THEMES AND DEBATES

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

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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.

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 where serious inequalities in health conditions and access to health services persist despite the development of programs designed to reverse them. 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.

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. 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 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

A. Liberal
- Market relations
- Free choice
- Minimization of the role of the State
- Welfare programs for the poor

B. Utilitarian
- Justice as basic or minimal equality
- Based on need and principle of equality of opportunity or difference principle

C. Contractualist
- Justice as complete equality of distribution
- Universality of satisfiers
- Collective needs which must be socially satisfied

D. Egalitarian
- Justice in terms of capability
- Linked to rights, social, economic and cultural development

The Rawlsian ideal
- Justice as basic or minimal equality
- Based on need and principle of equality of opportunity or difference principle

The Marxist tradition
- Justice as complete equality of distribution
- Universality of satisfiers
- Collective needs which must be socially satisfied

The thought of Sen
- Relationship between justice and the exercise of power
- Justice as an instrument of political and economic power or as a weapon against that power

The thought of Foucault
- Relationship between justice and the exercise of power
- Justice as an instrument of political and economic power or as a weapon against that power
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.

Peter and Evans 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 counterbalancing 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.

Amartya Sen 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, Sen conceptualizes 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. To quote Sen: “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.

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.\textsuperscript{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\textsuperscript{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” \textsuperscript{(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\textsuperscript{10}. While some use the concepts of inequality/inequality to express a sense of ‘justice,’ others use it to mean ‘equality’ in a purely mathematical sense\textsuperscript{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 macromacroeconomic 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\textsuperscript{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\textsuperscript{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\textsuperscript{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.\textsuperscript{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\textsuperscript{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\textsuperscript{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. 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.

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.
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. 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’.

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.” 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. Metzger 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 ‘inyiquidad’ [iniquity] does exist and carries the meaning of injustice. He suggests using the term ‘inyiquidad’ to mean inequality with iniquity, i.e., unfair inequality. 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 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. 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.

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.” 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.

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 and thus conforms to a meritocratic perspective. In contrast, Requena 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. Whitehead17 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, Berman30 and Daniels31 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.

WHO19, 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 Ramírez12, 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. 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.

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.

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 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. 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. 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. 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 are not determinants of inequities, since social medicine analysis is based on recognizing the historicity of human biology, the subordination of biological processes in more complex forms of social organization 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.

Urbanseja 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. This analysis is shared by Ahumada, 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.

In the conceptual debate on inequality/equity/inequity, Breilh 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.

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).”
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. 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. 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.

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.

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. 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.

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:

1. **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. 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.

2. **Marxist socio-epidemiological models**, based on social theories of conflict and contradiction, 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, 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.

3. **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.

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.

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