

Fair Access beyond Equal Eligibility: A Capability-Based Account of Interpretation, Navigation Support, and Institutional Responsibility in Equitable Patient-Centered Healthcare Systems

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Abstract

Equitable healthcare is often judged by eligibility, coverage, or service availability. These conditions are necessary but can misrepresent whether patients possess a meaningful opportunity to obtain and use care. This normative systems analysis applies the Capability Approach and systems-responsibility reasoning to interpretation, navigation support, and institutional access conditions. It distinguishes formal eligibility and access resources from the conversion conditions through which those resources become usable healthcare opportunities. Evidence across digital access, language barriers, organizational health literacy, and patient navigation shows that formally equal entry conditions can produce unequal practical opportunities when patients face avoidable informational, linguistic, administrative, technological, or coordination burdens. Navigation and interpretation support, however, are not uniformly effective, and nonuse cannot itself establish institutional failure. Fair access therefore requires attention to remediable conversion deficits while preserving patient agency and calibrating responsibility to what health systems can reasonably shape. Equal eligibility is ethically incomplete when system-shaped barriers prevent available healthcare from becoming a genuine option.

Keywords: Healthcare access, Capability Approach, Health equity, Patient navigation, Organizational health literacy, Interpretation services

Introduction

Healthcare access is commonly described through entitlement, insurance, service availability, appointment capacity, or digital entry points. These markers matter, but they do not establish that a person can identify the relevant service, understand what is required, communicate effectively, or sustain engagement across fragmented encounters. Digital exclusion shows the

distinction: a service may be technically available while remaining unusable because access, skills, confidence, connectivity, or interface demands exceed what some patients can mobilize [1]. Qualitative evidence likewise shows that access burdens can accumulate across repeated encounters when patients must repeatedly coordinate information, appointments, costs, and institutional expectations [2].

The Capability Approach distinguishes possession of a resource from a real opportunity to achieve a valued functioning. In healthcare, eligibility, insurance, information, a portal account, or an appointment slot are therefore inputs whose practical value depends on conversion conditions. A relational egalitarian interpretation links this distinction to equal standing and asks whether institutional arrangements leave some people systematically unable to use ostensibly equal

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opportunities [3]. Capability scholarship similarly identifies personal, social, and environmental conversion factors that explain why identical resources can generate different achievable opportunities [4].

This account shifts part of the analytic burden from patients to healthcare organizations. Organizational health literacy treats findability, understandability, and usability as properties for which institutions share responsibility [5]. Evidence concerning racialised populations in Europe shows that healthcare barriers span structural, administrative, linguistic, economic, and interactional domains [6], while research with refugees and asylum seekers demonstrates how legal position, cost, language, information, and service organization can interact to restrict practical access [7]. The question for this article is therefore whether equal eligibility is sufficient when patients differ in their ability to convert available healthcare resources into usable options. The analysis first separates eligibility from effective access, then examines interpretation and navigation as conversion conditions before assigning any institutional responsibility.

Why equal eligibility does not ensure fair access

Formal inclusion can coexist with substantial practical barriers. People seeking long-COVID care in Austria reported continuing difficulties within a universal healthcare system [8]. The point is not that universal coverage lacks value; it removes important forms of exclusion. The capability problem appears when coverage still leaves patients to overcome difficult service discovery, diagnostic recognition, communication, or coordination demands.

A similar distinction arises where disability and service design intersect. Women and girls using a humanitarian rehabilitation program in Lebanon faced barriers shaped by disability, gender, and service organization despite the existence of a program intended to meet their needs [9].

Evidence on health insurance among people with disabilities in low- and middle-income countries also shows why coverage status should not be equated with realized healthcare use or financial protection [10]. Insurance and program eligibility are access resources, but they do not themselves constitute effective opportunity.

Digital healthcare creates another version of the same problem. Comparative European evidence shows unequal distribution and use of digital healthcare opportunities [11]. Hospital portals may also be technically available while remaining linguistically inaccessible to patients whose preferred languages are poorly supported [12]. Here the resource is present, yet the conversion environment is unequal.

A capability-based account therefore separates four conditions. Formal eligibility concerns authorization to seek or receive a service. Access resources include coverage, services, appointments, information, portals, and referral mechanisms. Conversion conditions determine whether those resources can become practical options; they may be linguistic, informational, technological, social, administrative, or organizational. Effective healthcare capability is the genuine opportunity to identify, reach, understand, and use appropriate care. Actual use is a further functioning and should not be conflated with capability, because a person may possess a fair opportunity and still decline care.

This distinction also explains why unequal use cannot automatically be interpreted as either inequity or preference. Patients may have similar eligibility but different conversion burdens; informal support may offset some deficits temporarily; and illness, language demands, digital requirements, or fragmentation can alter what is usable over time. Fair access is therefore concerned with the quality of the opportunity available before the patient's final choice.

Table 1 summarizes the distinctions discussed above.

Table 1. Distinguishing equal eligibility from effective healthcare capability

Condition	What is present	What may still be absent	Capability meaning
Formal eligibility	Legal, policy, insurance, or program entitlement	Practical ability to initiate or sustain use	Permission to seek care
Access resources	Services, appointments, information, portals, referrals, coverage	Interpretability, navigability, coordination, language fit	Inputs requiring conversion
Conversion conditions	Linguistic, informational, technological, social, administrative, organizational supports	Adequacy, timing, continuity, responsiveness	Conditions that make resources usable

Effective healthcare capability	Genuine opportunity to identify, reach, understand, and use appropriate care	Actual uptake if the patient chooses otherwise	Substantively usable access
Realized functioning	Attendance, treatment uptake, follow-up, communication	Proof that opportunity was fairly distributed	Actual use shaped by capability and choice

Interpretation, navigation, and healthcare capabilities

Interpretation and navigation are often treated as ancillary services, yet they can determine whether access becomes usable. Language barriers among Nepali migrants in Finland affected communication, comprehension, and navigation of healthcare encounters [13]. Facility-level evidence from Malawi similarly shows that language mismatch arises within particular communicative environments, not solely from a patient's characteristics [14]. Interpretation can therefore be understood as a conversion function: it helps turn clinically relevant information into material a patient can use in deliberation and action.

Technology may support that conversion, but healthcare interpretation applications vary in function, context, and evidentiary support [15]. Their availability cannot justify an assumption of equivalence to professional interpretation. The relevant test is whether the communication support expands the patient's practical opportunity to understand and respond in the specific clinical setting.

Information design presents a related challenge. Consumer participation in health-literacy audits identifies problems of understandability and actionability that professional review can miss [16]. Organizational health-literacy research expands the unit of analysis further: a scoping review identified criteria concerning communication, navigation, access, staff capability, and organizational processes, while also finding heterogeneity in definitions and assessment tools [17]. Misunderstanding should therefore not be classified automatically as an individual deficit before examining whether the institution has made information findable and usable.

Some conversion conditions are modifiable. An organization-wide health-literacy intervention improved measured understandability and actionability of patient materials in a pre-post study [18]. Adaptation of the Vienna health-literate organization self-assessment tool likewise demonstrates that organizational health literacy can be assessed as an institutional property [19]. These findings do not establish downstream access or health

effects; they show that parts of the informational environment can be examined and changed.

Navigation adds coordination to interpretation. A Delphi study of health-system leaders identified patient access management as a set of organizational functions [20], while a primary-care scoping review found heterogeneous navigator roles involving information, coordination, service connection, and support across health and social systems [21]. Navigation is thus better understood as a family of practices that redistributes some of the cognitive, administrative, temporal, and coordination work required to use care.

Intervention evidence supports this function but also limits broad claims. A systematic review found that navigation generally improved breast, cervical, and colorectal cancer screening among immigrant populations in the United States [22]. A meta-analysis of randomized trials likewise reported improvements in several breast and cervical cancer screening and follow-up outcomes, with heterogeneity across interventions and populations [23]. Navigation can therefore expand effective opportunity in some contexts without constituting a universally sufficient remedy.

The limits are analytically important. In a randomized-trial subgroup analysis involving people with histories of homelessness, navigation effects differed by homelessness experience [24]. In another randomized trial among Hispanic patients with serious noncancer illness, navigation improved some care-planning and process outcomes but not the primary quality-of-life outcome [25]. These findings show why capability support must be assessed against the particular conversion deficit and valued opportunity at stake.

Implementation creates a further condition. A RE-AIM evaluation of community-focused cancer navigation showed that reach, adoption, implementation, and maintenance depended on organizational and community circumstances [26]. A support intervention may therefore exist formally without becoming a reliable institutional capability. The same analytical distinction recurs at two levels: services can exist without being usable by patients, and support programs can exist without being reliably delivered by organizations.

The resulting relationship is nonlinear. Interpretation affects whether information can enter deliberation; navigation affects whether pathways can be traversed; organizational health literacy affects the usability of institutional interfaces; digital design affects whether technical access becomes practical access; and coordination affects how much integrative work is transferred to patients. These conversion functions may

overlap, compensate for one another, or fail simultaneously.

Equal eligibility can therefore diverge from effective healthcare capability at several overlapping conversion points, while patient experience can feed back into organizational adaptation.

Figure 1 illustrates the relationships discussed above.

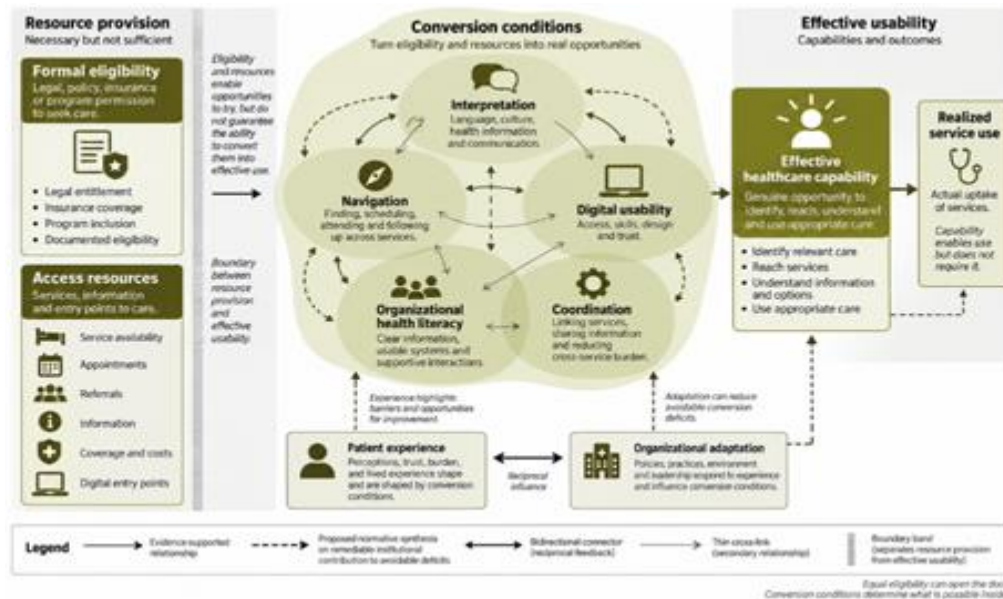


Figure 1. Where equal eligibility loses practical force in healthcare access

Table 2 summarizes the distinctions discussed above.

Table 2. Interpretation and navigation as healthcare capability-conversion functions

Conversion function	Capability deficit	Institutional support	Evidence-bounded limit
Interpretation	Clinical meaning cannot be reliably understood or expressed	Language concordance, professional interpretation, context-appropriate tools	Technology and interpretation models vary in quality and fit
Information usability	Information exists but cannot be located, understood, or acted on	Consumer-tested materials and organizational health-literacy practices	Better materials do not prove better access outcomes
Navigation	Services cannot be identified, sequenced, or reached without excessive administrative work	Navigation, referral support, scheduling and service linkage	Effects vary by population, setting, and outcome
Coordination	Patients must bridge disconnected services repeatedly	Cross-service linkage, continuity and shared access management	Implementation may be incomplete or unstable
Digital usability	Digital care exists but is practically inaccessible	Accessible design, language support, alternatives and assistance	Infrastructure alone does not establish equitable use
Context-responsive support	Standard support does not match accumulated disadvantage	Tailoring, intensity adjustment, community linkage	Navigation can produce mixed or null outcomes

Interpretation and navigation are therefore among the conditions through which access can become real, not proof that access has already been achieved. Their normative significance depends on adequacy, availability, fit, continuity, and implementation. The next analytical task is to determine when deficits in those conditions are sufficiently shaped by institutional design to generate responsibility for altering the access environment while still respecting informed patient choice.

A capability-based account of institutional responsibility

A capability account changes the question from whether a service was formally offered to whether institutional arrangements left the patient with a meaningful opportunity to use it. Observed utilization cannot answer that question by itself. Population-based evidence from British Columbia, for example, shows that relationships between neighborhood income and youth mental-health service use vary by immigration experience [27]. Similar utilization rates may therefore conceal different barriers, while different utilization rates may reflect preferences, needs, referral patterns, or unequal conversion conditions. Utilization is an outcome requiring interpretation, not a sufficient measure of fair access.

This distinction follows from a broader capability insight: resources acquire practical value through the circumstances in which people can convert them into valued functioning [28]. Applied to healthcare, the relevant institutional question is whether a system creates avoidable deficits between the resources it makes formally available and the opportunities patients can realistically exercise. Systems can influence appointment procedures, interpretation availability, referral coordination, portal design, communication practices, information quality, scheduling flexibility, and the distribution of navigational work. They cannot control every personal, social, or environmental condition that affects care.

Institutional responsibility should therefore be bounded by contribution, remediability, and burden asymmetry. Contribution concerns whether organizational arrangements materially generate or amplify the

conversion deficit. Remediability asks whether the institution has a reasonable means of reducing that deficit. Burden asymmetry asks whether the current arrangement transfers work to patients that the organization is substantially better positioned to absorb or simplify. The system-level conception of health literacy supports treating institutional usability as an organizational capacity rather than locating every difficulty within the individual patient [29].

This rule does not make every difference in healthcare use an institutional failure. A well-informed patient may decline an available service. Some barriers originate primarily outside healthcare organizations. Some forms of accommodation may be technically unavailable, clinically inappropriate, or disproportionate to their likely benefit. Responsibility is strongest where the institution itself controls a modifiable access condition and where leaving it unchanged predictably deprives particular patients of a meaningful opportunity that others can exercise with substantially less effort.

The same reasoning prevents navigation from becoming a substitute for structural reform. Evidence that navigation improves selected screening outcomes [22, 23] does not show that organizations should solve every access problem by assigning patients another helper. If administrative complexity, inaccessible information, or fragmented referral rules are the source of the burden, redesign may be more capability-enhancing than permanently compensating for the burden after it has been created. Conversely, where complexity cannot reasonably be eliminated, individualized navigation may remain justified.

Institutional responsibility is therefore relational rather than unlimited. It depends on how organizational design interacts with patient circumstances and whether feasible institutional action can alter that interaction without displacing patient authority.

The responsibility structure can be represented as a field of overlapping institutional leverage, patient agency, and contextual constraint rather than as a one-way sequence.

Figure 2 illustrates the relationships discussed above.

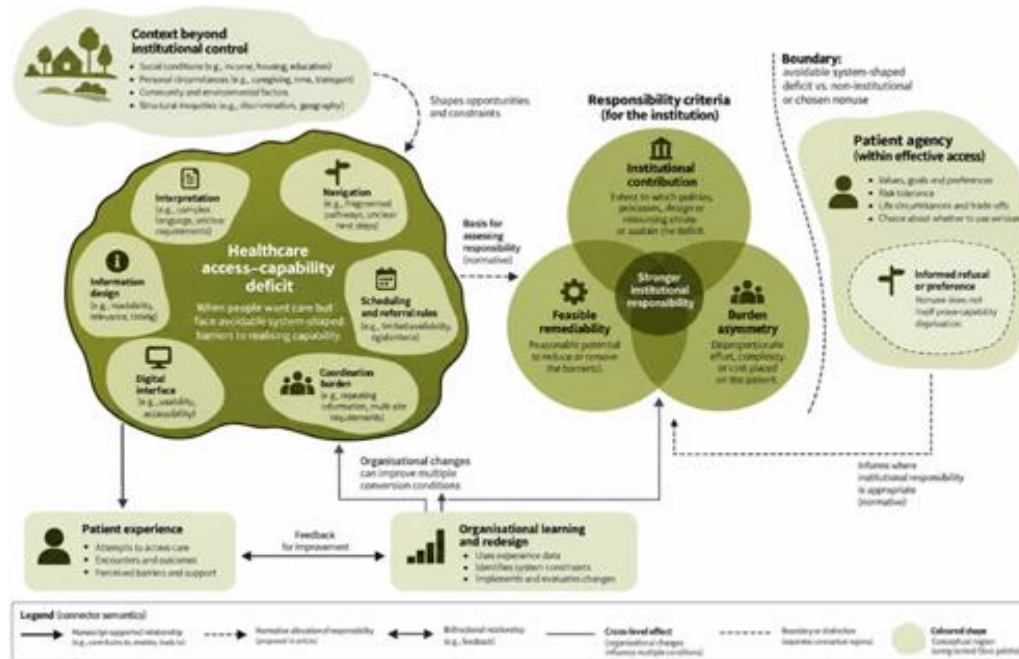


Figure 2. When access deficits become institutional responsibilities for healthcare capability

The allocation rule also changes how responsibility should be distributed across organizational functions.

Table 3 summarizes the distinctions discussed above.

Table 3. Allocating responsibility for avoidable healthcare capability deficits

Institutional condition	Capability problem created or amplified	Responsibility basis	Appropriate institutional response boundary
Inaccessible information	Patients cannot identify or act on clinically relevant options	Organization controls information design and presentation	Improve usability without presuming patient preference
Language-inaccessible communication	Clinically relevant meaning cannot be reliably exchanged	Institution structures communicative access	Provide proportionate interpretation or language support
Fragmented referral pathways	Patients carry excessive coordination work across services	Organization or network distributes coordination burden	Simplify pathways or provide navigation where fragmentation cannot be removed
Digital-only or poorly supported access	Formal access exists while practical use remains unequal	Interface and channel design are institutionally modifiable	Improve accessibility and maintain suitable alternatives
Complex scheduling and administrative rules	Opportunity depends on procedural knowledge or persistence	Burden is partly generated by service design	Remove unnecessary complexity before compensating for it
Context not materially controlled by the institution	Capability remains constrained despite reasonable healthcare access conditions	Institutional contribution or remediability is weak	Avoid attributing every disadvantage to the healthcare organization
Informed voluntary nonuse	Patient possesses a meaningful opportunity but declines it	Capability is present; functioning is not obligatory	Preserve patient authority rather than treating uptake as the equity endpoint

Health-system and policy implications

Policy should measure access at more than the point of entitlement. Digital and health literacy are associated

with digital-health behavior among rural residents in China [30], reinforcing the need to assess whether infrastructure is usable as well as available. A capability-

sensitive access dashboard would therefore distinguish entitlement, access resources, conversion conditions, effective opportunity, and realized use rather than collapsing them into a single utilization indicator.

The location of the conversion deficit should also determine the response. Language mismatch calls for communicative support; incomprehensible information calls for redesign; fragmented pathways may require coordination or navigation; inaccessible digital channels may require interface modification or viable alternatives. Organizational health-literacy and access-management evidence suggests that many such conditions are amenable to institutional action, although their effects must be evaluated at the level actually measured.

Navigation policy especially requires calibration. Screening evidence supports meaningful benefits in some populations [22, 23], while randomized evidence also

shows heterogeneous or null effects for some groups and outcomes [24, 25]. A health system should therefore avoid judging an intervention solely by its presence. The relevant question is whether the support actually changes the capability deficit for the population and decision at issue.

Policy evaluation should consequently pair implementation measures with capability-relevant outcomes. Reach, uptake, usability, continuity, language access, successful referral completion, and patients' reported ability to understand and act can illuminate different parts of the access pathway. None alone demonstrates justice. Their value lies in showing where formal access fails to become practically usable and whether institutional modification changes that failure.

Table 4 summarizes the distinctions discussed above.

Table 4. Matching health-system responses to the location of the access-capability failure

Location of failure	Misleading policy proxy	Capability-sensitive policy question	Appropriate response family	Evidence caution
Eligibility	Enrollment or entitlement alone	Can eligible patients practically initiate care?	Remove residual administrative or financial obstruction	Eligibility remains necessary but insufficient
Information	Availability of written or digital information	Can patients find, understand, and act on it?	Health-literate information design and communication support	Material improvement does not automatically establish better outcomes
Language	Existence of a service	Can clinically relevant meaning be exchanged reliably?	Interpretation, language-concordant support, suitable communication tools	Technology should not be assumed equivalent to professional interpretation
Navigation	Referral or appointment issuance	Can the pathway be traversed without disproportionate coordination burden?	Navigation, service linkage, pathway simplification	Effects are setting- and outcome-dependent
Digital access	Portal or remote-service availability	Is the channel usable across language, literacy, disability, and technology conditions?	Accessible design, assistance, viable alternatives	Infrastructure alone is not equitable access
Implementation	Adoption of an access-support program	Is the support actually reaching and functioning for intended users?	Implementation monitoring and organizational adaptation	Program existence does not establish capability gain
Evaluation	Service utilization rate	Did patients possess a meaningful opportunity to use appropriate care?	Separate capability measures from achieved use	Nonuse may reflect either constrained capability or informed choice

Results and Discussion

The article's central contribution is a distinction among formal eligibility, access resources, conversion conditions, effective healthcare capability, and realized use. This distinction does more than rename familiar barriers. It changes what counts as an equity problem and what must be shown before institutional responsibility is assigned.

A resource-centered account can plausibly argue that a health system has fulfilled its obligation once coverage,

services, and formally identical procedures are available. A capability account requires an additional question: can differently situated patients convert those arrangements into meaningful opportunities? That inquiry exposes forms of inequality hidden by formally neutral systems, especially where interpretation, information design, digital access, coordination, or administrative complexity systematically alter usability.

The account must nevertheless preserve agency. Institutional responsibility would become paternalistic if

every refusal, delayed uptake, or unconventional choice were treated as evidence that patients lacked capability. The relevant normative object is the opportunity available before choice. Patients can possess effective access and decide not to exercise it.

Evidence concerning navigation illustrates the same limit on institutional inference. Some interventions improve selected screening outcomes, while effects may differ by homelessness experience or remain absent for a primary patient-reported outcome [24, 25]. Neither success nor failure in one setting establishes a universal mechanism. Capability support depends on the relationship among the barrier, intervention, population, organizational context, and valued healthcare opportunity.

The responsibility rule is correspondingly conditional. Institutional responsibility strengthens when an organization contributes materially to a conversion deficit, can reasonably modify it, and otherwise leaves patients carrying burdens the organization is better positioned to reduce. It weakens when barriers are not substantially institution-generated, remediation is infeasible or disproportionate, or the patient already possesses a meaningful opportunity and chooses differently.

Future health-services research should therefore avoid using “access” as an undifferentiated outcome. Studies should specify whether they measure entitlement, resource availability, conversion conditions, effective opportunity, utilization, or downstream health outcomes. This would make rival explanations more discriminating and prevent successful service uptake from being mistaken automatically for equitable access—or low uptake from being treated automatically as institutional failure.

Conclusion

Equal eligibility is a necessary foundation for equitable healthcare, but it is not the endpoint of fair access. Interpretation, navigation, information design, digital usability, coordination, and organizational health literacy can determine whether available healthcare becomes a genuine option for a patient. The ethical significance of these conditions lies in their effect on capability: whether people can identify, understand, reach, and use appropriate care while retaining authority to choose otherwise.

Healthcare systems bear stronger responsibility for access deficits when institutional arrangements

materially create or amplify them, feasible remediation exists, and current arrangements shift disproportionate burdens onto patients. That responsibility is bounded by context, feasibility, proportionality, and patient agency. Fair access therefore requires more than equal permission to enter a system; it requires attention to avoidable differences in whether the system can actually be used.

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