits to the sickest, and the *approach derived from the Rawlsian ideal of society* seen as a just procedural system. The first three approaches provide perspectives on health equity as an independent social objective and focus on a distributive model of final health outcomes, as opposed to the *Rawlsian* approach which places the objective of health equity in the context of a wider search for social justice. The basic premise of the Rawlsian approach is that social inequalities in health are unfair because they result from a division of labor in society which places certain groups of people at a disadvantage not only in economic, social, and political terms, but also in terms of their possibilities of remaining healthy[6].

Amartya Sen[7] offers a different theoretical perspective on health justice and health equity, interpreting them in function of the capabilities of individuals to rights and to social, economic, and cultural development. According to Martinez and his colleagues[8] Sen concpetualizes health as interacting – both as a means and an end in itself – with other social goods within the context of human development. Thus health is a capability which renders possible the use and enjoyment of goods and is included within a more general redistributive framework aimed at compensating or alleviating social inequalities[8]. To quote Sen[7]: "*in any discussion of social equity and justice, illness and health must figure as a major concern*." This is true not only because of health's social character and the central role health equity plays in the general justice of social arrangements, but also because "*health equity cannot be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom.*" Thus understood, health equity is not just about the distribution of health; even less should it be reduced to the question of how personal health services are allocated. On the contrary, health equity should be seen from a multi-dimensional point of view, a conception that helps us to understand social justice[7].

In Michel Foucault's post-modern, post-structuralist thought, we can see that the principles governing the distribution of health services and care in a population result from the forced imposition and generalization of specific concepts of justice by dominant groups and rationalities. These principles are not the result of a consensus founded on a universally valid social conception or moral perspective. Foucault sees the workings of health services as the consequence of a victory by strategically organized forces who assume positions in the domains of knowledge and technology. These forces establish, choose or

are obliged to support one rationality over others which oppose their interests[5].

Explanatory models of health equity

In order to do away with the ambiguity, controversy, and terminological confusion arising from the notions of inequality-inequity, we need to define these concepts and identify the various ways they are understood. This allows us to fully comprehend the meaning and scope of health equity.

According to Ramírez[9], the term "equity" comes from the Latin *aequitas*, derived in turn from the word *aequus,* meaning "equal." It involves giving to each what is appropriate according to their merits or conditions. For Aristotle"*the nature of the equitable [is] a correction of law where it is defective owing to its universality*." The law is necessarily a generalization and, therefore, is sometimes shown to be imperfect or difficult to apply in particular cases. In such cases equity intervenes in order that judgment is made not on the basis of law, but on the basis of justice, which is what law is supposed to achieve. Therefore, notes Aristotle, justice and equity are one and the same thing: equity is superior, not to fairness itself, but to fairness formulated in a law which, by reason of its universality, is subject to error. *"Equity is the sense of justice which sometimes strays from the law in order to cover circumstances which, were they not taken into account, would give rise to a 'legal injustice', if you'll forgive the paradox"* [(9)].

What do we mean by 'health equity'? The answer is conceptually complex. And in practice there are multiple ways of answering it, for there are diverse ways of defining the concept, measuring it, and translating it into practice within the socio-economic context and health conditions of population groups[10]. While some use the concepts of inequality/inequity to express a sense of 'justice,' others use it to mean 'equality' in a purely mathematical sense[11]. Despite their inadequacies, these approaches have served to organize discussion on the determinants of the health status of human populations and of access to health care services; this has been true both when studying the relations between macroeconomic policies, social policies, and health, as well as when suggesting interventions to reduce inequities and improve levels of health and well-being of defined populations[12]. Perspectives on equity vary according to discipline. Economists, for instance, who are concerned with the efficiency and effectiveness of health care systems, analyze the impact on equity of different health care financing systems[13], the marked differences between public and private health care provision, and the differences between poor patients who use free public health services and those who are able to pay for private health care[14].

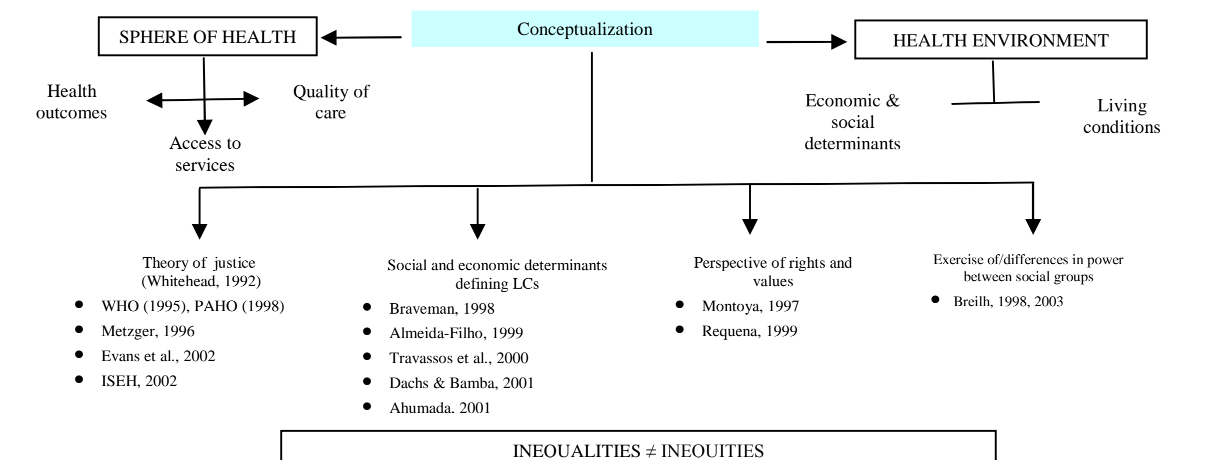
There is a degree of consensus on the various facets of health equity, whether or not its definition recognizes socio-historical processes; these are: poverty, income, level of education, nutrition, access to drinking water, and conditions of hygiene, among others[15]. Some are specific to the health sector such as access to basic health care and hospital treatment, and even differences in the health outcomes of specific groups[16]. Therefore, in conceptualizing health equity we can see the integration of two differentiated but closely linked dimensions. The first is health itself, measured by three components: access to health services, quality of care, and health outcomes. The second is the social context for health, made up of social, economic, political, and cultural determinants; this is measured by the living and working conditions of particular social groups. These conditions express the coming together of the contradictions of class, gender, ethnic/national origin, and age /generation. Within these interpretations of health equity, we can distinguish at least four approaches which attempt to define and explain it (Figure 2).

According to Margaret Whitehead[17], health inequity refers not simply to inequalities that are unnecessary and avoidable. They must

also be seen as unjust. For this author, health equity implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided[17]. She identifies seven possible determinants of health inequalities: 1) natural, biological variation; 2) health-damaging behavioral choices; 3) temporary health advantages occurring to one group when it adopts health-promoting behaviors (assuming other groups have equal chance of adopting the behavior); 4) health-damaging behaviors where the degree of choice is severely restricted; 5) exposure to unhealthy, stressful living and working conditions; 6) inadequate access to essential health and other basic services; and 7) natural selection or health-related social mobility involving the tendency for sick people to move down the social scale. She does not consider the first three of these as being unjust, while the last four are both avoidable and unjust. In operational terms, Whitehead argues for reducing differentials in health and health care access to an absolute minimum. Based on this explicitly pragmatic point, she defines equity using two antonyms, 'inequality' and 'inequity.' 'Inequality' refers to systematic, unavoidable, and meaningful differences among members of a population; 'inequity' refers to the existence of variations which are not only unnecessary and avoidable, but also unjust. Whitehead herself points out that equity does not mean that everyone should enjoy the same level of health and consume services and resources to the same degree. Rather the needs of each individual should be addressed. To describe a situation as inequitable or unjust, it needs to be examined and judged in a larger social context. To summarize, any inequity is an inequality but not every inequality is an inequity. An inequity is an unjust and potentially avoidable inequality[17].

Based on the work of Whitehead and other authors, WHO attempts to conceptualize equality/inequality through the dyad of equity/inequity. For WHO, equity means that health needs should guide the distribution of opportunities in a society, not social privilege. This entails using the principles of justice and impartiality to reduce unjust inequalities due to social status. In other words, the aim is to reduce avoidable gaps in health status and health service usage between groups with different levels of social privilege, as reflected in ethnic, religious, socio-economic, gender, geographical location, and age differences[18,19].

Figure 2. Equity: concepts, definitions and explanatory frameworks



For its part, the Pan American Health Organization (PAHO) argues that the terms equality/equity and inequality/inequity are commonly conflated. For PAHO, equality is uniformity and equity is impartiality. In a given situation, 'equal' can be inequitable and 'unequal' can be equitable. An ethical justification must be given for why a particular distribution is an inequity[20]. PAHO defines inequality and inequity the same way as Whitehead: equity as a value means *'striving for impartiality and justice through the elimination of differences that are avoidable and unnecessary'*[21].

In 'Challenging Inequities in Health' (edited by Evans, Whitehead, Diderichsen, Bhuiya and Wirth) the authors conclude: *"inequalities in health reflect differences between groups independently of any assessment of their fairness. Inequities refer to a subset of inequalities that are deemed unfair"*[22:4]. What characterizes injustice is first, a judgment as to whether inequalities are avoidable or not, and then a determination as to whether they are acceptable or not[22]. Metzger[23] concludes that the term 'inequality' is purely descriptive and carries with it no moral judgment. On the other hand, he contends that '*inequidad*' is a direct translation of the English term of 'inequity.' Although this word does not exist in Spanish or Portuguese, the term '*iniquidad*' [iniquity] does exist and carries the meaning of injustice. He suggests using the term '*iniquidad*' to mean inequality with *iniquity*, i.e., unfair inequality[23]. With this in mind, the author suggests that the characteristics of equity include a) being derived from legitimate modes of acquisition such as inheritance, savings, or state redistribution, b) providing universal access to a decent, basic minimum standard, and c) offering freedom of choice, i.e. there are more options than needs. Kawachi and colleagues[24] maintain that assessing inequities means measuring what is or is not fair in a society. This entails a value judgment premised upon one's theory of justice and, therefore, on the political-normative concept guiding it.

The International Society for Health Equity adopts as the operational definition of inequities as systematic and potentially remediable differences in one or more aspects of health status across socially, economically, demographically, or geographically defined populations or population sub-groups[25]. However, given the complexity of this definition, some suggest maintaining a focus on inequality, which is understood as a generic term used to designate differences, variations and disparities in the health achievements of individuals and groups, without implying any moral judgment of these differences or strict consideration of their solution[24].

The social and economic determinants of health disparities play a key role in this debate. Braveman, for instance, defines health equity operationally as "minimizing avoidable disparities in health and its determinants - including but not limited to health care - between groups of people who have different levels of underlying social advantage."[26]. Other statements of this idea can be found in papers by Casas, Dachs and Bambas which document large differences both in health status and in access to health care services among populations with different levels of well-being, education, geographic location, and physical and financial access to health services; such differences are also found with respect to ethnicity, gender, and national origin[27].

Other authors bring to the issue of equity a conceptualization based on rights and values in health. Montoya considers that health is a natural right, whereas equity is a civil right. In his conception, a social contract exists precisely to avoid any distortion stemming from inequalities in power and to keep such inequalities becoming injustices. For Montoya, equity is a way of distribution of goods according to the merits of each person[28] and thus conforms to a meritocratic perspective. In contrast, Requena[29] sees equity as a value and

suggests that values are polar, hierarchical qualities. He defines equity as the main value underpinning the right to health and gives an ethical dimension to the State's responsibility to deliver health for all. In other words, equity means justice; people's needs rather than social privilege guide the distribution of opportunities for well-being[29].

Equity in Health Care Services

Regarding health care services and medical treatment, various authors identify specific aspects of the different ways to operationalize the concept of health equity. Whitehead[17] identifies four types of equity: a) equality in available access for equal need, b) equality of utilization for equal need (referring to the adequate distribution of existing health resources among individuals who require them), c) equality in quality of care, and d) equality in outcome[17]. Similarly, Berman[30] and Daniels[31] state that the three key elements for achieving equity in health care systems are: progressive financing with equitable allocation of resources within the health care system; universal rights and universal access; and quality of health care services.

WHO[19], in attempting to give the term a more operational sense, has defined health care equity as: a) the way in which resources are allocated for health care, b) the way in which services are delivered, and c) the way in which health care services are paid for. This last consideration is taken up in the 2000 WHO Report which establishes that one of the aims of the organization is to assure financial protection for the poor against the cost of care, that is to say, to achieve equity in financial contribution[32]. According to this approach, the way in which health care is financed is perfectly equitable if the ratio between total contribution towards health and total non-food expenditures is identical for all families, regardless of income, health status, or utilization of the health system. The goal of financial equity encouraged by WHO responds to the principle of contribution according to ability to pay, but not to the principle of *to each according to his needs*, since it advocates financing health care by means of payment in advance through insurance systems. This approach to equity is questioned by some researchers who believe that this is not equity but rather impartiality. Contrary to what the WHO claims to promote, it favors inequity by increasing the role of financial capital in health care financing[33].

According to Starfield, the concept of health care equity means either that differences do not exist where needs are equal, or that expanded health services exist where there are greater needs[34] This statement introduces two different types of equity: *horizontal equity* (equal treatment for equal individuals) and *vertical equity* (unequal treatment for unequal individuals)[23]. Concerning this classification, Porto and colleagues state that it seems reasonable that two people with the same health problem should receive equal treatment (horizontal equity); on the other hand, if one of them - because they enjoy a better physical condition or better nutritional status - were more responsive to therapy, equal treatment would result in unequal outcomes[35]. Consequently, it would be more equitable to provide better care to the person with less capability to respond (vertical equity). Porto also mentions that other authors interpret the concepts of horizontal and vertical equity differently, relating the former to *internecesidades* ('inter-needs') treatment and the latter with *intranecesidades* ('intra-needs')[35]. In other words, horizontal equity is understood to mean equal treatment for equal health needs, taking into account the existence of different needs according to gender, age or social condition. Vertical equity seeks 'appropriately unequal' treatment of different health needs, incorporating the question of priorities in health care programs. In the review by Ramírez[12], horizontal equity is the allocation of equal or equivalent resources to equal needs, while vertical equity is the allocation of

different resources to different levels of need. Bambas and Casas point out that these two concepts of equity have different implications for policy and cannot be randomly applied to problems. Instead, the implementation of these concepts should depend upon specific circumstances which justify the choice of one or the other[36]. For example, a universal health care plan can be considered an instance of horizontal equity, since everyone needs health care to a certain extent, while programs focusing on the poor can be seen as applying the principle of vertical equity. The difference between these two situations lies in the interpretation of need: in the former the use of horizontal equity is justified by the fact that everyone, from a socio-biological point of view, needs health care, whereas in the latter the use of the concept of vertical equity is based on the greater financial needs of the poor who cannot meet their health care needs using their own resources; this situation does not apply to those who are not poor.

Nevertheless, for Knowles, Leighton and Stinson the concept of equity in relation to the health care system can refer equally to differences in status, utilization, or access to health among different socio-economic, demographic, ethnic, and/or gender groups. However, in most processes of health system reform the emphasis has been on equity in access to health services. As medical technology becomes more advanced and governments claim limited fiscal capacity for offering universal access to health care services, the definition of equity most commonly used is the most restrictive one[37].

Travassos and colleagues distinguish between health equity *per se* and equity in health care services. They put forward the idea that not all determinants of health inequalities are involved in determining inequalities in the use of health services; in other words, achieving equality in the use of health services does not guarantee equality of outcomes. Starting from the premise that health care needs are determined socially, these authors see the use of health care services as determined both by the health needs of the population and by the characteristics of the services offered; i.e., by the characteristics of the health care services market, the composition of the public/private mix, structures of finance, forms of payment, etc[38].

Evans and colleagues argue that while most international case studies of equity focus on *equity in final health outcomes*, this, albeit important, is not the only dimension of equity. There are others factors, such as *equity in access to health care* which must be taken into account in terms of their impact on health[22]

.

Equity from the Perspective of Collective Health

The theoretical/conceptual and methodological approaches to knowledge and practice in Latin American social medicine and collective health[39, 40] present alternatives to institutionalized public health. They have relevance not only for the scientific/technical and political aspects of health, but also for the actual practice of health[41]. Collective health approaches the question of inequality/inequity issue by (re)construction/understanding its social determinants and their mediators. They are seen as affecting both the process of health/disease and that of treatment/care. From this viewpoint not only are there inequalities/inequities in terms of final health outcomes, but also in the determinants of disease, in their distribution across populations and social groups, and in the solutions offered by health care systems for combating disease and promoting health[42]. Differential distributions of health/disease/treatment/care in populations are outlined and documented, placing emphasis on the social, economic, political, and cultural determinants which explain these inequalities/inequities, showing them as manifestations of social structure, of the production and distribution of wealth, of the forms of appropriation of resources and

producers, and of relations of power and dominance[43].

The analysis of disparities in health from a collective health standpoint implies the recognition that underlying these disparities are deep imbalances generated by forms of social organization and power relationships among different social groups. In addition, there is disagreement with Whitehead when she maintains that 1) natural biological variation, 2) damaging lifestyle choices, and 3) the health advantages of one group over another[17] are not determinants of inequities, since social medicine analysis is based on recognizing the historicity of human biology[44], the subordination of biological processes in more complex forms of social organization[45] and the social production of both needs and their satisfaction. These factors determine what is considered 'natural/biological.' They override, limit or stimulate 'free choice' of both damaging behavior and healthy lifestyles, and historically they have given rise to health advantages (or disadvantages) of one group over another. All this underlines the need for a comprehensive social vision of the inequality/inequity issue[43].

Urbaneja[46] argues that the discussion on health equity is important because the topic encompasses various aspects which are central to national economic development. Health equity is the cornerstone both of the problem and the solution for issues such as the loss of wellbeing, discrimination, oppression due to economic and social conditions, various forms of exclusion, and the marginalization of large majorities, among other issues. According to this author, it is paradoxical that international organizations which supposedly promote development continue to approach health equity with minimalist conceptions, displaying total unawareness of the complex reality of different countries, and that their proposals remain anchored in technocratic and efficiency-centered principles, ignoring the ethical dimension of social justice as seen from a humanitarian/human rights point of view[46]. This analysis is shared by Ahumada[47], who holds that the current crisis in public health, the deterioration of health care systems and the increase in health inequalities and inequities are due to structural adjustment policies developed since the 1980s in Latin American countries. These policies have had a negative impact on the productive sector of the economy, social conditions, and health equity while producing ever increasing profits for financial conglomerates[47].

In the conceptual debate on inequality/equity/iniquity, Breilh[48] focuses his analysis on the examination of power relationships within populations. Power relationships produce the large lifestyle differences between social groups and determine the ability different groups to produce and negotiate the reproduction of their lives under specific conditions. He argues that the core issue is inequity, pervading the workplaces and markets where life's necessities are obtained; affecting day-to-day living, relations between groups, and even cultural life. For a proper understanding of inequity, he suggests that we should distinguish clearly between the terms 'diversity', 'inequality', 'inequity' and 'difference' and the various ways in which they are interpreted within power structures due to the convergence of gender, class and ethnic contradictions[49].

He defines *diversity* as an inherent characteristic of human life which explains variation in attributes. Differences in gender, culture, age group, etc. are rooted in biological differences such as sex, race and age and give rise to cultural and power constructs. Inequity is the appropriation and concentration of power in certain classes or ethnic groups, or in one gender. Diversity then becomes a vehicle for exploitation and subordination. *"Inequity does not refer to injustice in distribution and access, but to the inherent process generating these injustices, i.e., to the way in which society determines the resulting unequal distribution and access (social inequality)"* [49,p]

[216]. *Inequality*, therefore, is the expected and visible result of inequity seen at the level of the group. Examples are the inequality in salaries between social classes due to the inequity in the process of economic production and distribution, or the inequality of access to health services among social groups or between men and women resulting from inequity in the market or from the State-regulated system of distribution[48]. *Inequity* is an analytical category at the heart of the problem, while inequality is an empirical reference seen in statistical aggregates which needs to be disentangled from the inequity generating it if inequity is to be properly understood. *Equity* is the inherent characteristic of a society which allocates to each according to their need and allows each to contribute according to their capability[50]. Lastly, *difference* is the combined product of diversity and inequity, and is in turn involved in the genesis of inequity and inequality, expressed in individual biological lives[49].

Naomar Almeida Filho sets out a common semantic matrix incorporating the following definitions: *Diversity*: variation of characteristics, systematic differentiation at the population level; *Inequality*: measurable differentiation at population level; empirical evidence of inequity which can serve as indicators; *Difference*: expression of the effects of diversity and inequality at an individual level, can serve as indicator of cumulative incidence; *Inequity:* implies systematic, unnecessary and avoidable differences or variations within human populations; and *Iniquity*: a concept referring to inequities which are not only avoidable but also iniquitous (unfair, shameful and unjust) resulting from social injustice in the presence of diversities, inequalities or differences[51].

The *equity of access, utilization and quality of health services* approach has defined equity as the equality of individuals in terms of opportunities of actual access to health services, i.e., health equity is understood from a theoretical and ethical conception, where equity implies that ideally we should all have a fair opportunity to care for our health and developing our full potential in life, and - more pragmatically - that no-one should be at a disadvantage in achieving this potential if it can be avoided[8]. Consequently, health care equity means equal access to available care for equal need, equal utilization for equal need and equal quality of care for all. Equity in access refers not only to the hypothetical availability of resources or to coverage, but also to the effective utilization of these services according to need[50].

The integration of theory and methodology in the field of inequality/inequity recognizes at least three explanatory theoretical models which deal with the issue of equity in all its dimensions[51]:

Functionalist socio-epidemiological models treat social and economic inequality as risk factors whose effects are manifested through differential exposure (with regard to pathogenesis) and unequal access to social and health resources[52]. This line of reasoning, peculiar to 'functionalist social epidemiology', is structured around two closely linked approaches: the theory of stress which operates at a *microsocial* level, and the theory of modernization and health, which relates to a *macrosocial* level, shaping hypotheses on the consequences of social change on health[53].

Marxist socio-epidemiological models, based on social theories of conflict and contradiction[52], highlight the dialectical processes in the social production of pathology, and have given rise to the school of Latin American social epidemiology. This has two theoretical variants which further analyze and identify inequalities: the production process approach[54], which explains where people stand in relation to the structure of production, and the approach based on epidemiological profiles of social class, building on the concept of social reproduction[55,56].

Ethno-epidemiological models, grounded in the analysis of 'cultural and social ways of

becoming ill' and 'lifestyles and living conditions', refer to epidemiological issues related to the processes of social reproduction of everyday life. This line of thinking - also Latin American - is technically known as 'lifestyle epidemiology' and incorporates qualitative, subjective, and contextual heterogeneities, differentiating health situations according to ethnicity, gender, generation, family, social networks and, in parallel, class relationships[53].

Closing remarks

This conceptual overview of the inequality/inequity issue demonstrates the importance of recognizing the underlying theoretical platforms and approaches to human development, social justice, and the exercise of power which are implicit in the interpretation of health equity, whether as a direct expression of the lack of justice or as a concrete expression of social inequality. The philosophical, ethical-evaluative, and theoretical starting points must be made clear in order to understand the definitions and interpretations of inequalities, inequities, and the practices designed to transform them.

The abundance of definitions in the inequality/inequity literature makes it difficult to adopt, use, and interpret these terms, whether in a systematic study or in the formulation of interventions aimed at attaining health equity. Nevertheless, the general consensus is that to tackle health equity, we need to explore those dimensions related to the field of health (equity in outcomes, access to services and quality of care) and also dimensions of the health environment (equity in living and working conditions and in social, economic, cultural, and political determinants), even when conceptual and methodological approaches are adopted separately for analytical purposes. A comprehensive vision will only be possible if all these dimensions are brought together.

The diversity of positions underlying the conceptualization and measurement of equity should not hinder recognition of the serious differences, inequalities, and inequities in health that exist in Latin America and the necessity and appropriateness of describing and analyzing them, using various methods, in order to advance our understanding of their determinants and to transform these inequalities/inequities.

Lastly, for collective health - which recognizes the complex, material, subjective, contextual nature of the inequality/inequity relationship in health and the processes of determination which define them - explanatory models need to be more sensitive to the socio-historical, cultural, political, and ideological processes which shape systems of inequalities /inequities. The challenge is to improve our understanding of social processes and the multiple dimensions which model the life of human communities, where processes of inequality and health inequity, disease, treatment and care are played out.

References

1. Alleyne GA. Equity and the goal of Health for All. In: Pan American Health Organization. A Quest for Equity / En busca de la equidad. Washington DC: PAHO; 2002a.
2. Schneider MC, Castillo-Salgado C, Bacallao J, Loyola E, Vidaurre M, Mujica O, Anne Roca. Métodos de medición de las desigualdades de salud. Rev Panam Salud Pública. 2002;12(6):398-414.
3. Alleyne GA, Castillo-Salgado C, Schneider MC, Loyola E, Vidaurre M. Overview of social inequalities in health in the Region of the Americas, using various methodological approaches. Rev Panam Salud Pública. 2002b;12(6):388-97.
4. Gwatkin DR. Health Inequalities and the Health of the Poor: What Do We Know? What Can We Do? WHO Bulletin. 2000;(3):3-17.
5. Vega-Romero R. Justicia sanitaria como igualdad: ¿universalismo o pluralismos? In: Pensamiento en Salud Pública: El derecho a la Salud. Facultad Nacional de Salud Pública. Universidad de Antioquia; 2001. p. 54-89.
6. Peter F, Evans T. Ethical Dimensions of Health Equity. In: Evans T, Whitehead M, Diderichsen F, Bhuiya A. & Wirth M (eds.) Challenging Inequities in Health: From Ethics to Action. New York: Oxford University Press, 2001: pp. 25-33.

7. Sen A. ¿Por qué la equidad en salud? Rev Panam Salud Pública. 2002;11(5/6):302-09.
8. Martínez P, Rodríguez LA, Agudelo CA. Equidad en la política de reforma del sistema de salud. In: Torres-Tobal M, editor. ¿Equidad? El problema de la equidad financiera en salud. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo. Bogotá; 2001. p. 183-204.
9. Ramírez A. Enfoques prevalecientes acerca del concepto de equidad y otros relacionados. Diseño de un Sistema de Monitoreo de la Equidad en Salud en Cuba. (PhD Thesis). Havanna: Universidad Médica de La Habana. Escuela de Salud Pública; 2004:4-24.
10. Samaja J. La reproducción social y la relación entre la salud y las condiciones de vida. Washington DC: PAHO; 1994.
11. Rosero-Bixby L, Aguilar C. Blanco L, León M. Equidad y salud en Centroamérica. Washington DC: PAHO; 2000.
12. Pan American Health Organization. Inequidades en la situación de salud, acceso y gasto en atención de salud. Washington DC: PAHO; 2000.
13. Aguilera X, Concha M, González C. Guía para el monitoreo de la equidad en el acceso a servicios básicos de salud. Washington DC: PAHO; 1999. (Photocopied document).
14. Málaga H, Latorre MC, Cárdenas J, et al. Equidad y reforma en salud en Colombia. Revista de Salud Pública de Colombia. 2000;2(3):1-16.
15. Pan American Health Organization. Metodología para el seguimiento y evaluación de las reformas del sector salud en América Latina y el Caribe. Iniciativa Reforma del Sector Salud en América Latina y el Caribe. Cuaderno 1. PAHO; 1997.
16. Leighton C, Maceira D. Guía básica de política: toma de decisiones para la equidad en la reforma del sector salud. Iniciativa Reforma del Sector Salud en América Latina y el Caribe. Cuaderno 6. Partnerships for Health Reform; 1999.
17. Whitehead M. The Concept and Principles of Equity and Health. International Journal of Health Services. 1992;22:429-45.
18. Word Health Organization. Renewing the Health for All Strategy: Elaboration of a policy for equity, solidarity and health. Geneva: WHO; 1995.
19. Word Health Organization. Health equity Care. Geneva: WHO; 1996.
20. Pan American Health Organization. Equidad en la situación de salud desde la perspectiva de género. Washington DC: PAHO; 1999.
21. Pan American Health Organization. La Salud en las Américas: informe de la Directora 2003. Washington DC: PAHO; 2003.
22. Evans T, Whitehead M, Diderichsen F., Bhuiya A. & Wirth M. Challenging Inequities in Health. Washington DC: The Rockefeller Foundation/PAHO; 2002. [Eng. version published by OUP, see ref. 6]
23. Metzger X. Conceptualización e indicadores para el término equidad y su aplicación en el campo de la salud. Washington DC: PAHO; 1996.
24. Kawachi I, Subramanian SV, Almeida-Filho N. A glossary for health inequalities. J. Epidemiol Community Health. 2002;56:647-52.
25. International Society for Health equity. The Toronto Declaration on Health equity Conference Statetment: 2nd International Conference. Toronto, June 2002.
26. Braveman P. Monitoring Health equity: A policy oriented approach in Low and Middle-Income Countries. Mimeograph. Geneva: WHO; 1998.
27. Casas JA, Dachs NW, Bambas A. Health Disparities in Latin America and the Caribbean: the Role of Social and Economic Determinants. Equity & Health. No. 8. Washington DC: PAHO; 2001. p. 22-49.
28. Montoya C. La equidad. Usos del concepto como criterios de progreso. Cuadernos Médicos Sociales. 1997;38(1):6-12.
29. Requena M. Focalizando la equidad. Cuadernos Médicos Sociales. 1997;38(1):3-5.
30. Berman P. Health sector reform: Making health development sustainable. Rev. Health Policy. 1995;32(3):13-28.
31. Daniels N, Bryant J, Castano RA, Dantés OG, Khan KS & Pannarunothai S. Benchmarks of fairness for health care reform: a policy tool for developing countries. WHO Bulletin. 2000; 78(6):740-50.
32. World Health Organization. The world health report 2000 - Health systems: improving performance. Geneva: WHO; 2000.
33. López C. Algunas consideraciones sobre el concepto de equidad financiera y su cuantificación. Presentación de una propuesta de medición de desigualdades de la salud en Las Américas. In: Torres-Tobal M, editor. ¿Equidad? El problema de la equidad financiera en salud. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo. Bogotá; 2001. p. 91-100.
34. Starfield B. Improving health equity: A research agenda. International Journal Services. 2001;31(3):545-66.
35. Porto SM. Equidad y distribución geográfica de recursos financieros en los sistemas de salud. Cad Saúde Pública. 2002;18(4):939-57.
36. Bambas A, Casas JA. Assessing Health equity: Conceptual Criteria. Equity & Health. No. 8. Washington DC: PAHO; 2001. p. 22-49.
37. Knowles JC, Leighton C, Stinson W. Indicadores de Medición del Desempeño del Sistema de Salud. Iniciativa Reforma del Sector Salud en América

Latina y el Caribe. Cuaderno 6. Partnerships for Health Reform; 1997.
38. Travassos C, Viacava F, Fernández C, Almeida C. Desigualdades Geográficas e Sociais na Utilização de Serviços de Saúde no Brasil. Ciência & Saúde Coletiva. 2000;4(3):429-45.
39. Waitzkin H, Iriart C, Estrada A, Lamadrid S. Social Medicine in Latin America: productivity and dangers facing the major groups. The Lancet. 2001;358:315-23.
40. López O, Peña F. Salud y sociedad. Aportaciones del pensamiento latinoamericano. n: De la Garza E, coord. Tratado de Sociología. Barcelona: Anthropos/UAM; 2006. p. 278-299.
41. Burlandy L, Bodstein RC. Política e saúde coletiva: reflexão sobre a produção científica (1976-1992). Cadernos de Saúde Pública. 1998;14(3):13h.
42. Almeida–Filho N, Paim JS. La crisis de la salud pública y el movimiento de la salud colectiva en Latinoamérica. Cuadernos Médico Sociales. 1999a;75:3-30.
43. López O. y Blanco J. Desigualdad social e inequidades en salud. Desarrollo de conceptos y comprensión de relaciones. Salud Problema, Nueva Epoca. 2003;8(14-15):7-16.
44. Laurell C. Sobre la concepción biológica y social del proceso salud-enfermedad [On the biological and social conception of the process of health and disease]. In: Rodríguez Ma. Isabel, coord. Lo biológico y lo social [The biological and the social]. Serie de Recursos Humanos No. 101. Washington DC: PAHO/WHO; 1994. p. 1-19.
45. Samaja J. Epistemología de la Salud. Reproducción Social, subjetividad y transdisciplina. Buenos Aires: Lugar Editorial; 2004. p. 25-43.
46. Urbaneja M. Salud, Equidad y Gestión Pública. In: Torres-Tobal M, editor. ¿Equidad? El problema de la equidad financiera en salud. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo. Bogotá; 2001. p. 119-24.
47. Ahumada C. Salud y Equidad en el contexto del ajuste social. In: Torres-Tobal M, editor. ¿Equidad? El problema de la equidad financiera en salud. Plataforma Interamericana de Derechos Humanos, Democracia y Desarrollo. Bogotá; 2001. p. 31-6.
48. Breilh J. La inequidad y la perspectiva de los sin poder: Construcción de lo social y del género. In: Breilh J. Cuerpos, Diferencias y Desigualdades. Bogotá: Utópica Ediciones; 1998.
49. Breilh J. De la epidemiología lineal a la epidemiología dialéctica: determinación epidemiológica e inequidad In: Breilh J. Epidemiología Crítica: ciencia emancipadora e interculturalidad. Buenos Aires: Lugar Editorial; 2003. p. 214-24.
50. Laurell C. Reducción de la exclusión en salud, removiendo el obstáculo económico. La experiencia del Gobierno del Distrito Federal. Mexico: Organización Panamericana de la Salud, Secretaría de Salud del Gobierno del Distrito Federal, Swedish Agency for International Cooperation and Development; 2004
51. Almeida-Filho N. Desigualdades de salud en función de las condiciones de vida. Washington DC: PAHO; 1999.
52. López O. y Blanco J. Modelos sociomédicos en Salud Pública. Coincidencias y desencuentros. Salud Pública de México. 1994;36(4):374-85.
53. Almeida-Filho N. La ciencia tímida: ensayos de desconstrucción de la epidemiología. Buenos Aires: Lugar Editorial; 2000. p. 138-44.
54. Laurell C. Para el estudio de la salud en su relación con el proceso de producción. In: Laurell C, Noriega M. La salud en la fábrica. Estudio sobre la industria siderúrgica en México. Mexico: ERA; 1989. p. 65-92.
55. Blanco J, López O. Condiciones de vida, salud y territorio. Un campo temático en (re)construcción. In: Jarillo E, Ginsberg E, coords. Temas y desafíos en salud colectiva. Argentina: Lugar Editorial; 2007. p. 103-25.
56. Breilh J. Nuevos conceptos y técnicas de investigación. Guía pedagógica para un taller de metodología. Quito: Centro de Estudios y Asesoría en Salud; 1994.