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The Hidden Psychology of Healthcare Inequity: How Structural Disadvantage Becomes Stress, Behavioral Constraint, and Reduced Health Opportunity

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Abstract

Healthcare inequity is often described through differences in access, utilization, adherence, or health behavior, yet these downstream observations can conceal the psychological consequences of unequal social conditions. This article develops a proposed structural-to-psychological account of healthcare inequity in which structural disadvantage alters not only material resources but also the conditions under which health-related decisions are made. Material scarcity can narrow feasible options; discrimination and stigma can increase perceived interpersonal risk; repeated difficult encounters can alter expectations of care; and organizational complexity can shift cognitive and navigational demands onto patients with unequal capacity to absorb them. Under these conditions, delayed care, nondisclosure, discontinuity, or apparently low engagement may represent constrained adaptation rather than unconstrained preference. The proposed model therefore separates structural exposure, psychological response, observed behavior, realized health opportunity, and clinical outcome rather than treating them as interchangeable. It also recognizes reciprocal processes: prior encounters can influence future trust and vigilance, while institutional responses to patient behavior can reinforce or interrupt inequity. The framework is intended as a bounded conceptual synthesis rather than an empirically validated causal model. Its principal implication is that equitable healthcare requires attention not only to whether services exist, but also to whether patients can use them without disproportionate material, psychological, relational, or organizational cost.

Keywords: Healthcare inequity, Structural disadvantage, Discrimination, Psychological stress, Behavioral constraint, Health opportunity

Introduction

Healthcare inequity is produced upstream of many encounters conventionally described as individual health behavior. Structural racism, historically embedded policy arrangements, and interacting institutional systems can shape exposure to resources, hazards, insurance, neighborhood conditions, and healthcare itself [1-3]. Distinguishing systemic, structural, and institutional processes is therefore essential because unequal outcomes may be generated before a clinician-patient interaction begins [4]. A behavior observed in the clinic—late presentation, missed follow-up, nondisclosure, discontinuity, or reluctance to accept a recommendation—cannot automatically reveal the degree of choice available to the person producing it.

The central argument of this article is that structural disadvantage can become psychologically consequential by altering the conditions under which attention, trust, anticipation, deliberation, and healthcare participation occur. The relevant pathway is neither exclusively structural nor exclusively psychological. Structural exposures may change material options, the expected

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risks of encounters, the cognitive work required to navigate systems, and the perceived likelihood that participation will produce benefit. These processes can then shape behavior without implying that structural position mechanically determines psychological response.

This distinction matters because several common healthcare interpretations collapse different levels of analysis. Access is treated as utilization, utilization as participation, participation as adherence, and adherence as evidence of motivation. Likewise, mistrust is sometimes interpreted as a patient characteristic rather than a potentially experience-responsive assessment of institutions. The proposed framework instead separates structural conditions, psychological exposure, behavioral constraint, realized health opportunity, and downstream outcomes. The objective is not to replace individual agency with structural determinism, but to specify when apparent choice may be substantially conditioned by unequal material and relational environments.

From structural inequality to psychological exposure

Structural inequality becomes relevant to psychology when it changes what people repeatedly encounter, anticipate, or must overcome. Contemporary frameworks of structural racism emphasize that institutional arrangements differ across domains, populations, and historical periods rather than operating as one fixed exposure [5]. This temporal and group-specific character prevents a simple inference from demographic category to psychological state. Structural disadvantage should therefore be treated as a patterned exposure environment, not as proof that any individual necessarily experiences distress, mistrust, vigilance, or behavioral constraint.

The same principle extends beyond racism. Structural sexism organizes unequal access to power, resources, and institutional protection, with effects that may vary across life stages and intersecting positions [6]. These distinctions matter conceptually because healthcare inequity can emerge through multiple systems whose psychological consequences are not interchangeable.

Qualitative evidence illustrates how formal rules can become lived healthcare conditions. Among asylum seekers in England, racialized and immigration-related governance was experienced through concrete barriers to obtaining appropriate care [7]. Research with immigrants in the United States similarly shows that systems described as inclusive can remain difficult to navigate when institutional routines fail to recognize immigration-specific circumstances [8]. At the population level, insurance coverage among Black immigrants also varies with intersecting racial, nativity, and immigration-related conditions [9].

The proposed concept of psychological exposure refers to the experiential layer through which such structural arrangements become relevant to future appraisal and participation. It includes repeated uncertainty about eligibility, anticipated administrative difficulty, expectations of unequal treatment, perceived risk in disclosure, and the accumulated experience of needing greater effort to obtain equivalent care. Psychological exposure is not assumed to mediate every structural effect. Some inequities operate directly through affordability, geographic availability, legal eligibility, or physical access. Its analytical value is narrower: it identifies circumstances in which structural conditions may change the perceived costs, risks, and expected returns of healthcare participation.

Material scarcity and chronic stress

Material scarcity can constrain health behavior without requiring a deficit account of judgment. Scarcity theory proposes that limited resources can narrow attention, increase cognitive burden, and shift temporal priorities, but a recent scoping review found heterogeneous evidence for tunneling, cognitive load, time orientation, and related behavioral mechanisms [10]. The literature therefore does not justify a universal sequence in which poverty automatically produces cognitive impairment and poor decisions.

Nevertheless, some findings are consistent with more conditional pathways. Financial scarcity has statistically mediated selected associations between income and health behavior, although the cross-sectional design prevents strong causal interpretation [11]. More extreme material instability illustrates an even more direct pathway: adults experiencing homelessness report distinctive barriers to usual healthcare access and patterns of service use that cannot reasonably be reduced to preference alone [12].

A useful distinction is therefore between resource constraint and psychological scarcity response. Resource constraint defines what is materially feasible; psychological responses concern how attention, stress, anticipation, and prioritization operate within that feasible set. Either can affect behavior, but they should not be treated as the same mechanism. The proposed model consequently places material conditions upstream

of, but not deterministically connected to, chronic stress and cognitive burden.

Discrimination, threat, and anticipatory vigilance

Discrimination introduces a different form of constraint because the relevant resource is not only money, time, or transportation but also perceived interpersonal and institutional safety. For transgender and gender-independent adults, healthcare discrimination and erasure experienced directly or vicariously were associated with mistrust and utilization-related behavior [13]. Among Black women living with HIV, healthcare stigma was associated with anticipated and internalized stigma, trust in HIV care, and health-related outcomes within an observational mediation model [14]. National data also show an association between reported racial discrimination in medical settings and lower healthcare-system trust [15].

These findings should not be converted into a single causal sequence. Much of the evidence is observational, different populations encounter different forms of stigma, and measured mistrust or vigilance may reflect both prior healthcare experiences and broader social contexts. Longitudinal evidence nevertheless strengthens the case for temporal accumulation: everyday stress appraisal and negative affect have been shown to partly account statistically for longer-term discrimination-health associations [16].

Anticipatory processes are also visible when exposure is indirect. During the COVID-19 period, both direct and vicarious discrimination were associated with heightened concern and vigilance among racial and ethnic minority participants [17]. Health-care stereotype threat has likewise been documented among sexual and gender minority adults, although within a historically specific pandemic context [18].

These patterns support a bounded interpretation: discrimination can alter the expected risk of future encounters even when no discriminatory event is occurring at that moment. Vigilance may therefore be adaptive to perceived threat while still carrying psychological or behavioral costs. It should not be inferred simply from group membership, and it should not be equated with generalized mistrust.

The distinction is sufficiently consequential that the principal states should be compared directly rather than collapsed into a generic category of "discrimination effects." **(Table 1)**.

Table 1. Discrimination-related encounter states that require different interpretations before healthcare behavior is judged

Discrimination state	Patient interpretation	Care context	Behavioral response	Alternative account	Judgment safeguard
Care-context state — Prior unequal treatment in healthcare					
Salient threat information	A personally experienced event indicates possible future interpersonal or institutional risk	**Potential anticipatory response**	Heightened monitoring, guarded communication, delayed engagement	**Competing explanation or uncertainty**	Current encounter may differ from prior encounters
Interpretation boundary	Prior discrimination does not prove present discrimination	**Practical decision implication**	Examine current interaction quality while recognizing historically informed expectations		
Care-context state — Vicarious exposure to unequal treatment					
Salient threat information	Harm experienced by peers, family, community, or identity-similar others	**Potential anticipatory response**	Increased vigilance before direct personal exposure occurs	**Competing explanation or uncertainty**	Media, community narratives, and broader social threat may also contribute
Interpretation boundary	Vicarious threat is not equivalent to direct exposure	**Practical decision implication**	Assess anticipated risk rather than treating concern as evidence of irrationality		
Care-context state — Repeated stigma in condition-specific care					
Salient threat information	Identity or diagnosis has repeatedly been associated	**Potential anticipatory response**	Anticipated stigma, selective disclosure, reduced trust	**Competing explanation or uncertainty**	Internalized stigma and non-healthcare

	with devaluation or dismissal				experiences may also contribute
Interpretation boundary	Anticipation, internalization, and experienced stigma remain distinct	**Practical decision implication**	Reduce encounter-level cues that make disclosure or participation costly		
Care-context state — Ambiguous negative encounter					
Salient threat information	The patient perceives disrespect, dismissal, or differential treatment but attribution is uncertain	**Potential anticipatory response**	Uncertainty, rumination, guarded participation	**Competing explanation or uncertainty**	Miscommunication, workload, organizational failure, or discrimination may overlap
Interpretation boundary	Ambiguity does not invalidate the reported experience	**Practical decision implication**	Investigate process failure without requiring certainty about motive before repair		
Care-context state — Recurrent cross-setting threat					
Salient threat information	Similar problems occur across clinicians, organizations, or administrative systems	**Potential anticipatory response**	Persistent vigilance and generalized expectation of difficulty	**Competing explanation or uncertainty**	Structural barriers and interpersonal processes may coexist
Interpretation boundary	Generalization across encounters should be treated as an empirical question	**Practical decision implication**	Look beyond single-clinician explanations toward organizational and system conditions		

Cognitive load and decision capacity

Cognitive explanations require particular caution because they can easily relocate responsibility from institutions to individuals. Patients facing scarcity, complex eligibility rules, multiple appointments, unstable transport, language barriers, or repeated uncertainty may carry greater decision workload, but the extent to which that workload produces specific cognitive effects remains context-dependent.

Cognitive demands also operate on clinicians. In an experimental study involving physician residents and fellows making chronic-pain decisions, patient socioeconomic status was associated with some decision differences, but evidence that cognitive load consistently amplified those differences was limited [19]. This is an important boundary finding. Cognitive load is plausible as one contributor to unequal decision environments, yet it should not become a universal explanation for inequity. Accordingly, the proposed model treats decision capacity as situationally distributed. Patients and clinicians operate within organizational systems that allocate time, information, administrative work, uncertainty, and interruption unevenly. Scarcity-related cognitive mechanisms may contribute in some contexts, but current evidence remains heterogeneous [10]. The more defensible inference is that unequal systems can impose unequal cognitive work; whether that work produces measurable changes in attention or decision quality must be tested rather than presumed.

Behavioral constraint versus behavioral choice

Observed behavior becomes analytically misleading when the available alternatives are ignored. Among adults with diabetes and hypertension, perceived healthcare discrimination was associated with nervousness-related care delay, with patient-clinician communication statistically contributing to the relationship [20]. The finding does not prove a universal causal pathway, but it shows why delayed care cannot automatically be interpreted as low motivation.

Disclosure decisions provide a second example. Black and Latine primary-care patients describing health-related social-needs screening reported that disclosure depended partly on whether revealing a need seemed safe and likely to produce useful assistance [21]. Withholding information can therefore represent a reasoned response to perceived risk, futility, or stigma rather than simple disengagement.

Navigation produces another form of constraint. Research on older adults moving from hospital to home shows that healthcare trajectories are easier to manage for people whose health literacy, social networks, and resources align with institutional expectations of an active, self-managing patient [22]. The same nominal

option may therefore represent different practical opportunities for different patients.

The proposed distinction is not between agency and structure as mutually exclusive explanations. It is between choice within a sufficiently open opportunity set and behavior produced within a substantially constrained opportunity set. People retain agency under constraint, but the meaning of the resulting behavior changes. A missed visit may reflect avoidance, competing caregiving, transport failure, fear of mistreatment, unstable housing, administrative complexity, or some combination. A choice-only interpretation discards this causal and contextual heterogeneity.

Because different mechanisms can converge on the same visible behavior, an explicit evidence–interpretation crosswalk is needed before adherence, engagement, or motivation is inferred **(Table 2)**.

Table 2. Crosswalk for interpreting apparently similar healthcare behaviors under unequal choice conditions

Observed healthcare behavior	Constraint configuration that may be operating	What a choice-only interpretation misses	Evidence status in the present synthesis	More defensible interpretation
Delayed presentation or postponed follow-up	Anticipated discrimination, nervousness, communication difficulty	Delay may reduce perceived interpersonal risk even while increasing health risk	Association supported; sequence not universally established	Treat delay as behavior requiring contextual explanation, not as proof of indifference
Nondisclosure of a social need	Low expected benefit, privacy concern, stigma, fear of consequences	Disclosure itself can carry perceived cost	Qualitative evidence supports context dependence	Ask whether the system has made disclosure safe and actionable
Difficulty coordinating post-discharge care	Limited health literacy, fragmented services, weak network support	"Self-management" demands are unequally distributed	Qualitative trajectory evidence	Interpret navigation performance relative to system complexity and available support
Irregular service use during severe material instability	Housing insecurity, transport difficulty, competing survival needs	Nominal service availability may not create practical accessibility	Observational evidence	Distinguish unstable opportunity from unstable preference
Reduced use after discriminatory encounters	Mistrust and anticipated recurrence of unequal treatment	Underuse may represent avoidance of expected harm rather than rejection of health care itself	Observational evidence	Evaluate the history and expected safety of encounters before assigning motivational explanations

The same observable behavior can therefore emerge from materially different pathways, while the same structural constraint can produce different behaviors depending on support, trust, prior experience, and available alternatives. **Figure 1** makes this convergence and divergence explicit so that behavior is not automatically treated as a direct readout of preference.

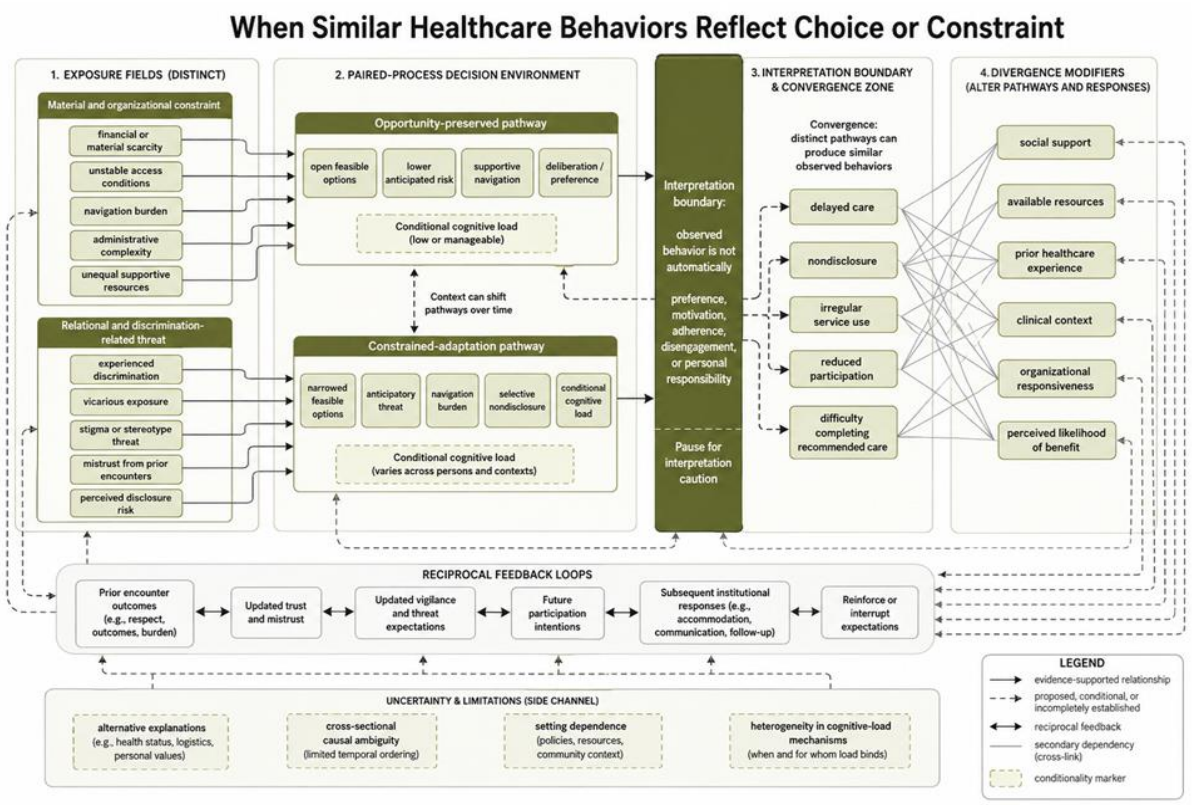

Figure 1. When the same healthcare behavior can reflect either available choice or constrained adaptation

Reduced access to health-promoting opportunities

A healthcare resource becomes an opportunity only when it can realistically be used. Geographic availability illustrates this distinction. In medically underserved areas, greater availability of federally qualified health centers influenced where patients received services, yet greater local availability did not translate uniformly into greater routine healthcare utilization across outcomes [23]. Physical proximity therefore matters, but it is not sufficient.

Insurance produces a parallel distinction. Insured adults with different coverage arrangements report differences in access, affordability, and satisfaction with care [24]. Formal coverage cannot therefore be treated as equivalent to financial accessibility, continuity, perceived quality, or successful use.

The article uses health opportunity to describe a service or health-promoting option that is not merely present but sufficiently usable within a person's material, organizational, relational, and psychological circumstances. Reduced health opportunity can arise through cost, distance, administrative complexity, language, unstable housing, inadequate time, mistrust, or expected interpersonal risk. These mechanisms should not be aggregated into one generic access variable because they imply different interventions and different interpretations of behavior.

This distinction also clarifies why equal service provision can coexist with unequal participation. If one patient can act on a recommendation with minimal additional work while another must overcome transport uncertainty, eligibility problems, lost wages, care responsibilities, disclosure risk, or prior mistreatment, the nominal recommendation is equal but the actionable opportunity is not.

Institutional encounters and unequal trust

Trust is often measured at the individual level but generated partly through relationships and institutions. In contraceptive care, epistemic discrepancies between patients and clinicians illustrate how privileging one form of knowledge can produce experienced harm and mistrust even when clinicians understand themselves to be providing evidence-based care [25]. Trust therefore depends not only on whether information is accurate but also on whether patients experience their observations, priorities, and uncertainty as recognizable within the encounter.

Institutional trust is also dynamic. Large US surveys during the COVID-19 period documented changing trust in physicians and hospitals and associations between trust and vaccination behavior [26]. Such findings do not establish that trust alone caused behavior, but they reinforce the idea that trust changes with historical and institutional context.

Qualitative work in a post-communist mental-health system further demonstrates that distrust may become reciprocal: patients respond to institutions they perceive as inaccessible or low quality, while institutions adapt to patient behavior in ways that can reproduce the original distrust [27]. This feedback logic is particularly important for healthcare inequity because a response initially produced by adverse experience can subsequently be interpreted by organizations as difficult behavior, low engagement, or lack of motivation.

The proposed framework therefore treats trust as an updated relational expectation, not a fixed psychological trait. Previous encounters, observed treatment of others, institutional responsiveness, communication quality, and the perceived consequences of disclosure can all influence whether future participation appears safe and worthwhile. Equally, mistrust should not be assumed to be justified in every instance or to operate identically across populations. Its source, object, duration, and behavioral consequence remain empirical questions.

This relational account also creates an important boundary for clinical practice. Improving trust cannot be reduced to persuading patients to trust more. Where mistrust reflects repeated barriers, epistemic dismissal, discrimination, or unreliable institutional response, a patient-focused intervention leaves the generating conditions intact. Conversely, changing institutional practice does not guarantee immediate psychological repair because expectations may persist after conditions improve. Healthcare inequity can therefore contain temporal feedback: structural and encounter conditions shape expectations, expectations shape subsequent participation, and subsequent encounters either reinforce or revise those expectations.

Cumulative and life-course effects

Healthcare opportunity is cumulative rather than episodic. Across 14 European countries, routine-care uptake followed heterogeneous trajectories from adolescence toward retirement, with socioeconomic inequalities varying across countries and cohorts [28]. Persistent socioeconomic disadvantage has also been associated longitudinally with greater infection burden and markers related to immunosenescence, although mobility patterns were less consistent [29]. Such biological associations do not establish the psychological pathway proposed here, but they reinforce the importance of duration and sequencing.

Methodological work on structural sexism similarly shows why point-in-time exposure measures can miss life-course and intersectional processes [30]. Accordingly, the proposed model treats current behavior as potentially shaped by accumulated experiences rather than only present circumstances **(Table 3)**.

Table 3. Life-course conditions that can make similar present-day healthcare situations represent different accumulated exposure histories

Accumulating process	Possible present consequence	Important heterogeneity boundary
Temporal condition — Persistent socioeconomic disadvantage		
Repeated material restriction and unequal opportunity	Greater cumulative burden before a current healthcare decision	Mobility and support can alter trajectories
Temporal condition — Recurrent difficult healthcare encounters		
Updating of expectations across encounters	Persistent vigilance or mistrust	Later positive encounters may revise expectations
Temporal condition — Unequal routine-care participation over time		
Repeated missed or inaccessible preventive opportunities	Diverging care trajectories	Patterns vary across systems and cohorts
Temporal condition — Changing structural position across the life course		
Exposure intensity and resources change over time	Present circumstances may poorly represent cumulative history	Snapshot measures can misclassify exposure

A structural-to-psychological inequity model

The article therefore proposes a multilevel model rather than a deterministic chain. Structural arrangements shape

material conditions and institutional encounters; these can modify psychological exposure, including stress appraisal, anticipated threat, trust, perceived disclosure risk, and expected benefit. These processes interact with practical constraints to influence healthcare participation and realized opportunity. Feedback is essential: encounter outcomes can update future expectations, while institutional reactions to patient behavior can reinforce or interrupt the process.

Available evidence does not validate this complete architecture. Evidence supports individual links and boundary conditions, whereas their integration is the article's proposed theoretical contribution. Life-course representation is particularly important because structural exposures and healthcare participation may evolve rather than remain static [28, 30].

Figure 2 is needed to keep these levels, reciprocal pathways, and evidence boundaries visible rather than implying that structural disadvantage acts directly and uniformly on behavior.

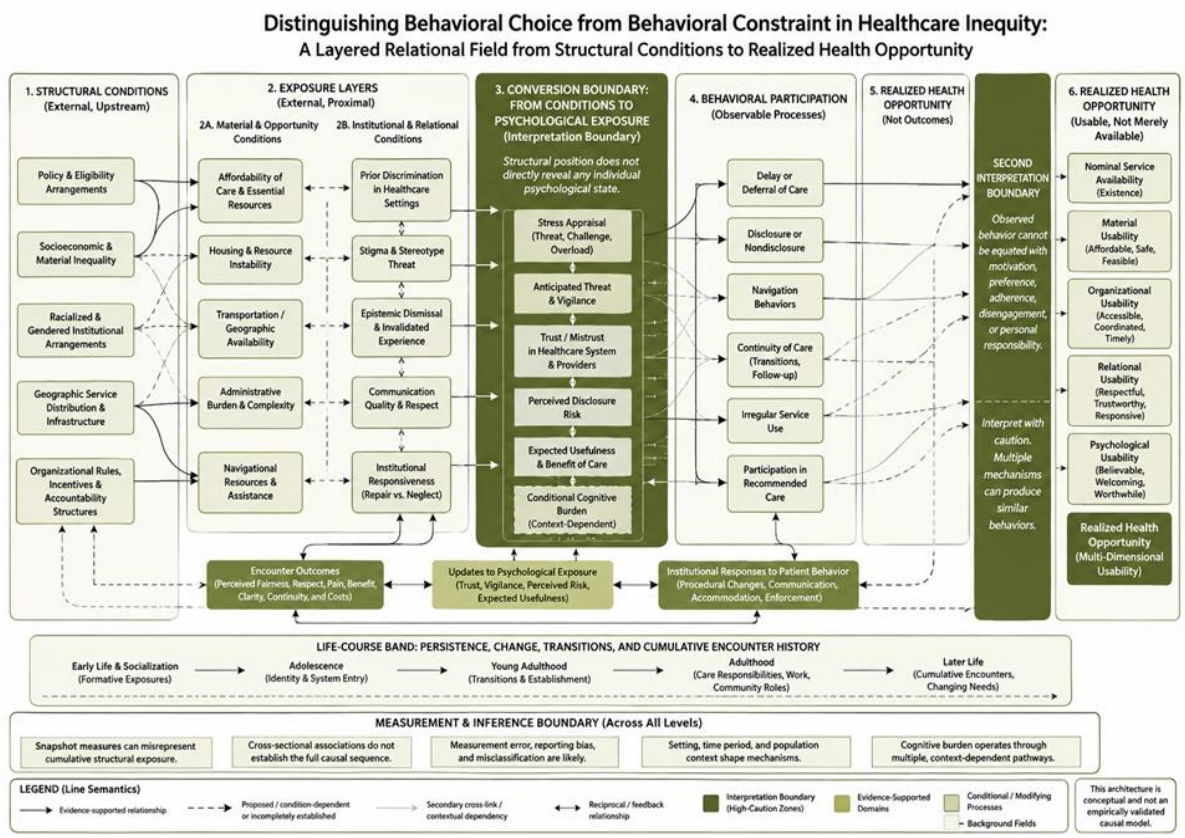

Figure 2. Cross-level conversion points linking structural disadvantage to psychological exposure and constrained healthcare opportunity

Intervention leverage points across levels

Intervention should follow the level at which constraint is generated. Downstream social-needs services cannot be presumed sufficient: one Medicaid program found no favorable one-year differences across major measured outcomes, while a broader review found heterogeneous intervention models and limited outcome evidence [31, 32]. Measurement is itself consequential. Different methods for identifying health-related social needs produce different false-negative patterns [33], and equity-oriented payment programs can still reach populations with lower measured social risk than the broader eligible population [34].

The proposed implication is therefore multilevel: alter material barriers, encounter conditions, organizational burden, measurement practices, and policy reach rather than asking patients alone to compensate for inequitable environments **(Table 4)**.

Table 4. Intervention leverage points and the consequences of measuring the wrong stage of the inequity process

Leverage location	What can be changed	Measurement consequence	Main boundary
Material conditions	Affordability, transport, housing-linked or practical barriers	Measure whether usable options expand	Service offer does not prove barrier resolution
Clinical encounter	Communication, respect, disclosure safety, responsiveness	Measure experience and subsequent participation separately	Trust cannot be inferred from satisfaction alone
Organization	Navigation burden, continuity, referral completion	Measure workload transferred to patients	Referral does not equal successful access
Screening and policy	Detection methods, eligibility, program reach	Audit false negatives and who is actually reached	Equity intent does not establish equitable impact

Implications for equity policy and clinical care

Clinical and policy responses should therefore avoid locating the entire solution in patient motivation. Social-needs screening is unlikely to be equitable when disclosure feels unsafe or futile, and measurement systems require fairness audits rather than assuming that undocumented need is absent. Likewise, programs intended to advance equity should assess who is reached, what burdens remain, and whether usable opportunities change.

The framework does not specify one superior intervention. It instead identifies where evaluation should occur: material conditions, encounter quality, organizational friction, psychological safety, behavioral participation, and distributional reach.

Results and Discussion

The assembled evidence supports a cautious reinterpretation of healthcare behavior. Structural disadvantage is associated with unequal material conditions, access, discrimination, trust, and life-course trajectories, but the literature does not establish one universal structural-to-psychological causal chain. Scarcity mechanisms remain heterogeneous, cognitive-load findings are conditional, service availability does not uniformly translate into utilization, and downstream interventions can produce mixed or null findings.

The proposed model is therefore best understood as a testable organizing theory. Longitudinal multilevel studies should measure structural exposure, psychological processes, observed behavior, and healthcare opportunity separately; comparative designs should test cultural and system dependence; and implementation studies should examine whether altering upstream conditions changes both material opportunity and encounter expectations. Reciprocal pathways also require explicit testing because mistrust, participation, and institutional response may influence one another over time.

The model's main boundary is equally important: structural explanation should not erase agency. Rather, agency should be interpreted within unequal sets of feasible options, expected risks, accumulated experiences, and institutional demands.

Conclusion

Healthcare inequity can remain hidden when downstream behavior is interpreted without reconstructing the conditions under which it occurred. The proposed structural-to-psychological model distinguishes material constraint, psychological exposure, relational experience, observable behavior, and realized health opportunity while allowing feedback and life-course accumulation. Its purpose is not to replace individual choice with structural determinism, but to prevent constrained adaptation from being mistaken automatically for free preference. Equity consequently requires attention to the conditions that make healthy action realistically possible, safe, and worthwhile.

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