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Peoples' expectations of healthcare: A conceptual review and proposed analytical framework

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ABSTRACT

Expectations shape how one experiences the healthcare one receives. In this paper we argue that the current conceptualisations of expectations within the healthcare literature have much to gain from the many recent and adjacent conceptual developments in other disciplines. The concept of expectations has been extensively studied across disciplines – we review the key texts on the subject in the business, management, social psychology, and sociology literatures to provide a conceptual overview and propose an integrative analytical framework for better understanding individuals' expectations in healthcare. We argue that peoples' expectations of a care encounter are usefully understood as being shaped by their social locations at particular points of time, which is at the intersection of multiple social structures and relations. Peoples' future expectations of care may also be influenced by the experiences of past and current care encounters, framed again by intersecting social structures and relations at that point in time. We demonstrate how an intersectional, translocational and relational analytical approach can allow researchers and practitioners to consider how peoples' social locations shape their expectations of care, not only within a given social environment, but at certain points in time and over time. We emphasise that, given the mobilities and mixing societies are experiencing globally, such an approach is particularly useful for understanding healthcare-related expectations and experiences of all.

1. Introduction

Expectations shape how one experiences the healthcare one receives. Expectations serve as the benchmarks by which patients assess systems performance during the care encounter and are central to both patient satisfaction and health system responsiveness (Mirzoev and Kane, 2017). While the concept of expectations has been articulated and understood in a variety of ways within healthcare, it remains an area of continual debate (de Silva, 2000), with conceptualisations primarily relating to patient satisfaction. It has also been argued that within the satisfaction-related literature, as well as the WHO responsiveness framework and other health service encounter frameworks, limited attention is paid to the various social, cultural, historical, and economic antecedents that shape people's expectations of healthcare (Mirzoev and Kane, 2017). These calls beg the question - through what perspectives and approaches should peoples' expectations of healthcare be understood?

At another level, the rapidly growing literature on migrants (international, and rural to urban alike) and health also engages with issues of

healthcare-related expectations, usually tacitly, but sometimes explicitly. However, insights from this literature remain marginally represented in the current conceptual understandings of people's expectations. For instance, the literature on expectations does not yet sufficiently engage with either the influence of pre- and post-migratory contextual factors (Hossin, 2020), or the migration trajectories and various phases including, pre-departure circumstances in the country-of-origin, destinations of long-term or short-term stay and return to country-of-origin for resettlement or temporary visits (Abubakar et al., 2018, Gostin and Roberts, 2015; Maskileyson, 2019, Zimmerman et al., 2011). All these phases of an individual's journey can have an impact on their healthcare-related expectations and experiences. We contend that the issues being articulated in the literature on migrant's health offer much value to the broader understandings of the healthcare experience and expectations – the migrant experience is important today more than ever given the high levels of population mobility within and across countries.

In this paper, considering the above, we tackle the question - through what perspectives, cartographies, and approaches should peoples'

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healthcare-related expectations be understood? A comprehensive and nuanced understanding of healthcare expectations is essential for the provision of responsive healthcare and to better satisfy people's needs (and expectations). We argue that the current conceptualisations of peoples' healthcare-related expectations can be improved by the explicit incorporation of the various contextual factors that shape such expectations. In this paper we engage with people's expectations broadly, and this includes those who are not ill and/or not seeking care and also those who are interacting with health services as patients. While we recognise that there are differences between the two categories, we focus on the commonalities and on the expectations of people generally — whether they are patients or not. In the following sections, we provide a conceptual overview of 'expectations' as articulated in the major disciplinary domains of business, social psychology, sociology, and healthcare. Though we refer to literature on expectations specifically within these major disciplines, we recognise that it is possible that the concept has been engaged with in other fields too. Throughout this review we will engage with some empirical examples from the healthcare literature (from different parts of the world) to illustrate key elements relevant to the conceptualisation of expectations of healthcare. Drawing on the insights from the conceptual review, we propose an integrative analytical framework for examining peoples' expectations of healthcare.

2. 'Expectations' within business and social psychology

In the organisational and management literature, expectations are defined in two broad ways. The first centres on behaviour, where an expectation is the subjective probability that a behaviour will lead to a specific outcome (Coye, 2004). By contrast, Olson and Dover (1979) propose that expectations should be defined as beliefs, representing the link between an object or event and an attribute. They argue that in order to understand the formation and modification of expectations, one must consider the theoretical basis of belief formation. According to Fishbein and Ajzen (1975), beliefs may be *descriptive*, *informational*, or *inferential*. Individuals form *descriptive beliefs* by direct observation or personal experience and are therefore held with a degree of certainty. When the connection between an object and an attribute is drawn from a prior belief, it is said to be an *inferential belief*. As these beliefs are based upon perceived relations between beliefs, they are subject to personal influences such as personality characteristics. *Informational beliefs* are those in which another source (an intermediate or unknown other) makes the connection between an object and attribute and is maintained if the source is deemed credible. Due to the lack of grounding in direct personal experience, *informational* and *inferential beliefs* can be held with varying degrees of confidence. Coye (2004) utilises this model to understand customer expectations in service encounters. A customer expectation is a belief about a future event that is the result of information gathered directly through personal observation, indirectly via information provided by others, or inferred by information or observation (Coye, 2004). For instance, this notion of *descriptive* beliefs is evident in a study by Fair et al. (2020), in which migrant women had differing expectations of maternity care in their host country. This was found to have stemmed from their past healthcare experiences in their country-of-origin; some women feared being treated poorly due to poor experiences in their home country. Expectations about what would be an appropriate medical intervention during childbirth and pregnancy were also shaped by cultural beliefs and experiences in their home country's health system (Fair et al., 2020). The point being that peoples' future interactions with the health system may be shaped by past experiences (*descriptive beliefs*) and, in the case of *inferential* and *informational beliefs*, personal factors such as desires and personality characteristics.

Expectation States Theory, within Social Psychology, provides useful insights on expectations within social interactions that are goal-oriented (Ridgeway, 1993). The theory contends that interactants form "performance expectations" which influence behaviour in a self-fulfilling manner. Crucially, social factors influence the formation of

performance expectations and include status characteristics, social rewards, and behavioural interchange patterns (Correll and Ridgeway, 2003, p. 31). Specifically, status characteristics are the attributes in which people differ (such as race, gender, class, and educational attainment) and for which there are widely held cultural beliefs that differentiate the "greater social worthiness" of one category over the other (Correll and Ridgeway, 2003, p. 32). Fochsen et al. (2006)'s study in rural India illustrates how the status characteristic of gender can influence power disparities in the doctor-patient relationship and the 'performance expectations' of female patients. In Fochsen et al. (2006)'s study context, women were perceived as dependent, vulnerable and to have an "inferior status" both in society, as well as within the family. This meant that family members (such as the husband or in-laws) were involved in consultations to communicate the woman's illness to the practitioner and make 'appropriate' decisions regarding the woman's treatment. In this way, internal family hierarchies relating to gender, as well as age, differentiated the 'social worthiness' of female patients, shaping their 'performance expectations' from and within the healthcare encounter. (Fochsen et al., 2006).

Status Characteristics Theory on the other hand contends that beliefs about social characteristics shape performance expectations. The theory argues that for status characteristics to influence behaviour, they must be salient; the attribute must be socially significant for actors in the specific setting in order to influence performance expectations (Correll and Ridgeway, 2003). Similarly, patients' interactions with the health system may be influenced by specific 'social' expectations. These expectations may present 'social accessibility' related barriers to health services, as was identified by Kane et al. (2018) in their study examining women's decisions to use maternal health services in South Sudan. They found that women's decisions to use such services were not solely related to quality or affordability but were influenced by certain social norms. Pregnancy was perceived as a matter of personal pride, and women were expected to dress well and be presentable in public places (such as the clinic). Fulfilling these salient 'social' expectations communicated to society that her pregnancy was celebrated and dignified by the family. However, women who were unable to present themselves in this way (because of missing husbands or having no family to provide for them) would forgo the use of antenatal health services, despite knowing the importance of such visits during and after pregnancy. Moreover, *Status Characteristics Theory* contends that multiple status characteristics, relating to gender, class, and ethnicity, may combine to form "aggregated performance expectations" (Correll and Ridgeway, 2003, p. 33). But also, that performance expectations formed in one encounter (based on status beliefs) shape expectations from future encounters. Nevertheless, this conceptualisation of expectations highlights a number of important considerations. Firstly, that beliefs relating to social status, which are relevant to a specific context, shape performance expectations in goal-oriented interactions. This indicates that the social context plays a key role in determining whether beliefs relating to social characteristics shape expectations. It also suggests that past experiences of encounters can shape one's performance expectations during a current encounter. Lastly, that social status characteristics can intersect to shape expectations during interactions.

Also, within Social Psychology, the concept of expectations is incorporated as a major consideration in the *Theory of Planned Behaviour* (De Jong, 2000). Here, intention is the primary determinant of behaviour and is the product of both social norms (one's perceptions of what others think about the behaviour) and expectations (achieving a valued goal due to the behaviour). Thus, according to Ajzen (2005), social norms are the main elements involved in translating expectations into behavioural intentions and subsequent action. The theory also identifies the role of background factors in facilitating or constraining behaviour. These factors may be *personal* (personality traits, values, or emotions), *social* (age, gender, ethnicity, or religion) or *informational* (experience or knowledge). Specifically, Ajzen (2005) concedes that a major facilitating factor is prior experience of engaging in a specific behaviour. But

also, one's interpretation of others' experiences, whether they be those within immediate social networks or unknown others observed in the media. These factors are shaped by the broader social environment which, in turn, influences intentions and actions. In this way, individuals in different social environments can possess diverse beliefs about the consequences of a behaviour, the normative expectations of others and the obstacles that may prevent them from engaging in a behaviour (Ajzen, 2005).

3. 'Expectations' within sociology

Luhmann (1995) has argued that the concept of expectations should have a central theoretical position within all social inquiry. In his social systems theory, Luhmann (1995) views environments as being excessively complex and various social systems as serving to reduce the complexity of these environments. Moreover, within each system, there may be sub-systems that reduce this complexity even further (Meyer et al., 2015). In the case of the health system, sub-system may include primary care, dentistry and maternity care. A system's complexity is reduced by structuring the possibilities of its own experiences and actions and, in doing so, the system maintains meaning (Meyer et al., 2015). Specifically, Luhmann (1995, p. 292) claims that social system structures are formed out of expectations, so much so that social structures are essentially "expectational structures". In this way, meaning for an action is constituted within a "horizon of expectation" (Koselleck, 2004; Faure, 2017, p. 2), and such expectations are pre-given and generalised. Structures of expectations are constantly re-activated, anticipating future actions and, in doing so, reducing the complexity of the system (Luhmann, 1995). These understandings signposts the reciprocal relationship of expectations and experiences. People may have generalised and pre-given expectations of healthcare that are defined by the organisational processes, resources, policies and actors of the health system, as well as the sub-systems they interact with. However, their expectations may also be defined by the social systems (and structures) they are part of and interact with and are also generalised and pre-given. We argue that these social systems (and structures) on the one hand may constrain patients' 'horizon of expectations' relating to the health system. On the other hand, this very constraining may help to reduce the complexity of these systems, enabling patients to better inhabit and interact with and cope with these complex social systems.

The concept of "horizon of expectation" thus offers a potential explanation of how expectations are shaped and further demonstrates the reciprocal relationship of expectations and experience. Indeed, Koselleck makes the compelling point of: "no expectations without experience; no experience without expectation" (Koselleck, 2004 p. 257). Expectations refer to a future which is the product of both individual and collective experiences; such experiences represent one's interpretation of the past, as well as the present (Faure, 2017). Koselleck (2004, p. 259) uses the 'horizon' as a temporal metaphor, arguing that "person-specific and interpersonal", expectations are shaped and constituted by "hope and fear, wishes and desires, cares and rational analysis" and is, essentially, "the future made present". The 'horizon' we contend can also be understood as referring to what individuals can imagine as being possible for themselves, given their *habitus*. The *habitus* being the processes of thinking in which one's social position, social norms, cultural conventions, and the experiences one has as a social being, are internalised in the mind, along with the individual's own inclinations, preferences, and interpretations. Drawing on Bourdieu (1990, p. 64), we argue that expectations are about "probable futures" that one can imagine for oneself; and that one's probable futures are imagined and "constituted in the prolonged relationship with a world structured according to the categories of the possible (for us) and the impossible (for us), of what is appropriated in advance by and for others and what one can reasonably expect for oneself". That is, life chances (experiences) are internalised and translated into specific expectations, which are subsequently externalised through actions that tend to

reproduce the same life chances (Hinote, 2015). Essentially, one's *habitus* is a result of one's socialisation throughout life, with one's expectations and actions reflecting what one is repeatedly subjected to. Therefore, expectations are socially constructed, collectively produced and are "transmitted and conveyed to offspring who see little evidence to contradict them" (Crossely, 2001, p. 91). As a result, one's 'horizon of expectations' may not only be influenced by one's *habitus*, one's own experiences, but also by the experiences of 'intermediate' others.

Importantly, Bourdieu proposes that one's *habitus* is a "structured structure" (Bourdieu, 1990); it comprises of perceptual structures that generate deeply structured dispositions that reflect the characteristics of a particular class or social group. Therefore, it is also a "structuring structure" in that individuals perform the appropriate practices for that social position, perpetuating existing social arrangements (King, 2000, p. 423, Hinote, 2015, p. 478). This can explain how advantage or disadvantage, that are internalised as behavioural dispositions and translated into specific expectations, can reproduce structural inequities across generations. But what if social conditions change, as is the case with migration? Nowicka (2015, p. 105) puts forth the notion that, in a new social context, one can experience a "tormented *habitus*". When confronted with new practices or social norms, migrants can undergo increasing self-analysis which can result in a "cleft *habitus*", that navigates the disparities between the norms and practices acquired prior to and post-migration, or a "transformed *habitus*" which loses its past qualities. Hinote (2015) reiterates that, though *habitus* can influence multiple aspects of cultural consumption and is enduring, it is not completely static and is somewhat adaptable. In this way, actions, and the expectations that guide them, can be shaped by the social environment and the broader structures to which individuals are "inextricably linked" (Hinote, 2015, p. 478). As an illustration, a study by Maharaj and Bandyopadhyay (2013) revealed that Indian migrant women who had lived in Australia for several years recognised the importance of work and being financially independent in Australian society and embraced these roles other than the traditional role of the 'mother'. Though aware of the importance and recommendation of exclusive breastfeeding for six months, such women substituted breast milk for infant formula to accommodate for their return to work. The authors contend that these women attempted to adopt the individualistic 'Western model' of healthcare and motherhood and, in this way, perhaps experienced a "transformed *habitus*". On the other hand, women who had recently migrated tended to embody the traditional gender role of 'mother', consonant with the 'Traditional' approach to mothering. Additionally, having no extended family in Australia meant that they relied on the advice of health professionals for the 'right' approach to breastfeeding (Maharaj and Bandyopadhyay, 2013). Such women experiencing a "cleft *habitus*" had specific expectations of health professionals to provide the support and advice that was lacking due to the absence of extended family. Ultimately, women's independence versus reliance underpinned the two approaches to motherhood and healthcare, which shaped their expectations of health service providers. This example demonstrates that the changing roles of migrant women in the new social context and over time can have varying influences on their healthcare-related expectations.

The social environment encapsulates institutionalised historical social and power structures, immediate physical surroundings, as well as cultural milieu (Barnett and Casper, 2001). Given then that the social environment encompasses both cultural and structural elements, what role does culture play in the shaping of expectations? Anthropologists define culture as, "systems of meaning, knowledge, and action" (Nastasi et al., 2017). As a "system of meaning", culture enables individuals and communities to organise the multiple components of their world into a cohesive whole, via a process of construction through social interaction (Nastasi et al., 2017, p. 137). As a "system of knowledge", culture permits normative behaviours which reinforce and transmit the constructed "meaningful" world over generations. As a "system of action", culture prompts individuals to act upon their world through which new

meanings can be negotiated (Nastasi et al., 2017, p. 137). At the collective level, culture represents a shared set of beliefs, values, and behavioural expectations. However, an individual's interpretations of this shared system may be influenced by experiences within different contexts that have varying cultural meanings (Nastasi et al., 2017). Thus, culture may play a role in the meaning associated with specific expectations which, in turn, prompts normative behaviours that maintain and transmit this constructed meaning. Importantly, this meaning is constructed via a process of social interaction and is shaped by one's experiences in varying contexts. Accordingly, Patterson (2014) insists that our understanding of how culture influences behaviour should be interactional; cultural structures do not autonomously influence social structures or human actors but, rather, interact with structural forces to enable and constrain human agency. Anthias (2011, p. 205) corroborates this argument by explaining that it is difficult to distinguish the boundary between the cultural and non-cultural as, "all social practice is imbued with the cultural".

4. 'Expectations' within the healthcare literature

Within healthcare, the importance of expectations is particularly salient in two bodies of scholarship – on patient satisfaction, and health systems responsiveness, overwhelmingly the former (de Silva, 2000; Kravitz, 1996). In their review of expectations as determinants of patients' satisfaction with health services, Thompson and Suñol (1995) identify four types of expectations: *ideal*, *predicted*, *unformed* and *normative*. The latter (which is central to responsiveness) represents what users believe should or ought to happen. *Ideal* expectations refer to patients' aspirations or desires, however, *predicted* expectations, on the contrary, are those that are realistic and practical; they are what users actually believe will happen and are likely the result of personal experience. When users are unwilling or unable to articulate their expectations, they are known as *unformed* expectations. Kravitz (1996) has put forth a model of patients' expectations in relation to visit satisfaction or the care interaction. In this model, a patients' expectations of care are formed prior to the medical encounter but can be modified as the encounter proceeds. The model also incorporates possible determinants of patients' *a priori* expectations such as socio-demographic characteristics, biopsychosocial concerns, as well as past experiences with the health system and the practitioner. Another critical dimension of patients' expectations is content; patients' expectations can relate to health care structures, processes and/or outcomes (Kravitz, 1996). For instance, patients can have specific 'structural' expectations relating to the health care facility, personnel, or organisational policies, however, these may be shaped by the patients' social situation. Pass, Kennelty, and Carter (2019) shed light on the barriers older adults with multiple co-morbidities experienced when accessing mental health services in rural Iowa. They found that while they could access primary care physicians who practiced locally, elderly patients had to travel some distance to access psychiatrists and therapists. Access was also difficult for patients who had limited mobility, could not travel independently or could not afford to travel. Patients' 'structural' expectations of accessing mental health care were therefore structured at the intersection of social structures and processes relating to their age, social class, and co-morbidity status. Alternatively, expectations could also concern technical medical processes (diagnostic testing, therapeutic processes) or interpersonal processes (patient-practitioner interaction). Finally, patients can have expectations of the physical, psychosocial, and financial outcomes of their care (Kravitz, 1996). Kravitz (1996), places satisfaction at the centre of his framework to distinguish between value expectations based in desires, necessities, entitlements, or importance (the emotional component), and probability expectations which are the probabilistic assessment and beliefs that something will occur (the cognitive component). Kravitz (1996) adds that expectations can be understood along three broad axes; whether they are defined as value expectations or probability expectations; whether expectations for

health care are in general or related to a specific treatment or care encounter; and whether related to the structure, process, or outcomes of care.

Bandura's (1977, Crow et al., 1999) work on expectancies allows one to make a further, important distinction between self-efficacy expectations that patients as social beings have, or have of themselves, and outcome expectations that patients have from their care encounters. Oliver and Winer (1987), while writing about service encounters more generally (in non-healthcare settings) differentiate between *active* and *passive* expectations. They posit that *active* expectations, which are at a high level of consciousness, are influential in the decision to use certain services. On the other hand, *passive* expectations may only exist as generally true assumptions that are not processed until they are disconfirmed. In this way, individuals may be neither satisfied nor dissatisfied with the particular service, until the interaction either confirms their *active* expectations or violates their *passive* expectations (Oliver and Winer, 1987). While this literature engages with the notion of expectations broadly, its reference point relates primarily to satisfaction with services.

The concept of expectations is also incorporated within Larson et al. (2019)'s proposed framework for person-centred measures of health system quality and responsiveness. In this framework, patients' needs, expectations and values are influenced by modifiers such as facility characteristics (availability of services and resources and number of healthcare providers), patients' characteristics (sociodemographic characteristics and clinical history) and the type of service (preventative or emergency care). These factors are, in turn, dependent on the country and health system context. Ultimately, patients' expectations, needs and values shape their experiences of care in relation to effective communication, respect and dignity and emotional support, as well as health outcomes, patient satisfaction and confidence in the health system. Larson et al. (2019) maintain that patients' expectations are affected not only by factors related to the health system, but also by the broader societal, community and family contexts. This model has been adopted by Ratcliffe et al. (2020) in their examination of the experiences of women of reproductive age, measured with respect to the elements of health system responsiveness (dignity, autonomy, choice of provider, confidentiality, quality of amenities, communication, and choice of provider). Women who experienced more responsive care were more likely to be educated and have good access to care that was provided at a private facility. More importantly, woman who reported the highest responsiveness levels were also likely to indicate that care was excellent at meeting their needs (Ratcliffe et al., 2020).

On the other hand, but still related to the literature on person-centred care, is the literature on health systems responsiveness; recent and limited though it still is, it approaches the notion of expectations a bit differently. Health systems responsiveness is defined as "the outcome that can be achieved when institutional and institutional relationships [...] respond appropriately to the universally legitimate expectations of individuals" (de Silva, 2000, p. 3). In this articulation, individuals in a particular society are considered to have specific expectations, in terms of how they should be treated both physically and psychologically, which that society chooses to regard as 'legitimate'. Thus, within responsiveness, there is an emphasis on *legitimate* expectations which are those that conform to recognised principles or accepted social norms and standards. de Silva (2000) argues that this differentiation is necessary as individuals may possess expectations of the health system that are unrealistic or unjustifiable. For example, a patient may consider a waiting period of six months for a given health condition the norm for a specific health system. However, people in another country may feel that a health system that requires this six-month waiting period is not a responsive health system. This reference to 'legitimacy' is primarily rooted in economic theoretical concerns around the rationing of finite resources, as well as the work on responsiveness and human rights. For instance, forced sterilisation and incarceration of individuals with communicable diseases are possible ways of improving population

health, but they also impact patients' dignity and autonomy. Therefore, it is considered not legitimate to improve health at the expense of reducing responsiveness (Valentine et al., 2003). While the notion of legitimacy has attracted its fair share of criticism, it also refers to and highlights the importance of acknowledging the role of societal and individual characteristics and experiences in the shaping of healthcare-related expectations (de Silva, 2000).

Noteworthy, however within the satisfaction-related literature, in the WHO responsiveness framework, and in other health service encounter frameworks (Mirzoev and Kane, 2017) is the limited attention paid to understanding what shapes people's expectations of healthcare. This is despite the recognition that healthcare expectations can be influenced by many factors, including socio-economic status, age, health status and past experiences of interaction with the health system (Coulter and Jenkinson, 2005). Similarly, Mirzoev and Kane (2017) recent conceptual framework identifies two aspects which comprise health system responsiveness: people's initial expectations and the health system's response to these expectations. These aspects are the determinants of people's experiences of their interaction with the health system, which Mirzoev and Kane (2017) locate at the centre of health system responsiveness. They observe that the seven elements of health system responsiveness are best understood by incorporating an understanding of the determinants of patients' expectations of their care encounter. Crucially, the framework also calls for the importance of taking into account the wider social, cultural, historical, and political contexts which shapes people's active and passive expectations of the health system.

Finally, the particular context of the health system and the ways in which this unique context also shapes patients' expectations of healthcare should be acknowledged. The affective state of a patient who is in pain is likely to be emotionally charged and this is not usually the case in other consumption experiences (Thompson and Suñol, 1995). In this way, distress and uncertainty can have specific implications for patient's healthcare expectations relating to, for example, autonomy and trust. The nature of the patient-practitioner interaction can also mean that the public and private lives of patients are "laid bare" both in a physical and emotional sense. However, the degree to which this occurs and the healthcare expectations associated with this is influenced by various intersecting social structures at that point in time. Another consideration is the asymmetry of information that exists in the patient-practitioner relationship. Though individuals are increasingly expecting greater provision of information from practitioners, evidence indicates that

information asymmetry can be more prominent in some specialities due to rapid advances in technical knowledge (Thompson and Suñol, 1995). Also, as Coulter and Jenkinson (2005) revealed, the extent to which patients expected to be provided with information and involved in treatment decisions can be influenced by factors such as age and country of residence. Furthermore, healthcare encounters (particularly when considering chronic illnesses) can occur over an extended period of time and are not momentary (Thompson and Suñol, 1995). This points to the notion that expectations are temporally defined, evolving, and developing as the healthcare interaction progresses. Therefore, individuals' expectations of healthcare are also shaped by these unique aspects of the healthcare encounter, that may differ from other service encounters, and which are also socially and culturally mediated.

5. An intersectional, translocational, and relational analytical framework for understanding peoples' healthcare expectations

In this section we draw upon the conceptual insights outlined so far to engage with the question - through what perspectives, cartographies, and approaches should peoples' healthcare-related expectations be understood? We propose an intersectional, translocational and relational analytical framework for understanding peoples' healthcare-related expectations. Fig. 1 is a visualisation; in the following sections we elaborate the analytical approach by drawing on the theoretical literature.

6. Insights from the conceptual review

From the conceptual review, it is evident that the concept of expectations can be defined in a variety of ways. But, despite this variation, there remain some key overlapping facets of these conceptualisation which are discussed below. In the organisational literature, expectations have been defined as a belief or as the probability that a given behaviour will result in a specific outcome. According to Luhmann (1995) structures of expectations (that are pre-given and generalised) are constantly re-activated, anticipating future actions and, in doing so, reducing the complexity of social systems (Luhmann, 1995). Furthermore, the concept of expectations can be usefully understood as embedded within Bourdieu's notion of *habitus*, the mechanism by which life chances are internalised and translated into specific expectations that guide one's actions (Hinote, 2015). Within Social Psychology's *Theory of Planned Behaviour* expectations are defined as one's perceptions of achieving a

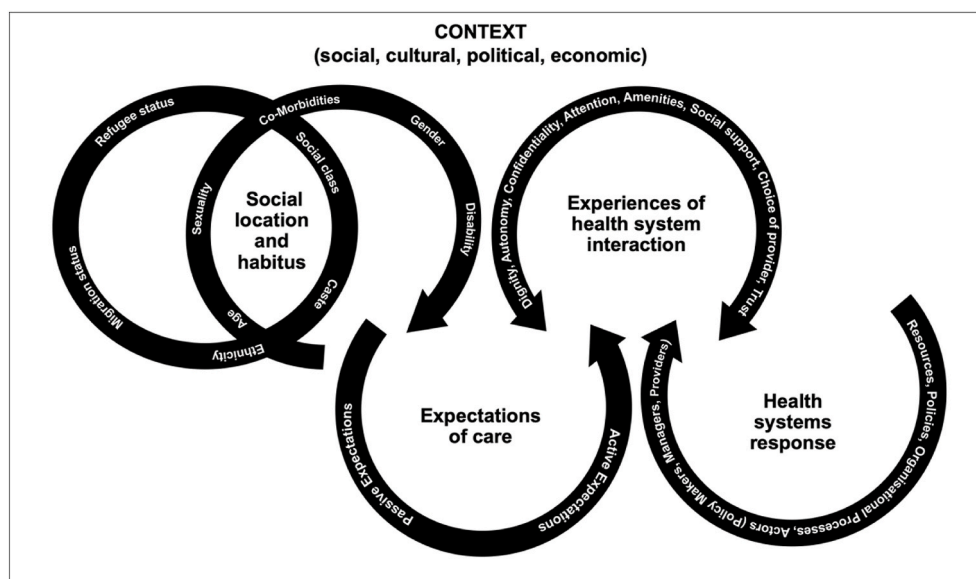


Fig. 1. An intersectional, translocational and relational analytical framework for examining peoples' healthcare-related expectations.

valued goal and, within *Expectations States Theory*, interactants form ‘performance expectations’ in goal-oriented interactions (Correll and Ridgeway, 2003). In the healthcare literature, health system responsiveness centres on expectations that are *normative* (what should or ought to be) and *legitimate* (those that are justifiable). By contrast, patient satisfaction broadly encompasses *ideal*, *predicted*, *unformed* and *normative* expectations.

Nevertheless, there are some key overlapping features in these conceptualisations. Specifically, that multiple contextual factors contribute towards the formation and revision of expectations. This is evident within *Expectations States Theory*, where social status characteristics (such as race or class) are said to influence the formation of ‘performance expectations’ in goal-oriented social interactions (Correll and Ridgeway, 2003). Moreover, *Status Characteristics Theory* proposes that multiple status characteristics can intertwine to form ‘aggregated performance expectations’ – within the healthcare context, these would apply to services users, individual providers, and institutions alike. But, in order to shape such expectations, social status beliefs must be relevant to the social context in which the interaction occurs (Correll and Ridgeway, 2003). In the *Theory of Planned Behaviour*, Ajzen (2005) acknowledges that various personal, social and informational background factors facilitate or constrain behaviour through influencing expectations. These factors are shaped by the broader social environment, explaining how individuals in different social environments possess diverse expectations about the consequences of a behaviour (Ajzen, 2005). Drawing on Luhmann (1995)’s work, it is possible to argue that expectations (which are pre-given and generalised) can be defined by the social systems (and structures) that individuals are part of and interact with. Such an understanding is not unlike the view that considers *habitus*, as a ‘structured structure’. That is, one’s *habitus* generates structured dispositions that are characteristic of specific social groups that are, in turn, translated into expectations. These expectations are externalised into behaviours that reproduce existing structured differences (Hinote, 2015). Similarly, Koselleck points out that the broader social environment “grants background to individuals” which shape and revises their expectations (Faure, 2017, p. 3). Yet, within the healthcare literature, there is limited acknowledgement of the contextual factors which shape peoples’ *a priori* expectations of healthcare. Kravitz (1996) does acknowledge that initial healthcare expectations can be influenced by socio-demographic characteristics and biopsychosocial concerns. But what these factors are and how they interact to shape healthcare expectations, is not focused on. Larson et al. (2019) also describe how patients’ characteristics, such as sociodemographic factors and previous care-seeking behaviours, influence their expectations, needs and values which ultimately shape their care experiences. Alternatively, in their conceptual framework of health system responsiveness, Mirzoev and Kane (2017) articulate the wider social, cultural, historical, and political contexts which shape expectations of healthcare. Evidently, the broader social factors which influence peoples’ expectations of healthcare remain insufficiently understood and articulated.

Another common feature is the role of past experiences in the shaping of expectations. In many ways, these conceptualisations reveal the reciprocal relationship of expectation and experience; perhaps most clearly articulated by Koselleck’s assertion of “no expectations without experience; no experience without expectation” (Koselleck, 2004, p. 257). Luhmann (1995) reaffirms this notion by maintaining that, the outcomes of expectations restructure a repertoire of possible future actions. Social Psychology’s *Status Characteristics Theory* also mentions that ‘performance expectations’ formed in one goal-oriented interaction can transfer to future interactions. Furthermore, within the services literature and according to Coye (2004), *descriptive* customer expectations (or beliefs) in service encounters can be formed by personal experience. A system of ‘circular relations’ also underpins the concept of *habitus*, in which life chances or experiences are translated into specific expectations that can reproduce the same life chances (Hinote, 2015). Having said that, Bourdieu also alludes to the fact that expectations are

socially constructed in that they are shaped and determined by what one is continually subjected to and experiences. This reveals that expectations are not only shaped by one’s own experiences, but also by the experiences of ‘intermediate’ others (Crossely, 2001). This notion is echoed within the *Theory of Planned Behaviour*; informational factors which shape behavioural expectations can include prior experience of engaging in the behaviour, as well as one’s understanding of others’ experiences. On the other hand, in the patient satisfaction literature, Kravitz (1996) identifies past experiences with the health system and practitioners as a possible important determinant of patients’ expectations of healthcare. This influence of past experiences with the health system on peoples’ expectations of healthcare, while salient and widely recognised, remains relatively under-studied.

7. An intersectional approach

The term “intersectionality” was coined by the legal scholar and black feminist theorist Kimberlé Crenshaw. Crenshaw (1991) stressed that black women’s lives could not be extensively captured by analysing race or gender dimensions separately, as these systems of oppression are experienced simultaneously. An intersectionality approach therefore recognises that multiple social structures and processes intersect to produce social positions and outcomes (Anthias, 2012). Above all, Crenshaw (1991) insisted that intersectionality can and should expand beyond examining the intersections between race and class to include social categories such as gender, age and colour. Patricia Hill Collins uses a Foucauldian framework to propose that gender, race and class are discursive means in the production of power (Anthias, 2012). In Collins’ view, intersecting oppressions linked to gender, race and class are organised through a “matrix of domination”, which comprises structural, disciplinary, hegemonic and interpersonal power relations (Anthias, 2012, p. 126). Along these lines, it is possible to locate the intersections of social categories and the exercise of power within a range of social and institutional domains, such as the health system. Larson et al. (2016) argue that an intersectionality informed approach is particularly suitable for health systems research as it can help unpack the complexities of the care encounter to understand and reveal the fluid and interconnected structures of power that characterise the care encounter.

According to Hill (1993), power relations (such as those that operate in the patient-practitioner relationship) relate to various *intersecting* social structures such as gender, social status (including class), and ethnicity, as outlined in Fig. 1. Differences in power, structured along these intersections, produce inequalities which shape individual experiences (Anthias, 2020). Thus, within an intersectional analytical approach and as illustrated in Fig. 1, power relations associated with various intersecting social structures influences peoples’ *active* and *passive* expectations of care which can, in turn, shape their experiences of a health system interaction. These experiences can relate to the various non-clinical aspects of the care encounter, as outlined within the WHO responsiveness framework. It follows then that peoples’ expectations of healthcare professionals relating to, for example, autonomy in decision-making (as described by Fochsen et al. (2006)) are shaped by intersecting systems of power. However, aside from specific expectations relating to the doctor-patient relationship (such as those within the ‘respect for persons’ domain of responsiveness), individuals can also have expectations of the structural aspects of the health system as illustrated by Pass et al. (2019). Expectations of having timely access to a health care facility or good quality amenities are not only shaped by the context of the health system, but also by various intersecting social and cultural forces.

Existing conceptualisations recognise that one’s spatial location plays a role in the shaping of expectations. For instance, in *Social Status Characteristic Theory*, status characteristics must be salient to a particular context in order to influence ‘performance expectations’ (Correll and Ridgeway, 2003). Koselleck’s notion of ‘horizon of expectation’ also

implies that different social environments can shape one's interpretation of past experiences which, in turn, influences their expectations (Faure, 2017). Furthermore, in Hinote (2015) view, one's *habitus* is not completely static or unchangeable and can perhaps adapt to changes in social context. Lee (1997, p. 133) corroborates this stating that, as the *habitus* "moves through time in response to changing objective conditions", it is in an ongoing state of evolution. It can therefore be argued that one's expectations are shaped by intersecting social structures and processes that exist within a particular social environment. This consideration is perhaps crucial for understanding the impact of migration on patients' expectations of care. Migration is a socio-spatial mobility; individuals can experience both geographical and social mobility as a result of the migration process. Power arrangements in the new social environment can reconstruct migrants' realities which can, in turn, shape both their expectations and experiences of healthcare (Thimm and Chaudhuri, 2019).

8. A translocational and relational approach

Lupton (1997, pp. 206) points out that in a care encounter patients present themselves as, "a certain 'type of person' engaged in 'rational and 'civilised' behaviour consonant with her or his social or embodied position at the time". Therefore, apart from *spatial* social location, it is also vital to consider the effect of one's *temporal* social location on their healthcare expectations. Existing conceptualisations of expectations in the healthcare literature tend to centre on *spatiality*, and therefore have not explicitly focused on the notion of *temporality*. However, Luhmann (1995) does mention that expectations are "temporally bound", and Oliver and Winer also remark (1987) that existing definitions appear to concur that expectations are associated with a particular point in the future. Similarly, temporality is also key to Kosselleck's notion of 'horizon of expectation'; one's representations of time are oriented from the present to the past or to the future. In this way, expectations (that determine the future or the "non-experienced") are shaped both by one's interpretations of past, as well as current experiences (Faure, 2017, p. 3, Kosselleck, 2004, p. 259). Lee (1997) also stresses the temporal dimension of *habitus* by maintaining that it is in a constant state of evolution as it moves through time; arguing that the dispositions, expectations, and actions it generates are therefore *temporally* and *spatially* modified. Nevertheless, how expectations change, not only in response to changes in the social environment, but over time requires consideration. Floya Anthias (2020) suggests that a more nuanced interpretation of intersectionality is possible through adopting a *translocational* lens. Such an approach centres on one's social 'location' which is embedded within relations of hierarchy that vary according to time, place and scale (Anthias, 2020). Hence, the concept of *translocational positionality* incorporates the spatial, temporal and the scalar as 'place' within hierarchical social ordering (Anthias, 2020). Critically, apart from changes in place and scale, the approach also takes into account temporality; considering social structures not only in relation to each other in time, but also *over* time (Anthias, 2020). Through an intersectional and translocational approach, it is therefore possible to consider how peoples' social locations shape their healthcare expectations within specific social environments, at certain points in time and over time. Fig. 1 illustrates how an individuals' expectations of care can be influenced by their social location, which is at the intersection of multiple social structures.

A translocational approach also has significant implications for understanding migrants' healthcare-related expectations; it allows one to examine changes in migrants' social locations pre- and post-migration and how these changes, in turn shape their expectations of healthcare. Understanding the care experiences of migrants is important now more than ever given that, in 2019, there were an estimated 272 million international migrants globally (IOM 2020). Major displacement events in recent years have also led to forced migration; experiences of trauma and loss of life can have a distinctive impact on the *habitus* of refugees,

ultimately influencing their expectations of their host country's health system (Hossin, 2020; Gostin and Roberts, 2015, Zimmerman et al., 2011).

Connected to this, is the need for the reciprocal relationship of expectation and experience to be acknowledged in this intersectional, translocational and relational analytical approach. As demonstrated earlier and in Fig. 1, a person's experiences of a particular care encounter can influence their future expectations of care. Patient's past healthcare interactions are framed by intersecting social structures and processes at that point in time. These healthcare experiences and the individuals' interpretation of these experiences shape their healthcare expectations during their current encounter (as revealed by Fair et al., 2020). In a sense, past healthcare experiences (particularly those of another country's health system) can broaden or limit one's 'horizon of expectations' relating to a current care encounter. However, and having said that, it should also be noted that peoples' expectations of healthcare can be shaped by their interpretation and understanding of others' (intermediate or unknown) experiences of a care encounter too. Fig. 1 also indicates that an individuals' experiences of care can be influenced by the health systems response to their expectations. This response can be shaped by the various policies, organisational processes, and resources of the health system. It may also be influenced by the expectations of actors within the health system, such as health professionals, as is evident within Fochsen et al. (2006)'s study. Female patients were perceived as 'vulnerable and 'dependent' both by health professionals, as well as family members and this shaped their expectations of and ability to actively participate and make decisions during the care encounter. This highlights the need to consider the broader social and cultural context within which the care encounter takes place, and which also shapes the health system's response to individuals' expectations of care.

In this sense and given the above, we argue that the study of peoples' healthcare-related expectations requires one to deliberately engage with some of the limitations and concerns about the current models of intersectionality – the concerns highlighted by Brah (2005), Puar (2008) and Pedwell (2010) are particularly salient here. Echoing Brah (2005); Puar (2008, p. 208) finds problematic the presumption (in intersectional models) that the axes of race, class, gender, sexuality, nation, age, religion are analytically separable; she argues that these axes are in fact interwoven and "merge and dissipate" over time, space, and bodies. Pedwell (2010, pp. 38-9) argues that inquiries into and analyses of the intersection must not only involve looking at multiple axes of differentiation; they need to do so such as to "avoid excluding particular subjectivities and experiences", and with constant awareness of "what kinds of knowledges, histories, practices and relations of power are legitimated or reified, and which are marginalised or occluded". In line with Brah (2005), Puar (2008), and Pedwell (2010), we contend that taking an *explicitly relational approach* which involves clearly recognising that "categories of 'self' and 'other' are constituted relationally through intersectional processes in which multiple axes of social differentiation articulate" (Pedwell, 2010, p. 41), to one's inquiries and analyses allows one to engage with, if not fully address, some of the concerns around intersectional models. Relationality here is understood as to "signify the ongoing, contextually specific processes through which cultures, bodies, practices and subjectivities are (re)constituted and gain meaning through discursive-material encounters with other cultures, bodies, practices and subjectivities" (Pedwell, 2010, p. 41). A relational perspective recognises that social and cultural differences exist and are produced in relation to and in connection with constitutive 'others'; and that these differences are also contingent as they are socially and relationally produced, maintained, and evolve – they are not a given (Brah, 2005; Puar, 2008). A relational perspective thus inevitably requires one to engage with the constitutive other and with 'difference' - conceptualised as 'experience', as 'social relation', as 'subjectivity' and as 'identity' (Brah, p. 14). Doing so as such allows one's inquiries and analyses to engage better with the differences (and asymmetries)

encountered within care encounters – by all, in all care encounters, but particularly so in the encounters experienced by migrants.

9. Conclusion

Gaps in the understanding of the concept of expectations within healthcare have led to calls for researchers and practitioners to consider the various contextual factors that shape individuals' expectations of their interactions with the health system. Also, despite various calls for the need to recognise the dynamic and complex nature of modern migration, current conceptualisations of expectations within healthcare are yet to systematically draw on the research on the healthcare experiences of migrants. In response, drawing on a review of how expectations, and the shaping of expectations, is understood in different disciplines, we have proposed an intersectional, translocational and relational analytical framework for understanding peoples' expectations of healthcare. Within this approach, an individuals' expectations of a health system interaction are shaped by their social location, the relational dynamics within these locations, as well as by their interpretation of past experiences of care. The framework considers both the *temporal* and *spatial* social locations of patients', echoing those current conceptualisations which indicate that expectations are *relationally*, *temporally*, and *spatially* defined and shaped. We contend that such an analytical framework would help researchers, policy makers and practitioners to better take into account the antecedents and determinants of peoples' expectations of care – for the former, in the inquiries they conduct, and for the latter in their efforts to improve the responsiveness of and satisfaction with the services they provide.

Declaration of competing interest

No declarations of interest.

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