Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.7
DOI: 10.1590/1413-81232024297.04932024EN

ARTICLE REVIEW

Expressions of inequalities in access to health services in Latin America: a scoping review

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Abstract *Latin America is one of the most unequal regions in the world. Due to colonization and occupation of the territory, structural inequalities mark people's living and health conditions. In health, we can observe how different dimensions of inequalities condition access and user experience in the service. This scoping review aimed to map and analyze the expressions of inequalities in access to health services in Latin American countries from the scientific production of the last ten years, from which 272 articles were selected. The categorical analysis classified articles into five dimensions, which characterize the expressions of inequalities in access to health services: socioeconomic, geospatial, ethnic/racial, gender, and people with disabilities. The most frequent access barriers were socioeconomic or ability to pay, geographic or transportation difficulty, availability of services, cultural/ethnic, communication, and architecture. The main conditioning factors of health inequalities were income, schooling, transportation, and living conditions. Combating health inequalities requires proposing structuring and sectorial policies.*

Key words *Inequalities, Health inequities, Access to health services*

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Introduction

This study focuses on inequalities and access to health services in Latin America (LA). It was developed from three arguments. Firstly, the recognition that social, environmental, and economic contexts greatly influence the lives and health of people and populations[1]. Some authors identify the social, economic, cultural, ethnic/racial, psychological, and behavioral factors that influence the occurrence of health problems and their risk factors in the population as social determinants of health[2,3]. Others are dedicated to understanding the origin of such factors, relating them to the production and reproduction of capital, naming them health determinations[4,5]. Such concepts are marked by political and epistemological differences that conditioned their historical development. The social determination of health in LA is related to the Social Medicine movement, which criticizes underdevelopment, Medicine liberalization, and individualized health-disease process, highlighting the influence of living, working, and environmental conditions on health[4,5]. This perspective will evoke the need for comprehensive public policies and those focusing on lifestyle changes to reduce individual risks.

Despite the specificities of each approach, both appreciate the weight of inequalities and their effects on health, which is the second argument on which this work is anchored. Inequalities can be understood as an unequal distribution produced by the social and historical process, stratifying people and social groups[6]. The term inequality presents a wide range of definitions. It can be related to health, economy, society, region, and culture. All of these aspects can reflect on health inequalities, generating unequal possibilities of access to services, available technologies, and innovations in the sector[7].

Multidimensional and always an important issue in public policies, health inequalities can be understood as differences in health status among individuals or groups. They are related to multiple factors: biological variation, choices people make, living and working conditions that make health vulnerable and harm it, inadequate access to health services or public services, and the impossibility of social mobility[8,9]. Ottersen[10] argues that there are many sources of health inequalities, and one is rooted in the format of development and global organization that we know today.

Barreto[7] highlights the relevance of investigations into inequalities being dedicated to evaluating the distribution/accumulation of income between countries and regions within the same country. In the context of health inequalities, Barata[6] says it is crucial to know the differences associated with factors such as income, education, occupation, race/ethnicity, gender, people with disabilities, and the conditions of the place where they live or work.

As a complex issue, health is conditioned by multiple interconnected, multi-dependent, and intercausal factors[11], the historical result of political directions and choices. Thus, some individuals are knowingly more exposed to situations of inequality than others, and some contexts make them more susceptible to external influences.

The third and final argument concerns health as a right and the importance of the State's role in producing public policies that promote equal access to health services[12]. Access to health services is defined by the user's relationship with the service, whether in appointments, hospitalizations, or tests[13,14]. Travassos and Martins[13] affirm that several factors condition access and use of services, such as the users' needs, sociodemographic characteristics (age, income, and schooling), service providers, organization of services, and politics (health system type). Sanchez and Ciconelli[14] corroborate this perspective and highlight some dimensions that can characterize access: service availability, payment capacity, information (service communication strategies with the population), and acceptance (defined as the health professional's expectations regarding guidelines and user expectations).

The term accessibility can also be found in texts related to access to health services. Starfield[15] uses the term accessibility, referring to the characteristics of the service offering, enabling people to reach the service, and defending reception's success in the first contact with the user. When evaluating the concepts of access to health services, Martins and Travassos[13] concluded that some common points can be traced despite variations in approach to access: accessibility is more often used as a characteristic associated with the service. In contrast, access to health services is a dimension of evaluating the performance of health systems and services.

In the Brazilian case, it is estimated that access to health services benefited from increased Primary Health Care (PHC) coverage[16,17]. The Family Health Strategy (ESF, acronym in Portuguese) was established as a model for reorienting health in Brazil and is associated with increased access and reduced health inequities, primarily due to the proximity to the reality being worked

on[16]. Viacava et al.[17] also credited PHC with expanding access under the ESF's incentives, especially among people with lower income and education levels. Using data from the National Household Sample Survey (PNAD, acronym in Portuguese), they concluded that access to health services in the country has generally increased in the last 30 years in the country[17].

The justification for carrying out the study is related to the arguments presented and the relevance of the topic in the Latin American setting. Latin America is the most unequal region in the world, marked by structural inequalities derived from colonization, people enslavement, and unequal land distribution, which favored the accumulation of goods and income by some families. Inequalities overlap so that the most vulnerable populations suffer the most[18,19].

Therefore, this work aimed to map and analyze the expressions of inequalities in access to health services in Latin American countries based on scientific production over the last ten years. We aimed to answer the following questions: What dimensions of inequalities influence access to health services? What are the most common access barriers? What factors seem to condition such inequalities? We expect to contribute to this debate in Public Health and the Unified Health System (SUS, acronym in Portuguese), aiding the reflection on the limits and possibilities of current and future public policies.

Methods

The research was developed through a scoping review, a method proposed by the Joanna Briggs Institute (JBI). The scoping review fits well with this research because it applies to an exploratory and broad question, providing an adequate mapping of the literature on the topic to identify critical aspects and gaps. With careful and less restrictive selection criteria than other systematic methods, it can gather diverse studies in results. It is a provenly crucial tool for synthesizing knowledge available in online health databases[20].

The method is based on a protocol, and the steps provided for in Scoping Reviews (PRISMA-ScR) are described here: 1. Definition of the research question; 2. Definition of eligibility criteria; 2. Mapping of information sources; 3. Presentation of the search strategy; 4. Description of the evidence source selection process; 5. Graphical presentation of the application of the method for screening and selecting manuscripts; 6. Analysis and summary of the results[21].

This scoping review was guided by a protocol built from the steps mentioned, with the definition of the research question as its central element. As recommended, it was built considering the PCC mnemonic, in which the letter "P" represents the population, "C" is the concept, and the other "C" is the context[21]. Chart 1 presents the question of this scoping review and its fundamental vital concepts.

According to the protocol, we included articles that address three key concepts (health disparities, health inequalities, and access to health services) in the 20 Latin American countries from 2012 to 2022. The languages selected were Portuguese, Spanish, and English. Scientific publications in article format were used as sources in the following databases: LILACS (via BVS), Medline (via BVS), SciELO, and Web of Science.

To adequately map the 20 countries comprising this study, due to their origin and cultural, ethnic, political, social, and economic approaches, we searched for each separately, such as disparities or (health inequities) and (access to health services) and name of the country of interest. The search keys were applied in Portuguese, English, and Spanish in the BVS and SciELO databases and English in the Web of Science database.

The selected articles were organized in the free software Zotero (bibliographic manager) to exclude duplicates. With this manager, we applied a new screening through their titles after exclusion. Titles should include one or some critical concepts defined in the eligibility criteria.

The third step was transporting the selected articles to an Excel spreadsheet to enable descriptive and categorical analysis under the study objectives. After categorization, we identified duplicate articles not detected by the reference manager. This new exclusion of duplicate titles was performed manually and eliminated an additional 64 articles.

The fourth stage was reading the summary of each article. We observed the inclusion of non-selected countries, and another 15 articles were excluded. The fifth step comprised the complete reading of the articles and their descriptive analysis. In the descriptive analysis stage, the following information was extracted from each article: country of publication, authors, year of study, indexing database, study type, and main results.

The last stage involved categorical analysis, in which the results were classified into five dimensions, which characterize the expressions of inequalities in access to health services: socioeconomic, geospatial, ethnic/racial, gender, and

Chart 1. Scoping review question and fundamental key concepts.

Scoping review question	Population	Concept	Context
What are the expressions of inequalities in the access to health services in Latin American countries?	Health service systems	Access inequalities	20 Latin American countries: Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, Cuba, Ecuador, El Salvador, Guatemala, Haiti, Honduras, Mexico, Nicaragua, Panama, Paraguay, Peru, Dominican Republic, Uruguay, and Venezuela
Key concepts for the scoping review question			
Key concepts	**Descriptors**	**Definitions**	
Disparities	Disparidades nos Níveis de Saúde Health Status Disparities Disparidades en el Estado de Salud	Health inequalities can be defined as differences in health status or the distribution of its determinants among different population groups. Some differences are attributable to biological variations or free choice and others are attributable to the external environment and conditions generally beyond the control of the individuals in question. In the latter case, unequal distribution may be unnecessary, avoidable, and unfair, such that health disparities lead to health inequality[6,7].	
Inequalities	Iniquidades em Saúde Health Inequalities Inequidades en Salud	Differences in health status or in the distribution of health resources between different population groups, arising from the social conditions in which people are born, grow, live, work, and age[8,9].	
Access to health	Acesso aos Serviços de Saúde Health Services Accessibility Accesibilidad a los Servicios de Salud	Individuals accessing and using healthcare services to solve problems that affect their health. Factors that influence this possibility include geographic, architectural, transportation, and financial considerations[13,14].	

Source: Authors.

people with disabilities. The categorical analysis aimed to answer: What concept of health disparity is found in the article? To which dimension(s) of disparity in access does the article refer? What characteristics of disparity in access to health services do they focus on (access barriers)? Are they associated with some conditioning factors? If so, which ones?

The search was conducted on November 30 and December 2, 2022; the former date relates to the Web of Science (WOS) database, and the latter relates to the Virtual Health Library (BVS) and SciELO databases. A total of 2,117 documents were retrieved, of which 91 were from WOS, 835 were from BVS, and 1,191 from SciELO. After two steps of excluding duplicate results, the final number of documents was 1,426. After two people applied the inclusion and exclusion criteria, 272 documents were selected. The PRISMA flowchart in Figure 1 summarizes the screening and selection process of the articles analyzed in this scoping review.

Results

Analysis of the temporal distribution (2012 to 2022) of the 272 selected articles shows a relatively stable average over the period. Most articles (48.52%) were published in English, followed by 31.98% in Portuguese and 19.48% in Spanish.

The selected articles were categorized into dimensions according to the inequalities in access to health services present in each one. This way, five dimensions were created: 1. Socioeconomic inequalities; 2. Geospatial inequalities; 3. Ethnic/

racial inequalities; 4. Gender inequalities ;and 5. Inequalities in people with disabilities.

Graph 1 shows the temporal distribution of articles selected in this scoping review by dimensions of inequalities from 2012 to 2022. We can observe the relevance and stability of the publication of studies focusing on socioeconomic inequalities, which were more frequent throughout the analyzed period (42.6% of articles). Articles related to geospatial inequalities are the second-most frequent over time (27.6%). At the onset of the period, this position was held by works dedicated to gender inequalities, which rose again between 2018 and 2020 after a slight drop, totaling 11.7% of the total. Articles addressing ethnic/racial inequalities rank third in the volume of publications over time (15.1%). Studies on the dimension of inequalities in people with disabilities represent, proportionally, the smallest number over time, with one exception in 2016 (3% of the total).

Analyzing articles on each of the dimensions of inequalities in access to health services enabled us to identify the primary access barriers associated with each and the main factors that condition them. The identified access barriers were grouped by their frequencies. All were present in all dimensions of inequalities, albeit with variations. On an increasing scale, the most frequent barriers were socioeconomic/ability to pay in more significant numbers (34.8%), followed by geographic or transportation difficulty (23.6%), functional or organizational availability (23.1%); cultural/ethnic (13.5%); acceptability/communication (3.3%); and architectural (1.8%). The graphical visualization of the distribution of access barriers in the articles analyzed is shown in Graph 2.

Considering all dimensions of inequalities, the main factors conditioning their occurrence were income (44%), expressing the weight of socioeconomic inequalities in access to health services; schooling level (35%), often associated with unequal income distribution, an essential factor in understanding the limits to social mobility; transportation (13.7%), highlighting the weight of the unequal distribution of services in the territory and the insufficient adaptation to the needs of people with disabilities; and housing conditions (7.4%), associated with socioeconomic inequalities, as an essential structural component.

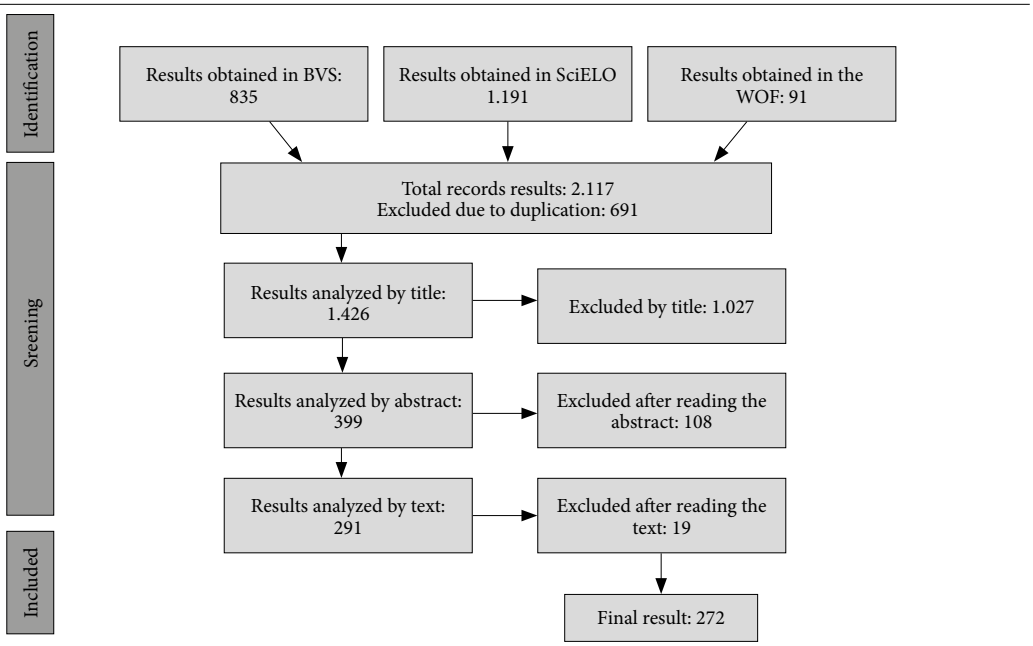
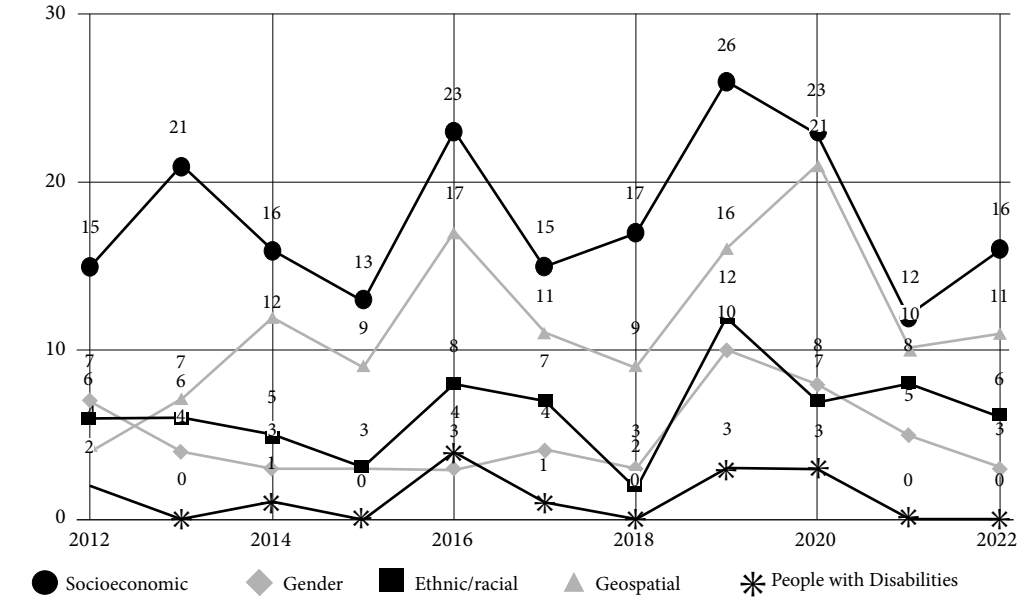


Figure 1. Prisma-ScR flowchart regarding the selection of evidence sources.

Source: Authors, adapted from PRISMA, 2020[22].



Graph 1. Temporal distribution of articles selected in this scoping review by dimensions of inequalities, 2012 to 2022.

Source: Authors.

Discussion

The results were discussed from the five dimensions of inequalities in access to health services already presented above.

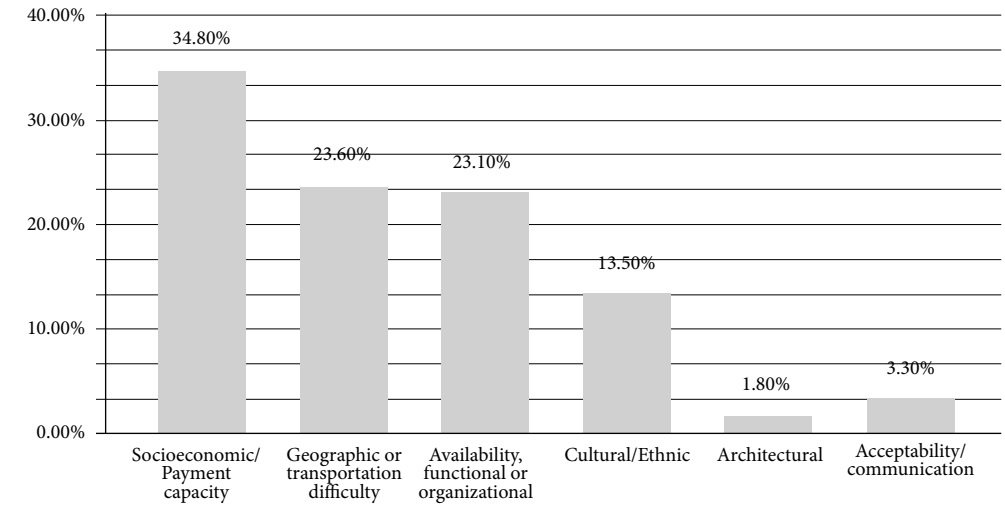
Socioeconomic inequalities

Latin America is one of the most unequal regions in the world[23]. Socioeconomic inequalities are related to its social and historical trajectory and tend to be aggravated by crises. The choices and priorities of public policies can alleviate or deepen them, depending on their directionality and scope. Although LA experienced a reduction in social inequalities from the early 2000s until 2013, there was stagnation from 2015 onwards, with the situation deteriorating in 2020 due to the multidimensional crisis generated by COVID-19[23].

Due to the historical-structural nature of socioeconomic inequalities in LA, the categorical analysis of scientific production classified in this dimension shows that it is, in almost all cases, cross-sectional to other inequalities. We identified associations with geospatial inequalities in around 50% of the articles, 30% with ethnic/racial, and 18% with gender. Thus, the main access barriers identified in the publications were socioeconomic (67% of articles), geographic (34.5%), availability of services (30.9%) and cultural (17.2%). The primary factors conditioning the inequalities expressed in the articles of this dimension were income (87.8% of citations) and education (68% of citations), showing the relationship between lower education and worse socioeconomic status.

This dimension gathers the most significant volume of articles in this scoping review, which also denotes its importance. The countries with the highest number of publications included were Brazil, Colombia, Mexico, and Argentina, and the years that concentrated most of them were 2013, 2016, 2019, and 2020. The methods varied, covering literature reviews, case studies, and ecological studies.

Thematically, studies that relate socioeconomic inequalities to difficulties in accessing PHC, oral health, and women's health services stand out – notably more deficient among the most vulnerable populations. Productions associating socioeconomic issues and restricted



Graph 2. Barriers to accessing health services found in the articles selected in this scoping review, 2012 to 2022.

Source: Authors.

access to health for women, immigrants, Black, riverside, and Indigenous populations were also observed.

Studies in Colombia, Mexico, and Brazil, which evaluated access to breast and cervical cancer screening tests, concluded that there are more barriers to access for more impoverished women who live in rural/peripheral areas. In Mexico, they mentioned low education and lower economic level[24]. In Brazil, crossing the dimension of people with disabilities was mentioned[25].

Articles in Argentina and Brazil explore associations between improved socioeconomic conditions and access to health, highlighting the universality and capillarization of PHC services (cited by more than 50% of the articles). In Brazil, a study that verified the growth pattern of children in several national surveys concluded that there was a relationship between the reduction in socioeconomic inequalities and differences in children's height, stating that the promotion of income redistribution and universal access to education and health can positively impact the health of Brazilian children[26].

Regarding the limitations and gaps, we should underscore only one study on access for the homeless population, the low presence of studies on the effects of direct and indirect income transfer on access to health, and the negligible mention of popular participation/social control (found in only 1.52% of the articles). Some of the most frequent conclusions in the articles analyzed are the increased health expenditure and investments, strengthening of the universal system, structural and specific policies to reduce inequalities and promote the adaptation of health services to the population's health needs, and prioritization of preventive actions and equity actions. Furthermore, they highlighted the incentive to train health workers, and also investment in other sectors, such as education, work, pensions, and social assistance, which are ways to reduce social gaps and social exclusion to strengthen comprehensive health as a right for all.

Geospatial inequalities

Latin America is one of the regions with the highest urbanization rate in the world, with an increase of 240% from 1970 to 2000[23]. Marked by historical and structural inequalities, LA is characterized by an urbanization dynamic with a lack of planning and dysfunctional growth in large centers[23].

The scientific production that makes up this dimension was mainly concentrated in Brazil,

Colombia, Mexico, and Argentina in 2016, 2019, and 2020. The categorical analysis performed revealed a strong association between geospatial and socioeconomic inequalities (75.78%) and a moderate association with ethnic/racial (26.76%), gender (21.88%), and people with disabilities (5.47%) inequalities.

Thematically, articles in this dimension address inequalities in access to health between urban and remote/rural areas. Some focus on specific actions and services; others evaluate travel time to access health units. The main access barriers identified were geographic (68.75%), socioeconomic (54.69%), and availability of services (35.94%), probably due to the difficulty in obtaining specialized inputs and services in locations further away from large urban centers. Transportation and housing conditions stood out as conditioning factors for geospatial inequalities but with an extensive expression of income and education. A gap identified in this dimension was the problematic access by the population in peripheral areas, such as favelas.

Articles published in Brazil, Mexico, and Argentina discuss decentralized services as essential for expanding access. An Argentine study showed that proximity increases the number of visits and appointments and cited the importance of a quality transport network, concluding that health services must be adapted considering geographic accessibility[27].

In Brazil, an ecological study assessed that municipalities far from downtown areas had less access to secondary care services and less availability of primary care services. The results suggest that investment differences in these areas preserved inequalities between municipalities[28]. In Colombia, a study assessed that indirect payment for health services, such as transportation, worsens access for residents of more remote areas.

The conclusions of the articles reviewed in this dimension indicate the need for reorganization and structuring of health systems and services, with expanded offers in rural/remote regions and the outskirts of large centers and improvements in the quality of the provision of transportation.

Gender inequalities

Latin America has significant inequalities regarding gender, sexual division of power, and labor[23]. Women report worse self-reported health, more significant work overload in double shifts, and worse pay, even when performing the same tasks as men[23].

In this dimension, the revised production covers 12 Latin American countries. It addresses topics such as difficulties in accessing specific levels of care or services (PHC, oral health, mental health, and women's health) or care for prevalent pathologies (diabetes, arterial hypertension, and tuberculosis). The articles focus on inequalities in access between men and women, between women living in urban and rural areas, and the barriers faced by immigrants, Indigenous, and women deprived of their liberty. A negligible number of works addresses issues related to men's and trans men's health. Methodologically, case studies are the most frequent, followed by ecological secondary data-based studies.

As a structural feature of the history of LA, there is an association between gender and socioeconomic inequalities in a large proportion of the articles reviewed (72.22%). The associations between this dimension and ethnic/racial (38.89% of articles) and geospatial (37.04%) inequalities are also significant. Aspects of inequalities among people with disabilities appeared in 7.41% of the articles. Given that health inequalities are multifactorial and complex, such findings corroborate the hypothesis of interfaces between dimensions. Consequently, the main access barriers identified in this dimension were socioeconomic (50.0%), cultural (33.33%), availability of services (29.63%), and geographic (20.37%). Income (70.37%) and education (64.81%) were mainly mentioned as factors conditioning gender inequalities in access to health services.

In Brazil, Cuba, and Uruguay, articles investigated gender and racial inequalities in access to PHC during the COVID-19 pandemic, highlighting the greater use of services by women. Gender barriers in adolescents' access to sexual and reproductive health services were addressed in articles addressing cases from Chile, Mexico, and Venezuela. There is an emphasis on the influence of the patriarchal model on gender inequality in access to health, reinforcing the need for health services to review their practices and calling on society to deconstruct the hegemonic discourse that fosters such inequalities and asymmetry in power relationships[28].

The difficulties in accessing healthcare for women deprived of their liberty were highlighted in cases in Brazil and Peru. The access barriers faced by Indigenous women are the focus of a review of the cases of Mexico, Peru and Bolivia and a study in Guatemala. Immigrant women

also find more access barriers, as shown by studies conducted in Chile and Colombia. In Brazil, a study to evaluate access to cervical cancer screening in specific regions identified difficulties in access for women with some disability and lesbian women and women living in rural areas[29].

The conclusion of most articles included in this dimension suggests measures to improve access to the health system. However, some warn of the need for broader actions that promote the improvement of women's study and work conditions, their participation in politics, and the elimination of all forms of violence against women and girls.

Ethnic/racial inequalities

Ethnic/racial inequalities are an issue of utmost importance for the region due to its history of colonization, which was anchored in the exploitation of people. Indigenous and Black people were killed and enslaved, forming one of the groups that suffered most from inequality and exclusion.

The analysis of scientific production classified in this dimension shows a strong association between ethnic/racial and socioeconomic inequalities (78.8%), followed by geospatial (47.8%) and gender (29.58%). Consequently, the main access barriers identified were socioeconomic (53.52%), availability of services (28.17%), and cultural (23.94%). The main conditioning factors were income and education (tied for more than 75% of citations).

In this dimension, Brazil, Colombia, Mexico, and Chile were the countries with the highest number of publications, and the years with the most significant volume were 2016, 2019, and 2021. The most frequent themes involved the access of racialized populations.

The ethnic/racial approach highlighted the cultural barrier, which is little mentioned in other dimensions. Articles about Colombia showed inequalities in the Indigenous population's access to health services associated with the structured pluralism model of its health system. Access barriers related to geographic distance, communication problems, and cultural issues were listed as decisive in preventing access for Indigenous populations in Guatemala, generating distrust in care[30], which also appeared in articles about access for Indigenous women in Brazil, Muslims in Colombia, and immigrants in Chile.

A Brazilian cross-sectional study evaluated breast cancer screening coverage in the urban area of Teresina. It concluded that failure to undergo mammography was related to Black people, lower education and income, tobacco use, and not having insurance or health insurance. The SUS was responsible for performing 56.3% of mammograms. Racial and socioeconomic barriers are mentioned, emphasizing education as a condition of unequal access to this service[31]. Also worth mentioning is a study that compared data on the later start of prenatal care in Black women, along with a lower number of appointments.

The reviewed articles conclude that, in general, policies are needed to repair/reduce inequalities in access for the Black, Indigenous, and immigrant populations. They indicate that more equal access to health services in the future depends on the current implementation of public health, educational, cultural, and housing policies.

Inequalities in people with disabilities

In 2021, approximately 1.3 billion people lived with some disability[32], around 16% of the global population. In Latin America, around 85 million people have some disability, around 14.7% of the total population[33].

The analysis of articles categorized in this dimension indicates a strong association of this type of inequality with socioeconomic inequality (64.29%), followed by geospatial (50% of citations), gender (28.57%), and ethnic/racial (14.29 %). Consequently, the most frequent access barriers in this set are socioeconomic (in 50% of manuscripts), availability and architectural (42%), acceptability (35.71%), and cultural (14.29%). These findings confirm the need for policies that produce the integration of this population into health systems and services. Furthermore, the results suggest that socioeconomic support and access to education measures are fundamental, as income (71.43%) and education (51.14%) were also significant conditioning factors.

The studies included in this dimension mainly cover Brazil, Colombia, Chile, and Peru. Thematically, they address analyses of access by people with disabilities to mental health care, oral health, cervical-uterine cancer prevention, and child care. We underscore inequalities in access to PHC and rehabilitation services in Brazil and access difficulties for immigrants in Peru.

In the case of Colombia, we highlight a literature review that maps the difficulties in accessing the health system for people with disabilities and a systematic review that presents the dominant logic in the organization of services, indicating

that they continue to exclude and disregard the needs of this population[34]. It states that access to health services is hampered by administrative, technological, economic, physical, and social barriers, each of which overly affects this population group, hindering or preventing the improvement of quality of life and full integration into society[34].

A systematic review to evaluate access to health services for children with disabilities in Latin America focused on the cases of Brazil, Peru, and Colombia. The main barriers were motor difficulties, family vulnerability, low link between health services and the community, low supply of specialized services, lack of health information, inefficient referrals, late diagnosis of comorbidities, and lack of public policies and infrastructure. They conclude that demographic and socioeconomic factors hinder access and that it is necessary to reduce discrimination and political-social abandonment to promote equal rights[35].

In general, the articles in this dimension converge on the importance of knowing the number of people with some disability, qualifying the types of disability, their particularities, and needs in order to increase investments for adequate access for people to health services, including infrastructure, inputs, and supporting technology.

Chart 2 summarizes the inequalities in access to health services in Latin America and the most relevant data from the analysis in this scoping review. The complete descriptive analysis of the articles that make up this review is found in the master's thesis available at https://docs.google.com/document/d/1bjd7UYZ1D-mzBaSZ3o-6AxHgE_vpy-jU7Kz1gpX0xBIQ/edit?usp=sharing.

Chart 2. Summary of expressions of inequalities in access to health services in Latin America in this scoping review.

Expressions of inequalities in access to health services			
Dimensions of inequalities	**Definition**	**Characteristics recurrent in the articles reviewed**	**Barriers and factors that conditioned access inequalities**
Socioeconomic Inequality	Refers to the way and intensity with which socioeconomic inequalities influence access to health services. Income concentration and poverty are key factors for understanding the dynamics of health inequalities in this dimension[18,24,26].	Cross-sectional to other dimensions of inequalities. Associations between socioeconomic inequality and difficulty in accessing PHC, oral health, and women's health services stand out – notably more deficient among vulnerable populations. Several articles address restricted access to healthcare for immigrants, Black, riverine, and Indigenous populations.	*Main access barriers identified:* socioeconomic, geographic, services' availability, and cultural. *Main conditioning factors:* income and schooling, showing the relationship between lower education and worse socioeconomic status.
Geospatial Inequality	It concerns the way and frequency in which geospatial inequalities influence access to health services. Aspects such as inequalities in the distribution of health services in the territory stand out[27,28].	Strong association between geospatial and socioeconomic inequalities and moderate association with ethnic/racial and gender inequality. The inequalities in access to health between urban and remote/rural areas and the travel time to access health units stand out. Some articles focus on specific health actions and services, such as specialized care.	*Main access barriers identified:* geographic, socioeconomic, and services' availability. *Main conditioning factors:* Transportation and housing, with significant expression of income and schooling.

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Chart 2. Summary of expressions of inequalities in access to health services in Latin America in this scoping review.

Expressions of inequalities in access to health services			
Dimensions of inequalities	**Definition**	**Characteristics recurrent in the articles reviewed**	**Barriers and factors that conditioned access inequalities**
Gender Inequality	Related to the way and intensity with which gender inequalities influence access to health services[19,29].	Strong association between gender and socioeconomic inequalities in most of the articles reviewed. Significant association between this dimension and ethnic/racial and geospatial inequalities. The inequalities in access between men and women, among women living in urban and rural areas, and the barriers faced by immigrant, Indigenous, and women deprived of liberty stand out.	*Main access barriers identified:* socioeconomic cultural, services' availability, and geographic. *Main conditioning factors:* income and schooling.
Ethnic/racial Inequality	It expresses how race/ethnicity issues influence access to health services[30].	Strong association between ethnic/racial and socioeconomic inequalities. Moderate association with geospatial and gender inequality. Studies that address access difficulties for original and racialized populations in Latin America and immigrants stand out. Some articles focus on how communication problems and cultural issues prevent access to health services.	*Main access barriers identified:* socioeconomic de services' availability, and cultural. Highlighting the cultural barrier, rarely mentioned in other dimensions. *Main conditioning factors:* income and schooling.
Inequalities in People with Disabilities	Gathers studies that address the inequalities faced by people with disabilities in accessing health services[33-35].	Strong association with socioeconomic inequalities and moderate association with geospatial and gender inequalities. Articles focusing on the difficulties in accessing mental health care, oral health, cervical-uterine cancer prevention and child care stand out for people with disabilities.	*Main access barriers identified:* socioeconomic, services' availability, architectural, acceptability and cultural barriers. *Main conditioning factors:* income and schooling, highlighting the importance of improving accessibility in schools.

Source: Authors.

Final considerations

This work aimed to understand the expressions of inequalities in access to health services in 20 Latin American countries through a scoping review that included 272 articles published from 2012 to 2022. Despite the differences between these countries, were identified similar access barriers and conditioning factors for health inequalities, which may be related to common history and structural contexts.

Socioeconomic inequality is a structural condition of access to health services in all dimensions studied. This finding is consistent with the Latin American context and reinforces the importance of comprehensive and intersectoral policies. Inequalities are expressed through the combination of barriers and factors that create unequal possibilities of accessing health services. The access barriers in health services reflect the different dimensions of inequalities. The population's income and education are the main factors conditioning the most diverse inequalities in access to health services. Higher income was associated with higher education, greater recognition of health needs and access to health services. The more vulnera-

ble the population, the less their needs and access to health services are recognized. In most cases, transportation and housing conditions were also associated with income and education.

The object of this article is scientific production on inequalities in access to health services in Latin America, recognizing as a limit the circumscription of what was published in the period analyzed. There may be gaps related to the lack of works that deviate from the canonical interpretation. Furthermore, LA has heterogeneous health policies and systems, with fragmented, mixed systems and public-private relationships that make access analysis even more complex. In the selected documents, we observed a gap in popular participation/social control and the approach to the right to health.

Stimulating spaces for knowledge production and social participation, and the understanding that access to health must be a right for all citizens is vital to consolidating a social base to strengthen public policies and health systems. It is an ethical, political, social, and economic commitment to reduce inequalities in all dimensions, and to this end, coordinated policies and actions on different fronts are fundamental.

Collaborations

TS Oliveira and AMM Pereira participated in the manuscript's design, drafting, and review.

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Article submitted 05/05/2023
Approved 01/02/2024
Final version submitted 22/03/2024

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva