Achieving health equity in Ecuador

We welcome the Comment by Irene Torres and Daniel López-Cevallos (August, 2018)[1] as an opportunity to expand on the structural challenges associated with seeking health equity in Ecuador. Although we generally agree with the authors, the Comment does not depict the roles of the public and private sectors with regard to health-care delivery.[2] We believe further discussion about reaching health equity without addressing the diversity of actors and contexts at play becomes superficial. By ignoring the heterogeneous locality-specific health dynamics, we fall into simplifying the complexity of the system. We argue that this oversimplification can be detrimental for the consolidation of long-standing processes that have resisted a homogenising model (eg, indigenous movements that have tried to conserve their historical practices) and have shaped more inclusive legislation and practices in past decades.[3] For instance, in the rural provinces of Imbabura and Chimborazo, initiatives to tackle maternal mortality have brought together public servants and civil society to work in innovative ways.[4]

Although Ecuador's health system remains segmented and fragmented, depending on who is trying to access health care, citizens do not simply bear the consequences of an exclusionary model. In practice, people navigate the system actively in ways that challenge traditional health-care models from inside and outside public health-care institutions. One example is the nationwide incorporation of delivery rooms adapted for vertical birth[5]—a result of collaborative work between different groups to expand hospitals' attention to local populations and comply with women's rights to choose their delivery position. Such initiatives were built upon current legislation regarding maternity and intercultural rights. They represent local initiatives that are crucial to advancing the process of achieving health equity in Ecuador, acknowledging local expertise of different actors and networks within which they negotiate and shape these changes. We suggest that structural changes in health systems benefit from legislation and policy changes but also from more stable processes of learning and adaptation among actors and institutions.

Efforts to reform the traditionally fragmented, vertical, and centralised health-care model, in both legislation and practice, have been made by third-sector organisations, social movements, and the state (eg, the Comprehensive Health-Care Model [MAIS] with a Family, Community and Intercultural Approach,[6] created in 2012 to expand on the traditional biomedical model). However, these efforts must be sustained and improved to better address structural challenges contributing to health inequity.

Changing Ecuador's exclusionary model of health necessitates recognition of the agency of the different actors shaping the system inside and outside the public sector. Criticisms addressing a homogeneous system reinforce a centralised, one-size-fits-all model. To successfully deliver the proposed community-based equity system approach suggested by Torres and López-Cevallos,[1] the multiple factors configuring these particular contexts must be taken into account.

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