The Limits of ‘Choice’ in Healthcare Access: A Critical Conceptual Perspective on Ethnic Minority Inequalities

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Abstract

Background:

Healthcare access is frequently framed in policy and practice as a matter of patient choice. This framing assumes that individuals are able to make informed and voluntary decisions about whether, when, and how to seek care. While widely used to interpret patterns of healthcare use, this assumption sits uneasily alongside persistent ethnic inequalities in access and health outcomes, particularly across European healthcare systems characterised by universal coverage but persistent inequities.

Aim:

This paper critically examines the concept of ‘choice’ as it is applied to healthcare access for ethnic minority patients, and advances a theoretically grounded alternative based on structural competence.

Approach:
The paper adopts a critical conceptual approach, drawing on scholarship from public health, medical sociology, and health policy. Rather than offering a systematic review, it uses established theoretical frameworks and selected empirical studies to examine how healthcare access is shaped by social position, institutional practices, and lived experience. It develops a conceptual framework that repositions healthcare access as structurally conditioned rather than individually determined.

Key arguments:
Behaviours frequently interpreted as patient choice, such as delayed presentation, non-attendance, or disengagement from services, are often better understood as responses to constrained circumstances. Language barriers, economic insecurity, administrative complexity, and experiences of discrimination significantly limit the options available to many ethnic minority patients. Building on this critique, the paper elaborates the concept of structural competence as a framework for understanding and addressing these constraints at the level of healthcare systems. Framing access as a matter of choice risks moralising disadvantage and shifting responsibility away from healthcare institutions.

Implications:
Moving beyond individualised notions of choice has important implications for policy, practice, and research. This paper proposes a structurally competent approach to healthcare access, outlining how institutions can operationalise this perspective through service design, accountability, and equity-oriented practice. Addressing ethnic inequalities in healthcare access requires greater attention to institutional responsibility, structural competence, and equity-oriented service design as foundations for meaningful patient autonomy, especially within European systems where formal universality coexists with stratified access. This paper makes a novel conceptual contribution by challenging dominant choice-based explanations of healthcare access and advancing structural competence as an alternative analytical framework for understanding ethnic minority inequalities within European universal healthcare systems.

Key Points

1. This paper argues that healthcare access for ethnic minority patients is too often framed as a matter of individual ‘choice’, despite being shaped by structural inequalities. Language barriers, economic insecurity, discrimination, and institutional complexity constrain meaningful autonomy, making many healthcare decisions responses to unequal conditions rather than freely exercised preferences.

2. Drawing on public health, medical sociology, and structural racism scholarship, the paper critiques behaviourally oriented models of healthcare access that individualise responsibility for unequal utilisation. It advances structural competence as an alternative framework that explains healthcare access as produced through institutional practices, social position, and broader relations of power.

3. The paper proposes a structurally competent approach to reducing ethnic inequalities in healthcare access, emphasising institutional accountability, equity-oriented service design, and reduced administrative burden. It argues that meaningful patient autonomy requires healthcare systems to address the structural conditions that shape access, particularly within European systems characterised by formal universalism but persistent inequity.

INTRODUCTION

Access to healthcare is widely regarded as a cornerstone of equitable health systems. In policy and practice, access is assessed through indicators such as service availability, utilisation rates, and patient engagement. These measures commonly rest on the assumption that individuals make active choices about seeking care and are broadly able to navigate healthcare systems on equal terms.[1,2] Missed appointments, delayed presentation, or low uptake of preventive services are interpreted as outcomes of patient decision-making rather than as reflections of systemic barriers.[3] For ethnic minority populations, this framing is particularly problematic. A substantial body of research has consistently documented ethnic inequalities in healthcare access and health outcomes across high-income countries.[4,5] This pattern is also evident across European contexts, where healthcare systems are organised around principles of universalism and equity, yet continue to exhibit marked ethnic disparities in access, utilisation, and outcomes.[6-8] In this paper, the term ‘ethnic minority’ is used as a socially and politically situated category that reflects historically produced patterns of marginalisation, racialisation, and unequal access to social and healthcare resources, rather than simply demographic minority status. Despite this evidence, explanations for unequal access revert to individual-level accounts, such as cultural beliefs, limited health literacy, or reluctance to engage with services.[9] These explanations implicitly position ethnic minority patients as autonomous actors making poor or irrational choices, while diverting attention away from the social, economic, and institutional conditions that shape those decisions. Healthcare access cannot be separated from individuals’ positions within social hierarchies structured by income, education, employment, housing, and legal status.[5,10] Ethnic minority groups are disproportionately exposed to socioeconomic disadvantage due to racialised labour markets, residential segregation, and the cumulative effects of discrimination over the life course.[11,12] Limited financial resources restrict the ability to absorb indirect costs of care, including unpaid time off work, transport expenses, childcare, and access to digital appointment systems. Under such conditions, what appears as a choice to delay or forego care often reflects constraint rather than preference. Across Europe, healthcare systems are assumed to deliver equitable access by virtue of universal coverage. However, comparative research demonstrates that ethnic minority and migrant populations continue to experience barriers to care, including unmet need, delayed access, and poorer quality of care. These patterns challenge the assumption that formal entitlement translates into equitable access in practice.[13,14]

Experiences of marginalisation further shape how ethnic minority patients engage with healthcare systems. Racism and discrimination, both within healthcare settings and across wider social institutions, are associated with reduced trust in providers, poorer communication, and worse health outcomes.[4,15] Anticipation of stigma or dismissal can influence decisions to delay or avoid care, behaviours that may be better understood as rational responses to prior harm rather than as disengagement or poor decision-making.[16] This paper argues that the concept of ‘choice’ is insufficient and potentially misleading when applied to healthcare access for ethnic minority patients. While previous research[4,5] has documented ethnic inequalities in healthcare access, less attention has been paid to how the language of ‘choice’ itself obscures the structural production of those inequalities. This paper’s central contribution is to reconceptualise healthcare access as structurally conditioned rather than behaviourally chosen, advancing structural competence as a framework for rethinking access within formally universal healthcare systems. Framing access as a matter of choice implies that individuals have meaningful alternatives and the freedom to act upon their preferences. This paper’s novel contribution is to reconceptualise healthcare access by directly challenging the assumption of meaningful ‘choice’ in explaining ethnic minority inequalities, and advancing structural competence as a more analytically robust framework for understanding how access is structurally produced rather than individually chosen. For many ethnic minority patients, however, decisions are made within contexts shaped by economic insecurity, discrimination, institutional complexity, and historical mistrust. In response, this paper advances a conceptual reframing of healthcare access grounded in structural competence, positioning access not as an outcome of individual decision-making but as a product of institutional and structural conditions. By doing so, it develops a more explicit theoretical account of how healthcare systems themselves produce or constrain the conditions for choice. The paper's contribution lies not simply in critiquing the discourse of patient choice, but in repositioning healthcare access itself as a structurally organised phenomenon.

ANALYTICAL APPROACH AND SCOPE

Conceptual Framework

This paper is a critical conceptual analysis rather than a systematic, scoping, or narrative review. Its aim to interrogate the conceptual assumptions underpinning the use of 'choice' as an explanatory framework in health policy and research. The analysis draws selectively on interdisciplinary literature from public health, medical sociology, health policy, and critical race scholarship. Sources were chosen to reflect influential theoretical frameworks such as social determinants of health, fundamental cause theory, and structural racism, as well as robust empirical studies that illustrate how healthcare access is shaped by social position, institutional practices, and lived experience. Empirical research is used illustratively to support conceptual arguments. Structural conditions are treated not as static background variables but as active forces that shape what is framed as patient 'choice'. This paper therefore contributes a theory-building exercise, synthesising existing critiques into a more explicit conceptual framework centred on structural competence as an alternative to choice-based models of healthcare access. In doing so, the paper moves beyond existing critiques of individualised access models by explicitly linking debates on patient choice to the structural competence literature. Rather than treating structural competence solely as a clinical orientation, the paper develops it as a broader framework for understanding how healthcare systems organise, constrain, and distribute access.

Conceptualising Choice in Healthcare

Choice occupies a central place in contemporary health policy, particularly in systems shaped by neoliberal governance. Within European health systems, the concept of patient choice has been actively promoted through reforms introducing provider competition, patient mobility, and quasi-market mechanisms. While intended to enhance efficiency and responsiveness, these policies have raised concerns about their distributional effects, particularly for socially disadvantaged and ethnically marginalised groups, as access to and benefits from 'choice' are unevenly distributed across populations and shaped by broader structural inequalities in European health systems.[17-19] It is commonly presented as both a marker of quality and a mechanism for enhancing accountability, efficiency, and patient empowerment,[2] driving system improvement by selecting providers, treatments, and modes of access. Meaningful choice requires available options, comprehensible information, and the practical capacity to act on preferences.[20]

In practice, these conditions are unevenly distributed. Social determinants such as income, education, employment, and housing strongly influence individuals' capacity to navigate healthcare systems and exercise choice.[5] Health literacy is also an endemic issue across populations and can further constrain healthcare-related decision-making by limiting individuals' ability to understand, interpret, and act on health information, thereby affecting the exercise of choice beyond ethnic minority groups alone. For ethnic minority patients, these determinants frequently intersect with racism, migration status, and linguistic exclusion, further narrowing the scope of possible choices. Despite this, patterns of healthcare use are often interpreted through an individualised lens. Non-attendance may be framed as disengagement, and lower uptake of preventive services attributed to cultural preferences. Such interpretations risk pathologising ethnic minority patients while obscuring the institutional conditions that produce exclusion.[21]

Structural Constraints on Choice for Ethnic Minority Patients

Language and communication

While many ethnic minority patients are fluent in the dominant language, language-related barriers remain significant for specific groups, including recent migrants, refugees, and some older adults. Limited proficiency can affect every stage of the healthcare journey, from booking appointments to understanding diagnoses and treatment plans.[22] Interpreter services are widely recognised as essential but remain inconsistently available, and reliance on informal interpreters such as family members is common.[2] Language discordance undermines informed decision-making and creates power imbalances that constrain meaningful choice. Studies consistently link language barriers to poorer communication, reduced adherence, and worse health outcomes.[23,24] When communication support is inadequate, apparent ‘choices’ may therefore reflect constrained responses to institutional failures in communication. Framing these outcomes as individual choices obscures institutional responsibility for providing accessible communication. In European contexts, increasing linguistic diversity linked to migration has intensified these challenges. Although many countries have formal provisions for interpretation services, access remains uneven and often dependent on local resources and institutional priorities.[7,25]

Economic and Time Constraints

Economic insecurity plays a central role in shaping healthcare access. Ethnic minority patients are disproportionately represented in low-paid and insecure employment, often with limited flexibility to attend appointments during standard working hours.[26] Even where care is free at the point of use, indirect costs such as transport, childcare, and lost income create substantial barriers. Long waiting times, fragmented care pathways, and repeated appointments require sustained investment that may be unmanageable for individuals balancing multiple jobs, caring responsibilities, or unstable housing. Delayed or forgone care under these conditions is better understood as a response to structural constraint than individual preference. Evidence from across Europe indicates that unmet healthcare need remains socially patterned, with lower-income and migrant populations more likely to forgo care due to financial, administrative, and time-related barriers, even within systems that provide universal coverage.[14]

Discrimination and Mistrust

Experiences of racism and discrimination within healthcare settings further shape access for ethnic minority patients. Such experiences contribute to mistrust, dissatisfaction, and disengagement and reflect broader patterns of institutional racism rather than isolated interpersonal encounters.[4] Patients who anticipate stereotyping or dismissal may delay seeking care or disengage from treatment. These behaviours are often labelled as non-compliance, yet research shows they frequently represent protective responses to prior harm.[27] Experiences of discrimination are associated with reduced trust in medical advice and lower uptake of preventive interventions, including vaccination.[28] Research across multiple European countries has documented experiences of discrimination in healthcare among ethnic minority populations, reflecting broader patterns of structural racism and contributing to inequalities in trust, access, and outcomes.[6,29,30]

The Moralisation of Access and Responsibility

Emphasising choice in healthcare access carries implicit moral judgements. Patients who do not engage with services as expected are often framed as irresponsible or undeserving, particularly in discussions of missed appointments and preventive care.[31] Ethnic minority patients are disproportionately positioned within these narratives, reinforcing racialised assumptions about compliance and motivation.[32] Such framing shifts responsibility away from institutions and onto individuals, rendering structural barriers invisible and legitimising interventions focused on behaviour change rather than institutional reform. This moralisation risks deepening mistrust and reinforcing existing inequalities.

DISCUSSION

Rather than reiterating existing critiques of individualised models, this paper extends them by integrating these insights within a structural competence framework, offering a more explicit account of how healthcare systems can be reoriented to address ethnic inequalities in access. This paper has argued that framing healthcare access as a matter of patient choice provides an incomplete and, in some cases, misleading account of ethnic inequalities in access and use. While the language of choice is deeply embedded in health policy and service design, it rests on assumptions that are not equally realised across social groups. In particular, it assumes that patients have similar levels of time, financial security, institutional familiarity, and freedom from discrimination conditions that are patterned by ethnicity and socioeconomic position.[5,33] Much existing research on healthcare access draws on behavioural models, most notably Andersen's Behavioural Model of Health Services Use.[1] These models have been influential in identifying disparities in utilisation and highlighting differences between population groups. They remain widely used in policy-oriented research because they offer a clear structure for analysing access in terms of individual characteristics, enabling resources, and perceived need. However, a growing body of scholarship has questioned whether these models are well suited to explaining inequalities rooted in structural disadvantage.[34]

One limitation of behavioural models is that they tend to treat structural conditions such as poverty, racism, or insecure employment as background factors rather than as active forces shaping decision-making. Ethnicity is often included as a demographic variable, but the social processes that produce ethnic disadvantage are left largely unexamined. As a result, behaviours such as non-attendance, delayed presentation, or low uptake of preventive services can appear as individual choices rather than as responses to constrained circumstances. This paper supports earlier critiques which argue that such frameworks risk locating responsibility for unequal access at the level of the individual rather than the system.[34] In contrast, social determinants of health frameworks and fundamental cause theory provide a more convincing account of ethnic inequalities in healthcare access. Link and Phelan[10] argue that access to flexible resources such as money, knowledge, power, and social connections shapes health outcomes across contexts and over time. From this perspective, healthcare access is not simply a matter of motivation or preference but is fundamentally tied to social position. Marmot[5] similarly demonstrates how disadvantage accumulates across the life course, influencing exposure to risk and access to care long before individuals make contact with health services. The concept of choice appears far less neutral or empowering than policy narratives suggest. For individuals with stable employment, flexible schedules, financial buffers, and confidence in navigating institutions, choice may indeed enhance autonomy. For many ethnic minority patients, however, choice operates under very different conditions. Economic precarity, language barriers, insecure immigration status, and prior experiences of discrimination narrow the range of realistic options long before any formal decision is made.[11,12] The European context provides a particularly important lens for interpreting these findings. Despite longstanding commitments to universal healthcare, many European systems continue to exhibit persistent ethnic inequalities in access and outcomes. This apparent paradox, universal coverage alongside unequal access, highlights the limitations of frameworks that rely on individual choice as an explanatory mechanism and underscores the importance of structural analysis.[8,13]

This paper suggests that, under such conditions, choice can function as a stratifying mechanism. Within European healthcare systems, policies that expand patient choice may inadvertently widen inequalities if they fail to account for differences in resources, health literacy, and institutional familiarity. Individuals with greater socioeconomic and cultural capital are better positioned to navigate complex systems and benefit from expanded choice, while those facing structural disadvantage may experience choice as an additional burden.[17,18]

Policies that emphasise choice often increase the cognitive, administrative, and emotional work required to access care. Booking appointments, comparing providers, attending multiple referrals, and advocating for oneself all demand time, confidence, and institutional knowledge.[31] For patients already facing multiple pressures, these demands can become barriers in themselves. Research on patient choice has shown that individuals with fewer resources are less able to benefit from expanded choice and may experience it as confusing or burdensome rather than empowering.[35,36] Experiences of racism and discrimination further shape how ethnic minority patients engage with healthcare systems. A substantial body of evidence shows that perceived and experienced discrimination in healthcare is associated with lower trust, poorer communication, reduced satisfaction, and worse health outcomes.[4,15,21] These experiences do not simply affect individual encounters but influence future decisions about whether, when, and how to seek care. Avoidance, delay, or disengagement are often interpreted within policy discourse as poor choices or lack of compliance. However, critical scholarship has highlighted that such behaviours can represent rational responses to anticipated harm, dismissal, or stereotyping.[16,27] When patients expect not to be listened to or taken seriously, disengagement may function as a form of self-protection rather than irresponsibility. Framing these responses as choices made in a neutral context obscures the relational and historical dimensions of healthcare access. The emphasis on choice also carries important moral implications. Patients who do not use services as expected are frequently positioned as irresponsible, disengaged, or undeserving, particularly in discussions of missed appointments and preventive care.[31] Ethnic minority patients are disproportionately affected by these narratives, which often draw on racialised assumptions about culture, motivation, or compliance.[32] Such framing shifts attention away from institutional practices and places the burden of access on individuals, reinforcing stigma and mistrust.

Structural competence offers a more analytically robust alternative to choice-based approaches because it shifts attention from individual behaviour to the institutional and structural organisation of healthcare access. Unlike cultural competence frameworks, which often focus on improving clinician awareness of difference at the interpersonal level, structural competence examines how policies, administrative systems, funding arrangements, labour markets, immigration regimes, and institutional practices shape clinical encounters and patterns of access.[27] In this framework, inequalities in healthcare access are not viewed primarily as failures of patient engagement but as predictable outcomes of structurally uneven conditions. This distinction is important because it changes both the explanatory focus and the locus of responsibility. Choice-based models tend to interpret healthcare utilisation through the lens of individual decision-making, whereas structural competence situates those decisions within broader relations of power, constraint, and institutional organisation. In doing so, it provides a framework for analysing how healthcare systems themselves actively produce unequal conditions of access, even within systems formally committed to universalism and equity.

Operationalising Structural Competence in Healthcare Access

Structural competence offers more than a critique of existing frameworks; it provides a basis for rethinking how healthcare systems are designed and evaluated through the lens of healthcare access inequality, and the structural conditions that shape administrative burden in accessing care. To move beyond abstraction, this section outlines how structural competence can be operationalised across three interrelated domains: clinical practice, organisational design, and research. First, at the level of clinical practice, structural competence requires clinicians to recognise how social and institutional conditions shape patient behaviour. Non-attendance, delayed presentation, or disengagement should not be interpreted solely as individual choices but as potential indicators of structural barriers and the unequal administrative burden embedded within healthcare systems. This shift reframes clinical encounters, encouraging practitioners to ask not only why a patient did not attend, but what conditions made attendance difficult or costly. Second, at the organisational level, structural competence involves redesigning services to reduce the burden placed on patients to navigate complex systems. This may include simplifying appointment systems, improving the availability and quality of interpreter services, offering flexible scheduling, and reducing administrative barriers and administrative burden that contributes to structural inequality in healthcare access. In doing so, responsibility for access is repositioned as an institutional obligation rather than an individual task. Third, at the level of research, a structurally competent approach requires moving beyond the treatment of ethnicity as a fixed variable and instead examining the processes through which inequality is produced. This includes greater use of qualitative methods, intersectional analysis, and engagement with critical race theory to understand how healthcare systems reproduce disadvantage. Importantly, operationalising structural competence requires moving beyond diversity rhetoric or culturally sensitive communication alone. A structurally competent approach would require healthcare organisations to examine how institutional rules, appointment systems, referral pathways, digital access requirements, and workforce practices may systematically disadvantage particular groups. This shifts equity work from the margins of professional training into the core organisation of healthcare systems themselves. Taken together, these dimensions illustrate that structural competence is not simply an abstract ideal but a practical framework for reorienting healthcare systems toward equity and reducing healthcare access inequality. By specifying concrete domains of action, this framework extends existing critiques of choice-based models and provides a clearer basis for institutional and policy intervention. In this sense, it provides a concrete alternative to choice-based models by specifying how institutions can create the conditions necessary for meaningful, rather than nominal, patient autonomy. In European healthcare systems, operationalising structural competence requires aligning equity goals with existing commitments to universalism. This includes embedding equity indicators into system performance frameworks, strengthening accountability for disparities, and ensuring that policies centred on patient choice do not exacerbate existing inequalities.[13]

This approach aligns closely with the arguments advanced in this paper, as it recognises that access problems are often produced by systems rather than by patients themselves. Importantly, moving beyond choice does not mean rejecting patient autonomy. Instead, it involves recognising that autonomy is shaped by social and institutional conditions. As Kyle et al.[35] argue, meaningful choice requires not only options but also the ability to act on them without undue constraint. In contexts characterised by economic insecurity, discrimination, and complex administrative systems, the language of choice risks overstating the degree of freedom patients actually possess.[37] The implications of this analysis are clear. For researchers, there is a need for greater caution in using choice-based explanations for ethnic differences in access and utilisation. Treating ethnicity as an independent variable without examining the processes that produce inequality risks reifying difference rather than explaining it.[11] Greater engagement with critical race scholarship, political economy, and qualitative research on lived experience would strengthen analyses of access. For policy and practice, interventions focused solely on changing patient behaviour are unlikely to reduce inequalities. Instead, efforts should focus on reducing institutional barriers, simplifying access pathways, improving communication support, and embedding accountability for equity within healthcare organisations.[28,38] Designing systems that work for those facing the greatest constraints is a prerequisite for meaningful choice, not an alternative to it. Overall, this paper reinforces the argument that healthcare access cannot be adequately understood through the lens of individual choice alone. When detached from structural context, choice obscures power relations, moralises disadvantage, and shifts responsibility away from institutions. A structurally informed reframing of access is therefore essential for addressing ethnic inequalities in healthcare in a way that is both analytically robust and ethically defensible.

CONCLUSION

Healthcare access continues to be framed as a matter of patient choice, yet for many ethnic minority patients, choices are shaped and constrained by socioeconomic insecurity, discrimination, and institutional complexity. Treating access as an individual decision obscures these realities and risks reproducing inequities within healthcare systems. This paper has argued for a shift away from individualised and behaviourally oriented explanations of healthcare access toward a structurally competent framework in which responsibility for equitable access is understood as an institutional and systemic obligation rather than an individual burden. In the European context, where healthcare systems are often assumed to be equitable by design, recognising the limits of 'choice' is particularly important. Without attention to structural inequalities, the language of choice risks obscuring the mechanisms through which inequities are reproduced, even within universal systems.[8,14] Rethinking choice is not a rejection of patient autonomy but a necessary step toward creating the conditions in which autonomy can meaningfully exist. By operationalising structural competence as a guiding framework, this paper contributes a theoretically grounded and practically relevant approach to addressing ethnic inequalities in healthcare access.

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