Social Science & Medicine 374 (2025) 118043

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Fundamental causation and candidacy: Harnessing explanatory frames to better understand how structural determinants of health inequalities shape disengagement from primary healthcare

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ARTICLE INFO

Handling Editor: Medical Sociology Office

ABSTRACT

This paper aims to better understand how structural determinants of health inequalities shape disengagement from healthcare for vulnerable groups across a range of social conditions. Using a sub-sample (N = 20) from a qualitative interview UK study of those missing from primary-care, it illuminates how structural drivers of health inequalities operate at organisational and practice levels to weaken engagement with primary-care. Finding ways of better analysing and demonstrating the causal chains between structural determinants and patterns of disengagement is important because previous research has shown that practitioner and policy understanding of structural determination, an important precursor for mitigatory action, is not always sufficient, and research on healthcare utilisation can itself be weak in investigating structures of inequality.

We address this deductively by testing a novel combination of Link and Phelan's Fundamental Cause Theory and Dixon-Woods and colleagues' Candidacy framework. Combining elements of these frameworks compensates for identified gaps in each. We demonstrate how Candidacy can be strengthened through incorporating more systematic theorisation of structural processes and that the more abstract arguments of fundamental (structural) causes can be made concrete via Candidacy's focus on inequalities in patients' access to, and utilisation of, healthcare. We also argue that both theories are enhanced by including Metzl and Hansen's concept of 'structural competency' as a potential mitigatory mechanism operating between fundamental causes and patient engagement.

1. Introduction

This paper addresses how we can best understand relationships between structural determinants of health and patterns of engagement/disengagement with primary healthcare for vulnerable groups. By 'structural', we refer to macro-level political, economic, legal and social mechanisms – laws, policies, regulations, budgets, institutional practices and associated values, beliefs, cultures and norms (Heller et al., 2024:357) – which (re)produce social stratification and class structures, sorting individuals and groups into socioeconomic positions in hierarchies of power, status and access to various forms of resources (CSDH, 2008). Structural *determinants of health* relate to the decisions and processes that (re)produce (or mitigate against) the unequal structuring of (dis)advantage in the conditions shaping health, including those deployed by the most powerful to maintain their advantage (Heller et al., 2024:351). This distinction between the structural determinants of health and wider *social determinants of health* is important; policies may improve the everyday "conditions in which people are born, grow,

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https://doi.org/10.1016/j.socscimed.2025.118043
Received 12 September 2024; Received in revised form 27 February 2025; Accepted 28 March 2025
Available online 4 April 2025

work, live and age" (CSDH, 2008: 1) but leave unaddressed the underlying structural processes and power imbalances by which these conditions are unequally distributed (Heller et al., 2024).

Much of the literature on structural drivers locates these at the upstream, macro-level with insufficient consideration of how structures of inequality are replicated within meso/organisational-level processes and micro-level encounters between service users and health-care professionals (Crammond and Carey, 2017). Given evidence that healthcare professionals (Bourgois et al., 2017; Metzl and Hansen, 2014) and healthcare-focused researchers (Ahmed et al., pre-print) can demonstrate limited understandings of the structural determinants of health, firm understanding of causation from macro-level structures to everyday practices of disengagement from services could improve mitigation approaches.

We bring together two theories: Link and Phelan's Fundamental Cause Theory (FCT) (1995, 2010) and Dixon-Woods and colleagues' Candidacy Framework (Candidacy) (2005). While both are well-utilised in research, they focus on differing ends of the macro-micro spectrum. FCT focuses on structural determinants of health, while Candidacy offers a meso-to-micro-level consideration of unequal journeys into/through health services. We use data from a study examining healthcare disengagement amongst populations with different vulnerabilities to explore how integrating the theories enhances understanding of how structural determinants influence processes shaping health at meso-micro-levels.

We describe our study background before outlining the theories and describing how we combined them analytically. Then we detail the methods and findings showing how the two frames provide synergies in understanding how structural drivers shape experiences of primary healthcare engagement. We discuss the strengths and weaknesses of this approach and identify the importance of structural, and related, condition competency (Metzl and Hansen, 2014) in both mitigating the health consequences of social inequalities and as an addition to both FCT and Candidacy.

2. Study background

We use data from an investigation of 'missingness' in UK primary-care. Missingness is 'the repeated tendency not to take up offers of care such that it has a negative impact on the person and their life chances' (Lindsay et al., 2024:3). The original epidemiological research found that those missing multiple appointments are more likely to live in poorer socioeconomic circumstances and have higher levels of multi-morbidity and premature mortality (Ellis et al., 2017, McQueenie et al., 2019). It highlighted the need for increased understanding of the lived-experiences of those most likely to disengage from services. The resulting study focused on missingness across different vulnerabilities often within the context of 'inclusion health', concerned with addressing 'extreme health and social inequities' (Luchenski et al., 2018:266). The study provides rich data of multiple social, economic and health disadvantage.

2.1. Fundamental Cause Theory

FCT (Link and Phelan, 1995) accounts for the endurance of health inequalities (HI) across time and place despite sweeping changes in disease patterns across populations (from cholera to cardiovascular disease to Covid-19) (Clouston and Link, 2021). In FCT, the enduring relationship between fundamental causes and health outcomes is understood not only as association but one within which certain causes *fundamentally determine* health outcomes. Link and Phelan (1995) first articulated socioeconomic position (SEP) as a fundamental cause. More recently, other fundamental causes have been elaborated on, including racism (Phelan and Link, 2015). The evolving theory and central criticisms are elaborated in Fig. 1.

Fundamental causes shape a vast and diverse array of *mechanisms* (the specific causal linkages between fundamental causes and health outcomes in a given context) which, in sum, sustain the relationship between fundamental causes and multiple direct causes of morbidity

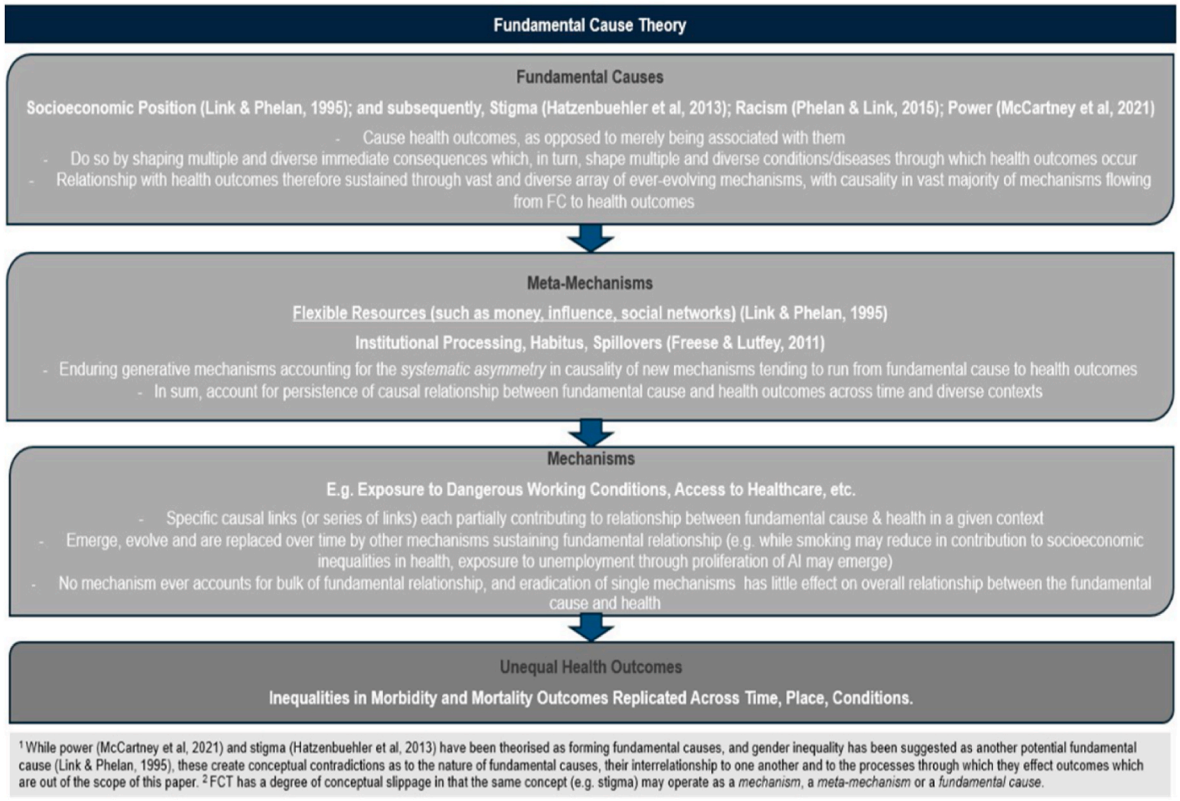

Fig. 1. Central components of fundamental cause theory (Hatzenbuehler et al., 2013).

and mortality (Lutfey and Freese, 2005:1331). Each *mechanism* provides only a partial contribution, such that each could be eradicated with little effect on the overall relationship (Lutfey and Freese, 2005), rendering ineffective any attempt to tackle HI through targeting proximal *mechanisms* alone (Zapata-Moya et al., 2023).

Importantly, FCT predicts that *mechanisms* will be systematically replaced over time in such a way that the causal relationship between FCs and health is sustained. '*Meta-mechanisms*' – durable generative mechanisms linked to FCs – are posited to account for this process (Freese and Lutfey, 2011). The original and central *meta-mechanism* is *flexible-resources*, whereby unequal SEP gives rise to differential access to resources (material, social, informational) which can be flexibly deployed to bolster health and avoid/mitigate the consequences of disease (Link and Phelan,1995). While this remains FCT's 'workhorse construct', Freese and Lutfey (2011) argue that its focus on agentive, individual deployment of resources overlooks many ways that health benefits are distributed unequally and propose additional *meta--mechanisms*: *habitus*, *spillovers* and *institutional-processing*.

In the context of this study, we place focus on the additional *meta-mechanism* of *institutional-processing* – the differential treatment of individuals and groups at an organisational level based on aspects of their status – alongside *flexible-resources*.

Lutfey and Freese (2005) ethnography of two US diabetes clinics serving contrasting socioeconomic populations illustrated several *mechanisms* through which *institutional-processing* reproduced wider socioeconomic inequalities in diabetes outcomes, including; funding inequalities affecting the quality of care; differential treatment regimens due to professionals' perceptions of patients' ability to manage complex treatment burdens; and clinicians' failure to understand patients' external circumstances, resulting in individualised explanations for, and responses to, treatment non-compliance.

Because proximal *mechanisms* shift in their relative contribution to the fundamental relationship over time and context, such an exposition of *mechanisms* is rare in FCT research. However, for researchers, policymakers and practitioners concerned to limit the further realisation of inequalities at healthcare engagement/utilisation level, it remains important to understand how political and economic structures determine drive such mechanisms.

While there remains space for further theorisation including clarification of the status and levels at which certain concepts such as power and stigma operate (Clouston and Link, 2021), FCT still valuably provides a robust theory accounting for the replication of health inequalities across diverse contexts, and in moving beyond 'deficit-based' models – which depict poor health as stemming from the failures of those who are disadvantaged – towards elucidating the causal processes through which structural determinants come to shape health unequally.

2.2. Candidacy

The second frame of interest is Candidacy (Dixon-Woods et al., 2005). Candidacy is a heavily-utilised theory of inequalities in access/service utilisation, developed by medical sociologists via a critical interpretive synthesis of literatures on healthcare access inequalities for marginalised/underserved populations. Candidacy was selected for the current study because of its explicit focus on inequalities across a range of vulnerabilities. It synthesises wide-ranging literatures including disparate sociological and psychological theories of 'social barriers', patient identities and help-seeking, health-service research on usage and organisational form and economic theories of supply/demand. The framework renders patient and engagement with services using an implicit journey metaphor, from: the *identification* of healthcare need; the physical, cognitive and emotional work required to *navigate* services; patient *presentation* to services; the adjudication of presentations by professionals; to *offers of* care and their *uptake* by patients. Engagement with care and treatment is viewed as a socially-constructed accomplishment of the patient in tandem with healthcare professional(s), located within local operating conditions (contextual elements impinging on the 'journey' described above) and shaped by socially-patterned expectations of what healthcare need and demand entail (Dixon-Woods et al., 2005). Although the stages of Candidacy are typically operationalised as discrete chronological stages, the frame explicitly emphasises recursivity and dynamic relations between patients and professionals. Within each stage of Candidacy, a contextually and temporally shifting array of *mechanisms,* through which inequalities develop, operate.

While Candidacy offers some conceptual clarity in understanding how existing inequalities can be exacerbated by health services (e.g., Liberati et al., 2022; Mackenzie et al., 2013), two main criticisms are salient. First, while the original framework recognises the existence of structural inequalities and their association with service access and utilisation, it doesn't discuss *how* these inequalities arise. Related, reflecting the limitations of the health-services literature from which it was synthesised, its explanations of how existing inequalities are reproduced are not sufficiently structural and thus do not offer solutions for tackling the root causes of HI. For example, the resources that socio-economically disadvantaged groups are posited to lack - 'Information, knowledge and beliefs, confidence in self-diagnosis and self-management, social support, advocates, practical resources, psychological resources'(ibid, 2005:p.35) - are not systematically connected to power, discrimination and marginalisation unlike flexible resources depicted within FCT. This then impacts on how Candidacy is used by researchers. Some explicitly deploy and argue for an overarching structural analysis that connects explicitly to healthcare access and utilistation, for example, analysing how racism (Koehn et al., 2016a), colonial power structures (Green et al., 2021), and intersections of gender/class (Mackenzie et al., 2019, 2020) impact on access and service experience. These approaches contrast with what we might call a 'social-determinants lite' approach. Examples of this are widespread in the Candidacy literature including: a review of primary care access (Sinnott et al., 2024) which covers socio-economic inequalities minimally, and never in terms that seeks nto understand their prior determinants; Tarrant and colleagues (2015) and Tookey et al. (2018), who apply Candidacy with a focus on interactional communications but do not address existing social inequalities; and, Hudson et al. (2016) who explore cultural reasons for uncontrolled asthma in South Asian communities without including potential structural racism in their analysis. There is, thus, a tendency within the Candidacy literature to treat existing social inequalities as phenomena related to patterns of access without exploring why these phenomena exist as they do. Candidacy, thus, leaves space for researchers to engage with structural thinking but does not guide its capture and analysis for those who use it without familiarity of the structural determinants of health; a lost opportunity to better understand and act upon the structural determinants of inequality in healthcare engagement.[1]

A second, related weakness can be levelled against Candidacy. Its focus on healthcare and its 'local operating conditions' such as staffing levels (whilst legitimate in terms of the purpose of the original research) does not sufficiently emphasise that, in comparison with wider social and economic determinants, healthcare plays a relatively minor role in the creation of HI (Mackenbach, 2016). Further, healthcare engagement sits within a wider ecosystem of public service and citizen engagement. Anon and colleagues (2013) have therefore argued that there is a need to analyse Candidacy in a wider inter-sectoral sense, viewing socially-patterned interactions with education, criminal justice, housing and health etc. as intertwined across life histories. Both these critiques, we

[1] McCartney et al. (2021) see power as encompassing *power-over* others, *power-to* do to others and *power-with* others (usually framed as empowerment). It covers power emanating from economic, informational, state, cultural and positional sources. We conceptualise power here as a component of the differential resources patterned by SEP.

argue, are important in thinking about marginalised groups whose lives come into most formal contact with statutory services.

3. Integrating FCT and candidacy – operationalising our conceptual framework

We bring together FCT and Candidacy (Fig. 1) to demonstrate how they strengthen each other through addressing less well-specified components – a structural lacuna in candidacy and a missing focus on specifying mechanisms operant across different contexts on the part of FCT. Our central research question is: do FCT and Candidacy combined illuminate how structural inequalities impact on access to, and utilisation of, primary-care for those with significant intersecting social, economic and health vulnerabilities?

Starting at the top, the macro/structural level where candidacy is weakest, we use FCT concepts, in particular the Fundamental Causes of SEP and racism) and the *meta-mechanism* of *flexible-resources*. We interrogate our data to show how those with professional- or lived-experience of social vulnerabilities understand the structural drivers of disengagement from primary healthcare. What policies and mechanisms do they pinpoint as shaping these experiences?

Moving down, at the meso/organisational level, we ask how structures of inequality at the macro-level shape what organisations do that might constrain engagement with healthcare. We continue to use fundamental causes and *flexible-resources* but add in the concepts of *operating-conditions* from Candidacy and Lutfey and Freese's *institutional-processing* (2006). These we argue have potential to be functionally equivalent *as long as operating conditions are expanded beyond the 'local' of the Dixon-Woods framework and beyond healthcare to other state and third sector provision* (Mackenzie et al., 2013). Each of these concepts or 'meta-mechanisms' generate possible *mechanisms* within particular service contexts. We use our data to identify mechanisms operant in our study (remembering that mechanisms, as *per* FCT, are endlessly evolving/replacing).

Finally, at a micro level, we continue to explore fundamental causes, *flexible-resources* and *institutional-processing/operating-conditions* as they manifest in patients' engagement with healthcare. We use a modified version of Candidacy and collapse some of the interlinking elements. Thus, as in previous work (Mackenzie et al., 2019, 2020), we combine *navigation* and *permeability* which significantly overlap, particularly given that UK primary-care operates as gatekeeper to onward healthcare. We discuss *identification* alongside these stages. While *identification* usually refers to recognising that one has healthcare needs, we broaden this to *identification* of need for *sustained* healthcare engagement (Koehn et al., 2024). Finally, we merge *presentation/adjudication* with the *offer/take-up of* support as these occur in dynamic encounters rather than separately.

4. Methods

4.1. The missingness study

Our study of 'missingness' had three parts: (1)a realist literature review (Lindsay et al., 2024); (2)qualitative semi-structured interviews with 28 people with experience of clinical, social or inclusion health issues known to correlate with primary-care non-attendance and 33 professionals supporting such groups (three of whom fell into both categories); (3)co-production stakeholder-workshops to discuss 'missingness' causes and solutions. We report on the interview data.

The overall study was approved by the Anon Research Ethics Committee in 2022: Reference:00220187. Questions in the interview schedule focused on drivers of missingness from the structural and organisational to the dynamics within healthcare interactions. The study used purposive and snowball sampling. Table 1 shows the breakdown of the study sample and subsample.

Table 1
Interview participant roles.

Category	Service/Vulnerability	No. Participants (Total)	No. Participants (Sub-Sample)
Professional	Third-Sector Specialist Service pertinent to Inclusion Health	10(3)[a]	7(2)[a]
Professional	NHS Inclusion Health	8	2
Professional	Local/National (Scotland/UK) Level Strategic/Policy Role	6	0
Professional	NHS Mainstream Healthcare	5	1
Professional	NHS Specialist Service pertinent to Inclusion Health	4	0
Expert-by-Experience	Participants with a range of vulnerabilities: e.g., homelessness, asylum-experienced, poverty, domestic abuse, diabetes, mental health condition(s), problem substance-use	28	10
Total		61	20

[a] Brackets indicates who were professionals *and* had their own lived experience of missingness in healthcare.

4.2. Subsample

We selected a purposive sub-sample of the full sample, because our aim is not to account for all explanations of 'missingness' but to examine the analytical advantage of combining FCT and Candidacy. Drawing this sub-sample involved identifying those offering heterogeneous vulnerabilities with narratives of 'missingness' placing substantial focus on wider organisational and structural contexts as well as the micro-level. Compared to the overall sample, the participants were more likely to be/work with those in the inclusion-health category. When referring to participants, we provide their pseudonym and role. *Analysis*.

Transcripts, coded using NVivo, were analysed using the framework described. The analytical framework was developed deductively and applied to identify instances where inequalities in *flexible-resources and institutional-processing/operating-conditions* generate poor health across levels and through the candidacy journey. AuthorA and AuthorB discussed coding and analysis in data-surgeries; findings were discussed with all authors.

4.3. Positionality

As a research team we have no singular positionality – we are multidisciplinary across clinical/social sciences with differing backgrounds (class, gender and race). The commonalities in our positionality include that: we have all either worked with people experiencing the vulnerabilities set out in this paper or have researched their lived experiences; and, we focus on policy research rooted in structural understandings of health inequalities.

5. Findings and discussion

The findings are discussed in three parts (see Fig. 3), analogous to the levels of our framework. First, we use our data to consider the macro-level structural/policy context for those in conditions of social, economic and health vulnerability and how this shapes disengagement from healthcare. We focus on the *meta-mechanism* of ill-distributed *resources* and mechanisms of *stigmatisation*. Then we explore the interrelated meso (organisational) context as reflected in participants' experiences of the financial and regulatory context for the National Health Service (NHS) as manifested at local levels, as well as the context for public, third-sector and community functioning. These two sections provide the multi-layered context which make up the *operating-conditions* for

participants' journeys into and through healthcare, including the *flexible-resources* available to institutions and the *institutional-processing* they deploy. The final section brings in the Candidacy journey more fully in tandem with a structural foregrounding and considers how these contexts shaped participants' experiences of candidacy for healthcare engagement including identification of need, the work required to navigate services, and the nature of the encounters experienced, including the offer/uptake of further support.

1. Macro-inequalities: the structural context

Link and Phelan's (2006) fundamental causes of SEP inequalities and racism were identified by participants (alongside parallel structures of inequality of gender and disablism), as explaining how they, or those they support, are excluded from society and policy decision-making, with implications for their healthcare engagement. Jason (Expert--by-Experience16) describes how he became disconnected from societal safety-nets (housing, social security, education) following extreme childhood poverty and subjected to pervasive sexual abuse and racism. These experiences, compounded by stigmatisation, restricted access to material and social *resources (*taken for granted by more advantaged people) for negotiating his life and health trajectories:

> "I got abused … left home at 15 … ended up on the street … And they sent me to prison, my first time, for the vagrancy act. That officer was the officer that gave me mouth-to-mouth resuscitation, after I'd been smothered, and killed, flatlined, as a ten-year-old child … Can you see all these layers of orange peel, why I do not trust any service?"

Niamh (Professional18), support worker for the Gypsy-Traveller community, quotes Trevor Philips (UK Equality and Human Rights Commission), calling anti-Traveller antagonism: *"the last bastion of racism",* noting that, in her support role, "we hear [about] this all the time". Meanwhile, the government-designated 'hostile environment' towards migrant groups viewed as 'undesirable,' introduced under Cameron's 2010 Conservative-led coalition, leaves Fatima (Expert-by-Experience22), an asylum seeker, feeling hopeless: "*It's so difficult to be sick in this country, because there is no way to survive"*. Here, political decisions terminate life-line *resources* and introduce hostile *institutional-processing/operating conditions* which have a direct impact on access to care via mechanisms of *structure-blind bureaucracy*. Gillian (Professional29), a women's advocate, positions domestic abuse and its links to reduced healthcare engagement as a sequela of women's broader societal inequality:

> "Until women aren't poorer than men and are at the tables that distribute resources in their community and have equal say over the resources in the family … we're not really going to shift the dial."

Taken together, these experiences align with Wright's (2023) depiction of predominantly white, privately-educated men as architects of welfare reform policies impacting most severely on working-class women, and with McCartney and colleagues' (2021) power framework[1] where *power-over* captures how elites dominate legal, economic and policy machinery. Justine (Professional15) suggests that this 'not-being-at-the-table' results in disengagement in poor areas:

> "When I look at the top of healthcare now … often they've come through graduate entry schemes or moved in from the private sector […] and always had a salary, and I think they live in a very different place … they don't sit alongside these [marginalised] people."

The structural inequalities above can be seen to be reproduced through *mechanisms* of stigmatisation as well as invisibilisation and direct exclusion, all detrimental to healthcare engagement. As Niamh (Professional18) highlights, these are endorsed by certain political and media elites:

> "If people in political positions and MPs didn't use their parliamentary privilege to talk about other groups in disparaging ways. That would be a first thing, to set good examples in the structures that we are living in … Stop the press … from recycling tropes and memes."

Again, this reflects McCartney et al.'s *power-over* concept (2021) and to elite self-interest in exercising the *flexible-resources* of political and professional power (Walsh and Dillard-Wright, 2020; Ignatow and Gutin, 2024) such that they shape government decisions and media narratives leading to inequality sustaining *institutional-processing/operating conditions*.

Participants also discuss problematic economic and social policies emerging from these processes and forming the structural context within which inequalities in healthcare engagement develop. Ruth (Professional22) identifies the decimation of the mining industry as having generated long-lasting, devastating effects on the wellbeing of her GP practice community, while Justine (Professional15) describes the "catastrophically disproportionate" effects of social security sanctions for those falling foul of increasingly draconian conditionality regimes. Austerity policies and the cost-of-living crises have had overlapping, deleterious impacts disproportionately affecting those in the most difficult socio-economic conditions and, for many of our professionals, explain subsequent disengagement from services: *"It's just trauma on trauma, isn't it? You see people get themselves better and then something else happens and it's like snakes and ladders. There's always a snake"* (Justine, Professional15).

Many participants reflect on the political choices made by governments which have shaped this structurally divisive context. Kate (Professional25), a civil servant, acknowledges that UK political interest in HI *"has plateaued and then taken a nosedive."* Stephen (Professional/Expert-by-Experience2), a support worker who had experienced problem substance use and ill-health, asks:

> "*Why not have a war on inequality?.. If they can afford this war on drugs that's cost us billions of pounds every year … a war on homelessness, a war on racism?*"

In summary, the structural context is recognised and experienced by participants as consisting of long-established systems of economic and political power directly resulting in policies sustaining the conditions for growing social inequalities via the iniquitous distribution of *material* and *power-to* influence resources and these in turn shape *institutional-processing/operating-conditions*. At the same time, *power-over* mechanisms can be seen in media representations of multiple vulnerable groups. While Candidacy and its research application rarely makes use of such concepts, the incorporation of FCT allows for a shift in focus beyond *local and healthcare operating conditions* towards elucidating how structural determinants provide the wider context through which inequalities in healthcare access are produced. Next, we discuss how this structural context shapes organisations such as the NHS and sister delivery organisations.[1]

2. Meso-level Inequalities: Organisational Context

Macro or structural/policy levels primarily imbue the organisational level via legal and policy frameworks. These shape how organisations operate nationally and form the context for primary-care. Here, concepts of *institutional-processing* and *operating-conditions* can come together to demonstrate structures of inequality as organisations respond to macro-level austerity and iniquitous distribution of resources between geographical areas. In this section we set out examples of how organisational decision-making increased experiences of exclusion and vulnerability via mechanisms of *resource allocation, condition (de)prioritisation* and *stigmatisation of certain patient groups* in the service of demand management. Each of these operates as mechanisms within Lutfey and Freese's meta-mechanism of *institutional-processing and Candidacy's operating-conditions.*

Unlike those with resources to pay for private healthcare, Vincent (Expert-by-Experience14) describes how the healthcare management of his mental health conditions has deteriorated over recent years, which he perceives as punishment for those living with such conditions:

> "*You feel the object of just a cold system … The punitive aspect comes, really, from the systems are collapsing. My conditions, diagnoses have never changed … however, the rationing began a long time ago … They've depleted it to a point where, where do we go?*"

Jodie (Expert-by-Experience2) echoes this experience of services cut to the bone: "*health and social care in the community, is on its knees, and people are not getting needs met across the board.*" Some, such as Alex (Expert-by-Experience6), recognised that decisions were being made to prioritise some services while cutting others with those already experiencing social inequalities hit hardest:

> *"Obviously there's … conditions like diabetes and cancer treatment … that the whole of the nation would look at and think, 'oh yeah, we know that'. If you looked at it from the public point of view, at homelessness, I'd say there's a good chance that 75 per cent of them'll think, 'oh, they're just scum'.*"

Liberati et al. (2022) describe similar *operating-conditions* in their study of mental health services during COVID-19, where *cutting* and *reprioritising services* become strategies for dealing with financial pressures and demands on services. Alex describes how these processes are underlined by his 'mystery shopper' exercise, which tested primary-care practices' openness to registering homeless patients without identification: *'eight of them told me to go elsewhere, and two of them hung up on me. I had a 100 per cent failure'*. From the service-provider end, Christine (Professional10) describes how people who don't turn up for appointments are viewed as bonus rather than problem, creating slack in a pressured system:

> "*If someone doesn't turn up, then the managers are more than happy to just remove them from the waiting list because they're getting so much pressure to get the waiting list down.*"

Participants who were professionals in the healthcare service depicted Tudor-Hart's inverse care law (1971) at play in primary-care. They argue this operates in two ways. First, through *resource allocation* mechanisms believed to discount need thus perpetuating practice-level inequalities. Ruth (Professional22) describes this:

> "*I think we've got this … illusion of equitable healthcare 'cause it's free at the point of contact, that actually it's universal healthcare. It isn't. It's healthcare for people who can … with the sharpest elbows get in. And, in order to reallocate that resource, it means those with the sharpest elbows will actually get less care.*"

She adds that political debates are '*weaponised*', stigmatising those groups with additional, legitimate healthcare needs. In this way, *flexible-resources* of responsive healthcare – extending this concept beyond the individual towards the collective and organisational levels – are concentrated in the most affluent primary-care practices and lead to financially driven *institutional-processing* and impoverished *operating-conditions*. Such political and social-patterning of service provision and of impacts of austerity cuts is replicated across the wider state (Gray and Barford, 2018; Fahy et al., 2023).

All these examples speak to material *resources,* and institutional funding regimes determined at a structural/macro level, impinging on the *operating conditions* of local authorities (responsible for housing, education, social services, childcare etc), health care and third-sector providers, in turn shaping *institutional-processing* practices which lead to *lesser prioritisation of specific conditions or groups* of individuals, and resulting in *exacerbating stigmatisation* and disengagement from services.

Again, we highlight that Candidacy, and especially its research applications, are limited in the extent to which they consider *operating-conditions* beyond the immediate healthcare context and in understanding why these conditions are as they are. Broadened out, however, operating-conditions align with *institutional-processing* as a meta-mechanism through which the relationship between SEP and health becomes baked-in. That such a meta-mechanism persists within a universal healthcare system is instructive in how even progressive healthcare systems require a continuous eye on equity as a corrective to other unfolding political mechanisms driving inequality. Honing focus on the Candidacy journey, the next two sections consider how primary-care access and utilisation is shaped by structures of inequality at the micro-level.

3. Micro-level Inequalities: Patient and Healthcare Professional Context

(a) Identification of candidacy to remain engaged with primary-care – priorities and navigational issues

In this section we describe how structures of inequality contribute to patients' identification of the need/right to be engaged with healthcare – their *candidacy*. These connect to inadequate *flexible-resources, stigmatisation* or to examples of problematic *institutional-processing/negative operating-conditions.*

At the extreme, we have Jason (Expert-by-Experience16) whose self-preservation, following sustained abuse, poverty and racism, was tied to avoiding state dependency. For most participants, though, 'missingness' was not a definitive decision never to engage, but a set of micro-decisions mediated by political, financial, cultural, practical and relational factors. This contingent set of decisions could be, but rarely is, captured by Candidacy. Several participants discussed how those holding down insecure/low-paid employment with unpredictable hours were unable to take time off work or turn down last-minute shifts. Niamh (Professional18) explains how those in poverty are compelled to weigh decisions about long-term health with pressing economic concerns:

> "*Is it go to the appointment, or I've just been offered this job, which is going to give me a couple of hundred quid in the pocket … means I can go out and get babies' nappies?*"

Natalie (Professional17) contrasts those in insecure low paid work with those in *"middle-class"* jobs and flexibility to attend to health needs.

Practical considerations raised by participants depict the messy reality of accomplishing candidacy, including significant travel constraints, compounded for those in poor circumstances required to criss-cross a city for appointments with and beyond health (e.g.,housing, social services, lawyers etc. (Paul Professional/Expert-by-Experience1; Joe Professional/Expert-by-Experience2).

Experiences of violence also disrupted healthcare engagement. Ellen (Expert-by-Experience3) routinely avoided appointments because attendance resulted in physical violence from her partner. Paul (Professional/Expert-by-Experience1) discusses the risk of territorial violence enroute to the GP and his fears of retribution from violent caregivers:

> "*I'm totally messed up … I'm getting abused in the hoose, right? … You're going to have to tell people, the police or whatever … And they're going to go and get the person who has done it to me … and I need to go back to that hoose … to the violence and everything else that goes wi' it."*

Stephen (Professional/Expert-by-Experience2) shares his account of growing up with trauma and poverty, and the challenge this poses to help-seeking and giving:

> "*Well, you're not deserving at this point … If you're not deserving, then you don't deserve …"*

Stephen also highlights the shifting salience of appointments for those facing challenges such as problem substance-use:

"*When you make the original appointment, you might be full o' good intentions … But then you wake up that morning wi nothing, you've no' got a pot to piss in, and you're a heroin addict, unfortunately heroin needs to come first.*"

Ease of navigation and service-entitlement were also challenged by practice gatekeeping processes or permeability. Receptionists, at the frontline of demand-management, were perceived to require too much personal information and to ration care on this basis. Additionally, as described earlier, some receptionists were found to bar patients based on their racialised surnames or homelessness. We mention these behaviours here because they neatly demonstrate *stigma* becoming embedded as a mechanism within *institutional-processing/operating-conditions* directly influencing patient service encounters. As Dixon-Woods identifies, such behaviours are part of the repertoire of *patient-sorting* for demand management. It is evident then that resource constraints, implicit rationing, the difficulty fitting health appointments within patients' lives (all mechanisms within *institutional-processing/operating-procedures*) combine with internalised, structurally sanctioned messages of *responsibilisation* and *undeservingness* within health and other services to impact on patients' identities as candidates for engagement with healthcare. We now consider how encounters with healthcare professionals further reveal or mitigate structural inequalities by depressing/strengthening candidacy for sustained engagement.

(b) Encounters With Healthcare Professionals

Healthcare professionals encounters are especially important in primary-care because patients and professionals are 'repeat players' in primary-care negotiations (Sinnott et al., 2024:687). While most Experts-by-Experience participants reported positive encounters with healthcare professionals, many also experienced alienating consultations. The facets of positive encounters, typically, mirrored poor experiences. Three highly interlinked themes emerged: the importance of developing trust; clinical understanding of the lived-experience of specific conditions (what we will call 'condition competency'); and instances of clinical practice imbued with a structural awareness of social and political determinants of health – what Metzl and Hansen (2014) term 'structural competency'. We discuss these in turn.

i. Trust

Trust was discussed by participants as human connection. For many Experts-by-Experience, such connection was uncommon meaning that *presentations* and *adjudications* of candidacy often failed. Stephen (Professional/Expert-by-Experience2) discusses how the "*window of opportunity*" for connection within an appointment can quickly close if trust is not established. Similarly, Paul describes not feeling listened to:

"*I'm telling this story about 40 times, naebody is listening. But they'll say, 'tell us what's wrang'. You tell them again and naebody takes it on board.*"

He then contrasts this with more positive relationship-building:

"See the first time like, if somebody comes through a door [of a service] … Instead of, 'oh, what's wrang wi' you?' … [what about] 'what can I do for you today?'"

He argues that this framing generates trust and, over time in his own experience, encouraged supportive dialogue over the long-term. Echoing the work of Bellis et al. (2018), Keith (Professional24), highlights that trust-building is particularly problematic for those who have been significantly let down by multiple people and systems within and outside healthcare:

"*My profession is full of fancy therapies that you're going to do with people once they're in a room and they trust you … what about the people who by virtue of their history do not trust you and do not want to get into a room with you?*"

ii. Condition Competency

Linked to trust is the idea that clinical competency should go hand-in-hand with condition competency, by which we refer to deep understanding of what conditions mean for lives lived outside the surgery door. Such understanding impacts on the ability of healthcare professionals to understand *presentations* of candidacy and to respond appropriately.

As in the above quote, examples of condition 'incompetency' were described across vulnerabilities. In some cases, efforts to deploy condition competency were thwarted in onward referrals. Vincent described how his 'patient profile,' which detailed specific support needs, was ignored by some secondary healthcare services. Vincent put this down to staff not having "*the time, or the expertise, or the willingness.*"

Ellen (Expert-by-Experience3), like Stephen and Paul, discusses how trauma could be retriggered by services. She described how her teenage daughter was unable to attend community mental health services for fear of traumatisation, due to questions of past events: "*she's like, "mum, I cannae go there, … it'll take me right back".*

Finally, condition 'incompetency' is displayed by systems and practices which fail to heed the day-to-day complexities of care, transport and finances which we have discussed earlier. Condition 'incompetency', therefore, exacerbates existing inequalities; where its opposite is present, people described remaining engaged with services.

iii. Structural Competency

Condition competency is only fully realised, we argue, when connected to 'structural competency' – a commitment to witness and act on the social and political determinants of health (Metzl and Hansen, 2014). Together these concepts share meaning with the concept of 'cultural safety,' developed primarily to understand the requirements of structurally aware practice relating to First-Nation communities in New Zealand (Whanau Kawa Whakaruruhau, 1991). We use 'structural competency' as it more clearly focuses attention on structural rather than cultural determinants. Across our sub-sample, we heard examples of both structural competency and incompetency.

First, supporting an emerging critical literature (Gibson et al., 2021) Justine (Professional15) argues that social prescribing–a prominent UK policy thread in supporting those who struggle to make optimal use of services–can be ineffective because it does not use a structurally-informed analysis of the problem:

"*Although social prescribing … works really well for middle-class areas … frankly, if you're battling to keep your house, pay your rent, get some energy on, make a meal, get some kids to school, the idea that you're going to go and do organic gardening and that's going to fix your anxiety is bonkers.*"

A similar 'structural blindness' was apparent in Stephanie's (Professional14) depiction of failure to engage women who have been sexually abused:

"*We solve 70 per cent of our smears by accessing alerts and text messages … the next 20 per cent of smears is relational nagging, and we know that the last ten per cent of all our smears is normally trauma. And we … don't ask people about it.*"

A specific example of this failure is provided by Gillian (Professional29) who describes how women experiencing violence can be labelled as 'noncompliant' when the causes of non-engagement are clear:

"A woman … had to crawl out the window to come to her appointment for alcohol counselling. And these women [are] consistently portrayed as people who were not complying with their care plans … The woman that climbed out the window had been raped the night before by a partner's friend … it's wilful blindness."

These examples show how *adjudications* and *offers of care* by healthcare professionals can fail to understand the drivers and circumstances of the presentations made by their patients, who do not display as 'ideal' candidates, and how these intensify future access problems (Dixon-Woods et al., 2005) and trigger disengagement.

Two types of good practice for healthcare professionals were discussed. One refers to practitioners understanding structures of inequality, being aware of how they affect health and demonstrating this through forms of interaction that do not endanger or disengage patients. Gillian (Professional29) explains this in relation to domestic abuse in the context of danger to life and harsh economic realities:

"*I think everybody's responsible … for being competent enough to understand, you know, what happens if a woman comes into your service, you need to think about all the things that go around her like does she have children … is she living, you know, in a perilous situation?*"

The responsibility for healthcare professionals to display this type of competency is described by Walsh and Dillard-Wright as a "moral imperative" (2020:1).

The second example came from Stephanie (Professional14) discussing a programme providing long-term support to those experiencing homelessness, abuse and/or multiple health conditions. Unlike other social prescribing models, the programme is not time limited and is focused on addressing material problems. The programme demonstrates an awareness of how people's lives are shaped by inequalities, but also highlights that structural awareness, when acted upon locally, can make the difference between individuals being engaged with public services or not. It simultaneously highlights that such action is mitigatory, and won't tackle structural problems. As Stephanie says: "*we know that we're working in a broken system and we can pick up those battles within the systems and within the professionals that we work with.*" The programme partially recreates safety nets dismantled by political decisions and economic responses to those by statutory institutions. Substitute and minimal *flexible resources* are being deployed in a mitigatory capacity to strengthen candidacies for sustained engagement in healthcare.

Having shown how our data exemplify the benefits of foregrounding a structural analysis within the concrete stages of Candidacy journeys, we summarise the limitations of our paper and the main contributions to the literature.

6. Limitations and contributions of the paper

Before setting out this paper's contributions, we outline three limitations. First, by drawing on lived-experience data from/about those with severely limited resources to protect their health, our paper might seem guilty of creating what Link and Garcia (2021:334) have described as 'health inequality diversions'. This concerns how a focus on the least affluent and powerful can obscure the causes of HI and responsibilise those at the sharp-end (Garthwaite et al., 2016). In that respect our analysis is limited by the focus of our study: what causes 'missingness' from primary care and what can primary care do to mitigate these causes. We argue, however, that, by foregrounding structural inequalities and their implications for health throughout, we ensure that such diversion from the root causes of HI does not occur.

Second, sampling in the Missingness study was purposive, involving participants well-placed to explain why vulnerable patients find healthcare disengaging. The professionals involved are unlikely to be typical, even of those working in economically-deprived areas. Similarly, those designated experts-by-experience included those connected to support organisations, who had likely been exposed to organisational narratives concerning service engagement and wider social problems. The sub-sample drawn for this paper was even more selective, chosen to explore the views of those who had framed their arguments about missingness in structural terms. This allows us to address our conceptual question but results in a greater understanding of structural causation of poor health being displayed than within other studies of HI discourse among healthcare professionals (Mackenzie et al., 2020).

Third, a strength of the paper is that it represents a range of vulnerabilities rather than focus on a particular condition or group thus identifying patterns that are not tied to individual diagnoses and types of inequality. Seeking diversity within a relatively small sample has, however, risked skating thinly over particular types of social and embodied experiences.

The paper makes a number of contributions.

Primarily, our study examines the analytical benefits of combining Candidacy and FCT. As described earlier, although Candidacy speaks to the importance of inequalities in determining service use, it does not specify how these might be analysed, and there are relatively few examples in the Candidacy literature where structures are systematically investigated. We argue that FCT helps fill in the gaps in several ways (depicted in Fig. 2 above). FCT pushes us to consider that SEP and race are not just descriptives but they are structurally determined and generate access to *resources* to bolster and sustain social, cultural and material goods that are, in turn, the social determinants of health. This means that we must focus on the politics of health as the context for the generation of HI and the practice of healthcare within that, thus encouraging researchers and practitioners not to divorce candidacy journeys from their structural context. Our data show how holding unequal volumes of different *flexible resources* come to determine access to and experiences within healthcare across the candidacy journey, and demonstrate i*nstitutional processing* of individuals and groups as they move through the system, including on the basis of these *flexible resources*. In doing so, combining FCT with its meta-mechanisms outlined provides greater *explanatory* power to Candidacy, in theorising *why* inequalities are patterned throughout the candidacy journey, thus mapping out the *operating-conditions* for patients themselves. This offers researchers more concrete tools of enquiry in operationalising structures of inequalities at the micro and meso-levels. Candidacy also brings important clarity to FCT. We have highlighted that FCT is less concerned with understanding downstream *mechanisms* (those that evolve and replace within the umbrella of more enduring *meta-mechanisms*). However, understanding how big picture structural *meta-mechanisms* affect real-life populations near the coal-face of service delivery is an important task in expanding practitioner awareness. The delineation of a person's journey through services into separate stages of identification, navigation etc. is a concrete means of thinking about and acting to mitigate inequalities. Candidacy, we argue, when meaningfully combined with structural understanding as offered by FCT, brings the debate directly to the consulting room, aligning more abstract concepts of *flexible resources* and i*nstitutional processing* with the journeys into and through services. We have also identified the functional equivalence of FCT's institutional processing with Candidacy's concept of operating conditions (albeit we argue for this to be used more broadly than at *local or healthcare levels)*. Finally, analysing data about missingness/healthcare engagement brings home how intertwined identification, navigation, presentation, adjudication and uptake of subsequent services are. For those let down by systems and multiple public services over time, it is no surprise that services which try to engage with patients are battling expectations and experiences that constrain the development of trusting relationships (Bellis et al., 2018). We therefore caution against using Candidacy to atomise service use and argue that the more detailed structural analysis of FCT helps to locate service use in broader contexts.

Second, we identify Structural Competency (Metzl and Hansen, 2014) as a mechanism which is a key component of how candidacies of healthcare engagement are enacted. Our argument here is that those in elite positions (nationally, institutionally and professionally) have

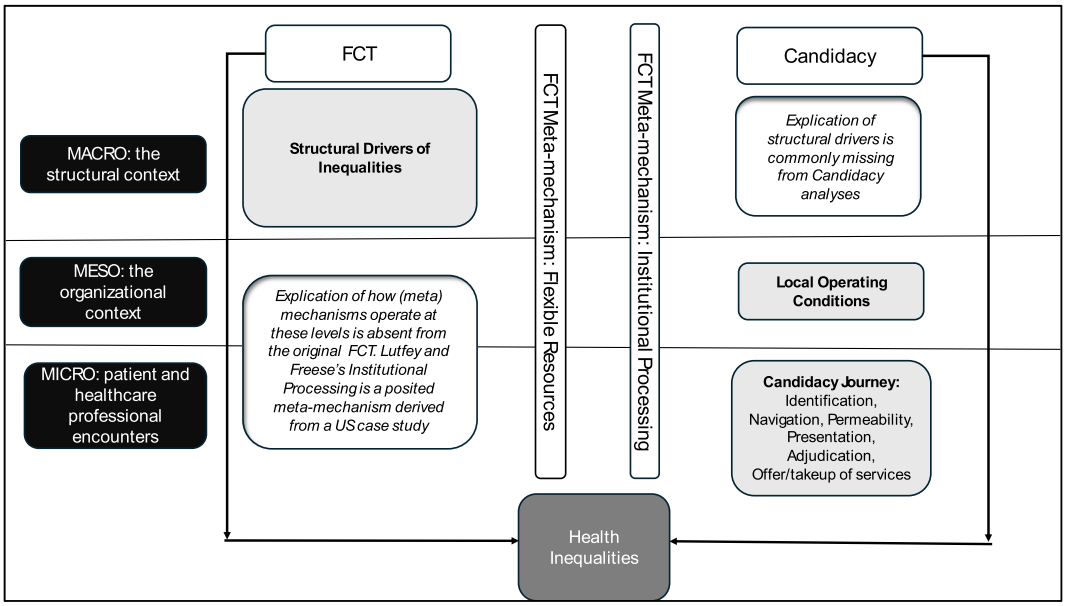

Fig. 2. Combining FCT and candidacy.

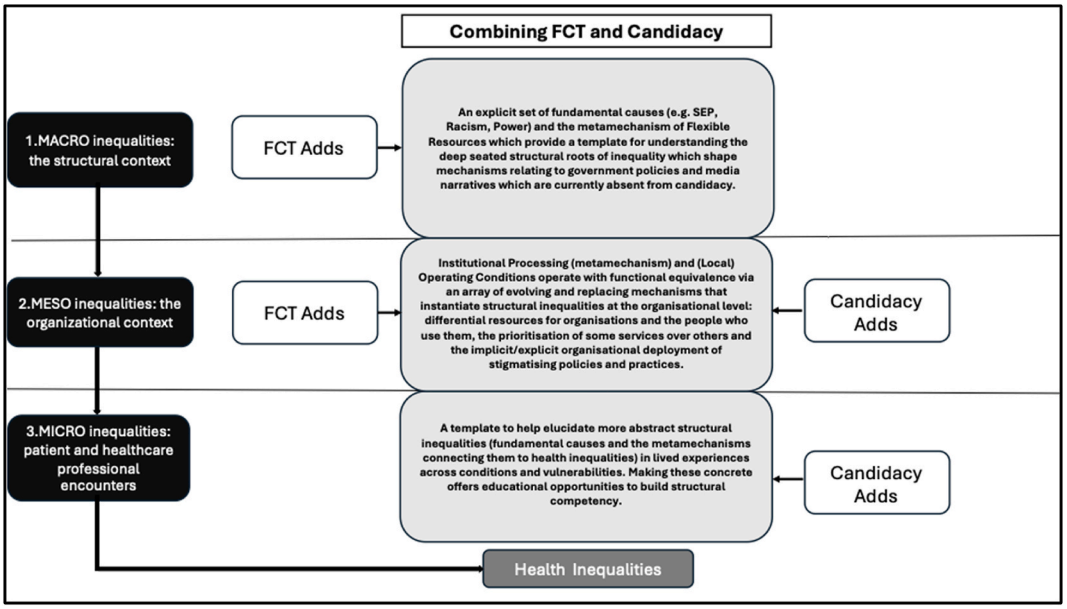

Fig. 3. Depicting the complementarity of FCT and candidacy.

opportunities to make policies, laws, regulations, to distribute *resources* and to practice in ways (including enacting *institutional-processing within the confines of operating-conditions*) that are structurally informed and equity-committed. Alternatively, they can remain uninformed of structures and how they connect to lived experiences or act in ways that explicitly seeks to drive inequalities (Brassolotto et al., 2013; Ignatow and Gutin, 2024). What this additional concept adds is the idea that *flexible resources* can be deployed strategically by the affluent and powerful at a societal level for the purposes of increasing, reducing or mitigating the social determinants of health in addition to at the individual level to improve individual health chances. In the health service we also draw attention to what we have called condition competency which is nested within this proposed mechanism – displaying deep understanding of how conditions are experienced in the real-world.

Third, our paper speaks to Lutfey and Freese's (2005) meta-mechanism of *institutional processing*. Our study, set in the context of universal primary healthcare within the UK, found similar processes at play. Tight and unequally distributed resources between practices in affluent and socio-economically deprived areas created conditions for primary-care practices that were felt to disengage those in the most difficult circumstances. The similarities between the two cases highlights that wherever gains are made through progressive policies (such as the establishment of the welfare state in the UK), Lutfey and Freese's 'massively multiplying mechanisms' operate to reassert fundamental causes of HI without significant equity-focused vigilance and endeavour.

Fourth, our paper asserts the necessity of mitigatory practices. Particularly in financially-constrained public services, our data remind us of the committed efforts of those working on the front-line of health and other services, to deal with the consequences of inequalities in the social determinants of health. In the current climate such efforts are necessary and can make profound differences to individual lives. Nonetheless, efforts to mitigate are not a plausible approach to tackling

the root causes of HI at a population level.

8. Summary

Across our findings we have provided concrete examples of fundamental causes at play – structural determinants that emerge from power relations and ensuing political decisions and stigmatising processes at the macro-level, which then shape organisational decision-making and processes of care so that these structures of inequality become embedded in public services. We argue that a more focused structural lens allows Candidacy's *operating conditions* to be extended beyond the *local and the health sphere*. In turn, combining elements of FCT and Candidacy, allows a richer explanation of how structural inequalities become manifest within the journeys that vulnerable people make through healthcare services including decisions to engage or not. The meta-mechanisms of *flexible-resources* and *institutional-processing/operating-conditions* are richly emphasised by our study, contributing an exemplar of how to combine FCT and Candidacy in practice. Finally, the addition of Condition/Structural Competency to a combined FCT and Candidacy analysis is, we argue, important for mitigation. Increasing recognition of the multiple downstream implications of structurally-determined social inequalities offers some prospect of mitigatory, equality focused action with impact on the meta-mechanisms of *flexible-resources* and *institutional-processing/operating-conditions*.

CRediT authorship contribution statement

Mhairi Mackenzie: Writing – review & editing, Writing – original draft, Validation, Supervision, Methodology, Formal analysis, Conceptualization. **David Baruffati:** Writing – review & editing, Software, Project administration, Investigation, Formal analysis, Data curation. **Calum Lindsay:** Writing – review & editing, Investigation, Formal analysis. **Kate O'Donnell:** Writing – review & editing, Methodology, Conceptualization. **David Ellis:** Writing – review & editing, Conceptualization. **Sharon Simpson:** Writing – review & editing, Conceptualization. **Geoffrey Wong:** Writing – review & editing, Conceptualization. **Michelle Major:** Writing – review & editing, Conceptualization. **Andrea Williamson:** Writing – review & editing, Supervision, Funding acquisition, Conceptualization.

Declaration of competing interest

None of the above authors have a conflict of interest to declare.

Acknowledgements

Our research was funded by the National Institute for Health and Care Research UK, grant number:135034. We would like to thank our funder, research participants and Research Oversight Group and Professor Gerry McCartney, University of Glasgow whose insightful comments have helped to improve the manuscript prior to submission.

Data availability

Data will be made available on request.

References

Ahmed, F., Woodhead, C., Hossaini, A., et al. (preprint) Guiding principles for accelerating change through health inequities research and practice: A modified Delphi consensus process,doi: https://doi.org/10.1101/2024.04.26.24306421.

Bellis, M.A., Hughes, K., Ford, K., et al., 2018. Adverse childhood experiences and sources of childhood resilience: a retrospective study of their combined relationships with child health and educational attendance. BMC Public Health 18 (792). https://doi.org/10.1186/s12889-018-5699-8.

Bourgois, P., Holmes, S., Sue, K., et al., 2017. Structural vulnerability: operationalizing the concept to address health disparities in clinical care. Acad. Med. 92 (3), 299–307. https://doi.org/10.1097/ACM.0000000000001294.

Brassolotto, J., Raphael, D., Baldeo, N., 2013. Epistemological barriers to addressing the social determinants of health among public health professionals in Ontario, Canada: a qualitative inquiry. Crit. Public Health 24 (3), 321–336. https://doi.org/10.1080/09581596.2013.820256.

Clouston, S.A.P., Link, B.G., 2021. A retrospective on fundamental cause theory: state of the literature, and goals for the future. Annu. Rev. Sociol. 47 (1), 131–156. https://doi.org/10.1146/annurev-soc-090320-094912.

Crammond, B.R., Carey, G., 2017. What do we mean by 'structure' when we talk about structural influences on the social determinants of the inequalities? Soc. Theor. Health 15, 84–98. https://doi.org/10.1057/s41285-016-0020-3.

Dixon-Woods, M., Kirk, D., Agarwal, S., et al., 2005. Vulnerable Groups and Access to Health Care: a Critical Interpretive Review. National Co-ordinating Centre for NHS Service Delivery and Organisation, Southampton.

Ellis, D.A., McQueenie, R., McConnachie, A., Wilson, P., Williamson, A.E., 2017. Demographic and practice factors predicting repeated non-attendance in primary care: a national retrospective cohort analysis. Lancet Public Health 2 (12), E551–E559. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2817%2930217-7/fulltext.

Fahy, K., Alexiou, A., Mason, K., et al., 2023. Inequalities in local government spending on cultural, environmental and planning services: a time-trend analysis in England, Scotland, and Wales. BMC Public Health 23, 408. https://doi.org/10.1186/s12889-023-15179-9.

Freese, J., Lutfey, K., 2011. Fundamental causality: challenges of an animating concept for medical Sociology. In: Pescosolido, B., Martin, J., McLeod, J., Rogers, A. (Eds.), Handbook of the Sociology of Health, Illness, and Healing: Handbooks of Sociology and Social Research. Springer, New York. https://doi.org/10.1007/978-1-4419-7261-3_4.

Garthwaite, K., Smith, K.E., Bambra, C., Pearce, J., 2016. Desperately seeking reductions in health inequalities: perspectives of UK researchers on past, present and future directions in health inequalities research. Sociol. Health Illness 38 (3), 459–478. https://doi.org/10.1111/1467-9566.12374. PMID: 27358991; PMCID: PMC4950297.

Gibson, K., Pollard, M.P., Moffatt, S., 2021. Social prescribing and classed inequality: a journey of upward health mobility? Soc. Sci. Med. 280, 114037. https://doi.org/10.1016/j.socscimed.2021.114037.

Gray, M., Barford, M., 2018. The depths of the cuts: the uneven geography of local government austerity. Camb. J. Reg. Econ. Soc. 11 (3), 541–563. https://doi.org/10.1093/cjres/rsy019.

Green, A., Abbott, P., Luckett, T., et al., 2021. 'It's quite a complex trail for families now' – provider understanding of access to services for Aboriginal children with a disability. J. Child Health Care 25 (2), 194–211. https://doi.org/10.1177/1367493520919305.

Hatzenbuehler, M., Link, B., Phelan, J., 2013. Stigma as a fundamental cause of population health inequalities. Am. J. Publ. Health 103 (5), 813–821. https://doi.org/10.2105/AJPH.2012.301069.

Heller, J.C., Givens, M.J., Johnson, S.P., Kindig, D.A., 2024. Keeping it political and powerful: defining the structural determinants of health. Milbank Q. 102 (2), 351–366.

Hudson, N., Culley, L., Johnson, M., et al., 2016. Asthma management in British South Asian children: an application of the candidacy framework to a qualitative understanding of barriers to effective and accessible asthma care. BMC Public Health 16, 510. https://doi.org/10.1186/s12889-016-3181-z.

Ignatow, G., Gutin, I., 2024. Elite class self-interest, socioeconomic inequality and U.S. population health. Sociol. Health Illness 46 (8). https://doi.org/10.1111/1467-9566.13813, 17490-1711.

Kawa Whakaruruhau, Whanau, 1991. Cultural Safety Hui of the Whanau Kawa Whakaruruhau. Apumoana Mara, Rotorua.

Koehn, S., Habib, S., Bukhari, S., 2016. S4AC case study: enhancing underserved seniors' access to health promotion programs. Can. J. Aging 35 (1), 89–102. https://doi.org/10.1017/S0714980815000586.

Koehn, S., Jones, C.A., Barber, C., et al., 2024. Candidacy 2.0 (CC) – an enhanced theory of access to healthcare for chronic conditions: lessons from a critical interpretive synthesis on access to rheumatoid arthritis care. BMC Health Serv. Res. 24, 986. https://doi.org/10.1186/s12913-024-11438-6.

Liberati, E., Richards, N., Parker, et al., 2022. Qualitative study of candidacy and access to secondary mental health services during the COVID-19 pandemic. Soc. Sci. Med. 296, 114711. https://doi.org/10.1016/j.socscimed.2022.114711.

Lindsay, C., Baruffati, D., Mackenzie, M., et al., 2024. Understanding the causes of missingness in primary care: a realist review. BMC Med. 22, 235. https://doi.org/10.1186/s12916-024-03456-2.

Link, B.G., García, S.J., 2021. Diversions: how the underrepresentation of research on advantaged groups leaves explanations for health inequalities incomplete. J. Health Soc. Behav. 62 (3), 334–349. https://doi.org/10.1177/00221465211028152.

Link, B.G., Phelan, J.C., 1995. Social conditions as fundamental causes of disease. J. Health Soc. Behav. 80–94. https://doi.org/10.2307/2626958. PMID:7560851.

Link, B.G., Phelan, J.C., 2006. Stigma and its public health implications. Lancet 367 (9509), 528–529. https://doi.org/10.1016/S0140-6736(06)68184-1.

Luchenski, S., Macguire, N., Aldridge, R.W., et al., 2018. What works in inclusion health: overview of effective interventions for marginalised and excluded populations. Lancet 391 (10117), 266–280. https://doi.org/10.1016/S0140-6736(06)68184-1.

Lutfey, K., Freese, J., 2005. Toward some fundamentals of fundamental causality: socioeconomic status and health in the routine clinic visit for diabetes. Am. J. Sociol. 110 (5), 1326–1372. https://doi.org/10.1086/428914.

Mackenzie, M., Conway, E., Hastings, A., et al., 2013. Is 'Candidacy' a useful concept for understanding journeys through public services? a critical interpretive literature

synthesis. Soc. Pol. Adm. 47 (7), 806–825. https://doi.org/10.1111/j.1467-9515.2012.00864.x.

Mackenzie, M., Gannon, M., Stanley, N., et al., 2019. 'You certainly don't go back to the doctor once you've been told, "I'll never understand women like you."' Seeking candidacy and structural competency in the dynamics of domestic abuse disclosure. Sociol. Health Illness 45 (2), 231–249. https://doi.org/10.1111/1467-9566.12893.

Mackenzie, M., Skivington, K., Fergie, G., 2020. "The state they're in": unpicking fantasy paradigms of health improvement interventions as tools for addressing health inequalities. So. Sci. Med. 256, 113047. https://doi.org/10.1016/j.socscimed.2020.113047.

McCartney, G., Dickie, E., Escobar, O., et al., 2021. Health inequalities, fundamental causes and power: towards the practice of good theory. Sociol. Health Illness 43 (1), 20–39. https://doi.org/10.1111/1467-9566.13181.

McQueenie, R., Ellis, D.A., McConnachie, A., et al., 2019. Morbidity, mortality and missed appointments in healthcare: a national retrospective data linkage study. BMC Med. 17 (2). https://doi.org/10.1186/s12916-018-1234-0.

Metzl, J.M., Hansen, H., 2014. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc. Sci. Med. 103, 126–133. https://doi.org/10.1016/j.socscimed.2013.06.032.

Sinnott, C., Ansari, A., Price, E., et al., 2024. Understanding access to general practice through the lens of candidacy: a critical review of the literature. Br. J. Gen. Pract. 74 (747), e683–e694. https://doi.org/10.3399/BJGP.2024.0033, 2024.

Tarrant, C., Windridge, K., Baker, R., et al., 2015. 'Falling through gaps': primary care patients' accounts of breakdowns in experienced continuity of care. Fam. Pract. 32 (1), 82-7doi: 10.1093.

Tookey, S., Renzi, C., Waller, J., et al., 2018. Using the candidacy framework to understand how doctor-patient interactions influence perceived eligibility to seek help for cancer alarm symptoms: a qualitative interview study. BMC Health Serv. Res. 18, 937. https://doi.org/10.1186/s12913-018-3730-5.

Tudor-Hart, J., 1971. The inverse care law. Lancet 297 (7696), 405–412. https://doi.org/10.1016/s0140-6736(71)92410-x.

Walsh, J.H., Dillard-Wright, J., 2020. The case for "structural missingness:" A critical discourse of missed care. Nurs. Philos. 21 (1). https://doi.org/10.1111/nup.12279.

Zapata-Moya, A.R., Freese, J., Bracke, P., 2023. Mechanism substitution in preventive innovations: dissecting the reproduction of health inequalities in health. Soc. Sci. Med. 337. https://doi.org/10.1016/j.socscimed.2023.116262.