

Health-Related Stigma and Healthcare Inequality: A Systematic Review of Psychological Consequences, Access Barriers, and Intervention Strategies

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Abstract

Health-related stigma can shape healthcare inequality through more than overt discrimination. Anticipated rejection, internalized devaluation, stigmatizing clinical encounters, institutional practices, and structurally unequal conditions may influence psychological well-being, help-seeking, access, communication, diagnostic processes, treatment engagement, and continuity of care. These processes are often studied separately, limiting understanding of how stigma operates across levels. This systematic review was structured according to PRISMA 2020 reporting principles and used a prespecified 2017–2026 evidence window. Evidence was classified by stigma level, healthcare-inequality outcome, study design, population, setting, and intervention target. Because clinical, qualitative, observational, experimental, implementation, and review evidence addressed heterogeneous constructs and outcomes, synthesis emphasized structured comparison rather than unsupported quantitative pooling. Numerical review-flow counts were not reconstructed where source-level retrieval and deduplication data were unavailable. The literature consistently distinguished experienced, anticipated, internalized, interpersonal, healthcare-organizational, and structural forms of stigma, although measurement practices varied substantially. Psychological consequences were most consistently documented for depressive symptoms, distress, identity threat, and internalized stigma. Healthcare consequences included delayed or avoided care, impaired trust, burdens associated with disclosure and identity management, stigmatizing documentation, poorer communication, and barriers embedded in organizational or structural conditions. Effects were strongly conditioned by population, illness context, visibility of the stigmatized characteristic, social support, institutional arrangements, and intersecting disadvantage. Health-related stigma is better understood as a multilevel inequality process than as a single individual exposure. Its consequences can emerge through psychological burden and through constrained healthcare opportunity, and these pathways may converge, diverge, or reinforce one another. Intervention strategies therefore require explicit alignment between the level at which stigma is generated and the level at which change is attempted.

Keywords: Health-related stigma, Healthcare inequality, Structural stigma, Healthcare discrimination, Help-seeking, Patient experience

Introduction

Health-related stigma has increasingly been conceptualized as a process distributed across

individuals, relationships, organizations, communities, and structural environments rather than as a fixed negative attitude held by one person toward another. Cross-condition frameworks distinguish stigma drivers and marking processes from subsequent manifestations such as experienced discrimination, anticipated rejection, internalization, and structural disadvantage, while intersectional approaches emphasize that stigmatized identities and social positions do not operate independently. Structural-stigma scholarship further locates disadvantage within laws, policies, institutional

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arrangements, cultural norms, and resource distributions that can shape exposure to risk and access to protection [1-3].

This broader framing is important because measurement remains fragmented. A recent systematic review identified extensive variation in definitions, instruments, adaptations, and targeted populations, demonstrating that studies labeled as measuring “stigma” may in fact capture different psychological, interpersonal, or structural phenomena [4]. Such heterogeneity affects interpretation: a scale assessing internalized devaluation does not measure discriminatory treatment, and neither directly demonstrates organizational exclusion.

Psychological consequences are similarly heterogeneous. Anticipated and internalized stigma are frequently associated with depression, but longitudinal evidence is less uniform than cross-sectional evidence, cautioning against assuming a single directional psychological mechanism [5]. Within healthcare, perceived discrimination has also been associated with delayed care among people managing chronic conditions, illustrating that stigma-related experiences can extend beyond emotional distress to behavioral and service-use consequences [6].

Intervention evidence reinforces the importance of level discrimination. Reviews of multilevel stigma-reduction programs show that interventions simultaneously targeting individuals, healthcare workers, organizations, and structural conditions remain less common than interventions concentrated at one level [7]. The present review therefore examines stigma as an inequality-generating process linking psychological consequences, healthcare avoidance, access constraints, care-process differences, and intervention opportunities. Its central analytical task is to distinguish where stigma is located, what outcome is being measured, and what inference is warranted from each type of evidence.

Materials and Methods

The review was designed as a structured systematic synthesis of peer-reviewed literature published from 2017 through 2026. Eligible evidence addressed health-related stigma in relation to psychological consequences, healthcare-seeking behavior, access or utilization, quality of care, treatment processes, structural inequality, or stigma-reduction intervention strategies. Evidence was organized before interpretation by stigma form, analytic

level, population, healthcare setting, outcome domain, study design, and intervention target.

Because the evidence base included qualitative studies, cross-sectional and cohort analyses, randomized experiments, implementation studies, systematic reviews, and theoretical syntheses, designs were not treated as interchangeable. Descriptive findings were separated from causal interpretation, and evidence concerning psychological states was distinguished from observed behavior, healthcare-process outcomes, and clinical outcomes.

Protocol and reporting standard

Reporting was structured around PRISMA 2020 principles, including transparent differentiation of identification, screening, eligibility, and inclusion stages [8]. Selection numbers were not inferred from the final bibliography. Where complete source-level export and deduplication records were unavailable, numerical PRISMA values were treated as non-reportable rather than retrospectively reconstructed.

Eligibility criteria

Eligible sources were peer-reviewed publications from 2017–2026 examining health-related stigma or discrimination in a healthcare-relevant context. Studies were considered when they examined at least one of the following: experienced, anticipated, internalized, interpersonal, organizational, or structural stigma; psychological consequences; healthcare avoidance or delayed help-seeking; access or utilization constraints; treatment or diagnostic consequences; patient–professional interactions; intersectional inequality; or stigma-reduction interventions.

Empirical qualitative, observational, longitudinal, experimental, and implementation studies were eligible alongside systematic or integrative reviews when the latter contributed construct definition, measurement appraisal, intervention synthesis, or evidence-boundary analysis. Evidence was not considered interchangeable across designs, and review-level conclusions were not used as substitutes for primary evidence when a direct behavioral or care-process claim required primary data.

Information sources and search strategy

Search concepts were organized around four intersecting families: stigma constructs, healthcare inequality outcomes, stigmatized conditions or populations, and intervention or implementation concepts. Stigma terms

incorporated discrimination, anticipated stigma, internalized stigma, healthcare stigma, provider stigma, structural stigma, stereotype threat, stigmatizing language, and intersectional stigma. Healthcare terms captured access, avoidance, delayed care, utilization, trust, communication, diagnostic processes, treatment engagement, retention, patient experience, and quality of care.

Searches additionally targeted population- and condition-specific literatures in which healthcare stigma has been extensively studied, including HIV, higher body weight, substance-use disorders, mental illness, LGBTQ+ and transgender healthcare, persistent physical symptoms, and Long COVID. Search outputs were screened for direct relevance rather than topical proximity alone.

Study selection

Potential sources were evaluated against the eligibility framework at title, abstract, and source level where retrievable. Selection prioritized evidence capable of resolving the review's central distinctions: stigma form, location of the stigmatizing process, measured consequence, affected population, healthcare context, and inferential strength.

The available search record did not retain a complete export-level universe permitting valid reconstruction of total retrieval, duplicate removal, screening exclusions, and full-text exclusion reasons. Accordingly, no retrospective numerical flow was generated. This restriction prevents false precision but also limits conventional PRISMA count reporting.

Data extraction

Extraction fields included evidence-source design; population or analytical unit; health condition or stigma target; country and healthcare setting; conceptual stigma construct; determinant, exposure, or intervention; comparator where relevant; operationalization or measurement approach; healthcare-inequality outcome;

principal finding; direction or heterogeneity; contextual and equity modifiers; reported quality or risk-of-bias information; study limitations; and relevance to the review's analytical domains.

Source-reported findings were kept separate from interpretive synthesis. Missing variables were not imputed from surrounding literature.

Stigma-level classification

Stigma classification required more than identifying a stigmatized population. Structural LGBTQ+ health research, for example, distinguishes objective policy, institutional, and community-level conditions from personal experiences of rejection or discrimination [9]. A socioecological account extends this distinction by proposing that stigma can operate through nested systems and across time, with individual responses partly conditioned by interpersonal and structural environments [10]. Quantitative structural-stigma research nevertheless remains methodologically uneven, particularly in causal identification, exposure measurement, mediation analysis, and geographic generalizability [11].

Healthcare encounters add another level. Stigma may be enacted through clinician behavior or become embedded in documentation practices. Studies of medical records have identified stigmatizing language reflecting negative judgments about patients, differences in how such language is distributed across groups, and associations between stigmatizing documentation, social disadvantage, and diagnostic-process problems [12-14]. These findings justify distinguishing interpersonal enactment from organizationally persistent documentation while avoiding the stronger claim that stigmatizing wording alone causes downstream clinical harm.

The crosswalk below is required because identical downstream outcomes can arise from analytically different stigma processes (**Table 1**).

Table 1. Distinguishing stigma location from the inference that can legitimately be drawn from it

Stigma form	Primary locus	Minimum evidence needed for classification	Common interpretive confusion	Healthcare-inequality consequence most directly assessable	Interpretation boundary
Experienced stigma	Encounter or social interaction	Reported or observed discriminatory treatment	Conflated with anticipation of future treatment	Immediate communication, trust, avoidance, perceived care quality	Experience does not alone establish institutional causation

Anticipated stigma	Expectation before an encounter or disclosure	Expectation of rejection, judgment, or mistreatment	Treated as if discrimination has already occurred	Delayed help-seeking, concealment, avoidance, altered disclosure	Expectations may arise from prior experience, social learning, or both
Internalized stigma	Self-evaluation and identity	Adoption of devaluing social meanings into self-appraisal	Misclassified as a personality characteristic	Distress, shame, self-efficacy, treatment engagement	Internalization does not remove the social origin of devaluation
Interpersonal or clinical enactment	Patient–professional relationship	Observable communication, conduct, judgment, or differential treatment	Reduced to patient perception alone	Communication quality, diagnostic interaction, treatment relationship	Unequal treatment requires contextual interpretation
Organizationally embedded stigma	Healthcare routines and institutional practices	Repeated institutional pattern, workflow, documentation, environment, or resource constraint	Treated as isolated clinician bias	Access, continuity, care-process consistency	Organizational pattern may interact with broader structural conditions
Structural stigma	Policy, institutional, legal, or sociocultural environment	Evidence of systematically unequal conditions beyond individual encounters	Inferred solely from individual attitudes	Availability, accessibility, exposure to exclusion, population-level opportunity	Structural association requires careful causal and geographic interpretation

Note: The crosswalk is the review's proposed evidence–interpretation classification and does not imply that stigma levels form a fixed temporal sequence.

Healthcare-inequality outcome classification

Healthcare inequality was classified separately from stigma exposure. Access referred to the practical ability to obtain suitable services; utilization referred to actual service use; avoidance and delay represented behavioral responses that could occur despite nominal service availability; quality of care concerned what occurred after entry into care; and clinical outcomes were treated as still further downstream.

This distinction matters because an association between discrimination and delayed care does not demonstrate the same mechanism as an association between stigma and reduced trust, and neither necessarily explains a clinical endpoint. Outcomes were therefore mapped to the closest directly measured healthcare process before considering possible connections across domains.

Quality / risk-of-bias assessment

Quality interpretation was design-sensitive. Systematic reviews were assessed according to their search transparency, construct consistency, study-quality procedures, and handling of heterogeneity. Observational studies were interpreted with attention to sampling, temporality, confounding, exposure measurement, and outcome ascertainment. Qualitative studies were evaluated primarily for appropriateness of sampling, analytic transparency, contextual depth, and fit between

data and interpretation. Experimental evidence received greater weight for immediate causal effects of assigned communications or interventions but was not assumed to demonstrate durable behavior or system-level change.

Synthesis methods

Because the literature differed substantially in stigma construct, population, health condition, measurement instrument, healthcare setting, intervention target, and outcome, quantitative pooling across the entire evidence base was neither conceptually nor statistically appropriate. The synthesis therefore followed structured synthesis principles consistent with SWiM guidance, emphasizing transparent grouping of evidence and explicit reporting of heterogeneity rather than generation of an artificial pooled estimate [15].

Evidence was synthesized across four linked questions: what form of stigma was observed; at what level it operated; which psychological or healthcare inequality outcome was measured; and which contextual conditions altered interpretation. Proposed cross-level relationships were reserved for the Discussion rather than presented as empirical Results.

Results and Discussion

The evidence showed substantial consistency in one respect: health-related stigma was rarely reducible to a single level. Across conditions, psychological responses, interpersonal encounters, institutional practices, and structural environments appeared in different combinations. However, the relative prominence of each process varied markedly by population, visibility of the stigmatized characteristic, healthcare setting, and measurement approach.

Study selection

Selection emphasized evidentiary relevance to the relationship between stigma and healthcare inequality rather than mere inclusion of a stigma measure. Evidence addressing only public attitudes without a healthcare, psychological, behavioral, or structural consequence was less informative for the review's central question than studies linking stigma to care-seeking, clinical encounters, organizational processes, or measurable psychological outcomes.

No numerical denominator is reported because the retained search materials do not permit arithmetic reconciliation from identification through final inclusion.

Study characteristics

The evidence covered markedly different populations and care environments. Sexual and gender minority research demonstrated that healthcare discrimination could be associated with avoidance and that identity discordance between patients and clinicians could become relevant to decisions about seeking care [16]. Among transgender women, intersectional discrimination was associated with both mental-health burden and healthcare-access disadvantage, illustrating why single-axis interpretations are often inadequate [17]. Access to gender-affirming medical care also depended on more than formal availability. Healthcare stereotype threat and social support were associated with actual use of desired services, suggesting that anticipated judgment and relational protection may operate simultaneously [18]. In Long COVID, qualitative evidence described delayed recognition, contested legitimacy, and barriers intensified by wider social disadvantage [19]. Similarly, persistent physical symptoms and functional disorders frequently involved stigmatizing clinical encounters in which legitimacy, credibility, and clinician interpretation became central [20].

These differences make a simple “stigma present versus absent” classification analytically insufficient. **Table 2** instead maps recurring conditions that altered how stigma could translate into healthcare inequality.

Table 2. Multilevel conditions shaping whether stigma becomes a healthcare constraint

Relational or system condition	Where the constraint enters care	Process made visible by the reviewed evidence	Context that can intensify or buffer it	Main competing explanation	Consequence most relevant to this review
Identity visibility or disclosure	Before or during entry to care	Anticipation of judgment changes disclosure or service choice	Social support, prior discrimination, perceived identity concordance	General mistrust unrelated to stigma	Avoidance, concealment, delayed access
Credibility of symptoms or illness	Clinical encounter	Patient account is discounted, moralized, or treated as illegitimate	Diagnostic uncertainty, contested illness categories	Ordinary diagnostic uncertainty	Repeated consultations, distress, disrupted continuity
Clinician recognition and communication	Patient–professional relationship	Language and interaction communicate respect or devaluation	Training, workload, cultural competence, institutional norms	Communication failure without stigma	Trust, disclosure, engagement
Documentation environment	Clinical and organizational interface	Judgment becomes persistent within the record and may travel across encounters	Record-sharing practices and organizational culture	Neutral shorthand or disease-severity documentation	Repeated exposure to biased framing
Practical accessibility	Organizational or structural level	Services, pathways, equipment, or policies fit some patients better than others	Geography, resources, policy, institutional design	General service scarcity	Unequal availability or usability of care

Relational protection	Across care pathway	Support, trust, and affirming relationships reduce the practical impact of anticipated stigma	Continuity, advocacy, social networks	Baseline differences in healthcare engagement	Greater willingness to seek and remain in care
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Note: Rows describe recurring analytical conditions rather than a ranked causal sequence.

Stigmatized conditions and populations

Weight-related stigma illustrates the importance of separating social exposure from internal psychological processes. Weight-bias internalization has been consistently associated with poorer mental-health outcomes, but it is not equivalent to experienced discrimination [21]. Broader reviews of weight stigma report associations with both psychological and physiological outcomes while emphasizing substantial variation in study design and measurement [22]. Proposed pathways include stress responses, altered health behavior, and healthcare avoidance, but individual mechanisms are not equally established across outcomes [23].

Within obesity care, stigma can affect communication, perceived respect, and willingness to seek treatment [24].

Qualitative patient accounts further show that healthcare experiences are not uniformly stigmatizing: participants describe demeaning or embarrassing encounters alongside affirming interactions, underscoring the importance of relational and organizational context [25]. Other literatures show different configurations. LGBTQ+ and transgender healthcare often foreground identity safety, disclosure, structural exclusion, and access to specialized care. HIV-related stigma may involve disclosure, anticipated rejection, internalization, and trust in care. Persistent physical symptoms and Long COVID foreground contested legitimacy. Substance-use and mental-health stigma frequently involve moral judgment, assumptions regarding responsibility, and provider attitudes. These patterns overlap, but they are not interchangeable (**Table 3**).

Table 3. Why stigmatized populations cannot be collapsed into a single healthcare-stigma category

Condition or population context	Stigma process especially salient in the reviewed literature	Healthcare inequality locus	Distinct measurement problem	Contextual boundary that must remain visible
LGBTQ+ and transgender populations	Identity disclosure, stereotype threat, interpersonal and structural stigma	Access, avoidance, specialized-care availability, relational safety	Structural exposure and personal discrimination are often measured separately	Legal, geographic, policy, and social-support environments vary substantially
People living with HIV	Anticipated, internalized, experienced, and disclosure-related stigma	Testing, engagement, trust, retention, treatment relationship	Stigma may be condition-specific or intersect with sexuality, race, gender, or poverty	Effects differ across epidemic, community, and health-system contexts
Higher-weight patients	Experienced and internalized weight stigma	Communication, dignity, obesity-care access, clinical environment	Weight bias, internalization, discrimination, and identity threat are distinct constructs	Clinical advice may be simultaneously useful and stigmatizing
Long COVID and persistent physical symptoms	Credibility and legitimacy stigma	Diagnostic recognition, referral, continuity, patient–clinician relationship	Stigma can be difficult to distinguish from uncertainty surrounding diagnosis	Evolving disease knowledge changes interpretation over time
Substance-use disorders	Moralized provider and institutional stigma	Treatment quality, communication, treatment willingness, service pathways	Attitudes do not necessarily predict clinical behavior	Substance type and professional role influence observed stigma

Mental illness	Public, provider, institutional, and internalized stigma	Help-seeking, communication, treatment engagement	Knowledge, attitudes, intended behavior, and enacted behavior are separate outcomes	Intervention effects on attitudes may not persist or transfer to practice
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Note: The matrix is a construct-discrimination device; it does not infer psychological states from membership in any population.

Experienced, anticipated, internalized, and structural stigma

Experienced stigma refers to actual discriminatory or devaluing encounters, whereas anticipated stigma concerns expectations that such treatment will occur. Internalized stigma describes incorporation of stigmatizing social meanings into self-appraisal. Structural stigma concerns patterned disadvantage generated through institutional, policy, legal, cultural, or resource arrangements. These forms can coexist without forming a mandatory sequence.

A patient may anticipate mistreatment without experiencing discrimination during a particular visit; conversely, repeated discriminatory encounters can alter future expectations. Internalization may intensify psychological consequences but cannot be understood as evidence that stigma has become solely an individual problem. Structural conditions can shape which encounters occur, what services exist, which identities are protected, and how easily patients can change providers or institutions.

The central analytical implication is therefore reciprocal rather than linear: experiences can affect expectations; expectations can alter disclosure and help-seeking; institutional environments can influence both; and patient responses can change subsequent exposure to healthcare settings. Evidence concerning one component should not automatically be used to infer all others.

Psychological consequences

Psychological effects represent one of the most consistently documented consequences of stigma, but they vary according to the construct measured. Depression, psychological distress, shame, diminished self-worth, stereotype threat, and internalized stigma appear across several condition-specific literatures. Associations between anticipated or internalized stigma and depression are common, although longitudinal findings are less consistent than cross-sectional results, leaving temporal direction and reciprocal effects incompletely resolved.

Healthcare itself can become a setting in which psychological burden is produced or reinforced. Among

Black women living with HIV, experienced stigma in healthcare was associated with internalized and anticipated stigma and with reduced trust in HIV care, illustrating how an encounter-level exposure may coexist with intrapersonal and relational consequences [26]. Such evidence is compatible with a cross-level pathway but does not establish a universal causal chain.

Psychological consequences may also influence subsequent healthcare behavior, creating the possibility of feedback between distress and healthcare exposure. Fear of judgment can increase vigilance before future encounters; internalized devaluation can alter willingness to advocate for oneself; identity threat can make otherwise routine communication feel unsafe; and mistrust can reduce confidence that disclosure will produce respectful treatment. At the same time, patients may maintain engagement despite stigma through social support, trusted clinicians, continuity, advocacy, or practical necessity. The evidence therefore supports psychological burden as a consequential domain of health-related stigma while requiring caution against treating distress as an inevitable response or as the sole pathway through which healthcare inequality develops.

Help-seeking and healthcare avoidance

Stigma can affect healthcare before a clinical encounter occurs. Anticipated judgment, uncertainty about confidentiality, fear of disclosure, or expectations of disrespect may alter whether patients seek care, where they seek it, and what information they disclose. These processes should not be interpreted as simple unwillingness to engage with healthcare because avoidance may represent an attempt to reduce exposure to perceived interpersonal or institutional threat.

HIV research illustrates the interaction between stigma and relational conditions. In a US population study, avoidance-oriented HIV stigma was associated with lower testing likelihood particularly when trust in healthcare professionals was low [27]. Trust therefore cannot be treated merely as a downstream consequence of stigma; it may also modify whether stigmatizing expectations translate into behavior. Similar conditionality is plausible in other healthcare contexts,

although it should not be generalized without direct evidence.

Avoidance may also be partial rather than absolute. Patients may delay appointments, selectively disclose information, seek alternative providers, avoid stigmatized services while maintaining other healthcare, or attend care while remaining psychologically guarded. Consequently, utilization counts alone may underestimate the burden created by stigma.

Access and utilization barriers

Access inequalities extend beyond decisions made by individual patients. An integrative review of retention in HIV care identified stigma among a wider set of interacting patient, relational, organizational, and structural barriers [28]. This supports a multicausal interpretation in which stigma can compound transportation difficulties, fragmented services, financial constraints, competing responsibilities, or mistrust rather than independently determining disengagement.

Qualitative work with gay and bisexual men similarly describes stigma management as additional “patient work.” Participants reported having to evaluate whether services were safe, decide what identities or behaviors could be disclosed, anticipate judgment, and manage prior negative encounters while attempting to obtain ordinary healthcare [29]. Such labor is analytically important because equal formal availability of services does not guarantee equal usability.

The distinction between access and utilization should therefore remain explicit. A service may exist but remain difficult to use because of language, geography, cost, inaccessible equipment, identity-safety concerns, restrictive policies, or anticipated mistreatment. Conversely, continued utilization does not demonstrate the absence of stigma when care is medically necessary or alternatives are unavailable.

Quality-of-care and treatment consequences

Once patients enter care, stigma can influence communication, diagnostic interpretation, treatment relationships, and continuity. Stigmatizing clinical language is especially important because documentation can extend judgments beyond a single encounter. Descriptors introduced by one clinician may be available to subsequent professionals and may therefore contribute to an organizational memory of the patient.

However, documentation studies require careful interpretation. The presence of stigmatizing language

does not prove that every subsequent clinical decision is biased, while associations between such language and diagnostic errors do not establish a simple causal pathway. More defensible interpretation recognizes documentation as one observable marker of a potentially wider relational and organizational process.

Treatment consequences are similarly heterogeneous. Some evidence connects healthcare stigma with mistrust, reduced engagement, disclosure difficulty, or adherence-related outcomes, but these relationships are embedded in disease severity, treatment burden, resource availability, continuity, and social support. Stigma should therefore be treated as one determinant within a broader care ecology rather than as a universal explanation for treatment differences.

Intersectional and structural inequalities

Intersectionality alters both exposure to stigma and the resources available for responding to it. Patients may simultaneously occupy social positions associated with racism, sexism, poverty, disability, sexual or gender minority status, stigmatized illness, or body-size discrimination. These conditions cannot reliably be represented by simply adding independent stigma scores because institutional arrangements may make particular combinations of identity more consequential than others. Structural stigma further shifts analysis away from interpersonal prejudice alone. Laws, policies, funding priorities, service distribution, institutional routines, physical environments, record systems, and prevailing cultural expectations can shape who encounters barriers before any identifiable discriminatory interaction occurs. Structural weight-stigma research, for example, identifies healthcare policies, equipment, professional roles, and organizational environments as potential sources of unequal care [30].

Structural evidence nevertheless presents methodological difficulties. Geographic measures can be crude, policy exposures may change over time, individual mobility can complicate exposure classification, and structural conditions often correlate with other forms of disadvantage. Stronger structural analysis therefore requires temporal precision, explicit causal assumptions, and measurement strategies capable of separating stigma-related structures from adjacent inequalities.

Stigma-reduction interventions

Intervention design should correspond to the level at which stigma is produced. Facility-level HIV initiatives demonstrate one approach in which awareness, contact, skills development, institutional participation, and organizational action are combined rather than relying solely on patient coping or individual clinician education [31]. Such approaches are important because they redistribute responsibility for change toward the healthcare environment.

Evidence directed at healthcare professionals is more developed but remains heterogeneous. A randomized trial found that visual campaigns and narrative vignettes could reduce addiction stigma among healthcare professionals, while systematic-review and national provider-survey evidence indicates that substance-use stigma is widespread, varies by substance and professional context, and is associated with some clinical practice patterns [32-34]. These findings support intervention potential but do not establish that short-term attitude change automatically produces sustained changes in treatment behavior.

Intervention effectiveness and implementation

Educational approaches targeting mental-illness stigma among healthcare professionals and students show measurable improvement in some attitude-related outcomes, although effects on knowledge, behavior, durability, and patient experience are less consistent [35]. This distinction is central to implementation: an intervention can improve a questionnaire score without changing how patients are spoken to, documented, diagnosed, referred, or treated.

Broader stakeholder syntheses identify strategies operating at patient, family, professional, organizational, community, and structural levels [36]. The diversity of strategies suggests that intervention effectiveness should not be framed as a competition for one universally superior method. Contact-based approaches, education, policy reform, workflow redesign, communication

training, environmental modification, and accountability mechanisms address different determinants.

Implementation assessment should therefore examine reach, fidelity, durability, workforce participation, organizational reinforcement, patient-reported experience, and unintended effects in addition to immediate stigma scores.

Evidence gaps

Several gaps recur across the evidence base. First, stigma measurement remains considerably more developed at the individual and interpersonal levels than at organizational and structural levels. Second, many studies are cross-sectional, limiting inference about whether stigma precedes psychological distress, avoidance, mistrust, or treatment disruption. Third, intervention evidence frequently concentrates on attitudes rather than patient-level care processes or long-term organizational change.

Policy research also reveals unresolved tensions. Weight-stigma reduction, for example, must navigate competing public-health framings, clinical objectives, and weight-inclusive approaches without assuming that one communication strategy is universally non-stigmatizing [37]. Structural weight-stigma evidence further shows that exclusion can be embedded in healthcare environments and institutional arrangements rather than only in explicit provider attitudes [30].

A further boundary is illustrated experimentally by weight-loss counselling: advice framed as clinically beneficial can increase motivation while simultaneously increasing weight-based identity threat [38]. This coexistence of potentially beneficial and stigmatizing effects challenges binary classifications of communication as either supportive or harmful.

Table 4 translates these gaps into implementation and validation decisions rather than treating them as a generic research agenda.

Table 4. Evidence gaps as decisions about what must be measured, changed, and validated next

Unresolved state	What current evidence can support	What remains uncertain	Implementation decision	Minimum useful validation
Individual stigma scales dominate measurement	Psychological and perceived-experience associations can be described	Whether organizational and structural exposure is adequately captured	Add level-specific measures rather than enlarging one global stigma score	Convergent validity across patient, organizational, and structural indicators

Cross-sectional association dominates a domain	Correlation and patterning can be estimated	Temporal direction, feedback, and mediation	Avoid causal intervention logic based only on cross-sectional pathways	Longitudinal or quasi-experimental testing
Provider attitudes improve after training	Immediate attitudinal responsiveness can be demonstrated	Whether behavior, documentation, referral, or patient experience changes	Pair education with observable care-process outcomes	Follow-up including patient-reported and behavioral measures
Structural constraint is identified	Institutional conditions can be mapped	Which component is causally influential	Target policy, workflow, environment, or resource allocation explicitly	Comparative implementation across settings or policy changes
Clinical communication has mixed effects	Advice may motivate while generating identity threat	Which framing preserves benefit without stigma-related harm	Test alternative communication strategies rather than assuming neutrality	Patient-centered experimental and real-world replication
Intervention works in one population or setting	Local feasibility or effectiveness can be supported	Transferability across cultures, conditions, and health systems	Adapt before scale-up	Replication with contextual and equity modifiers measured

Note: The register identifies evidence-to-decision requirements; it does not rank interventions or assign unvalidated effectiveness scores.

The reviewed literature supports a multilevel account of healthcare stigma but does not support a universal causal sequence. Psychological burden, anticipation of mistreatment, interpersonal discrimination, organizational practices, and structural exclusion can occur separately or together. Their effects depend on illness characteristics, identity visibility, available alternatives, continuity of care, social support, policy environment, and institutional power.

A central synthesis is that healthcare inequality can arise through at least two distinguishable processes. One involves psychological and relational consequences: stigma can alter identity threat, distress, trust, disclosure, and expectations surrounding future encounters. The other involves constrained healthcare opportunity: institutional routines, inaccessible services, discriminatory treatment, documentation practices, and structural conditions can alter what care is available or how it is delivered. These processes may converge—for example, when prior discrimination reduces trust in an already difficult-to-access service—but neither should be assumed to mediate the other in every case.

This distinction also prevents inappropriate individualization. When barriers originate in organizational practices or policy, interventions directed only at resilience, coping, or patient communication may leave the source of inequality intact. Conversely,

structural reforms do not automatically eliminate interpersonal or internalized consequences accumulated through previous experiences.

Integrated stigma–inequality pathways

The review therefore proposes a paired-process interpretation of stigma-related healthcare inequality. The first process concerns psychosocial burden, including anticipated judgment, internalization, distress, identity threat, reduced trust, guarded disclosure, and altered expectations. The second concerns constrained healthcare opportunity, including discriminatory encounters, communication failures, stigmatizing documentation, service inaccessibility, organizational routines, and structural exclusion.

The two processes can converge when psychosocial burden makes an already constrained service more difficult to use; diverge when patients maintain engagement despite substantial psychological burden; or operate reciprocally when negative encounters alter expectations that subsequently shape disclosure and future service use. Protective relationships, social support, affirming clinicians, continuity, and accessible institutions can interrupt these patterns without necessarily removing every form of stigma.

Figure 1 represents this synthesis as a bounded reciprocal field rather than a deterministic pathway.

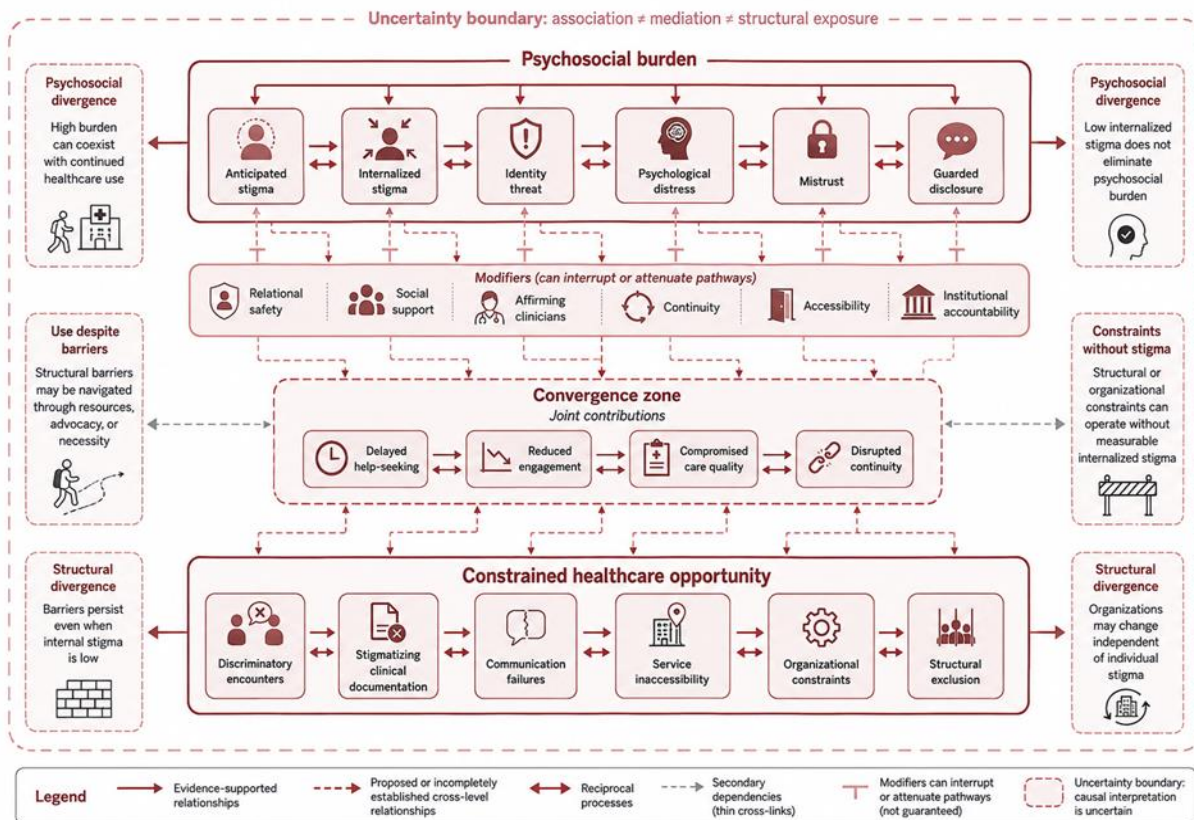


Figure 1. Convergence and divergence of psychosocial burden and constrained healthcare opportunity

Clinical and policy implications

Clinical responses should focus on observable care processes as well as attitudes. Respectful communication, non-stigmatizing documentation, continuity, appropriate equipment, accessible pathways, and opportunities for safe disclosure are actionable targets. Patient feedback can be particularly important because clinician self-assessment may not capture stigmatizing effects experienced during care.

At organizational and policy levels, intervention should be matched to the source of disadvantage. A structural barrier cannot be adequately addressed by teaching individual patients coping strategies, while clinician education alone cannot correct inaccessible facilities or exclusionary eligibility rules. Multilevel strategies are therefore justified when evidence indicates that stigma is produced at multiple levels, although superiority of any specific multilevel package requires direct testing.

Strengths and limitations

The review's principal strength is explicit separation of stigma form from healthcare-inequality outcome. This

reduces conceptual slippage between internalized stigma, discrimination, access, utilization, patient experience, and clinical consequence. It also preserves heterogeneity across conditions rather than assuming that mechanisms identified in HIV, weight stigma, mental illness, substance use, or LGBTQ+ healthcare transfer unchanged to other populations.

Important limitations remain. Measurement is inconsistent, structural evidence is uneven, and several domains rely heavily on cross-sectional or qualitative designs. Intervention studies often emphasize attitudes rather than sustained behavior or patient outcomes. The retained review-search record also did not permit defensible reconstruction of a complete numerical identification-to-inclusion chain; consequently, fabricated PRISMA counts were deliberately avoided.

Future research

Future studies should test cross-level relationships longitudinally rather than assuming temporal order from conceptual frameworks. Research should distinguish whether experienced stigma changes anticipated stigma

and trust, whether those changes subsequently alter disclosure or healthcare use, and under what conditions reciprocal effects occur.

Measurement development should expand organizational and structural indicators while preserving comparability with patient-reported experiences. Intervention research should prioritize sustained clinical behavior, documentation, referral patterns, patient experience, accessibility, and continuity rather than relying primarily on immediate attitude scores. Comparative implementation studies are also needed to determine when provider-focused interventions are sufficient and when organizational or policy change is necessary.

Greater attention to intersectionality is essential. Rather than treating identities as independent covariates, studies should examine how institutional arrangements modify the consequences of combined social positions. Finally, policy evaluation should test whether reforms reduce unequal healthcare opportunity without producing unintended barriers elsewhere in the care pathway.

Conclusion

Health-related stigma contributes to healthcare inequality through processes that are simultaneously psychological, relational, organizational, and structural. The evidence does not support reducing stigma to either individual attitudes or patient vulnerability. Experienced, anticipated, internalized, interpersonal, organizational, and structural forms are distinct but may interact, while their consequences range from distress and identity threat to avoidance, constrained access, altered communication, and unequal care processes.

The synthesis developed here therefore separates psychosocial burden from constrained healthcare opportunity while allowing reciprocal interaction between them. This distinction helps identify when patient-level support is appropriate, when relational practice must change, and when organizational or structural intervention is required. Progress will depend less on finding a single universal stigma intervention than on matching measurement and intervention to the level at which inequality is actually produced.

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