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What can one legitimately expect from a health system? A conceptual analysis and a proposal for research and action

Kimberly Lakin , Sumit Kane

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Nossal Institute for Global Health, Melbourne School of Population and Global Health, The University of Melbourne, Melbourne, Victoria, Australia

Correspondence to
Prof Sumit Kane;
sumit.kane@unimelb.edu.au

ABSTRACT

In 2007, the WHO proposed the Building Blocks Framework and articulated 'responsiveness' as one of the four goals for health systems. While researchers have studied and measured health systems responsiveness since, several aspects of the concept remain unexamined, including, understanding the notion of 'legitimate expectations'—a notion central to the definition of responsiveness. We begin this analysis by providing a conceptual overview of how 'legitimacy' is understood in key social science disciplines. Drawing on insights from this overview, we examine how 'legitimacy' is understood in the literature on health systems responsiveness and reveal that there is currently little critical engagement with this notion of the 'legitimacy' of expectations. In response, we unpack the concept of 'legitimate' expectations and propose approaches and areas for reflection, research, and action. We conclude that contestation, and ongoing negotiation of entrenched health system processes and norms which establish citizens' 'legitimate' expectations of health systems, is needed—through processes that ensure equitable and wide participation. We also call on researchers, in their capacity as key health policy actors, to trigger and initiate processes and help create equitable spaces for citizens to participate in establishing 'legitimate' expectations of health systems.

SUMMARY BOX

⇒ The idea of 'legitimate expectations' is a key feature of the definition of health systems responsiveness.
⇒ There is limited critical engagement with the notion of the legitimacy of expectations within current literature on health systems responsiveness.
⇒ Drawing on insights from across disciplines, we analyse and discuss the notion of a 'legitimate' expectation of a health system.
⇒ While what is a legitimate expectation and what is not is a feature of social norms and shared beliefs, it is also the result of negotiation and contestation.
⇒ It is vital that citizens can imagine, contest, and negotiate what to legitimately expect from their health system.
⇒ Researchers and policymakers can help create equitable, regularised spaces for active citizen participation and contestation.

INTRODUCTION

In 2007, the World Health Organisation (WHO) proposed the Building Blocks Framework which outlined four overall goals and outcomes of well-functioning health systems—improved health, social and financial risk protection, improved efficiency, and responsiveness.[1] In response to this, and as a result of growing interest, an increasing number of publications have focused on the concept of responsiveness in the last 20 years.[2] However, several scholars have also identified key theoretical shortcomings in existing understandings of responsiveness.[2–4] The WHO defines responsiveness as 'the health system's ability to meet the population's legitimate expectations'. The demarcation of 'legitimate' expectations within responsiveness, de Silva argues,[5] is necessary to tackle the issue of divergence of expectations—people may have unrealistic or unjustifiable expectations of health systems which are not considered within articulations of health system responsiveness.[5 6] While there are clear reasons for focusing on 'legitimate' expectations within responsiveness, there is very limited critical engagement with the notion of the 'legitimacy' of peoples' healthcare-related expectations within the scholarly literature.

The concept of legitimacy has been the subject of extensive theorisation and research in various disciplines and multiple theoretical and empirical contexts. However, the widespread application of legitimacy has layered the construct with multiple meanings and conceptualisations.[7] This complexity could account for the lack of engagement with 'legitimacy' within the responsiveness literature.[7] Consequently, we argue, as do Khan *et al*,[2] that several conceptual questions remain, such as what is a 'legitimate' expectation? Who decides what is a 'legitimate' expectation? But also, what denotes a *universally* legitimate expectation? In this analysis, we engage with key conceptualisations of legitimacy

within the social sciences to respond to these questions and conceptual gaps. Ultimately, our aim is to tackle the question—what is a 'legitimate' expectation? In light of our findings, we argue that 'legitimate' expectations of health systems are social constructs which need to be negotiated, established and revisited on an ongoing basis through a process of participation and contestation. We propose an agenda for reflection, debate, research, and action.

A CONCEPTUAL REVIEW OF 'LEGITIMACY'

This analysis begins by providing a brief review of 'legitimacy' as it is conceptualised in what we identify as key theoretical work in social psychology, political science, and organisational studies. While the concept of 'legitimacy' has been incorporated within the broader health systems literature in various ways, we take a critical look at how the health systems responsiveness literature specifically engages with the concept.

'LEGITIMACY' IN SOCIAL PSYCHOLOGY, POLITICAL SCIENCE, AND ORGANISATIONAL STUDIES

Within their social psychological theory of 'legitimation of interpersonal status hierarchies', Ridgeway and Berger[8] define legitimacy as a 'process by which cultural accounts from a larger social framework' can be used to explain the 'existence' of a particular social entity, regardless if that entity is a group, structure of inequality or a position of authority. The central tenet here is that Ridgeway and Berger[8] distinguish between the 'object' of legitimation at one level, and the broader beliefs, values, and norms that actors possess at a more encompassing, social level. Drawing on work from both social psychology and institutional theory, Johnson *et al*[8] articulate the link between these two levels, showing how patterns of behaviour or beliefs are widely accepted into the broader cultural framework and become taken-for-granted social features. In the first stage (*innovation*), a new social innovation is created to address a need or desire at the level of actors (such as an organisation developing new procedures to meet policies). For an innovation to be accepted locally, local actors must believe that it is consonant with an existing, widely accepted cultural framework. As a result of being implicitly accepted, the innovation achieves *local validation*. Eventually, the new social innovation may diffuse into new, local situations and is adopted by actors in other contexts. As the new social object diffuses across contexts, it acquires widespread acceptance and is *generally validated*, becoming a 'taken-for-granted' social innovation.[8]

One of the most widely accepted definitions of legitimacy stems from the organisational literature.[8] Suchman[9] describes legitimacy as, 'a generalised perception or assumption that the actions of an entity are desirable, proper or appropriate within some socially constructed norms, values, beliefs and definitions'. Here, as do Ridgeway and Berger,[8] Suchman[9] emphasises the collective nature of legitimacy; it is a shared cognitive construct that is consistent with a cultural framework of beliefs, norms and values that are generally accepted by a group as a whole.[10] According to Suchman,[9] there are three primary forms of legitimacy within organisations: *pragmatic* (based on the audiences' self-interest), *normative* or *moral* (based on what is right) and *cognitive* (acceptance of an organisation as necessary or inevitable). Although each form of legitimacy is based on different 'behavioural dynamics', they all involve a generalised perception that the activities of an organisation are appropriate and desirable according to a 'taken-for-granted' set of norms, values and beliefs.[8] That being said, in their multilevel theory, Bitektine and Haack[10] approach organisational legitimacy from evaluators' perspectives. In this way, legitimacy is not seen as a 'property' or 'asset' of an organisation, rather a 'judgement'. Bitektine and Haack[10] propose that legitimacy is a cross-level construct, consisting of individual-level *propriety* and collective-level *validity*.[8 11] When assessing the 'normative acceptability of an organisation' (*propriety*), the evaluator refers to a set of social norms against which the organisation's properties are compared and expectations are constructed. In a stable institutional environment, the choice of norm is 'obvious'; it is a taken-for-granted set of norms. Again, Bitektine and Haack[10] echo existing conceptualisations by emphasising the 'collective' nature of legitimacy through the notion of *validity*—the extent to which there is general consensus, within a collective, that an organisation is appropriate for its social context.[10] Dornbusch and Scott[11] suggest that *validity* is reinforced by authorisation (support of higher authorities) and endorsement (support of one's peers). In this way, an individual evaluator's legitimacy judgement (*propriety*) is not only based on their perceptions of an institution's properties and behaviours, but also on their observations of collective legitimacy judgements (*validity*). That being said, 'major environmental jolts' and changes in social norms, values and judgements may provide the conditions for norm change, as well as institutional change.[10] 'Jolts' may also occur at the individual-level through major life-changing events, such as illness or job loss, altering a person's perspective of the institutional field. Their altered perspective may create new expectations that could go unmet. This connects to recent work by Lakin and Kane[4] in which they argue that changes in one's social location can prompt the construction of a new 'horizon of expectation'.

Stillman,[12] drawing on political science, defines a government as being 'legitimate', 'if and only if the results of governmental output are compatible with the value pattern of the society' (p. 39).[12] Here, there is a parallel with conceptualisations in the organisational and social psychological literature which also stress the collective nature of legitimacy. By 'the value pattern of society', Stillman[12] refers to society's generalised criteria of desirability, standards of evaluation or normative properties which should be compatible with the results

of a government's actions (or outputs). Importantly, a legitimate government can exercise power and influence society's values, while also assuring society and its members that their 'value pattern' is respected. Weatherford[13] has elaborated on this interaction between a government and its citizens and, the construction of governmental legitimacy, in his revised conceptualisation of legitimacy in political science. He distinguishes between macro-level, system-level properties (the formal structures and processes of political systems) and micro-level, individual-level properties (citizen's attitudes and actions). Notably, macro-level components of legitimacy include the *accountability* of governments to their citizens by allowing wide, effective public participation, *efficiency*, *procedural fairness* and *distributive fairness*. Weatherford[13] further classifies the *accountability* and *responsiveness* of political systems as the representational procedures which link governments and their citizens. He emphasises that accountability mechanisms, such as regular elections, are crucial structures of legitimate governments.

'LEGITIMACY' IN HEALTH SYSTEMS RESPONSIVENESS

The healthcare literature engages with the notion of 'legitimacy' in different ways, drawing on existing theorisations from institutional theory and political science. Work by Lockett *et al*,[14] for instance, drew on interpretations of 'legitimacy' within institutional theory, particularly by Suchman,[9] to understand the dynamics of institutional change in the UK National Health Service. Lockett *et al*'s.[14] study revealed that health system actors who have limited structural legitimacy—'the power that emanates from professional hierarchy'—are most willing to provoke change but are least able to do so. By contrast, those who have a combination of both structural and normative legitimacy—'the ability to convince others of 'what ought to be'—are the most able to promote institutional change. The concept is also linked to accountability; as theoretical work from political science highlights, accountability is a macro-level component of legitimacy and are the representational procedures which link governments with their citizens.[12] In the health systems literature, social accountability suggests that political and governmental actors, as well as service providers, are held to account by citizens for their decisions and actions.[15] The link between social accountability and legitimacy is highlighted in a realist synthesis by Lodenstein *et al*[16] in which they reveal that the ability of citizen groups to engage in social accountability mechanisms is dependent on providers perceiving these groups as 'legitimate'.

That being said, we sought to understand how literature examining the responsiveness of health systems engages with the concept of 'legitimacy'. Specifically, how (and if) such literature articulates and defines peoples' 'legitimate' expectations of their health systems. Our search of the literature (for details, see online supplemental files 1 and 2) revealed that scholars appear to only engage with the notion of 'legitimacy' when defining health systems responsiveness. As online supplemental file 2 highlights, all included papers were of the consensus that responsiveness relates to the health system's (or indeed health system actors') ability to meet peoples' 'legitimate' expectations of care. However, only one paper, by Joarder *et al*,[17] drew on the work of de Silva to define 'legitimate' expectations as those that are based on ethical norms and values. De Silva's[5] work on responsiveness provides the first and, to our knowledge, the only articulation of a 'legitimate' expectation: 'Legitimate can be defined as conforming to recognised principles or accepted rules and standards'. De Silva[5] cautions that, while 'legitimate' standards and norms with an ethical basis (such as those related to dignity and respect) can be set without much debate, the setting of 'legitimate' norms related to infrastructure and access to care could be more difficult specify. Apart from this exception, no paper clarified or elaborated on what demotes a 'legitimate' expectation. Thus, as Khan *et al*[2] also recognise, there is yet no critical engagement with what is a 'legitimate' expectation and, in particular, who decides what is considered 'legitimate' expectations of responsive health systems.

A CONCEPTUAL ANALYSIS OF 'LEGITIMACY'

In this section, we unpack the conceptual overview presented above to highlight the common facets of existing conceptualisations of legitimacy. We then respond to the question—what is a 'legitimate' expectation of a health system?

INSIGHTS FROM THE CONCEPTUAL OVERVIEW

Several common facets in these conceptualisations of 'legitimacy' are evident. Primarily, that a 'legitimate' entity—whether that be an organisation, government, social innovation, judgement, or status order—is one that is based on a cultural framework of widely shared, *normative* beliefs and values on how things should or ought to be. In social psychology, Ridgeway and Berger[8] terms these belief as the 'cultural accounts from a larger social framework'. Bitektine and Haack[10] also reveal that the 'normative acceptability of an organisation' is evaluated against a 'taken-for-granted' set of social norms. Moreover, Stillman[12] suggests that a government is deemed 'legitimate' if its output is consistent with 'the value pattern of society'; society's generalised criteria, standards, or normative properties. Hence, as Ridgeway and Berger[8] put it, there is a distinction between the entity which is perceived as 'legitimate', and the cultural framework that people possess which is situated within the broader social environment. Connected to this, is the 'collective' nature of legitimacy; that whether or not an entity is deemed 'legitimate' is dependent on general consensus of other actors, groups, or society in general.[8–11] Dornbusch and Scott[11] suggest collective legitimacy judgements are particularly reinforced by the authorisation of higher authorities. That being said, in the political science, we see how 'legitimacy' of an

entity is conferred through active citizen participation in accountability initiatives.[12] Yet, it is important to note that perceptions of 'legitimacy' are not stable—changes to both individual-level and collective-level social norms and values can prompt a revision in one's judgements of 'legitimacy'.[10]

WHAT IS A 'LEGITIMATE' EXPECTATION OF A HEALTH SYSTEM?

Incorporating the above insights from the conceptual overview and analysis, we propose that a 'legitimate' expectation of a health system encounter is one which reflects and complies with widely shared norms, values, beliefs, and standards. These beliefs, values, and standards are *normative*—they are peoples' views about how a health system should or ought to be. Such 'legitimate' expectations are also collective in nature; though mediated by the views of individuals, they are ultimately collective and socially constructed, emerging through and depending on the presence of a social audience accepting of the encompassing framework of beliefs, norms, and values.[8] The inclusion of the term 'universal', when specifying 'legitimate' expectations within responsiveness, can be viewed as an attempt to acknowledge this social construction and collective nature of the accordement of legitimacy.[5] Echoing work by Bitektine and Haack,[10] and Lakin and Kane,[4] we also emphasise that peoples' 'legitimate' expectations of health systems are not static, but constantly evolving in response to 'environmental jolts', and changes in peoples' social locations which prompt the re-construction of their 'horizon of expectations'. Aside from being *spatially* defined, and as Lakin and Kane also suggest,[4] 'legitimate' expectations may also be *temporally* shaped by peoples' past and current experiences of their health system interaction.

But what are the norms, values, beliefs, and standards in the context of the health system? Can they provide an accurate reference for defining what is considered a 'legitimate' expectation? Norms or 'accepted standards' may be institutionalised in the form of, for example, standards created by governments or public and private actors (such as the United Nations Global Compact).[5 10] Within health systems, national safety and quality health service standards are developed to improve the quality of health service provision and protect the public from harm. For example, this can include policies and standards to ensure comprehensive care involving integrated screening and assessment, as well as systems and strategies around medication safety.[18] Therefore, widely accepted standards such as these could provide an objective reference for defining peoples' 'legitimate' expectations of the various aspects of health system responsiveness. However, these standards vary across country and health system contexts, and, for this reason, de Silva[5] concedes that it can be difficult to set standards for a health system's infrastructure, as well as access to care. Therefore, how might one then go about establishing 'legitimate' expectations in a particular context? While this question has been directly and indirectly recognised and asked by many (including in the early conceptualisations of responsiveness), much needs to be done to tackle this question. In this paper, we have taken what we consider the first explicit step in this direction. In the sections that follow, we draw on insights from political science and public policy to discuss how legitimacy is established in the public square through a process of participation and contestation, with the former itself being contested and negotiated.

ESTABLISHING 'LEGITIMATE' EXPECTATIONS THROUGH PARTICIPATION AND CONTESTATION

Within political theory, Dhal[19] terms an 'ideal' democracy in which governments exhibit continuing responsiveness to the preferences of their citizens, as a *polyarchy*.[19–21] The two main underlying dimensions of this ideal-type liberal democracy, Dhal[19] proposes, is contestation and inclusiveness (or participation). Contestation, within a democracy, exists when citizens have 'unimpaired opportunities' to not only articulate their preferences, but to also communicate them to fellow citizens and the government via individual and collective action. However, these preferences must be given equal consideration in the actions of the government. On the other hand, participation is considered as the proportion of the population that is, 'entitled to participate on a more or less equal plane in controlling and contesting the conduct of the government…' (p. 633).[20] In Dhal's[19] view, a central quality of a democracy is enabling minority groups to communicate their preferences, as well as the presence of representatives to respond to these preferences. Establishing an 'equal plane' for participation is therefore a subject of much debate and negotiation.[20 21] For instance, those who are better educated have been found to vote more often that those who are less educated. In this way, the interests of this under-represented group may be overlooked in the creation of public policy.[22]

More broadly, this links to the notion of the 'collective' nature of legitimacy—that the establishment of 'legitimacy' is dependent on general consensus or the endorsement of actors, groups, or society in general.[8–12] More specifically, in political science, Weatherford[13] proposed that a key macro-level component of legitimacy is the accountability of governments to their citizens by allowing public participation. Therefore, 'legitimacy' can be established within systems or organisations through a process of contestation and participation. Within health systems, this may involve the 'elite'—politicians, policymakers, and managers—initially setting the boundaries for contestation.[21] This is echoed within Dornbush and Scott's[11] articulations of organisational legitimacy, in which they argue that authorisation and endorsement of higher authorities is required for an organisation or organisational procedure to be defined as legitimate. However, Suchman[9] proposes that *normative* legitimacy within organisations is derived from actors who specify 'what is right'. Patients and citizen groups are these

actors who specify their *normative* expectations of what should or ought to happen during their healthcare encounters.[5] As Lodenstein *et al*,[16] Cleary *et al*[15] and other scholars reveal that one such way is through the participation of citizens and citizen groups in social accountability initiatives. Hence, in order to define what is a 'legitimate' expectation of a health system, active citizen participation is vital. Thus, while authorities may set the standards for a health system's infrastructure and processes which specify *universally* 'legitimate' expectations, we argue that citizens, understood broadly, need to be able to contest and regularly revisit these standards of what counts as a responsive health system. This requires active and broad-based citizen participation in health policy and practice with, as Dhal[19] emphasises, an 'equal plane' for participation.

CREATING SPACES FOR EQUITABLE PARTICIPATION AND CONTESTATION

Arenas which promote opportunities for public participation can be usefully understood through the concept of *space*. A *space* for public participation can be bounded in time and dimension, with sealed or permeable boundaries between citizens and institutions.[23] 'Invited spaces' are spaces created by institutions who 'invite' citizens to contribute towards the shaping and implementation of policy. Some 'invited spaces' may be transient and are only briefly opened for communication and participation. Others are more durable, regularised 'invited spaces' for public engagement and participation.[23 24] However, as with other participatory institutions, 'invited spaces' often lack the conditions for equitable participation. This may be the case for 'invited spaces' that have been transplanted onto institutional landscapes where entrenched structures and relations of privilege undermine equitable participation.[25] For instance, Mohanty[26] shows how, in India, women's participation in committees within the Integrated Child Development Scheme was shaped by gendered norms whereby they were viewed only as mothers rather than as individual citizens. She adds that though the state had created these spaces for participation, it had done little to 'actualise' the spaces; women's participation and agency in these spaces was structured within and constrained by the scheme officials' assignment of a particular identity to the involved women.[25 26] The point being that in as much as the presence of spaces for participation and contestation is important, it is important to not lose sight of the fact that such spaces are not 'bounded'—they are inevitably embedded within, interact with and are influenced by existing structures, entrenched norms, and established social and organisational processes. That being said, several methods or approaches can strengthen or enhance equitable participation. Within the sphere of political participation, one such approach includes ongoing dialogue and awareness raising.[24] As such, work by Cornwall has similarly highlighted that education can be key to both individual and collective empowerment of community groups—to enable such groups to 'gain a voice' for engagement in and contestation of health-related concerns.[23]

Therefore, we argue that the creation of durable, regularised 'invited spaces' by healthcare institutions is a necessary, though not necessarily sufficient step, to enable citizens to contest the standards for a health system's infrastructure and processes which specify the legitimacy of what citizens can expect from the system. This must involve all citizens, particularly minority or disadvantaged groups. For instance, the implementation of country-specific health policies, which set the standards for peoples' 'legitimate' expectations, should not only involve the 'elite' who make decisions based on 'universal', professional criteria.[27] At a global level, this translates into spaces and processes being such that the poorer and weaker low/middle-income countries (LMICs) can meaningfully participate in and contest the development of recommendations and policies by powerful multilateral organisations, international non-government organisations, and donors.[28] We also contend that, through active citizen participation and contestation, it is possible to understand how social structures, such as culture, gender, and socioeconomic status, intersect to shape peoples' expectations of a care encounter.[4] This consideration is necessary for determining how expectations, whether they relate to a health system's infrastructure or the ethical norms of a care interaction, vary across contexts.[5] Ultimately, we argue that active citizen participation and contestation is vital for specifying what can be considered *universally* 'legitimate' expectations of responsive health systems. However, in order to establish an 'equal plane' for participation and contestation, we argue that these 'invited spaces' need to be 'actualised'.[19 26] This involves taking into account the impact that existing social structures and relations can have on restricting equitable participation and contestation in particular contexts and for certain social groups. In establishing 'invited spaces' for contestation and participation, it is therefore vital that healthcare institutions actively create the conditions for equivalence to strengthen the participation of marginalised groups.[25 26]

PARTICIPATION AND CONTESTATION ACROSS DIFFERENT POLITICAL SYSTEMS AND REALITIES

It is important to acknowledge that the above discussion around the establishment of legitimacy of expectations from a health system assumes and refers to an 'ideal' liberal democratic context where participation and contestation are seen as basic citizen rights and spaces for participation are many, are formalised, and tend to have constitutional bases.[29] Political systems vary in their degree of political space for citizen participation and in the bases, processes, and platforms for citizens to participate in public discourse and policy. For instance, one can expect this to be different across single-party political systems and dictatorships as in

parts of the Middle East, Latin American and parts of East Asia, to two-party or multi-party systems in liberal democracies in different parts of the world. Therefore, we argue that any scholarship that seeks to understand the nature of contestation and participation (including but not limited to health services-related matters) needs to explicitly take into account the political system context. While it is not within the scope of this analysis to examine how the processes of contestation and participation for establishing 'legitimate' expectations varies across political systems, we propose this as an area for future research. As an illustration, we look at the case of some countries in East Asia that have single-party polities. In these countries, understandings of citizen participation (and contestation) in the public sphere are influenced by the doctrine of *'Minben'*, a distinctly paternalistic idea in which the power of the government is based on responding to the welfare of common people and not in extending autonomy or participation in government.[30] Within the *Minben* doctrine, the scope of citizens' political participation is limited to conveying their concerns to political leaders, with leaders having the power and freedom to deviate from public opinion when implementing policy. In this way, governmental legitimacy is established through the outcomes of policy, rather than through fair elections, such as in liberal democracies.[30] It is therefore important to recognise that, in such polities, prevailing political traditions may constrain or even prevent the creation of 'invited spaces' for citizen participation and contestation in public policy. Moreover, peoples' expectations of their role could also be shaped by these cultural and political traditions, and they may in fact regard political leaders as, 'guardians of their interests' (p. 129).[30] This, in turn, could influence their desire to contest and participate.

All processes, particularly the participatory processes for the social construction of, and agreement about what one might legitimately expect from and of a health system are at risk of becoming about pandering to 'all' social norms, or worse, to being captured by powerful groups. These processes also risk the legitimation of unscientific and damaging medical treatments that may not be medically sound or appropriate from a health system point of view but might be widely preferred. For instance, how would the demand for antibiotics for common viral infections be processed? Or how would the widely shared preference to be seen/evaluated by a clinical specialist when a primary care provider might be better suited for the condition, be navigated? The point is that all processes for agreeing about what people can legitimately expect from and of a health system, require the explicit inclusion of safeguards against the reproduction and perpetuation of harmful and discriminatory social norms, and against the legitimation of scientifically and medically unsound or unsafe preferences. An inclusion that requires a delicate balance between democratic (where citizens decide) and epistocratic (where experts decide) concerns.[31]

AN AGENDA FOR REFLECTION, RESEARCH, ACTION, AND POLICY

In this section, we propose an agenda for reflection, research, action, and policy. Drawing on our findings from the conceptual review and analysis, we first outline areas for reflection and future research on 'legitimate' expectations of health systems—this is by no means a comprehensive or complete set of questions. We also call on researchers in their capacity as key actors in health policy development, to trigger and initiate actions towards establishing 'legitimate' expectations of health systems.

AREAS FOR FUTURE RESEARCH: A CALL TO ACTION

Insights from this paper pave the way for the asking of a range of questions—the answers to which could ultimately help improve the responsiveness of health systems globally: What are 'legitimate' expectations of a health system? How is the legitimacy of an expectation established? Who defines what are 'legitimate' expectations? What are the perspectives of various health system actors, that is, citizens (including, but not limited to patients), policymakers, and practitioners, on what counts as legitimate expectations? Cross-country, comparative studies could also shed light on how 'legitimate' expectations vary across contexts, overtime and in response to major 'environmental jolts'. But also, how peoples' past and current experiences of their interactions with health systems, and with other social and political institutions and systems, shape what they consider as 'legitimate' expectations. What strategies can optimally improve citizens' understanding about health and health service provision? The organisational studies literature reveals the role of authority figures and endorsements by such figures in establishing legitimacy within organisations.[11] Future research could examine the key actors (from within and outside the health system) involved in the authorisation and endorsement of these expectations. Finally, drawing from the political sciences literature, we have argued that 'legitimate' expectations are ideally established through a process of participation and contestation. This requires the presence of or the establishment of spaces where citizens can participate, question, and contest normative health system processes and be involved in healthcare related decision-making. Studies are needed to examine: what, if any, are the processes of and spaces for participation and contestation in different health system contexts? And how effective and inclusive are these? But also, how can health systems create the conditions to strengthen the participation of marginalised groups in these processes and spaces[25 26]? Another question that follows is—what else, that is, alongside instituting participatory processes, do health systems need to do, to become better responsive to the various populations they serve? We have acknowledged that participation and contestation can primarily refer to the context of liberal democracies, and that processes and spaces for

citizen's participation in public policy and planning, will vary across political systems. We contend that there is a need for studies to understand the nature and varieties of contestation and participation for establishing 'legitimate' expectations from health systems across different political system contexts.

We also call on researchers as key actors in the health policy and systems arena to initiate inquiries, trigger processes towards, and help create spaces for equitable and meaningful participation, contestation, and ongoing negotiation of entrenched processes and norms which currently define 'legitimate' expectations in their health systems. There is room for action and real possibilities for achieving meaningful change in such an enterprise as there are instances where the legitimacy or not of care-related norms and expectations have been vigorously contested, resulting in incremental social and policy change. One such example is the international-level and national-level response, across the range of polities, to the care needs of people who inject drugs.[32] An evidence-informed, combination approach involving needle and syringe programmes, opioid substitution therapy, HIV testing and counselling and antiretroviral therapy, is now an established and socially accepted approach to providing care to people who inject drugs. However, it took decades of patience, participation and diligent contestation before countries and societies came to recognise this approach as being socially legitimate and acceptable. While criminalisation, long-term prison sentences, compulsory treatment, even the death penalty,[32] remain part of the formal law in many contexts, the broader policy and social environment increasingly recognises injection drug users' expectations of having timely access to respectful, non-discriminatory healthcare as being 'legitimate'.

CONCLUSION

As constraints around availability and accessibility of health services increasingly get loosened in LMIC-contexts, scholars, policymakers, and practitioners in global health are increasingly interested in and focusing on improving the responsiveness of health systems to the needs and expectations of the populations they serve. In this analysis, we have unpacked an important element of the definition of health systems responsiveness—the notion of 'legitimate expectations'—an element, that though central to the definition, has hitherto not received much critical attention. We highlight the need for research which seeks to understand how 'legitimate' expectations are established, through what forms of participation and contestation, in various political system contexts. We also highlight the potential role researchers can play to initiate processes and help create spaces for equitable and meaningful participation, contestation, and ongoing negotiation of entrenched processes and norms which currently define 'legitimate' expectations from health systems.

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ORCID iDs
Kimberly Lakin http://orcid.org/0000-0001-6016-3416
Sumit Kane http://orcid.org/0000-0002-4858-7344

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