Equity in access to health care in Serbia

Exploring the role of informal patient payments in health care in the Western Balkan

---

PhD Thesis

Sofie Buch Mejsner

Unit for Health Promotion Research

Faculty of Health Sciences

University of Southern Denmark

2022

To be presented with permission from the Faculty of Health Sciences, University of Southern Denmark, for public examination on March 7th 2022 at University of Southern Denmark, Degnevej 14, 6750 Esbjerg

Table of Contents

List of original contribution

The present PhD project is based on the following papers:

Paper I

Buch Mejsner, S., & Eklund Karlsson, L. (2017). Informal payments and health system governance in Serbia: A pilot study. *Sage Open*, *7*(3), 13. https://doi.org/10.1177/2158244017728322

Paper II

Buch Mejsner, S., & Eklund Karlsson, L. (2017). Informal patient payments and bought and brought goods in the Western Balkans – a scoping review. *International Journal of Health Policy and Management*, *6*(11), 621.https://doi.org/10.15171/IJHPM.2017.73

Paper III

Buch Mejsner, S., Kristiansen, M., & Eklund Karlsson, L. (2021). Non-Western migrants and civil servants' perceptions on pathways to access health care in Serbia – A grounded theory multi-perspective study. *International Journal of Environmental Research and Public Health***,** *18*(19), 10247. https://doi.org/10.3390/ijerph181910247

Paper IV

Buch Mejsner, S., Davidovic, M., Kristiansen, M., Mahato, S., & Eklund Karlsson, L. Cultural mediators and their role in migrants' access to health care services in Serbia *(To be submitted to Journal of Health Services Research and Policy)*.

List of tables and figures

Figures

Tables

List of abbreviations

BBG: Bought and brought goods

CERQual: Confidence of the Evidence from Reviews of Qualitative Research

CeSID: Center for Free Elections and Democracy

EU: European Union

IOM: International Organization for Migration

IPP: Informal patient payments

OOP: Out-of-pocket payments

MMAT: Mixed Method Appraisal Tool

NGO: Non-Governmental Organization

NICE: National Institute for Health and Care Excellence

NMS: New Member States

OECD: Organization for Economic Coorporation and Development

UDP: Unregulated Direct Payments

UNDP: United Nations Development Programme

WHO: World Health Organization

Summary

Background

Informal patient payments are discussed in various literature, showing negative effects on the access to health care, health equity, and population health. They include gifts and bribes given to health care providers to receive (easier) access to health care services. These payments may widen health inequities in societies, as those who are able to pay or those with favourable networks may receive (easier) access to health care services. Countries in transition often face challenges with the growing complexity of governance of their health systems. Informal patient payments are seen as a symptom of poor health systems governance. Evidence regarding informal patient payments and their effect on inequity in access to health care in the Western Balkan countries and in particular Serbia is scarce. This thesis sought to contribute in filling this knowledge gap.

Aim and research questions

The overall aim of this thesis was to examine informal patient payments and equity in access to health care as parts of health systems governance. The thesis identifies and describes the process through which these payments may take place, using Serbia as a case. Evidence from the other Western Balkan countries were included to capture the overall picture on informal patient payments (including also bought and brought goods) in the region. The specific objectives of the thesis were:

1. To explore existing evidence on informal patient payments in Western Balkan and to analyse what are public health civil servants' perceptions on informal patient payments and service provision, and how do they perceive governance of the health care system in Serbia? **(Paper I)**

2. To explore what is known about informal patient payments and bought and brought goods in Western Balkan, to examine their influence on healthcare, and to identify from the evidence what actions can be taken to tackle this problem? **(Paper II)**

3. From a health governance and equity perspective, to specifically investigate what are civil servants' and asylum-seeking migrants' perceptions of informal patient payments in Serbian health care and barriers and facilitators to access care? **(Paper III and IV)**

Methods

Qualitative methods were used as means of data collection. The pilot study (**Paper I**) included both empirical data and a literature review. The empirical part consisted of semi-structured interviews of public health civil servants and health care providers (n=4), which was analysed using a phenomenological hermeneutical approach. The literature review focused on mapping the existing evidence of informal patient payments in all

Western Balkan countries. The pilot study was followed by a deeper exploration of the existing evidence regarding informal patient payments in the region. In the form of a scoping review (**Paper II**), the study identified key aspects of informal patient payments and bought and brought goods in all Western Balkan countries through a systematic analysis of 24 published and unpublished studies. The final empirical part of the study (**Paper III** and **Paper IV**) focused specifically on Serbia. The focus was to examine civil servants' (N=8) and asylum-seeking migrants' (N=6) perceptions of informal patient payments and barriers and facilitators in accessing health care services in Serbia. The data was collected through qualitative interviews and analysed using Grounded Theory Approach.

Results

The Pilot study **(Paper I)** indicated that informal patient payments and quasi-formal payments mostly took place in inpatient care and were done due to perceived low salaries of doctors, poor health care resources, a desire to receive better or faster service, fear of being denied treatment, and willingness to express gratitude through gifts. The Scoping Review **(Paper II)** revealed that incidents of informal patient payments took place on a wide scale. Evidence regarding bought and brought goods remained limited, indicating that such practices may be even more problematic than informal patient payments. The qualitative study (**Paper III**) findings suggest that the main triggering elements to pay informally was the high value put into doctors and the lacking resources of the health care system. Migrants further navigated the health care system differently than other locals in Serbia which resulted in different outcomes of paying informal patient payments. The final part of the qualitative study (**Paper IV**) showed that the intercultural mediators had a pivotal role in shaping better and quicker access to health care services for asylum-seeking migrants in Serbia. Overall, the four studies showed that culture and the lacking resources of the Serbian health care system seemed to rationalize paying informally for health care. From all Western Balkan countries, evidence was lacking on bought and brought goods and quasi-formal payments.

Conclusion

This thesis provides new insights on the perceptions and experiences with paying informally and the equitable access to health of asylum-seeking migrants in Serbia. Together the four papers addressed the complexity around informal patient payments and bought and brought goods in the Western Balkan countries. The thesis finds that providing gifts to providers was somewhat accepted, while others believed it to be corrupt and unacceptable. Though, a commonness in paying informally was found in Serbia, especially due to the high value put into doctors and the lacking resources of the health care system. The asylum-seeking migrants seemed to be exempted from such payments. Reducing these informal patient payments for health care is highly important to facilitate equity in access to health care.

Sammenfatning

Baggrund

Uformelle patientbetalinger (informal patient payments) diskuteres i forskellig litteratur og viser en negativ effekt på adgang til sundhed, lighed og befolkningens sundhed. De omfatter gaver og bestikkelse givet til sundhedsprofessionelle for at modtage (lettere) adgang til sundhedsydelser. Sådanne betalinger kan styrke uligheden i sundhed, da de personer, som kan betale eller som har gunstige netværk, kan få (lettere) adgang til sundhedsydelser. Udviklingslande står ofte over for udfordringer med voksende kompleksitet i styringen af deres sundhedssystemer. Uformelle patientbetalinger ses som et symptom på utilstrækkelig styring af sundhedssystemer. Evidensen er sparsom omkring uformelle patientbetalinger og deres indvirkning på ulighed i adgang til sundhed i landene på det vestlige Balkan og især i Serbien. Denne afhandling søgte at bidrage til at øge viden indenfor dette område.

Mål og forskningsspørgsmål

Det overordnede formål med denne afhandling var at undersøge uformelle patientbetalinger og lighed i adgang til sundhed som en del af sundhedssystemernes styring. Idéen var at identificere og beskrive den proces, hvorigennem disse betalinger kan finde sted, ved at bruge Serbien som case. Evidens fra de andre vestlige Balkanlande blev inkluderet for at forstå det overordnede billede af uformelle patientbetalinger, herunder også købte og medbragte varer (bought and brought goods) i regionen. De specifikke mål for afhandlingen var:

1. At undersøge eksisterende evidens om uformelle patientbetalinger i det vestlige Balkan og at analysere, hvad offentlige sundhedsprofessionelles opfattelse er af uformelle patientbetalinger og sundhedsydelser, og hvordan de opfatter styringen af sundhedssystemet i Serbien? **(Artikel I)**

2. At undersøge, hvilken evidens der er omkring uformelle patientbetalinger og købte og medbragte varer i det vestlige Balkan, hvilken indvirkning de har på sundhedsvæsenet, og hvordan dette problem kan håndteres ud fra evidensen? **(Artikel II)**

3. At undersøge specifikt, ud fra et styrings- og lighedsperspektiv, hvad sundhedsprofessionelles og asylansøgende migranters opfattelse er af uformelle patientbetalinger i det serbiske sundhedsvæsen og barrierer og facilitatorer i adgangen til sundhedsydelser? **(Artikel III og IV)**

Metoder

Kvalitative metoder blev brugt som middel til dataindsamling. Pilotstudiet **(Artikel I)** omfattede både empiri og en litteraturgennemgang. Den empiriske del inkluderede semistrukturerede interviews af sundhedsprofessionelle (n=4), som blev analyseret ved hjælp af en fænomenologisk hermeneutisk tilgang. Litteraturgennemgangen fokuserede på styring

af sundhedssystemet og uformelle patientbetalinger i alle vestlige Balkanlande. Pilotstudiet efterfulgtes af en dybere udforskning af den eksisterende evidens vedrørende uformelle patientbetalinger i regionen. I form af en scoping review **(Artikel II)** identificerede undersøgelsen nøgleaspekter af uformelle patientbetalinger og købte og medbragte varer i alle vestlige Balkanlande igennem en analyse af 24 studier. Den sidste empiriske del af afhandlingen **(Artikel III** og **Artikel IV)** fokuserede specifikt på Serbien. Studiet undersøgte sundhedsprofessionelles (N=8) og asylansøgende migranters (N=6) opfattelser af uformelle patientbetalinger, barrierer og facilitatorer for at få adgang til sundhedsydelser i Serbien. Kvalitative interviews blev gennemført og analyseret gennem en Grounded Theory-tilgang.

Resultater

Pilotundersøgelsen **(Artikel I)** indikerede, at uformelle patientbetalinger og kvasi-formelle betalinger oftest fandt sted ved døgnbehandling og forekom grundet en opfattelse af lave læge-lønninger, dårlige sundhedsressourcer, ønsket om bedre eller hurtigere service, frygt for at blive nægtet behandling, eller et udtryk for taknemmelighed gennem gaver. Scoping review'et **(Artikel II)** indikerede, at uformelle patientbetalinger var rapporteret bredt. Evidensen omkring købte og medbragte varer var begrænset, hvilket indikerede at sådan praksis potentielt kan være endnu mere problematisk end uformelle patientbetalinger. Resultaterne af den kvalitative undersøgelse **(Artikel III)** antydede, at de vigtigste elementer for at betale uformelt var den høje værdi, der blev tildelt læger og de manglende ressourcer i sundhedsvæsenet. Migranter og andre lokale i Serbien havde desuden forskellige udfald i uformelle patientbetalinger. Den sidste kvalitative undersøgelse **(Artikel IV)** viste, at interkulturelle mæglere havde en central rolle i at forme bedre og hurtigere adgang til sundhedsydelser for asylansøgende migranter i Serbien. Samlet set viste de fire undersøgelser, at kulturen og de manglende ressourcer i det serbiske sundhedssystem syntes at rationalisere de uformelle patientbetalinger. I undersøgelsen af alle de vestlige Balkanlande var det tydeligt, at der mangler evidens omkring købte og medbragte varer og kvasi-formelle betalinger. Der blev samtidig fundet mindre enighed om disse betalinger blev givet i taknemmelighed eller tvunget og hvem i samfundet, der betalte mest uformelt.

Konklusion

Denne afhandling giver ny indsigt i opfattelser og erfaringer med at betale uformelt og lige adgang til sundhed for asylansøgende migranter i Serbien. Sammen behandlede de fire artikler kompleksiteten omkring uformelle patientbetalinger og købte og medbragte varer i det vestlige Balkan. Afhandlingen finder, at det i nogen grad er acceptabelt at give gaver til sundhedsprofessionelle, mens andre mener, at det er korrupt og uacceptabelt. Der blev dog fundet en almindelig tilgang til uformelle betalinger i Serbien, især på grund af den høje værdi, der blev tillagt læger samt sundhedssystemets manglende ressourcer. De asylsøgende migranter synes fritaget for sådanne betalinger. At reducere disse uformelle patientbetalinger er således yderst vigtigt for at lette den lige adgang til sundhed.

Foreword and acknowledgements

To understand the current thesis, I will firstly introduce the process of the project. Following that, comes my acknowledgements to those making this project possible.

I have always had a personal interest in the vulnerable groups of society and the challenges that may lie in creating equitable societies. Further, I have also professionally been seeking to understand why some institutions or states function better than others. Knowing the challenges of accessing health care services in some European countries, I became interested in finding the triggering element. Informal patient payments became a clear symptom of the poorly functioning health care systems in which people were struggling to access health care services equally. The obvious lack of evidence from the Western Balkan countries, and notably Serbia, consequently made these countries the focus for my study.

In 2014 I travelled to Serbia to interview participants, who were contacted beforehand. Though, several withdrew when upon arrival they realized the topic, which was seen as taboo. Thus, I needed to recruit new participants on the spot. I succeeded in establishing a connection to important local people and organisations who, through their existing networks, were able to find few public health civil servants (public health officials and primary care doctors) who were willing to participate as interviewees. Due to the unsuccessful attempt in finding more informants, the first article of the thesis functioned as a pilot study, complemented with a literature review to support the empirical findings.

The next step was to conduct a scoping review to probe the issue of informal patient payments and its influence in access to health care more comprehensively. It became clear that evidence was lacking in Serbia, while one study also specifically identified the bought and brought goods in Serbia. For these reasons, the qualitative study was planned to be conducted in Serbia. I also had a previous established network in Serbia, while Serbia became central in the migrant crisis.

In 2017 I went on my first maternity leave and had to put my study on hold. In the meantime, we were challenged to officially begin the PhD. The 2014 data collection and the scoping review were included in the PhD plan, which was accepted and sent for review in 2016. However, there were months of delay in the administration and in the review process of the University of Southern Denmark. Consequently, the project was delayed one year and coincided with my first maternity leave. Thus, I was not able to begin before my return from maternity leave in late 2017.

My PhD work continued with the second data collection period in 2018 in Serbia. The qualitative data collection was a success, as I was able to make effective use of my previously established contacts with Belgrade University, Red Cross, Doctors without Borders and other locally based NGOs. I benefitted from their existing networks to recruit voluntary interviewees relatively quickly in Serbia. Before the data collection, I found that many

migrants were stranded in Serbia, while potentially needing to access the Serbian health care system. The question became whether the asylum-seeking migrants' needs for health care would increase the "informality" (seeking informal networks and informal patient payments) in the health care system. The third article was therefore dealing with access to health care perceived by civil servants (information workers and intercultural mediators) and intended asylum-seeking and asylum-seeking migrants in Serbia. They will throughout the paper be mentioned in combination as asylum-seeking migrants. The fourth article regarded the asylum-seeking migrants' access to health care with the assistance of intercultural mediators. After the data collection I once again went on maternity leave in 2019 and returned November 2020.

The original idea was also to include questionnaires to the health care providers and policy makers and analyse those quantitatively. However, this turned out to be highly challenging. I reached out to my local partners to help expand the network for the quantitative data collection. The local unit for World Health Organization in Serbia also assisted in finding respondents, and the questionnaire was translated into local Serbian language and could be answered in Serbian and English. However, only 20 out of more than 300 questionnaire receivers replied. The Covid-19 pandemic began at this point to spread throughout the Western Balkan countries, which potentially further limited the response rate. After multiple unsuccessful attempts and a concluding deadline for the data collection period, I decided in consensus with my supervisors to give up the quantitative data collection.

When ending my studies in 2021, I look back at a PhD journey that has been both passionate and rewarding but also emotional and frustrating. Though, gaining new perspectives on migrants' access to health and the Western Balkan countries' challenges to create equitable societies, is something that will always be a close interest of mine.

In completing this project, I would like to thank my academic supervisors Leena Eklund Karlsson and Maria Kristiansen, for always being available when needed, endless encouragement, inspiring questions, good laughs, for their kind and warm nature, and for being 'two walking scientific libraries'. Leena, I further owe you my deepest gratitude for believing in my capacity to obtain a PhD. Without your persistence and enthusiasm, this project would not have been a reality. I would also like to thank the Unit for Health Promotion Research for providing an insightful, inspiring, and kind environment, and for all the fun stories along the way. A special thanks goes to the junior group, for being an irreplicable source of support on the irregular PhD ride.

During the data collection I was supported by Professor Vesna Bjegovic-Mikanovic and her team of researchers at the Institute of Social Medicine of the University of Belgrade, the Red Cross of Serbia, and the World Health Organization country office for Serbia. This project would not have been successful without their assistance, and I owe them my sincerest gratitude. A special thanks goes to Ms Masa Davidovic from the Institute of Social Medicine of the University of Belgrade, the team at Refugee Aid Serbia and the team at InfoPark for

their persistence in making the 2018 data collection a success. Masa, I owe you a special thanks for your determination in obtaining the ethical approval and access to the asylum centre in Belgrade. This project would not either have become true without the willingness of the people who agreed to be the interviewees and to share their stories with me. I am very grateful for their trust in me, and I sincerely thank them all for being so openhearted. A special and deep gratitude goes to the migrants in Belgrade, who kindly agreed to assist and talk with me despite being in a highly vulnerable and difficult situation.

Lastly, I wish to thank my dear friends and family who have supported me throughout ups and downs of completing this project. It would not have been the same without their motivation and encouragement.

Sofie Buch Mejsner

Esbjerg, November 2021

1. Introduction

In the introductory chapter, I will initially explain informal patient payments (IPP) and equity in access to health care as part of health systems governance. I will then provide a deeper understanding of the Serbian health care system and migrants access to health care in Serbia, followed by the research objectives and the theoretical background. This is thus a study into IPP and its influence on the equitable access to health care, using Serbia and the asylum-seeking migrants in Serbia as a case, due to mainly lacking evidence and for being a predominant country for migration flows. IPP, also known as bribery and gift giving to health care providers, have further been discussed in various literature as being among the main barriers in access to health care services around the world (1, 2). Other evidence suggests that vulnerable groups, such as asylum-seeking migrants, may pay informally more often than other population groups in some Western Balkan countries (3, 4). The study into IPP and their influence on equity in access to health care in these countries is therefore important.

IPP are frequently described as a type of corruption in the health care system, since they are often used to gain access to services that patients are otherwise entitled to (5-7). Health care systems are further particularly susceptible to corruption (8-10), while such corruption is typically embedded and undermines good governance and weakens the systems (11-13). Health systems are considered a large sector in the world economy, since population health is crucial to countries' wealth and prosperity (14). The governance of health systems is therefore crucial to properly be able to address population health (14, 15). Countries experiencing higher levels of corruption in health systems often also have higher rates of mortality (16-22).

IPP, also categorized as private out-of-pocket payments (OOP) or unregulated direct payments (UDP) (23), create a financial barrier that may result in unmet needs or financial hardship for those needing to access health services (24, 25) . The World Health Organization (WHO) (26) finds that millions of people cannot utilize health care services or suffer financial hardship due to the user payments at the time of receiving health care services. Though, there are differences between population groups, as individuals only experience financial hardships when OOP are larger than their ability to pay. Some may therefore be challenged by OOP, while others can cope (24). OOP, may therefore threaten the efforts of universal health care coverage and contribute into a risk of poverty of people as they absorb the households' financial resources (11, 27, 28). WHO (25) finds that the poorest of the European populations are most vulnerable to OOP, as they are pushed further into poverty. Migrants are particularly vulnerable to OOP as their legal status (based on their type of migrant status) is one of the main determinants of social security and health care benefits in a country (29-32). Vulnerable migrants in the European region, such as the asylum-seeking migrants, have further shown to be particularly exposed to barriers in accessing health care services equally, due to e.g., the poor responsiveness of the health system, poor entitlements in this group, or hesitation of migrants to access services (31, 33).

In Southeast Europe, the Western Balkan countries (Albania, Bosnia and Herzegovina, Croatia, North Macedonia, Kosovo, Montenegro, Serbia (See Appendix 1) have shown reluctant in providing health care services to some migrants such as irregular migrants or asylum-seekers (34). These countries are at various stages of entering the European Union (EU), but must firstly adopt the commonly agreed EU laws into their national legislation (35). Studying their efforts in providing universal health care is therefore important. One way to assess health systems performance and consumer friendliness is through the *Euro Health Consumer Index* (36), comparing indicators based on waiting times, results and generosity. In the 2018 index, Serbia ranks in an 18th place out of 35.

Based on these arguments this thesis focuses on IPP and their influence on the equitable access to health care in Serbia. Serbia is an important case to study since little evidence is available on Serbia, while it was one of the main transit countries for migrants during the migration crisis in 2015. Serbia also faces social, economic, and demographic difficulties, meanwhile vulnerable groups report high unmet health care needs, and the health care system suffers from underfunding and high private OOP spending (37-41). Great inequality between the richest and the poorest is seen, affecting particularly the migrants in the country (42). The following sections will look deeper into the Serbian health care system and migrants' access to health care in Serbia.

1.1. The Serbian health care system

The Serbian health care system is publicly financed and publicly provided, where the National Health Insurance Fund manages the compulsory contributions that come from the state, employees and employers (43). The Serbian social health insurance system is therefore similar to those of other Western Balkan countries' health care systems (44). It provides universal healthcare coverage, but co-payments are still required for selected services (45). Challenges thus exist in protecting against financial risks and improving population health (45, 46). The twenties' political history of Europe has consequently left behind differences in population health between Western and Eastern Europe (47, 48), such as differences in average life expectancy of 76 in the Western Balkan countries and 80 in other European countries (OECD-EU) (46, 49).

In Serbia, the social health insurance coverage is 98%, though private OOP spending has been nearly 40% of total health expenditure over the past years (45, 50). IPP are included in this private spending on health and have in other literature shown to be common in Serbia (51-53). The reliance on such private patient payments may have an adverse equity effect, particularly in countries with widespread IPP (54).

The health system corruption that continues to persist in the systems is also illustrated in Transparency Internationals' (12) *Corruption Perception Index 2020*, ranking Serbia on a 94th

place out of 180 in terms of the perceived level of public sector corruption. Reforms have recently been implemented to improve access to the healthcare system and to reduce inequalities in health (45, 55). However, high unmet needs are reported among e.g., elderly, women, and people from lower socio-economic groups when utilizing health care services in Serbia (39). The highest reported unmet need were financial reasons, waiting times, and distance or transportation difficulties (39). Inequities in the access to Serbian health care services are observed for particularly Roma and uninsured persons (45). In the coming section, the access to health care of migrants in Serbia will therefore be described.

1.1.1. Migrants and access to healthcare in Serbia

Evidence on IPP and migrants in Western Balkan countries have mainly focused on Roma People and Bosnian immigrants, while little literature is available on IPP and the access to health care of vulnerable migrants such as the recent wave of non-western asylum-seekers and refugees in Western Balkan countries (34, 56-58). Investigating the access to health care of migrants is however essential, since this group often suffer poor access to health in the European region, either due to poor legal entitlements, cultural or language barriers or the poor knowledge or information of their rights to health care (56, 59, 60).

The Western Balkan countries, and in particular Serbia, was affected by the 2015 migration crisis (40, 61, 62). Migrants transit Serbia and typically use the asylum centres as a place to rest and to prepare moving on to the EU (61). Though after closing the Balkan Route in 2016, the migrants became stranded in Serbia (34, 40, 62). Serbia initially provided mainly emergency care services to migrants (63), though due to the border closures, Serbia's health care system needed to be responsive to the changing circumstances (61, 63). Several initiatives were taken to provide better access to services and better-quality care for migrants (63). Most notably was the implementation of intercultural mediators to be used when migrants needed to access health care services. These mediators may diminish barriers to health care by bridging different cultural viewpoints on health and health care and build trust, while providing information and guidance in the quality and access to services (64). Migrants in Serbia may further choose to register as an *intended* asylum-seeker, contrary migrants in other Western Balkan countries (62). This gives them access to accommodation and health care services, while still being able to leave the country to apply asylum elsewhere (62, 65, 66). The large influx was however not predicted, and it was difficult to finance services for this group. The costs typically go to the public health care institutions, who are already under constraint (37, 41, 55, 67-69). Generally, migrants in Serbia are covered by the national health insurance scheme, whereas some services come with additional co-payments (45). I focused on the migrants that intended to apply for asylum or those applying asylum in Serbia, since this group is one of the most vulnerable in having health care entitlements that are based on their migrant status (62, 65, 66). Their status may change when deciding to leave Serbia and become an irregular migrant, or if having their asylum application accepted to attain refugee

status in Serbia. Having introduced the main topics of the thesis, the following section will outline the specific objectives of the study.

2. Research objectives

The overall aim of this thesis was to examine the IPP and equity in access to health care as parts of health systems governance. The idea was to identify and describe the process through which these payments may take place, using Serbia as a case. Evidence from the other Western Balkan countries was included to capture the overall picture on IPP (including also bought and brought goods - BBG) in the region.

By combining literature review data with qualitative data, representing asylum-seeking migrants' and civil servants' perspectives, the study sought to contribute to the understanding of how IPP unfolds specifically for recent migrants, and how this affects equity in access to health care. The specific objectives for the thesis were:

1. To explore existing evidence on informal patient payments in Western Balkan and to analyse what are public health civil servants' perceptions on informal patient payments and service provision, and how do they perceive governance of the health care system in Serbia? **(Paper I)**

2. To explore what is known about informal patient payments and bought and brought goods in Western Balkan, to examine their influence on healthcare, and to identify from the evidence what actions can be taken to tackle this problem? **(Paper II)**

3. From a health governance and equity perspective, to specifically investigate what are civil servants' and asylum-seeking migrants' perceptions of informal patient payments in Serbian health care and barriers and facilitators to access care? **(Paper III and IV)**

In the coming chapter, the earlier knowledge, theories, and frameworks used in the thesis are described in detail. These served as the backbone needed to understand the complex phenomenon of health systems governance, IPP and inequity in access to health care in this study.

3. Theoretical background

In this chapter I will begin by introducing important concepts and terminology employed in the thesis. I then introduce the existing evidence on IPP and the typologies and frameworks on IPP, trust, and health systems governance that was also used. The theoretical background chapter concludes by introducing the inequitable access to health care of migrants, to understand how vulnerable groups typically become more susceptible to barriers in accessing health care.

3.1. Concepts and terminology

Informal patient payments (IPP) (the central concept in the thesis) is defined by Gaal, Belli, Mckee and Szócska (6) as *a direct contribution, which is made in addition to any contribution determined by the terms of entitlement, in cash or in-kind, by patients or others, acting on their behalf, to health care providers for services that the patients are entitled to.* This definition also includes the term 'bought and brought goods' (BBG), although this term differs from IPP in practice. BBG are identified as the illegitimate goods such as equipment, materials or medicine bought and brought by patients to hospitals or clinics when needing health care services (70, 71) (See *Figure 1*). These types of payments are therefore not a counter-favour but are brought by the patients when accessing health care services. In the thesis I consequently distinguished goods (products) from services (assistance or advice) in health care, as there exists different practices around providing goods or paying for a service that one is entitled to (6, 70, 71) (See *Figure 1*). Though, due to the different practices around goods and services, the BBG in this study remained limited to only examine the overall scope. I therefore only refer to BBG when data is available in the four sub-studies.

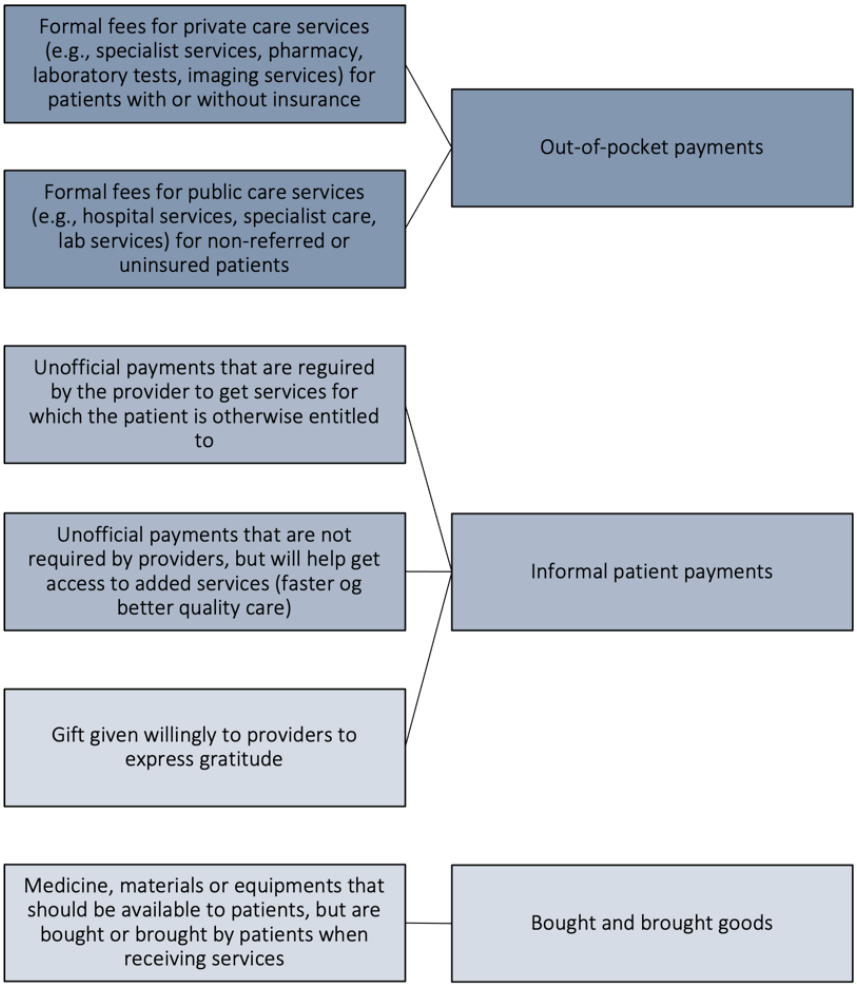

Figure 1. Types of formal and informal out-of-pocket payments

IPP are often regarded as a type of bribe and thus corruption (72). Corruption may take several forms of for instance, extortion, fraud, embezzlement, or bribes (72, 73). I regarded IPP as corruption when being similar to the definition of corruption by Transparency International (72) '*The abuse of entrusted power for private gain'.* It was for instance in situations where IPP were used as means to gain access to health care services, to speed up the service or to increase the quality of services that patients are otherwise entitled to (5-7). Following this definition, doctors in public positions asking for extra payments as a prerequisite for giving treatments were considered misusing or abusing their power for purposes of private gain. This was the aspect of corruption that I focused on in the thesis, while other practices of gratitude were considered as cultural aspects.

Despite increasing literature on IPP, I found a conceptual confusion in the area (See *Figure 1*). There are namely various beliefs about whether payments are a fee-for-service or out of gratitude, whether they are forced or voluntary and what it constitutes when they are paid out of money or in a form of gifts (e.g., beverages, flowers, chocolate) (9, 74-76). In research I found that one side typically featured the cultural aspect and see IPP as expressing gratitude, whereas another included feeling compelled to make unofficial payments to receive higher

quality care (9, 76). Discussions about coercion or voluntaryism when paying informally, however, makes researchers question the existence of gratuity in health care in its pure form (5). Though, it is ambiguous what represents a voluntary free choice. In line with the WHO (15), I therefore considered IPP as an illegal or unregulated fee.

Health systems governance is a relatively new concept that is widely discussed for its meaning and ways to assess it (77). Dodgson et al. *(78)* define the health systems governance as '*the actions that a society takes to organize itself in the promotion and protection of the health of its population',* whereas Balabanova and colleagues (79) describe it as *'an aggregation of normative values such as equity and transparency within the political system in which a health system functions'*. It is important to understand the various aspects revolving health systems governance, and to comprehend some of the nuances of what this concept may constitute (77). Good health systems governance is characterised by e.g., high transparency, accountability, rule of law and equity in access to care, which are some of the vital indicators to avoid corruption and thus also IPP (77, 80-83). Since health systems are crucial when addressing population health, the good governance of these is important, as inadequately funded and ineffectively organized health systems may result in large numbers of otherwise preventable deaths, disabilities, inequality and injustice (14, 15). The way health systems are governed consequently influences the (equity in) access to health care services and further on the differences in health between groups of society (14, 15, 80, 81)

Health inequities are linked directly to social factors such as stressors, norms and values, socioeconomic status, unhealthy lifestyle, access to health care, or work and living conditions (84-86). Social factors are however not pathogens but may initiate the onset of the pathology if they are not considered in the prevention of disease and promotion of health (84, 86). Inequities in health is therefore interchangeably connected to the life expectancy of populations (84). Especially four features distinguish these differences in health, in that they are systematic, socially produced, unfair, but avoidable (84-87). Such inequities may arise from e.g., poor governance, corruption, or cultural exclusion, while the inequality in health refers to the uneven distribution of health or health resources as a result of e.g., genetics or lack of resources (85, 88). Good governance of health systems is therefore crucial in addressing the promotion of equity in health, since equity is preventable through, for example, policies and other interventions (89-91). Targeted policies towards disadvantaged groups of society may benefit those in greater need, rather than providing the same and disproportionate health care services to everyone (91).

The equitable access to necessary health care services is one of the key elements of assessing the quality of health systems governance (89). Inefficient health care institutions are susceptible to corruption that fosters inequity, according to, for instance, Vian, Jain et al., World Bank and the European Commission (13, 92-94). People facing barriers in the access to health care services may be more vulnerable to engage in IPP (2, 9, 94, 95). In the following section I will therefore move on to describe deeper the prevalence of IPP in Europe and the

Western Balkan countries. Subsequently, I will address the typologies and frameworks that was used in the present thesis.

3.2. Informal patient payments for health care services

Worldwide, IPP are frequent and widespread as an important source of health care financing (96), but tends to be overlooked as it is difficult to define and makes dysfunctional systems work (11). IPP have been found in regions all over the world, like South Asia, East Asia, Africa, South America and Central and Eastern Europe (96). The frequency varies from approximately 3% in Slovenia to 96% in Pakistan (96) and the variation in reporting of these payments is great (1, 97-99). In Europe, the recent Special Eurobarometer on corruption (97, 98) shows that less than a fifth of respondents in the EU27 countries had to give additional payments or gifts to health care providers. In this study, payments or gifts are higher in the newest member states (NMS13) such as Romania (19%), Austria (17%), Greece, (14%) and Hungary (14%) (97, 98). Other evidence, based on the 2010 Life-in-Transition country survey (1), however, finds that Romanians report giving IPP in 44% of cases, whereas Hungary reports 34 %. These payments are also embedded in the health systems of the Western Balkan countries, such as Albania (65%), Montenegro (21%), Bosnia (14%) and Serbia (12%) (1). This variation in research indicates the importance of an in-depth understanding of the phenomenon, both qualitatively and quantitatively.

Within Europe, the Southern and Eastern European countries remain affected by the persistent corruption in their health systems, namely IPP (92). Corruption erodes trust between people and institutions, which is the lubricant to democratic societies (100). The poor performance of institutions may therefore affect people's trust in them, creating a mutually reinforcing effect of low trust between institutions and citizens (101). Lack of trust can in that sense lead to higher corruption, in that distrust may make people feel less morally obliged to avoid corrupt behaviour, such as paying informally for health care services (74). Corruption in health is thus a complex phenomenon that constitute various aspect related to the social acceptability of corruption and institutional failures (102). The social acceptability, may be curved through awareness raising campaigns, media attention or empowering the patient with information on their health care needs (92). Similarly, the dysfunctional institutions could be tackled with improved health system governance (e.g., strengthening financial structures, fraud control, controlling physician-industry interactions) (13), higher transparency, and higher accountability (13, 102).

In the next section of this chapter, I will turn to the typologies and frameworks employed in the study.

3.2.1. Typologies and frameworks

Most of the typologies and frameworks that I relied on contributed to explaining IPP in health systems. Overall, the theories have two main perspectives; they either address the informal behaviour or they advocate for creating stronger institutions. Numerous theories also combine the two, advocating that dysfunctional institutions create incentives for informal behaviour.

One of those theories is **The INXIT theory** (103), which analyses people's reactions to dysfunctional institutions or states. It is assumes that people either 'Exit' the institutions, complain using their 'Voice', or assumes 'Loyalty' to the institutions (104). When talking about IPP, consumers or employees however do not exit the organization but makes an informal/internal exit, whereby the name INXIT. They thus seek change through informal methods such as payments or connections (103).

Another theory is **The Framework of Corruption in the Health Sector** (9) where Vian illustrates the reasons and opportunities for IPP. She suggests that civil servants abusing their public position and power, do so because they are able to rationalize their behaviour, feel pressured to abuse, or because they have the opportunity to abuse. Consequently, civil servants will act to maximizes their own self-interest and thus weighing cost and benefits of acting in a corrupt manner versus with integrity (9).

Also **The Institutional Asymmetry Perspective** of Williams and Horodnic (99) distinguish between formal institutions, with codified laws and regulations, and informal institutions with socially shared (unwritten) rules (See *Figure 2*). Institutional asymmetry occurs when informal institutions take over the formal ones which perform imperfectly (99, 105, 106). The higher the asymmetry between the institutions, the higher is the likelihood for IPP.

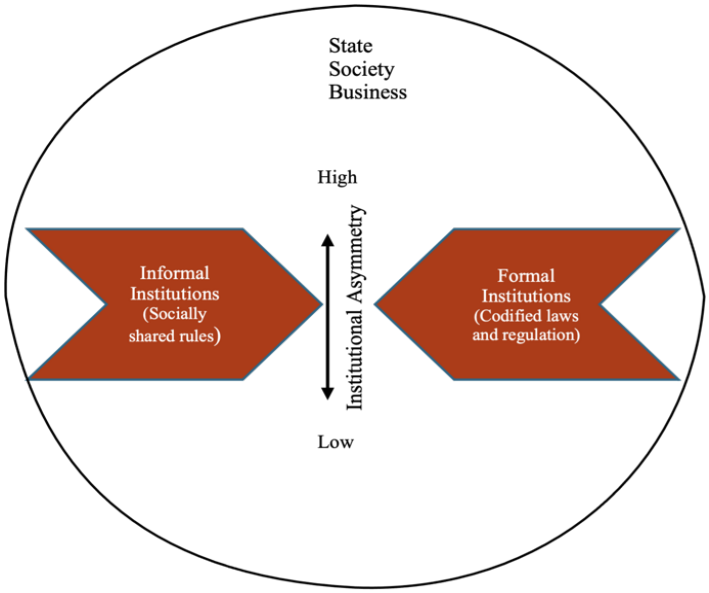

Figure 2. Institutional asymmetry between institutions

I was further inspired by the concept of **trust** as perceived by Aasland, Grødeland and Pleines (74), since trust is believed to be the lubricant for functioning welfare states (100). These researchers consider generalised (interpersonal and social) trust as the trust in unknown people, and institutional trust as the trust in major institutions of state and society (e.g., governments, associations, police, media). Trust in relevant actors in that sense becomes important for a functioning and democratic system that relies on participation and compromise (74).

Finally, I was inspired by the WHO's (15) **four main functions for well-performing health systems**, being service provision, resource generation, financing, and stewardship (See *Figure 3*).

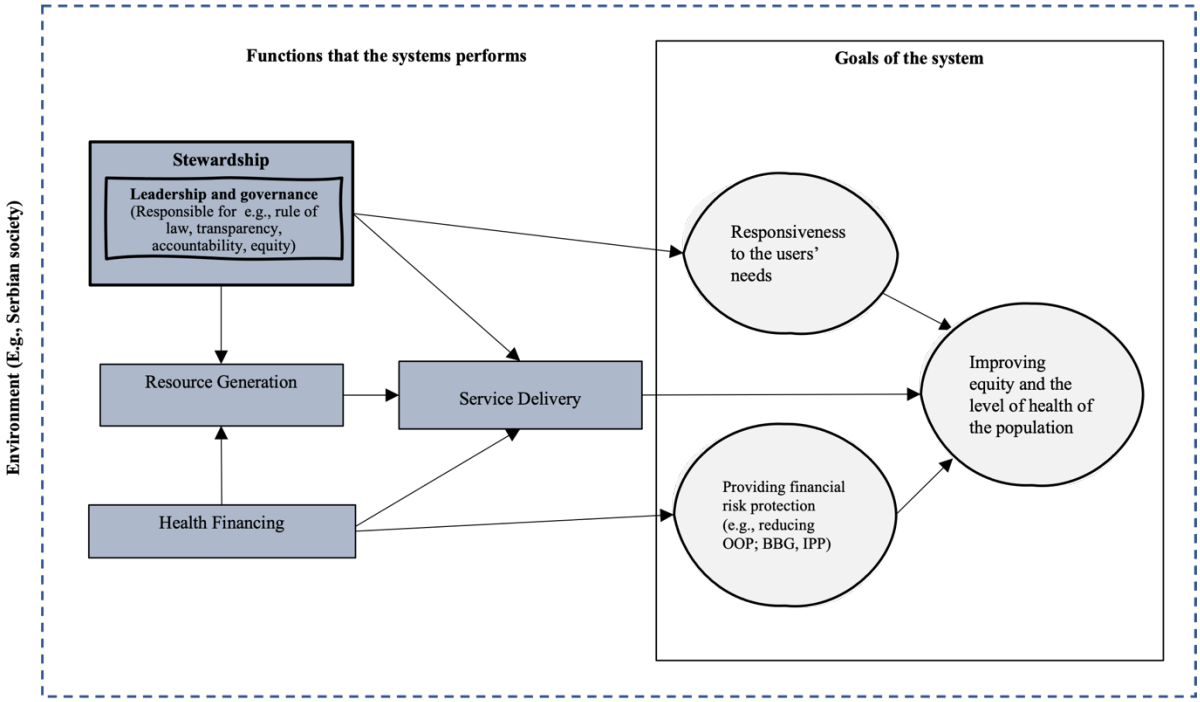

Figure 3. Functions and goals of health systems.

Health service provision should in that regard be organized to protect the population and investments should be made to *generate resources*. Revenues should be collected to be used at the systems disposal, to provide *financial* risk protection and distribute the burden of payment fairly in society. The financial protection of citizens is an important factor regarding IPP. Poor performing health systems, measured in the financial protection of patients, typically have higher levels of OOP and thus IPP (28). The last function, *stewardship*, regards the management of the health system and therefore influences the other functions profoundly. Governments are often stewards of the health care systems and are therefore responsible to tackle IPP. However, when governments are not able to finance the health care services through taxes, social insurance or private health insurance, the burden falls to the patients through OOP (15, 107). Often the most vulnerable people in society are those who

suffer most when barriers exist to access health care services (31, 92). Vulnerable groups such as migrants will often be more susceptible to OOP, and the asylum-seeking migrants were therefore used in this thesis to explain such inequities in access to care. Their barriers in access to health care will be addressed deeper in the following section.

3.3. Migrants' equitable access to health care

Migrants are a diverse group that is challenging to define. In the present thesis I applied the International Organization for Migration's (IOM) working definition of migrants as *a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons* (108). Migrants may, however, be either irregular, asylum-seekers, refugees, environmental migrants or labour migrants (57, 108). Such migration status is based on for instance reasons for moving or the conditions people are in. Labour migrants may thus move for purposes of employment, environmental migrants due to environmental or climate changes, irregular migrants are travelling without appropriate documentation, and asylum-seekers have an undecided claim in a country where they seek international protection (108). The difficulty in defining migrants and the diversity of migrants thus create wide discrepancies in entitlements (109). In the current thesis the focus was on the asylum-seeking migrants as being those in a process of applying for asylum or those *intending* to apply for asylum (66).

The access to health care of migrants in countries that they transit or settle in is crucial. Their migratory journey often leads to experiences of violence, exploitation and abuse and exposes migrants to serious illnesses such as post-traumatic stress disorder, mood and anxiety disorders, panic attacks or vaccine-preventable diseases (33, 110-113). One of the EU's main pillars are particularly a timely access to affordable health care of good quality (114) and thus the European societies have a responsibility to ensure the equitable access to health care of migrants. WHO (115-118) further advocate that linguistics and culture should be embedded in the European health systems, focusing on provision of interpretation services, emphasising information to migrants on health care entitlements, and training health care providers in culturally sensitive health care services.

For many years, migrants have turned towards European borders (119), reaching a high point in 2015 with 1.2 million asylum seekers, while almost 500.000 asylum seekers applied for protection in Europe in 2020 (120). Though, despite being in good health before migration, migrants in Europe are often susceptible to several non-communicable diseases such as chronic, cardiovascular and respiratory diseases (33, 112, 121). When resettling in European societies, migrants may face challenges of integration as well as communicative, legal, cultural, economic, and bureaucratic barriers, leading to an inequitable access to health care (33, 111, 122).

Migrants are highly vulnerable to formal and informal barriers when needing health care services. Formal barriers are for instance legislation or OOP, whereas informal barriers are indicators such as language, psychology (e.g., lacking trust to health care providers), and socio-cultural factors (123). Most notably, their legal status, communication problems, and lack of information are creating high unmet needs among this group (32, 45). Some migrants thus become apprehensive about engaging with western health care systems (124, 125). Intercultural mediators may in that regard be a tool in providing easier access to migrants, as they bridge access to the health care system by providing interpretation, share information to migrants, or guide them to services (64, 126).

The asylum-seeking migrants are particularly vulnerable to negative health outcomes due to the poor social environment, economic struggles, and harsh living conditions in the asylum centres (127). They further face challenges in Europe of long waiting times, financial barriers to access health care, and being new coming migrants who are unknowing of entitlements, culture, and languages (110, 128-131). Studying their access to health care is therefore highly relevant.

Having explained IPP and the access to health care of migrants, the fourth chapter will now move on to describe the different materials and methods that I have used in the thesis.

4. Materials and methods

Due to the different methodological approaches in the sub-studies, the materials and methods of **Paper I** will initially be presented, followed by the materials and methods of **Papers II, III** and **IV**, respectively.

4.1. Overview

The thesis consists of original empirical data and literature reviews. **Paper I** includes qualitative interview data of public health civil servants (public health officials and primary care doctors) in Serbia and a review of literature from all Western Balkan countries. **Paper II** is a scoping review of literature in the field covering all Western Balkan countries. The **papers III** and **IV** are based on qualitative interviews of civil servants (information workers and intercultural mediators) and intended asylum-seekers or asylum-seeking migrants in Serbia. **Paper IV** arose from the data analysis of **Paper III** and are therefore grounded in the same qualitative interviews. The analysis for these interviews were conducted with two different approaches (See *Table 1*).

Table 1 below presents an overview of the aims, data sources, study designs and data analyses for all four papers.

	Paper I	Paper II	Paper III	Paper IV
Aim	To explore existing evidence on informal patient payments in Western Balkan and to analyse what are public health civil servants' perceptions on informal patient payments and service provision, and how do they perceive governance of the health care system in Serbia?	To explore what is known about informal patient payments and bought and brought goods in Western Balkan, to examine their influence on healthcare, and to identify from the evidence what actions can be taken to tackle this problem?	From a health governance and equity perspective, to specifically investigate what are civil servants' and asylum-seeking migrants' perceptions of informal patient payments in Serbian health care and barriers and facilitators to access care?	From a health governance and equity perspective, to specifically investigate what are civil servants' and asylum-seeking migrants' perceptions of informal patient payments in Serbian health care and barriers and facilitators to access care?
Data Source	4 public health civil servants and 6 scientific journal articles	24 published and unpublished studies (scientific journal articles, reports, master theses)	8 civil servants and 6 migrants	8 civil servants and 6 migrants

Study design	Semi-structured interviews and a literature review	Scoping review	Qualitative interviews	Qualitative interviews
Data analysis	Phenomenological hermeneutical analysis and thematic analysis	Qualitative thematic synthesis	Grounded theory analysis	Phenomenological hermeneutical analysis

Table 1. Overview of the aims, data sources and methods for paper I-IV

4.2. Methodological designs

This thesis is a qualitative methodological design. Within qualitative research there are different perspectives as to which approach one may have on the collected empirical data (132). The data collections were thus similar in the pilot study and the main qualitative study, while two different types of persuasion were used to analyse the data. In the pilot study, I used a phenomenological hermeneutical approach (133) and in the main qualitative study I employed a grounded theory approach (134, 135) (See *Table 1* and *Figure 5*). The thesis also includes a literature review and a scoping review to provide increased rigor to the data and deeper insights into IPP and BBG. These reviews are also qualitatively driven in using narrative syntheses methods in the analysis of the data. In the literature review of the pilot study, I was inspired by Popay and colleagues' thematic analysis (136) and in the scoping review, I employed Thomas and Hardens' qualitative thematic synthesis (137).

I further used several theories as background knowledge, to understand the phenomenon of health systems governance, IPP, and equity in access to health care during the data collection and analysis process. Most notably were the *four main functions of health systems* (15), *the INXIT Theory* (103), *the Framework of Corruption in the Health Sector* (9), *the Institutional Asymmetry Perspective* (99) and the concept of *trust* (74). I used the *Institutional Asymmetry Perspective* as a tool to inspire the pathways of paying informally, as described in **Paper III**, and so the depicturing of the complex interaction occurring between formal and informal institutions when paying informally for health care.

The pilot study of **Paper I** aimed to identify the perceptions of IPP and health system governance in Serbia. The scoping review (**Paper II**) seeked to identify the existing knowledge, influence of and actions to be taken in the area of IPP and BBG in Western Balkan countries. The final **Papers III and IV** then looked deeper into the barriers and facilitators in access to care and IPP, also including some evidence on BBG, in civil servants and asylum-seeking migrants in Serbia. To comprehend the methods and methodologies of the four papers, an overall account of the methods is firstly presented followed by a more specific description of each paper.

4.2.1. Qualitative methods

The interview method is the most effective and important tool in understanding people's experiences, thoughts and behaviour towards a certain phenomenon (132). According to Merleau-Ponty and Smith (138) all scientific theories are to be understood as secondary expressions of phenomena that people experience in their every-day life. Theories about for example institutional asymmetry or IPP are based on the abstractions of concrete events or experiences that are uncovered through, for instance, in-depth interviews (132, 138). Interviews may thus provide a privileged access to people's experiences and be a beginning to the construction of theories and frameworks (132). Qualitative methods are though rarely generalizable and are often criticized for lacking reproducibility and scientific rigour (139). In conducting qualitative studies, it is therefore important to maintain a systematic and conscious research design, data collection, interpretation, and communication (132, 139). Examples of increasing validity are for instance studying different groups of respondents around the same topic, as they might share different perspectives on an issue (140). Also seeking to understand 'negative' or 'deviant' cases, that may contradict the built theory, is important to validate the analysis of the collected data (139). Observation may also be a tool to gain first-hand evidence on participants behaviour in a certain setting, leading to potentially new perspectives on the collected data (139).

Despite the criticism around qualitative methods, they are nonetheless critical to understanding *the why* of a phenomenon, contrary quantitative methods that typically seek to understand *how much* (132). In choosing an interview method, I sought to identify the life situations, attitudes, and experiences towards the topic in question, which can feed into the existing theories and frameworks on health systems governance, IPP, and equity in access to health care. Further, in combining the qualitative interviews with literature reviews I sought to increase the rigor, depth and strength of these results.

4.2.2. Systematic reviews and literature reviews

Literature reviews are typically conducted to systematically collect and synthesize previous research in an area (141). This kind of methodology therefore makes it possible to integrate findings and perspectives from many different empirical studies and thus gaining a power that no single study has (142). Synthesizing research at a meta-level and identifying the gaps in research makes these reviews critical to theory development (141). There are numerous types of reviews that can be made, namely systematic reviews, meta-analysis, rapid reviews, or research synthesis. In the present thesis a literature review (in the pilot phase) and a more systematic scoping review was conducted. Contrary the full systematic reviews, that seek to answer a narrow and focused clinical question, the traditional literature review provides context or background information on a specific topic (143). Literature reviews are typically

also narratively synthesized, rather than using statistical methods (143). The scoping reviews further tend to address broader topics and include different study designs to map the literature in the area (144). In that, they also differ from the narrow and often statistical focus of full systematic reviews (144).

In the present thesis, both reviews are mixed studies reviews, integrating quantitative, qualitative, and mixed methods studies that entails the synthesis of results from various study designs (145). In combining several research designs, the present thesis sought to probe deeper into the results with an increased rigor. At the time of conducting the reviews, few qualitative studies were available on IPP and BBG in the Western Balkan countries. Therefore, mostly quantitative studies were included in both reviews, and the results were narratively summarized. Conducting mixed studies reviews nonetheless combines the power of numbers and stories told by participants and provide rich understandings of complex phenomena, such as IPP and BBG (145, 146). Researchers are meanwhile faced with the issues of comparing results originating from different methodological genres (146). Qualitatively, the problems arise with the philosophical differences in research traditions and the differences in research participants (145, 146). Quantitatively, is somewhat similarly about the heterogeneity of studies. Studies are rarely identical, causing criticism about the comparison of results (136, 146-148). It is therefore important to care for the translation of concepts and themes by for instance checking that the transfer is valid. This can be done by providing transparency of data processing and making structured summaries of the studies (136, 139). Problems of transparency is nevertheless typically seen in thematic and narrative analyses, and reviewers should therefore disclose as many details as possible about the analytical process (e.g., how themes were identified) (136). In that sense, I will in the coming sections present a deeper understanding into the methods of each paper.

4.3. Paper I - Pilot study on informal payments and health system governance

The first paper of the PhD relates to research question 1. It is a pilot study consisting of a literature review and qualitative interviews of four public health civil servants in Serbia, working in institutes of public health or primary care centres. The qualitative interviews outline their perceptions of IPP and health system governance and were analysed drawing on a phenomenological hermeneutical approach (133).

4.3.1. Data collection and analysis for the empirical part

To conduct the pilot study, I initially searched different online websites of health institutions to find those relevant to answer the research question. Sampling was purposive and done before traveling to Serbia to conduct the two semi-structured group interviews (n=4). I conducted the interviews in august 2014 in Belgrade and Vojvodina, while one follow-up interview was conducted later via Skype. The interview guide included questions about the informants' views on IPP, their perceptions about the health care system and its governance and service delivery (See Appendix 2 and 3). It was based on several theories, including Vian's framework (9) and theory on trust as perceived by Aasland, Grødeland and Pleines (74).

In the analysis of the interview transcripts, I employed the phenomenological hermeneutical approach as suggested by Lindseth and Norberg (133). The respondents of the study believed that health care providers made decisions that were not ethically correct but necessary. Especially when talking about asking for or receiving gifts or money that laid outside the entitlements of patients. Lindseth and Norberg (133) imply that the norms, values, principles, and attitudes that people live by are not necessarily reflected on explicitly, but must be interpreted e.g., through written text (e.g., transcripts of interviews). In the hermeneutical phenomenological analysis this is done through three steps: 1) a naïve reading of the text; 2) making a structural thematic analysis; and 3) providing a comprehensive understanding. The phenomenological hermeneutical thinking was therefore suitable in that it allowed me to be inspired by the phenomenological thinking of Husserl (149) and investigating the lived experiences and what the respondents believed was (the essential meaning of the) ethically good human conduct of health care providers. For example, when is it acceptable to give gifts or cash to health care providers, and when is it not? When we have such an understanding, it is possible to discuss how to understand (the essence of) this ethically good or bad behaviour. In this case, whether paying informally for health care services.

4.3.2. Data collection and analysis of the literature review

To complement the qualitative data, I also conducted a literature review with inspiration from the work of Popay and colleagues (136). The review focused on health system governance and IPP in all Western Balkan countries. It aimed to identify existing evidence on IPP and the dispersion of these in the Western Balkan countries. The inclusion of studies was based on the criteria of including Western Balkan countries, concerning governance and IPP in health care, including primary data, having a sufficient quality, being in English language, and from the time frame 1991-2015. From the search, 387 studies were identified and six were at the end included after the screening process. I then assessed these six studies for their methodological quality by using the Mixed Method Appraisal Tool (MMAT) (150). Generally, the studies scored from moderate to good quality, mainly due to lack of information in the reporting.

In the analysis of data, I was also inspired by the thematic analysis of Popay et.al. (136), which contributes to maintain consistency between the qualitative study and the literature review. The method presents six elements to undertake a literature review (136). This approach suggests tools and techniques to extract the quantitative findings as themes in the same way as conceptual themes are extracted from qualitative studies. One being a thematic analysis, where quantitative measures may be translated into qualitative (136). This technique is inductive and provides means to organize and summarize findings from diverse research fields (136). To preserve the context of the studies, I further completed structured summaries of all studies, detailing the aim, methods, and methodological quality, setting and sample. The themes for the current study included for instance paying gifts and bribes to health care providers, informal networks, and the perceived functioning of health systems. These were then summarized narratively in the findings section of the **paper I**.

4.4. Paper II – Scoping review on informal patient payments and bought and brought goods

The second paper links to research question 2 of the thesis and outlined key aspects of IPP and BBG in all Western Balkan countries through a scoping review of published and unpublished studies. The data collected from the included studies was synthesized narratively, using a thematic synthesis with inspiration from Thomas and Harden (137).

4.4.1. Data collection

The scoping review was conducted as a form of knowledge synthesis to address the exploratory research question and further map the key concepts, types of evidence and find gaps in the literature (144). I was inspired by the work of Levac, Colquhhoun and O'Brien (151) and Daudt, Van Mossel and Scott (152) and their recommendations. These recommendations are based on the initial framework of Arksey and O'Malley (144), who propose six stages of conducting a scoping review. The current scoping review relied on these six stages and the proposed recommendations. Most notably to remain flexible in revising the research question or search terms; to remain iterative in the process of selecting studies; to conduct quality assessment of studies; and to develop a data-charting form and determine which variables to extract to answer the research question (151, 152).

I completed searches in databases, international and national institutions, and specific scientific journals. Having an iterative search strategy throughout searching and selecting relevant literature made it possible to ensure the comprehensiveness of evidence in the review. I further included studies with the criteria that they related to one or more of the Western Balkan countries, included primary data from 2002-2015 that addressed the issue of IPP or BBG, and was written in English. The included studies were then assessed for their

quality, using tools for qualitative, quantitative and interventions studies that are developed by the National Institute for Health and Care Excellence (NICE) (153). This process left 24 studies to be included in the scoping review. For more details on the selection of studies, see *Figure 4* below and **Paper II**.

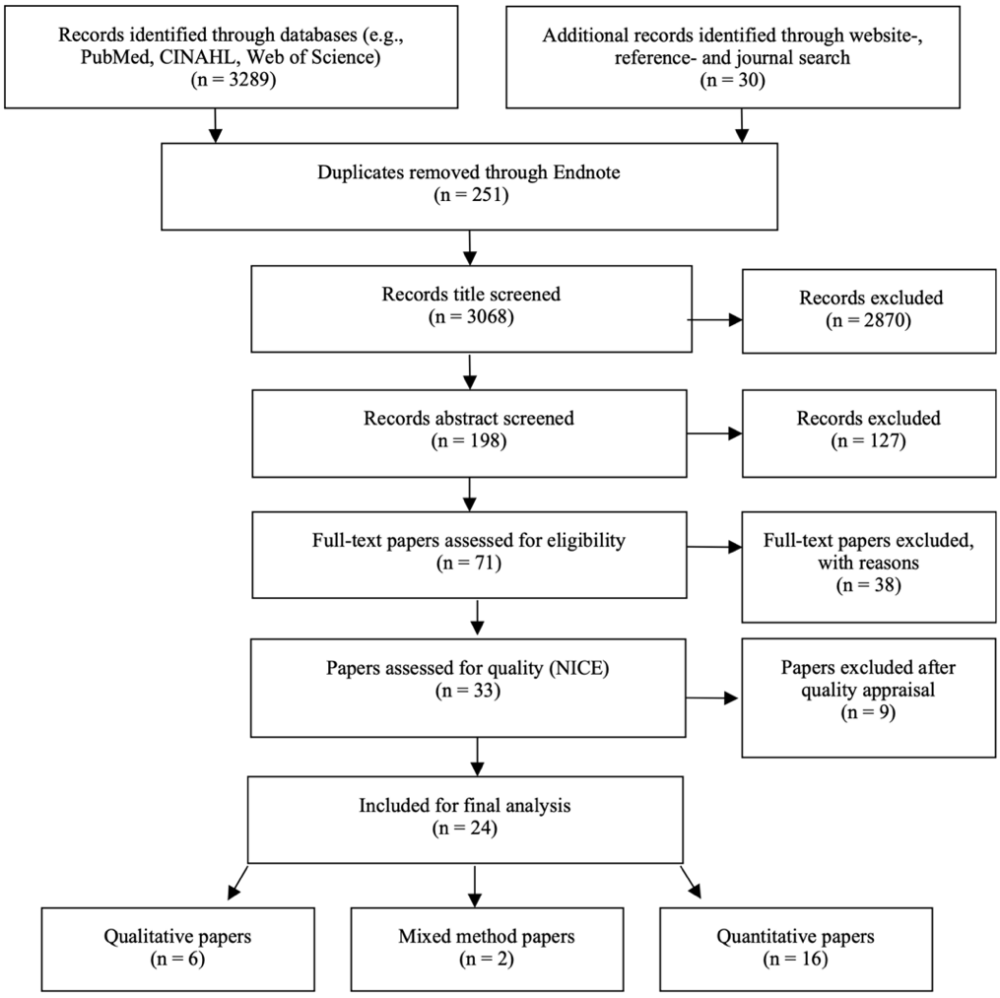

Figure 4. PRISMA diagram of included and excluded literature.

4.4.2. Data analysis

To extract and report the data from the included papers, I used the PRISMA checklist for systematic reviews (154). Structured summaries were completed of all studies, including the aim, methods, and methodological quality, setting and sample. Data for the thematic synthesis that were extracted, included only evidence on IPP or goods to health care providers. The analysis of results rested on the thematic synthesis method of Thomas and Harden (137), including three steps: 1) coding text; 2) organizing the codes in descriptive themes; and 3) generate analytical themes. These steps emphasize the importance of rigorousness in conducting reviews and to facilitate transparency of reporting (137). I finally graded the evidence in the included studies for their confidence, using the Confidence of the

Evidence from Reviews of Qualitative Research (CERQual) tool (155). This grading is based on the methodological limitations, relevance, coherence, and adequacy. From the testing of evidence with both the NICE tool (153) and the CERQual tool (155), I found that the included studies have minor or moderate concerns to be taken into account, but that the findings are reliable to place an emphasis on. The analytical codes that I identified, included definitions and measures; incidents; effects of and drivers for paying informally; perceptions about inpatient and outpatient care; forms and amounts paid for health care services and goods; and perceptions regarding remedies to fight IPP.

4.5. Paper III – Civil servants and migrants' perceptions on pathways to health care

The third paper relates to research question 3 and focused also only on Serbia. It aimed to explore civil servants and asylum-seeking migrants' perceptions about health system governance, including access to health services, IPP and BBG. During the data collection and analysis I used the grounded theory (134, 135) methodological steps.

4.5.1. Data collection

I collected the data in Belgrade in August and September of 2018. Qualitative interviews were conducted with eight civil servants (intercultural mediators and information workers) and six asylum-seeking or intended asylum-seeking migrants. The asylum-seeking migrants lived in asylum centres and civil servants lived in the Belgrade area. They were asked about their perceptions on the health care users' experiences in and satisfaction with health care services, their perceptions of trust between user and health care provider, and their perception of IPP and BBG. To recruit and interview participants, several NGOs, the local WHO unit for Serbia and the University of Belgrade assisted in accessing the local hubs or the asylum centre. At the asylum centre, migrants were invited to participate by the staff at the centre. They were invited if they had recent experiences with health care services in Serbia. I only interviewed the newly arrived, non-western, asylum-seeking migrants in order to generate a meaningful analysis, since migrants generally are a highly heterogenous group. When interviewing the migrants, I used the intercultural mediators to interpret the questions posed into their local language (Farsi, Dari, Persian). The civil servants spoke fluently English. The interviews lasted from 45 minutes to two hours and included overall four questions to remain open to the respondents' perceptions on the topics (See Appendix 3 and 4).

4.5.2. Data analysis

I applied the grounded theory (134, 135) methodological steps when analysing the data. Grounded theory was initially developed by Glaser and Strauss in the 1960's (156), with other

second-generation theorists further developing the method, such as Clarke (157), Bowers and Schatzman (158), Charmaz (135). Being a highly popular research design, with various seminal texts guiding researchers in using the method, the methodological genres of grounded theory are different. The present study identified with Charmaz's constructivist grounded theory, believing that data is co-constructed between researchers and respondents (135). Charmaz believes that grounded theory is a method to learn about the world we study and to develop theories to understand them (135). Theory is not emerging through data, as believed by Glaser and Straus (156), but researchers' understanding of the data are part of the theory construction that is grounded in the data. Theories are in that sense constructed through the researchers' past and present involvements and interactions with people, perspectives and research practices (135).

Besides the classical steps of qualitative analysis (initial and intermediate coding, and categorization of data), the methods essential to grounded theory are the concurrent data generation and analysis; writing memos; theoretical sampling; constant comparative analysis of incidents, codes and categories; theoretical sensitivity; identifying a core category; and generating a theory (134) (See *Figure 5*). Glaser and Strauss in that sense sought to develop a theory that produced an integrated theory and went beyond a qualitative descriptive analysis (156).

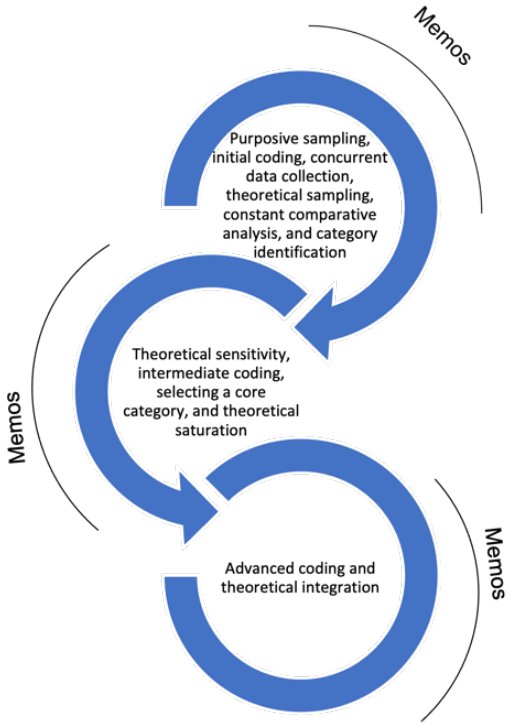

Figure 5. Grounded theory methods

To apply these steps, the transcribed text was initially condensed into codes and categories, while in parallel collecting new data based on the information that was gained in the initial interviews. This concurrent data collection is a fundamental element of the grounded theory

method and is used to evolve categories and concepts that become grounded in the data (135). The codes were initially developed by identifying words or sections in the transcripts, from where the most significant codes were selected and divided into overall categories (group of similar codes). I also conducted a constant comparative analysis throughout the entire data analysis that involved the constant comparing of incidents, codes, and categories with each other. Another element in the data analysis was the memos that were written from early stages to completion of concepts. They included questions, thoughts and ideas that emerged during the data collection and analysis.

Finally, the theoretical integration resulted in the models on the pathway to paying informally. This was a process of moving between theory and empirical data, through abstraction, reflecting on the categories and concepts and their relationship while re-confirming these with the collected data. The existing theory on institutional asymmetry, developed by Williams and Horodnic (99) (See *Figure 2*), was used to inspire the models. In that sense, the theory inspired the depicturing of the complex interaction between formal and informal institutions when paying informally for health care.

For more insights into the data analysis, please see the methodological section in **Paper III**, and the *Figure 6* and *Figure 7* below.

4.6. Paper IV – Intercultural mediators' role in access to health care

The fourth paper also relates to research question 3 and arose from the data analysis of the previous paper III. It focused on the practices revolving the migrants' access to health care with the assistance of intercultural mediators and whether migrants paid informally for health care. I analysed the data using the phenomenological hermeneutical approach (133).

4.6.1. Data collection

The data for this article was drawn from the qualitative interviews conducted in 2018 with civil servants (intercultural mediators and information workers, n=8) and asylum-seeking migrants (n=6) in Serbia. The data was thus part of the main interview data collection but explored the intercultural mediators' role in migrants' access to health care in Serbia. The detailed data collection is described in section 4.5.1. Data collection.

*4.6.2. Data **analysis***

I used Lindseth and Nordberg's phenomenological hermeneutical (133) approach to analyse the data on the role of intercultural mediators on migrants' access to health care. Initially, the data was read through several times to get an understanding of the data, thus conducting a naïve understanding. This guided the following structural thematic analysis, identifying several themes and sub-themes in the text. After the initial categorisation, further reflection was done on the themes and sub-themes, which were then reorganised into final themes and sub-themes. The main themes used in the analysis were; *Easier access to health care with intercultural mediators; Better quality care with intercultural mediators; Migrants' hesitancy to access health care services; Paying informally and the role of intercultural mediators; Migrants trusting intercultural mediators.*

In the previous section, I have explained the methods of data collection and analysis in the four sub-studies of the thesis. Before continuing to the results of these studies, I will address the ethical considerations that I considered in doing qualitative interviews. These considerations will be further considered in the methodological discussion.

4.7. Ethical considerations

Research must protect the rights, interests, and safety of those participating, as they become vulnerable to researchers integrity in, for instance, understanding the researched topic and consent in participation (159). Being a migrant research participant further adds to this vulnerability, as they become more susceptible to harm, burden, or undue influence when being investigated (159, 160). This group is for instance not protected by the same rights as citizens of their country of asylum, and thus any forms of maltreatment (159). Issues therefore exist between the need for data to inform evidence-based practice on the one hand, and protecting vulnerable groups from research-related risks on the other(159). Though being experts on their current situation, excluding migrants would give an inadequate and inaccurate representation (161-163). Considering the highest research ethics at all stages of the investigation in the current study was therefore important (161, 164). Similar to the 'best-practices' investigation matters that Seagle and colleagues (161) propose, I included community leaders and stakeholders (NGOs and the University of Belgrade), ensured informed consent and the education of their rights, considered privacy in using interpreters, and ensured the review of protocols by an ethical committee in the country of the investigator (Denmark) and the investigation (Serbia).

For both the pilot study (**Paper I**) and the qualitative study (**Paper III** and **IV**) ethical approvals were given to conduct interviews. In the pilot study, I sent an application to the Ethical Committee at the Institute of Public Health of Serbia including the informed consent form, the study protocol, an explanation of the interview process and the interview guide. The

ethical approval was given on August 26, 2014. To conduct the interviews of the qualitative study (**Paper III** and **IV),** an ethical approval was received at the University of Belgrade (Number: 2650/VI-12). I further received approvals in Denmark from the University of Southern Denmark (SDU) (Number: 18/33066 CEAN) and the South Regional Committee on Health Research Ethics (Number: S-20182000-84).

5. Results

In the coming section the results of the four sub-studies are outlined. Following that a discussion of these is given, to contextualize the findings of the present thesis.

5.1. Results of Paper I

The current paper consists of qualitative interviews and a literature review. The results from these studies are outlined in two separate sections below, followed by a joint conclusion.

5.1.1. Empirical results

The main themes of the phenomenological hermeneutical analysis include perceptions that primary care should be the main functioning part of the health care system, e.g., due to the close patient-provider relationship compared to the two other levels of care. Though primary health care was perceived to be poorly governed by the state, creating low motivation and poor incentives for doctors to perform. Respondents thus believed that general practitioners had a low social status in society and that the government generally emphasized treatments rather than prevention in the health care system. Patients' expectations of the primary care service provision to meet their needs were therefore low.

The respondents believed that, overall, the primary care system functioned well. However, they also stated that there was a poor communication between the primary, secondary, and tertiary care levels, making the system inefficient. This caused informal rules to take over formal ones, when for example patient could pay informally to be referred to specialist care or when doctors used their private network, rather than professional to navigate the health care system. They further stated that IPP existed in health care, mainly within some hospitals such as in surgery departments and gynaecology. Gift giving to health care providers was also a common phenomenon and perceived as a positive aspect of the patient-provider relationship. The respondents thus distinguished the gratitude gifts from bribes in the size of gifts and whether it was voluntary or forced.

5.1.2. Literature review results

The included studies were mainly peer reviewed and mostly about Albania. Two studies considered IPP in Serbia, while the rest concerned Bosnia Herzegovina, Montenegro, Kosovo, or Croatia. No data was included about Macedonia, since no studies fulfilling the inclusion criteria examined this country. The study designs were commonly quantitative, while only one was qualitative and one a mixed methods study. The main themes identified when

analysing the data were the effects of poor governance and frequency of IPP in Western Balkan, the causes of IPP in Western Balkan, and the informal networks in health care systems of Western Balkan.

In Serbia the quasi-formal payments (payments enforced in the absence of clear official regulation) in maternity care made it difficult for patients to navigate the rights and wrongs when utilizing the services. Thus, there was a perceived discrepancy between the official and hospital guidelines, making these quasi-formal payments possible. The existence of quasi-formal payments and IPP also varied a great deal, depending on how they were defined in the heterogenous sources of data, such as governmental literature, non-governmental literature and to online questionnaires. The included studies generally showed a common pattern that vulnerable groups were more likely to pay IPP, while people with more resources spent more on IPP. Further, these payments were higher in inpatient care than outpatient care.

Usually, these payments were made to receive faster care, better attention when receiving care or because the patients experience anxiety towards substandard care when, for instance, giving birth. Literature also showed that some people believed that payments should be made to contribute to the poor salary of doctors, whereas doctors similarly rationalised their behaviour to receive a better standard of living.

5.1.3. Joint conclusion

According to the literature and the Serbian respondents, underfunding of the health care system and the poor motivation of doctors seemed to be the triggering elements for the informality in the system, such as the informal networks and IPP. Typically, these payments took place in inpatient care on either a voluntary or forced basis. Mostly to either motivate health care providers or to ensure (better quality) care. The difficulty in defining IPP and gratitude gifts became obvious in the perceived legitimacy or illegitimacy of these payments. Such confusion may lead to underreporting of such payments, curbing of prevention, and making the rights and wrongs of these payments difficult to understand for those experiencing it.

5.2. Results of Paper II

The 24 included studies were scientific journal articles, master theses, reports, and a working paper. Studies mainly focused on Albania and were often focused on single countries, while others were cross-national. Studies included all the Western Balkan countries, although research on BBG was conducted only in Serbia. Other studies mentioned the practical terms, such as paying for epidural analgesia or provision of a bed. Generally, the included studies described IPP from the perspectives of the general public. Few studies also included literature

reviews, governmental decisions, legislation, books, and journals. In the papers, the term IPP was typically defined as a gift to health care providers or as being either voluntary or forced payments. Some studies however also merely described the payments as 'corruption to healthcare staff'.

Overall, the studies included reports of patients making IPP from 4% up to 91% of the time, indicating a great diversity in the reporting. Further, the reports on BBG were limited, which became clear in that these goods were identified from 1% of the study population in Serbia and Kosovo and up to 90% in Albania. Even though the researchers indicated these payments to be illegitimate, the data was uncertain, since BBG was not specifically used to describe these transactions.

When looking in to giving gifts to health care providers, it became clear that small gifts were often given to express gratitude, whereas larger payments, such as hotel stays, typically were in reciprocation for services. The included studies showed a great driver to express gratitude, due to for instance local customs. Gifts were reported to be on both voluntary and forced basis and paying to receive better quality care was found in all seven Western Balkan countries. The argument for costumery gift thus becomes difficult in that it seems to be required in several of the cases.

When looking into who in society pays informally, there seemed to be no definite pattern and data varied in between the countries. The payments were further used by health care providers to increase their standard of living or career advancement. Consequently, it was argued that these payments were necessary. The remedies to fight the practice were broadly identified with suggestions such as introducing a performance-based system, legalising the payments, including the media in anti-corruption initiatives, or changing the mind-set of citizens. For deeper insights into the findings, see **Paper II**, including a broader overview in the table 'Summary of Findings' (page 625-629).

5.3. Results of Paper III

The *Figure 6* and *Figure 7* give an illustration of the results of the current sub-study, excluding the BBG due to only finding little evidence on this issue. Generally, asylum-seeking migrants navigated the health care system differently than other local Serbians, which resulted in different outcomes for paying IPP (See *Figure 7*). Asylum-seeking migrants accessed services through the asylum centre and would often be assisted by a nurse or an intercultural mediator when utilizing services. Therefore, it was believed that paying informally was not possible. The asylum-seeking migrants would further access the health care services quicker than others, due to accessing care in a highly organized manner through the asylum centre.

Most of the civil servants regarded IPP as an illegal practice, however some also acknowledged the motivation of doctors through gratitude gifts (See *Figure 6*). Many of the

civil servants and migrants believed the traditional practice of gratitude gifts should be allowed in some form, while others believed it to be a practice that exists due to the high value put into doctors. IPP and BBG were perceived to be due to, for instance, poor working conditions, the low salary of doctors or the lacking equipment or drugs in the institutions, rooted in the lacking resources of the health care system. Therefore, it was also believed that patients were asked to sometimes bring goods, such as sheets, medicine, equipment, to the hospitals

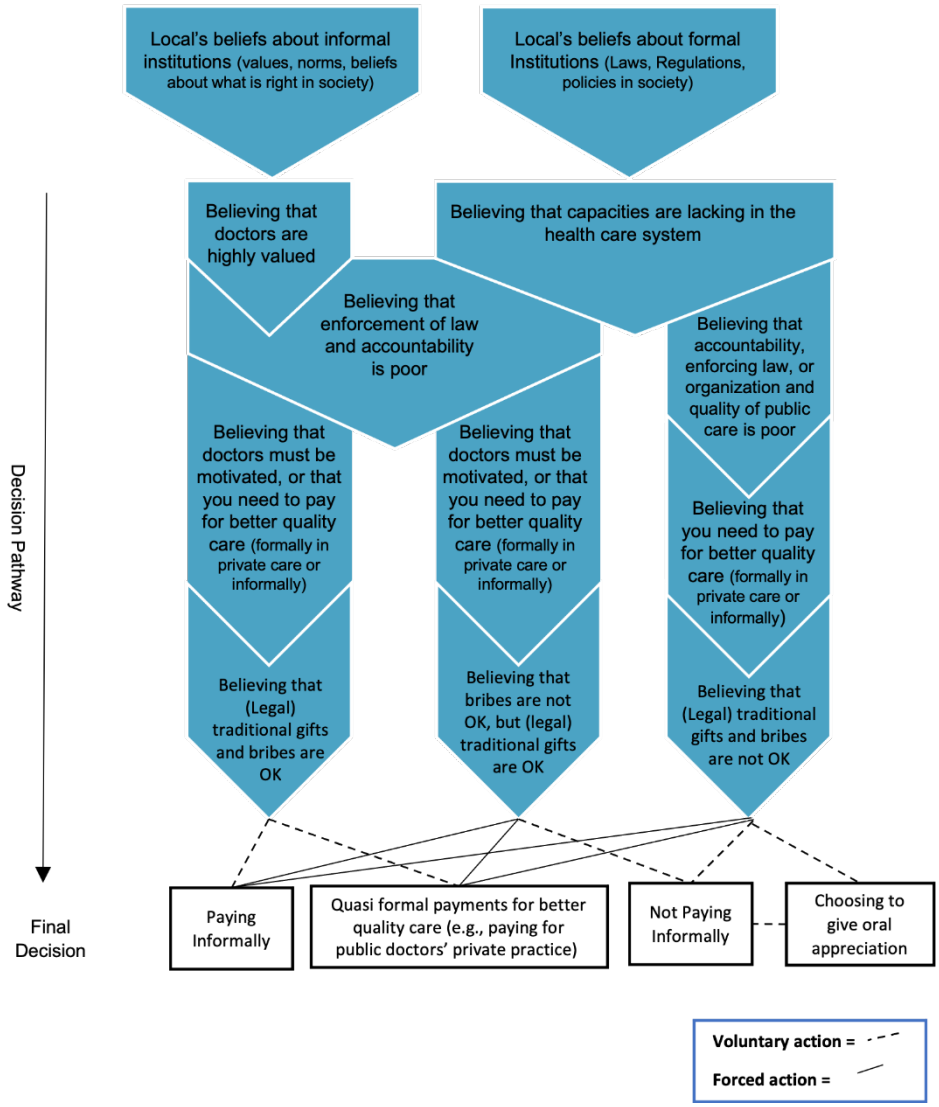

Figure 6. Illustration of potential pathways to informal patient payments perceived by locals (civil servants)

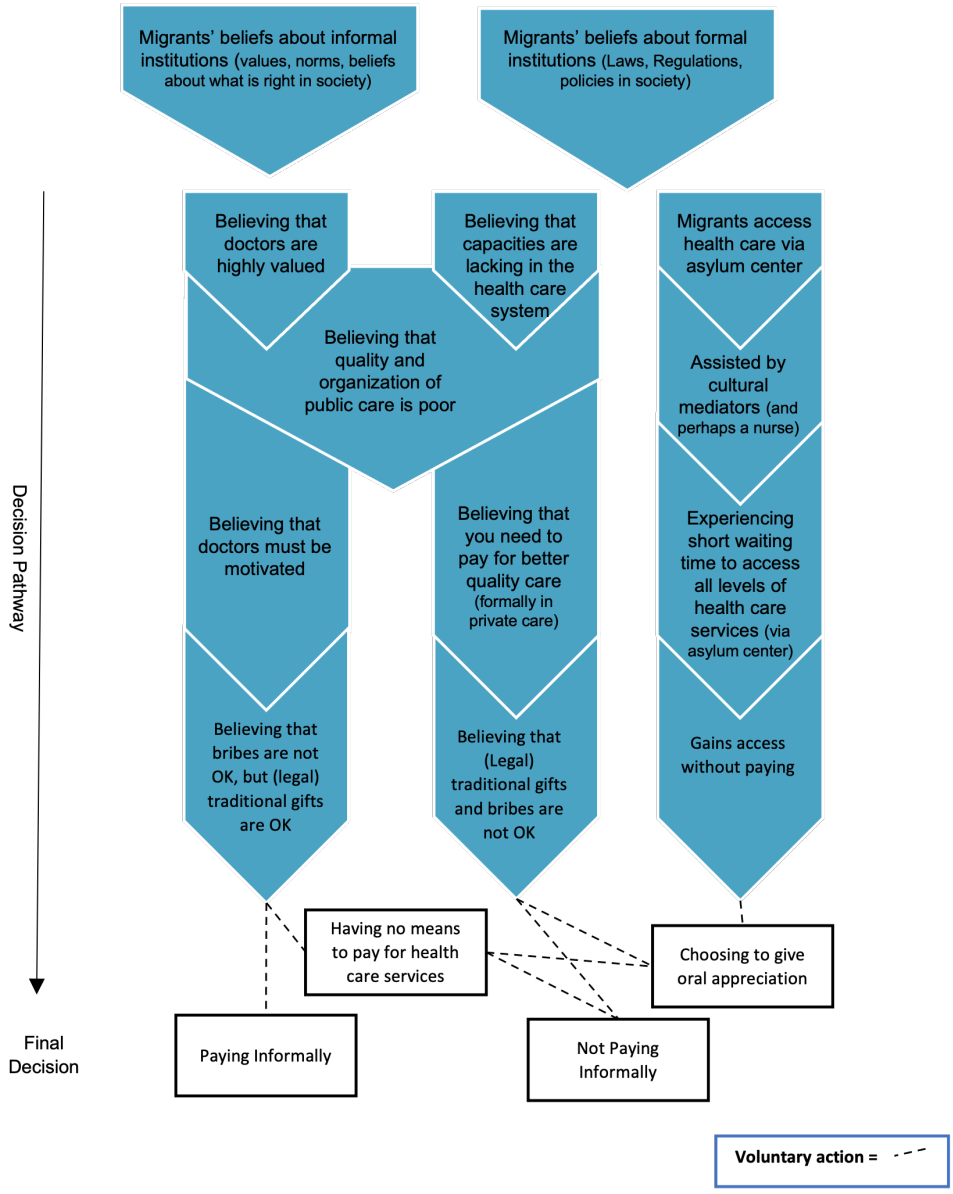

Figure 7. Illustration of potential pathways to informal patient payments perceived by migrants

IPP were generally believed by the civil servants to be decreasing and mostly to occur within specialists' areas of the health care system. Especially maternity care was mentioned by the civil servant, as an example of the systematic practice in which IPP, BBG and quasi-formal payments occurred. Many patients seeking maternity care would pay a doctor, at his own private practice, to take care of them when giving birth in the public hospital, ensuring better-quality care.

In choosing to pay informally, civil servants and migrants argued that patients would regard doctors with too high value, believing in an ability to cure diseases. Further the poor functioning and underfunding of the health care system was a triggering element to choosing to pay informally, in effect of the long waiting lists, ambulances being late or denying treatment of elderly. Doctors working in poorly equipped public institutions should in that sense be rewarded for staying in these institutions, rather than working in private practices.

The perception of the public institutions consequently made people believe that private institutions were better, and they would rather pay for their own private medical care than going to the public health care services.

5.4. Results of Paper IV

All civil servants believed that the asylum-seeking migrants had better access to health care than other migrants and locals in Serbia. They were perceived to access care in a more organized manner through the asylum centre and were believed to always be assisted by an intercultural mediator and sometimes a nurse (See *Figure 7*). This contributed to potentially shorter waiting times, reporting of inappropriate behaviour and a potential inability to pay IPP or BBG. Both civil servants and migrants believed that it was generally not possible for migrants to pay informally for services, in the form of goods, gifts or money. However, other vulnerable groups in Serbia that were also unable to pay extra for instance for maternity care, seemed to be exposed to poorer access or poorer quality care if they refuse.

The intercultural mediators were perceived by most of the civil servants to play a pivotal role in asylum-seeking migrants' access to health care since there seemed to be a high degree of trust between them. The mediators created and maintained a high degree of trust by being always available and having a broad understanding of the migrants' background, due to themselves being migrants or being trained to have such knowledge. The main roles of the intercultural mediators were interpreting, bridging sociocultural gaps, promoting migrants' health in guiding them to (certain) health care services, building trust between migrants and health care providers, and easing access to the health care system through e.g., information and advocating for the migrants' needs. The low number of available (and trained) intercultural mediators, however, made those who were available highly busy in trying to provide services for everyone in need. The migrants further seemed apprehensive to and could not access health care services without them, as they did not speak the local language and did not know the country. Some migrants appeared hesitant in seeking professional help for clear symptoms of disease or medical emergency, as they wished to continue their journey towards Europe. Others appeared to have preconceived ideas and prejudices of Western health care professionals not understanding migrants' culture and thus their priorities and needs. The intercultural mediators may often curve such hesitation, in building cultural bridges and guiding them towards utilising health care services.

6. Discussion

In this section I will discuss theories and literature in the field in relation to the combined findings of the four sub-studies. I will discuss the consequences of health systems governance on access to health care and health outcomes, using Serbia and the implementation of intercultural mediators as a case.

6.2. The interplay between informal patient payments and health systems governance

Findings from both the qualitative studies and the literature reviews suggested that the current way of health systems governance, particularly in Serbia, might create negative effects on the systems' functioning. Poor performing health systems may lead to the inequity in access to health care and consequently poorer health outcomes in the population (15). Other researchers (82) similarly argue that corruption in the health systems, regardless of how well funded or organised, undermines the performance of health systems and may ultimately disrupt the health spending, leading to poorer health outcomes. In Serbia, indicators such as low salary of doctors, poor incentives to perform, underfunding and thus lacking equipment seemed to create motivation and rationalisation to coping strategies such as IPP and BBG. When having less money to spend on health care, Uslaner and other researchers (82, 165) similarly suggest that salaries are pushed down, making for instance health care providers likely to extort funding from patients (165). Barriers in access to health care, such as the IPP, therefore appear to be interchangeably connected to lacking management, underfunding, or a lack of accountability (7, 8). Such issues of lacking access to health care is highly important, as it may cause people to seek alternative health-seeking strategies that create inequity and undermines the health care systems (166). As in the INXIT theory (103), people will make alternative informal strategies in the light of a believed dysfunctional health care system, e.g., giving gifts, paying cash or bringing and buying goods when needing health care services.

Similar to the United Nations Development Programme (UNDP) and CeSID (167), several civil servants of the present study believed that individuals made alternative informal strategies due to a lacking trust in government and in the light of a believed dysfunctional health care system. The level of IPP was thus believed by some civil servants to be due to poor management of the system, creating a barrier in access to health care. Health systems performance is namely measured in the level and distribution of cost, health, and responsiveness (15). The performance of the Western Balkan countries' health systems are particularly also placed in low and intermediate rankings (36, 168), while high OOP appear to create high levels of unmet needs in these countries (55). Serbia in that regard demonstrates the highest reported unmet needs of the region (42, 169). High levels of OOP and IPP may however disrupt the access to health care, as vulnerable groups are often incapable of paying

out-of-pocket (71, 96, 170, 171). Poor public spending and great divisions between rich and poor are also observed in Serbia, demonstrating inequities in the population (42). The civil servants of the current study equally argued that people in Serbia would rather choose private care, believing that the access was easier and of better quality. Those who were unable to pay for private services would in that sense need to accept the poor conditions in the public health care system. Vulnerable groups of society may thus become more susceptible to unmet needs and IPP (42). The consequence of the poor spending on health care in Serbia may therefore create higher poverty rates and less utilisation of health care services to those in need (168).

The highest levels of unmet needs in Serbia are namely also reported in women, elderly, lower educated, and those with lower income (45). Migrants residing in Serbia are in particular vulnerable to unmet health care needs in Serbia creating great inequity in the access to care (45). This evidence however contradicts the findings regarding the asylum-seeking migrants of the current study, showing easy access and better-quality care for those living in the asylum centres. The next section will therefore discuss deeper the structural determinants around the asylum-seeking migrants' access to health care, to uncover potential successes in providing equitable access to health care.

6.2.1. Intercultural mediators' role in migrants' access to health care

In studying the asylum-seeking migrants, the present thesis provides new insights into the perceptions and experiences with paying informally and the equitable access to health of asylum-seeking migrants in Serbia. Although being a highly heterogeneous group, migrants are typically more exposed to exploitation, violence, and abuse than other groups of society (172). They travel to countries with unfamiliar languages or culture, putting them in a vulnerable situation when needing health care (64, 172). Even though IPP, BBG and quasi formal payments appear to be common in Serbia, the asylum-seeking migrants of the present study reported easier access and better-quality care than what evidence shows on other types of migrants in Serbia (45). Being one of the main transit countries for refugees and asylum-seekers, Serbia needed to respond to these challenges. The organised access to health care and the implementation of intercultural mediators in Serbia seem to increase the migrants' utilization of care and their experiences of quality. For instance, increasing trust, bridging sociocultural gaps, and decreasing prejudices through information and advocacy between health care providers and asylum-seeking migrants. The Health Evidence Network (64) identify similar findings and acknowledge the improvement of quality in health care when migrants and refugees use intercultural mediators. However, integrating into society would likely expose these asylum-seeking migrants to the same risks as other migrants in Serbia, who face the highest unmet needs in the country (32). Implementing intercultural mediators to all migrants in Serbia needing such assistance, may increase the utilisation of health care for this group. These mediators are however often hired in precarious and temporary

positions and lack sufficient training and certification (64, 173). Particularly providing professional training and systematic and consistent implementation of intercultural mediator programmes may increase the quality and reach of these mediators and thereby increasing the quality and utilisation of services for the most vulnerable migrants (64).

In the present study, the asylum-seeking migrants often did not visit health care providers without an intercultural mediator and were therefore highly dependent on their services. Other evidence suggest that migrants may not wish intercultural mediators to be present (64, 126), as speaking their native language during treatments can raise traumatic memories. There may however be differences in the effect when using intercultural mediators, as migrants are a highly heterogenous group. Evidence on the various types of migrants and their utilisation of health care services with the assistance of an intercultural mediator is therefore needed. The effect of intercultural mediators with different types of migrants could provide deeper insight into the effective implementation of these. Overall, migrants need information on the assistance of the intercultural mediators and reassurance on codes of conduct and confidentiality when accepting the assistance of these mediators (126). More evidence on the successful and unsuccessful practices of providing health care for all types of migrants in Serbia could further increase the quality of care for other migrants residing in the Western Balkan region.

Having discussed the health systems governance and the access to health care and health outcomes, I will now move on to discuss the findings of IPP and BBG as a symptom of poor health systems governance. The focus of the discussion will thus turn to the overall occurrence, the causes of occurrence and how they may be prevented.

6.3. Informal patient payments and bought and brought goods

Findings from the qualitative studies and the literature reviews suggested that IPP were mostly frequent in inpatient care than in outpatient care. These results are also found in other studies from other Eastern European countries (174), showing that inpatient care carries the highest cost and highest risks for the patients (175). Similarly, the respondents of the qualitative studies believed that patients paid informally due to, for example, a sense of security when giving birth or when needing surgery. The studies however showed a limited definite indication of who in society paid most. Some studies in the scoping review reported that those with higher education were perceived to be those avoiding IPP, while other studies showed that having education was an indicator to pay informally or higher amounts in their IPP. In both literature reviews, however, the poorest groups were found to be those that paid more often than others, while those with money paid higher amounts. In some studies, the richer populations were however also found to be most likely to pay.

Across all studies in the literature reviews, evidence regarding the incidents of IPP and BBG were fragmented. IPP were overall reported from 2% up to 91% of cases, indicating a great diversity in the reporting. BBG were only studied explicitly in two studies, however indicating the same diversity from less than 1% to 90% of the study populations reporting bringing goods when needing health care services. Lewis (8) similarly finds that IPP largely goes unreported, while also existing alongside formal co-payments. The reporting of these payments therefore becomes difficult, as patients may find it challenging to distinguish whether they are paying formally or informally for health care services. In the present study, there was similarly a perception among some of the respondents that these payments were not so widespread, while others believed them to be highly embedded in the systems, as for example the quasi-formal payments in maternity care. Being a sensitive topic, it may additionally be difficult to estimate the real terms and magnitude of these IPP (176). Especially the unclear definition of BBG is challenging. The collection of data in the present study relied on the specificity of whether the goods were legitimate or illegitimate. Therefore, only two studies were included in the Scoping review (**Paper II**) and some information may have been missed. Other studies from the Southern and Eastern European area, similarly, describe the contributions of medicine, food, bed linens or other materials that are supposed to be provided by the hospital during treatment (177-179). Although the practice of patients' responsibility for bringing and buying goods appears to have existed for many years, the focus on the issue seems to be lacking by decision makers and researchers in the Western Balkan countries. There is therefore a need to define BBG in health care and emphasise the reporting on both IPP and BBG.

6.3.1. The structural and cultural aspects of informal patient payments

In some Eastern European countries, gift giving and favours among relatives and local government officials are commonly viewed as a social logic (180). Reciprocity is common and rooted in sociocultural factors, where patients may express gratitude through gifts (103, 175). In the present study, respondents believed IPP occurred due to a perceived dysfunctional health system, but also as a cultural legacy. The discussion on whether it is the constrained health care system that forces people to pay informally or whether it is the cultural legacy of people in society is a complex discussion. It is a well-known fact that IPP are damaging and should be avoided in any health care system to ensure equitable access to health care services (181). However, even diminishing such payments, cultural beliefs may still foster the gratitude gifts to health care providers. Uslaner (182) in this regard believes that corruption has both cultural and structural roots, while corruption may not be eradicated by merely replacing leaders, but also occurs in changing of people's mindset.

In research considerable attention is typically given to the structural factors around corruption in health and the institutional culture (180). However, people's expression of culture may illustrate different perspectives on the social acceptability of some types of

corruption. Williams and Horodnic (99, 105, 106) similarly argues from the Institutional Asymmetry Perspective that there should be alignment between socially shared rules and formal rules, in order for institutions to be function well. When having a high asymmetry between these rules, then IPP is more likely to occur (99). Some respondents of the current study described doctors as being 'god-like' and thus patients felt a need to compensate them. A study from Taiwan similarly describes Taiwanese people to view doctors as having a high social position and therefore feel obliged to respond in a way that demonstrates gratitude (183). Thus, it is rooted in the cultural legacy that the persons with a high status in society have a choice in providing care to those with a lower status, and when they do the recipient is perceived to be in dept to the provider (183). These cultural beliefs may provide an explanation for the beliefs put forward by the respondents in the present study. Some believed that doctors needed the motivation, others believed doctors to be 'god-like', while most believed it to be an erroneous practice to give gifts. The aspect of cultural gift giving practices may with these various beliefs provide confusion, although several researchers acknowledge that the poor working conditions of doctors are an important aspect of expressing gratitude (76, 184, 185). Patients are in that sense often ill-equipped to assess the quality of care and the adequacy of health care providers' decisions and actions (184). They will then rather secure a fair treatment by paying informally, as also argued by the respondents of the current study. The quality of care is however, often not maximised when giving gifts or bribes, as patients are often not able to judge the medical quality (184). Vian (9) further identifies this as the rationalisation and pressure to abuse, where health care professionals may feel a need to accept IPP because they have debt and need to make a living. Patients rationalise their behaviour by finding IPP acceptable in the current situation, despite free entitlement to health care (9).

The respondents in the present study, believed that change is to come with the younger generation, while the older generation holds on to cultural beliefs of doctors having a 'god-like' image. Grødeland (180) in that regard also argues that the existence of informal practices began several years ago when coping with the shortages provided by the state during the socialism era. She believes that when transitioning, these informal practices became a way to cope with bottlenecks and financial hardship. The current change of mind-set of younger people in Serbia may give decision makers an opportunity to reduce gift-giving practices in health care, while simultaneously improving the structural factors causing informality, such as poor working conditions. For the moment however, legislators in Serbia legalised small gifts to health care providers by introducing the new Health Protection Act (Zakon o zdravstvenoj zaštiti "Official Gazette of RS", No. 25/2019) and Health Insurance Act (Zakon o zdravstvenom osiguranju "Official Gazette of RS", no.25/2019). A study on the lessons learned in reducing IPP in Sweden similarly suggests legalising such payments (186). Though, previous attempts to legalise payments have resulted in confusion and mixes of formal and informal payments (54, 177, 187, 188). Additionally, the burden of private spending on patients, which

is already at a high level in the Western Balkan countries, may potentially increase poverty rates (28). Comparatively, in Denmark, the least corrupt country in the world (12), gifts to public health care providers are only recommended on special occasions such as for anniversaries or birthdays (189).

Even though the deeper historical and cultural aspects of gift giving is not examined in the present study, as it lays outside the scope, the insights into the cultural legacy in the patient-provider relationship and IPP may provide a deeper understanding of the prevention of these.

6.3.2. Preventing informality in health systems

In the Scoping Review (**Paper II**) only few studies included the measures to reduce IPP, none included the prevention of BBG. Some measures were however suggested, believing that reducing IPP may be successful when legalising the payments, introducing performance-based systems of payment, strengthening reporting, changing mentalities, or involving the media, and/or including the EU or religious organisations. Similarly, Miller and Vian (190) suggest that both harder and softer measures are important, including legislative, judicial, political and financial restructuring and behavioural changes in the public. Other researchers (187) further claim that a context-specific strategy is important, for instance by including an assessment of the motivators of patients and providers, the structure of the healthcare financing and delivery system, and the resources available. Lerberghe and colleagues (185) in that sense find that corruption is a coping strategy to poor working environment, and that regulations and salary increases are not enough to tackle the problem. Value's systems and the pressure from users and peers are similarly necessary to address. Therefore combining the two would most likely be the most successful in reducing corruption in health (185). The efficient strategies to reducing IPP are rare, due to the highly complex phenomenon (187). Though, stable and adequate (public) funding for healthcare and comprehensive policy instruments to tackle these payments are important (187). In the meantime, it can be questioned whether the inadequate funding and financial cuts to public health care facilities may facilitate the IPP and BBG in Western Balkan countries. If not addressing these payments and goods in the systems, patients may choose private health insurance or informal ways to insure themselves, outside the public health care system. Access to healthcare in this case may become inequitable, since resourceful populations will have better opportunities. Only limited evidence-based research is available on the effectiveness of measures to reduce IPP and BBG in the Western Balkan countries.

Trust in health care providers may also provide an explanation for the difficulties in tackling corruption in health. Trust is in that sense known to be a predictor for corruption in a society (74, 182), where people trusting each other endorses stronger standards of moral and legal behaviour (191) and contribute to a well-functioning system (74). In the Western Balkan countries, trust has declined between 2007 – 2019 (46). The civil servants from the pilot study

similarly told that the trust level between health care professionals was low. They thus sought informal strategies in their daily working routine. Some civil servants from the qualitative study (**Paper III**) described a low trust from patients to health care providers, leaving insecurities whether needing to pay informally to get a service of good quality. Leaders in society may breed distrust in society and societies that are more trusting have less corruption (182). On the other hand, a decline in corruption does not automatically make societies more trusting (182). Therefore, trust is particularly important in a society tackling corruption and needs to be addressed to the same level as other anti-corruption strategies. Patients need to be ensured that they can trust their eligibility of entitlements, without needing to seek informal strategies.

After discussing the collected data with other evidence and theories in the field, I will now move on to discussing the methodological considerations that I have had before, during, and after conducting the study.

6.4. Methodological considerations

This thesis demonstrates the usefulness in applying qualitative methods and literature reviews to understand IPP and BBG in the Western Balkan region. The qualitative data added a richness and new dimensions to evidence (132), while the literature reviews provided a deeper insight into existing evidence. Mixing the two methodologies enabled a unique opportunity for comparison around IPP, BBG, health systems governance and equity in access to health care. The combination of data increased the validity of findings, in the ability to cross-check results and increase the trustworthiness of these. Several consistencies were further found between the qualitative findings and the literature reviews. The methodological strengths and limitations that I have considered in conducting this study will be discussed in the following sections. Initially, the methods of the qualitative study will be discussed, followed by the literature reviews.

6.4.1. Strengths and limitations of the qualitative study

Considerations about validity and reliability

Validity and reliability in qualitative research are key factors in assessing the trustworthiness and quality of results (192, 193). However, there is seldom consensus for assessing the quality of qualitative studies (193). Qualitative data can further rarely be generalised, due to their focus on considering a specific phenomenon in certain populations (193).

Validity is discussed for being similar to a multiple array of terms such as adequacy, authenticity, trustworthiness, and plausibility. It is thus a concept that is complex and rather grounded in the transparent process and intentions of particular research methodologies

(194). Therefore, before and during the data collection, I discussed the methods design with my supervisors and other researchers, to ensure the appropriateness in answering the research questions. When in the field, I further produced rich data until saturation was done using the phenomenological hermeneutical approach and grounded theory. These data were then checked by other researchers in a reliability test. Conducting grounded theory also allowed me to stay close to the data and moving between theory and data in the analysis. The memo tool, analysing negative or rival explanations, and articulating the data analysis decisions were therefore part of ensuring validity (192, 193).

To ensure reliability of the qualitative studies, I used the phenomenological hermeneutical approach and the grounded theory steps in collecting and analysing the data. The replicability in qualitative studies is, however, ambiguous since human behaviours and interactions are not static. Repeatability of studies, to ensure the best quality, is thus problematic in qualitative research (192). Reliability may instead be based on the consistency and care in the application of the research, while being transparent about the limitations of the study (195).

Considerations in the data collection phase

In the present study, four participants were included in the pilot study and 14 participants in the final qualitative study. Overall, a saturation of data was reached, as no new information was discovered, though generalisability is not present. In the two qualitative studies the sampling was conducted in a purposive manner, to identify respondents who were able to answer the research questions. In qualitative research purposive sampling is often used to gather information-rich data, based on the characteristics of the respondents, while also thoroughly considering the construction of the sample (132, 196). Sampling bias may however be a potential limitation to the study, as only those speaking English and those who were willing to talk about the topic in question participated. In the second qualitative research phase (**Paper III** and **IV**) I was able to include more participants with the assistance of local researchers and NGOs. Overall, however, the migrants' population was difficult to get access to and public health providers were typically not motivated to participate, often due to their high working hours. Other researchers have similarly identified limitations in recruiting participants for qualitative research (197, 198). They suggest e.g., to support non-English speakers, reducing the participants burden or forming collaboration to access participants. Several of these considerations were carried out in the present study, though there appeared to be a need for broader and more comprehensive collaboration with relevant local institutions to increase the respondent participation.

During both qualitative data collection phases, there has been a focus to include health care professionals as they were believed to have valuable insights. When discovering that they were difficult to include in a qualitative interview, questionnaires were developed (for both data collections) in local languages and were distributed to various local clinics and hospitals. The WHO regional office for Serbia, local NGOs and local researchers assisted in identifying participants for the questionnaire, however only a limited number replied. Further, during

the data collection process some participants withdrew their acceptance to the qualitative interviews, when realising the topic to relate to IPP. Corruption is thus a sensitive topic where participants often would avoid self-incrimination (199), leaving participants unwilling to discuss it and contributing to under-reporting (200). The real scope and its consequences may therefore be undermined (92).

Recruiting migrants for the final qualitative study was challenging, as they were living in precarious situations. Other researchers similarly experienced such challenges, advising the creation of a multicultural team to build trust between researchers and migrants, and conducting snowball sampling (201, 202). I included the intercultural mediators and other local researchers from Belgrade to establish a team that could assist in gaining access to migrants and collecting data. When we received the approval to interview migrants, we could however not select these participants ourselves and those included were interviewed under time-constraints. This contradicts the time-consuming nature of qualitative research methodology (132). Some migrants may be recruited successfully by approaching them through their network (198). In the present study we approached migrants in the local hubs or in the areas they socialised in. Though, as these were mainly irregular migrants who were not motivated to participate, only (intended) asylum-seeking migrants in the local asylum centres were interviewed. The recruitment of participants was generally a long process in the study and sampling bias may be present.

Considerations in conducting the interviews

Those interviewed were willing and able to participate and therefore not those under greater physical or psychological pressure. There may be several limitations in interviewing vulnerable migrants, such as their willingness to participate due to for example religious beliefs, language barriers, or educational level (198, 203). Therefore, I included the intercultural mediators, who were known to the migrants. Positive and negative aspects may arise when having a known interpreter, although the migrants of the present study appeared comfortable during the interview. They were further continuedly made aware that they could withdraw at any time. Before beginning, I clarified the roles of me as the researcher, the intercultural mediator, and the assistant researcher from the university of Belgrade. However, the presence of an interpreter makes interviews less spontaneous and disjointed (204). Prompting becomes difficult and the researcher lose some control over how the questions are phrased (non-leading and neutral) (204). Validity in the data may in that sense be questioned, as responses from the migrants were translated and misunderstandings of questions might have occurred (205). Question marks raised by the respondents were however taken into great consideration, to avoid such pitfalls. The intercultural mediator would also provide background information on for instance the social context or migrants' situation to both me and the migrants, avoiding misunderstandings.

To have multiple perspectives on the migrants' stories, the intercultural mediators and information workers working with the migrants were included to the second qualitative data

collection. These professionals were able to provide a more nuanced picture of the asylum-seeking migrants' access to health care services, while some were themselves local Serbians. Ensuring their integrity and confidentiality was also of greatest concern. The ethical approvals, informed consent, the right to withdraw and securing of data files were therefore similar to the civil servants of the pilot study and to the civil servants and migrants of the qualitative study. Having the intercultural mediators as both assistants in the study and respondents could provide ethical dilemmas in terms of ensuring migrants' integrity (159). The migrants were however highly trusting towards the intercultural mediators. The intercultural mediators were further interviewed after the migrants' interviews were completed, minimising the opportunity to answer on the migrants' behalf.

Comparing the civil servants with the asylum-seeking migrants is difficult. They were in different positions to access health care and had different legal entitlements. One group further resided locally, whereas the other intended to leave Serbia. Interviewing both groups, however, gave an interesting dynamic and the possibility to uncover aspects of IPP and BBG from both sides.

6.4.2. Strengths and limitations of the literature reviews

The two literature reviews were conducted in a comprehensive and rigours manner and included much of the well-known literature on IPP and BBG in Western Balkan at the time. Though the completeness of data by other researchers is a potential limitation to such studies (145). The studies included is often collected with another focus in mind, other than for instance paying informally or addressing BBG. For the current scoping review, it was especially challenging to gather data on BBG, as they are not nearly as recognized in the literature as IPP. Consensus on a definition of BBG is further lacking, as only one study from Serbia defines the concept. I therefore chose to focus only on those goods that were perceived as illegitimate. Evidence may have been missed in that respondents may perceive such goods as legitimate, not knowing that BBG are illegitimate.

The scoping review methodology is well described in the literature, however, an accepted definition and the development of methodological rigor to assess the quality seems unresolved in these types of studies (152). I therefore chose to use the tested and updated versions of the methodology (151, 152), which provided rigorous and comprehensive steps in scoping the evidence. The literature review of the **Paper I** was conducted with a narrow inclusion of studies. Having a broader focus could have provided more knowledge. Nevertheless, the scoping review that was conducted afterwards included all studies of relevance. No results were found to change the scope of this particular literature review.

Both reviews were synthesized narratively, one with Thomas and Hardens (137) approach and the other Popay et.al's (136) approach. Synthesising qualitative literature has been debated and may be critiqued for not being commensurable or de-contextualizing the findings (206,

207). The validity may in that regard become uncertain, as the data collection and analysis are conducted by others. Mixing qualitative and quantitative research strengthened the findings in combining the why questions with quantitative elements of paying informally. Including also the CERQual tool (155), the NICE tool (153), and the MMAT (150) to appraise the quality of studies, increased the validity. The rigor in conducting these studies are furthermore critical to the replicability and thus reliability (145). Such rigour was provided in the current study by applying the steps from Thomas and Harden (137) and the scoping review methodology (151, 152).

Although some limitations are present in the current thesis, the data collections and analyses were done with great rigor and consideration to the validity and reliability of findings.

7. Implications for practice, policy, and research

As the final part of this thesis, I will discuss some key implications for practice, policy, and research, followed by the conclusions of the study. The perspectives below are based on the integrated findings of the study in promoting migrants' and other population groups' equitable access to health care.

Perspectives for practice

IPP and BBG are mostly believed to occur due to a perceived dysfunctional health system, but also as a cultural legacy. When being faced with lacking resources in health care, it makes changes difficult for those working in practice. When gathering data in Serbia, there appeared to be different cultures between institutions or health care providers in accepting or disregarding IPP. There is a need to know more about lower-level governance and institutional differences in the occurrence of IPP, studying e.g., why there is a difference between providers or institutions and when these payments are considered legal/illegal in practice. Patients and communities should further be empowered to understand and act on the informal practices that they are faced with. There is therefore a need for further research into the effect of modifying community perceptions of IPP, empowering patients in reinforcing social resistance towards unofficial payments (e.g., implement community monitoring mechanisms), and building social capital in health care communities.

Patients appear to have preconceived ideas about the need to provide IPP for services that they are otherwise entitled to. Such ideas seem to make patients either hesitant to seek health care or engage in informality. Practitioners and managers should always consider that allowing any (legal or illegal) payments or gifts besides entitlements will likely reduce utilisation of health care, particularly for the vulnerable groups of society. Although reducing bribes, cultural beliefs may still facilitate the gratitude gifts to health care providers. Practitioners can therefore be a core tool to change the culture in their communities, in for instance clearly communicating when they accept gratitude gifts, what they may constitute and of what value.

Perspectives for policy makers

Solutions to tackle IPP are diverse and complex and thus a series of strategies are needed at country-level to rid health systems of these payments.

Serbia has a comprehensive universal health care system, however high unmet needs are reported and barriers exist in utilising services for particularly some vulnerable groups. To ensure equitable access to health care service, IPP should be avoided in any health care system. Although research on the legalisation of IPP was fragmented, any anticipated gifts or payments besides entitlements appear to create inequity in access to care.

Besides legalising gifts, it seems that other strategies might be effective such as improving quality of health services, implementing measures to improve access to services (e.g., reduce

OOP, IPP and medicine cost), improving health staff motivation, and promoting transparency and accountability (especially in financing). The current change in mindset of the younger generation in Serbia may be a timely opportunity for policy makers to reduce IPP in health care.

The structural determinants in access to health care in the vulnerable asylum-seeking migrants in the present study, seem to be a tool in reducing vulnerable groups' barriers in access to health. Namely the provision of intercultural mediators to guide and inform about health care utilisation and the increased level of management in accessing health care services (e.g., introducing timeslots for vulnerable groups). Intercultural mediators however need to be introduced consistently and systematically and with enough resources to be effective. Transferring these elements to other vulnerable groups in Serbia or other Western Balkan countries, who face high unmet needs, appears to be feasible in improving the utilisation of care and experiences of quality in the region.

Perspectives for research

The concluding results show that although literature on IPP is increasing, the evidence appears fragmented in terms of the who in society pays most and how dispersed these payments are. Namely the BBG are lacking in research and should be investigated quantitatively and qualitatively in detail to define these goods and to understand their implications for health care access in both the Western Balkan countries and in Europe. Qualitative and quantitative evidence is also needed at community level on interventions that could be successful in preventing IPP effectively at this level.

As discovered in the present study, the implementation of intercultural mediators made it nearly impossible for migrants to give such payments. Evidence on the distribution and impact of IPP and BBG in various migrant populations need more studying, to clearly identify the consequences and distribution of these payments in this population group. The evidence into all types of migrants and their access to care in Western Balkan countries is further lacking and could provide more knowledge into barriers and facilitators. Especially the implementation of intercultural mediators and migrants' access to health care in Europe and Western Balkan could be further studied.

8. Conclusions

The aim of the thesis was to investigate the nature of IPP and BBG in the Western Balkan health care systems, while identifying mechanisms through which these payments may affect equity in access to Serbian health care. Some of the most salient findings that the thesis uncovered was the great diversity in reporting of IPP and BBG in Western Balkan, the scarce research on BBG, the severity of quasi-formal payments in Serbia, and the more equitable access to health care of asylum-seeking migrants with the reduced likelihood of paying informally.

In both **Paper I**, **II** and **III** the perceived root cause for IPP and BBG to occur was the underfunding of the health care systems. This made patients and health care providers rationalize their behaviour towards accepting or giving IPP or BBG. In the empirical part of the pilot study (**Paper I**) and in the qualitative study (**Paper III**) a commonness in gift giving was found, while also being perceived as a positive aspect of the patient-provider relationship. These two studies further uncovered the quasi-formal payments in maternity care (in Serbia), which made it difficult for patients to navigate the rights and wrongs when utilizing health care services. In the literature review (**Paper I**), but contrary the scoping review results (**Paper II**), I found that vulnerable groups in the Western Balkan countries were more prone to paying informally and that those with money often spent more on these payments. The Scoping review (**Paper II**) uncovered a great diversity when reporting on IPP and BBG in the Western Balkan countries. Similar to the qualitative studies, there was further a great wish to be able to express gratitude to health care providers, but at the same time these gifts were reported on both voluntary and forced basis. In parallel, the **Paper I** identified IPP as necessary to increase the healthcare providers' standard of living or career advancement. In the final qualitative part of the study (**Paper III**), most respondents regarded the IPP to be illegal, but some acknowledged the gift giving practices. BBG were also perceived to occur, mainly as the Serbian health system was underfunded and thus lacked these materials and equipment. The asylum-seeking migrants in Serbia further appeared to be protected from paying informally when accessing health care services. Similarly, the **Paper IV** revealed that the use of intercultural mediators seemed to be an important facilitator for migrants' access to health care services. When being assisted by intercultural mediators and when receiving more organised access to health care services, the migrants appeared to experience fewer barriers, such as a perceived need for paying informally.

Investigating IPP in the context of Serbia provided insights into the complex cultural and institutional aspects that may exist when attempting to eradicate IPP. To be successful, informality seems to be best tackled with both harder (e.g.,legislation) and softer (e.g., changing mindsets) measures. As the Western Balkan countries are entering the EU, this thesis also more broadly highlights the importance of governments and societies of these countries to emphasize leadership, more resources, and a culture change when health care systems tackle IPP and BBG.

9. References

1. Habibov, N, Cheung A. Revisiting informal payments in 29 transitional countries: the scale and socio-economic correlates. Social Science & Medicine. 2017;178:28-37.

2. Stepurko T, Pavlova M, Gryga I, Groot W. Informal payments for health care services–Corruption or gratitude? A study on public attitudes, perceptions and opinions in six Central and Eastern European countries. Communist and Post-Communist Studies. 2013;46(4):419-31.

3. Colombini M, Rechel B, Mayhew SH. Access of Roma to sexual and reproductive health services: qualitative findings from Albania, Bulgaria and Macedonia. Global Public Health. 2012;7(5):522-34.

4. Krupic F, Krupic R, Jasarevic M, Sadic S, Fatahi N. Being immigrant in their own country: experiences of Bosnians immigrants in contact with health care system in Bosnia and Herzegovina. Materia socio-medica. 2015;27(1):4.

5. Balabanova D, McKee M. Understanding informal payments for health care: the example of Bulgaria. Health policy. 2002;62(3):243-73.

6. Gaal P, Belli PC, McKee M, Szocska M. Informal payments for health care: definitions, distinctions, and dilemmas. Journal of Health Politics, Policy and Law. 2006;31(2):251-93.

7. Gaal P, McKee M. Fee-for-service or donation? Hungarian perspectives on informal payment for health care. Social Science & Medicine. 2005;60(7):1445-57.

8. Lewis M. Informal payments and the financing of health care in developing and transition countries. Health Affairs. 2007;26(4):984-97.

9. Vian T. Review of corruption in the health sector: theory, methods and interventions. Health policy and planning. 2008;23(2):83-94.

10. Mackey T, Liang B. Combating healthcare corruption and fraud with improved global health governance. BMC International Health Human Rights. 2012;12(23).

11. García PJ. Corruption in global health: the open secret. The Lancet. 2019;394(10214):2119-24.

12. Transparency International. Corruption Perception Index. Berlin (Germany): Transparency International; 2020. ISBN: 978-3-96076-157-0

13. Vian T. Anti-corruption, transparency and accountability in health: concepts, frameworks, and approaches. Global health action. 2020;13(sup1):1694744.

14. Merson MH, Black RE, Mills AJ. 3rd edition. Global health: Diseases, programs, systems, and policies. Burlington, MA (USA): Jones & Bartlett Publishers; 2011.

15. World Health Organization. The world health report 2000: health systems: improving performance. Geneva (Switzerland): World Health Organization; 2000. Report No.: 924156198X.

16. Ciccone DK, Vian T, Maurer L, Bradley EH. Linking governance mechanisms to health outcomes: a review of the literature in low-and middle-income countries. Social science & medicine. 2014;117:86-95.

17. Fagan C. The anti-corruption catalist: realising the MDGs by 2015. Berlin (Germany): Transparency International. 2010.

18. Lin R-T, Chien L-C, Chen Y-M, Chan C-C. Governance matters: an ecological association between governance and child mortality. International health. 2014;6(3):249-57.

19. Muldoon KA, Galway LP, Nakajima M, Kanters S, Hogg RS, Bendavid E, et al. Health system determinants of infant, child and maternal mortality: A cross-sectional study of UN member countries. Globalization and health. 2011;7(1):1-10.

20. Pinzón-Flórez CE, Fernández-Niño JA, Ruiz-Rodríguez M, Idrovo ÁJ, López AAA. Determinants of performance of health systems concerning maternal and child health: a global approach. PloS one. 2015;10(3):e0120747.

21. Pinzon-Rondon AM, Attaran A, Botero JC, Ruiz-Sternberg AM. Association of rule of law and health outcomes: an ecological study. BMJ open. 2015;5(10).

22. Witvliet MI, Kunst AE, Arah OA, Stronks K. Sick regimes and sick people: a multilevel investigation of the population health consequences of perceived national corruption. Tropical Medicine & International Health. 2013;18(10):1240-7.

23. OECD. Health at a Glance 2015. OECD indicators, OECD Publishing, Paris (France). DOI: https://doiorg/101787/health_glance-2015-en, Accessed October 2021. 2015;15:2016.

24. Thomson S, Cylus J, Evetovits T. Can people afford to pay for health care? New evidence on financial protection in Europe. Eurohealth. 2019;25(3):41-6.

25. World Health Organization. Out-of-pocket payments for health, particularly for medicines, are unaffordable for many in Europe. Copenhagen (Denmark): WHO regional office for Europe; 2019 [Available from: https://www.euro.who.int/en/health-topics/Health-systems/pages/news/news/2019/4/out-of-pocket-payments-for-health,-particularly-for-medicines,-are-unaffordable-for-many-in-europe, Accessed October 2021.

26. World Health Organization. The world health report: health systems financing: the path to universal coverage: executive summary. Geneva (Switzerland): World Health Organization; 2010. ISBN: 9789241564021

27. World Health Organization. The impact of health expenditure on households and options for alternative financing. 2004. Geneva (Switzerland): World Health Organization. EM/RC51/R.6

28. World Health Organization. Out-of-pocket payments, user fees and catastrophic expenditure [Internet]. Who Regional Office for Europe 2019 [cited November 2021] Available from: https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/.

29. World Health Organization. International migration, health and human rights. Geneva (Switzerland): World Health Organization; 2003. ENG0258

30. Fang ML, Sixsmith J, Lawthom R, Mountian I, Shahrin A. Experiencing 'pathologized presence and normalized absence'; understanding health related experiences and access to health care among Iraqi and Somali asylum seekers, refugees and persons without legal status. BMC public health. 2015;15(1):1-12.

31. Ingleby De. Inequalities in health care for migrants and ethnic minorities. Volume 2. Antwerp (Belgium): Garant Publishers; 2012.

32. Lebano A, Hamed S, Bradby H, Gil-Salmerón A, Durá-Ferrandis E, Garcés-Ferrer J, et al. Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. BMC Public Health. 2020;20(1):1-22.

33. Pavli A, Maltezou H. Health problems of newly arrived migrants and refugees in Europe. Journal of travel medicine. 2017;24(4).

34. UNHCR. Regional Refugee and Migrant Response Plan for Europe - Eastern Mediterranean and Western Balkans Route. January to December 2016 (Revision May 2016). Geneva (Switzerland): United Nations High Commissioner for Refugees; 2016.

35. European Commission. European neighbourhood policy and enlargement negotiations: Conditions for membership [Internet]. European Commission 2020 [cited October 2021] Available from: https://ec.europa.eu/neighbourhood-enlargement/policy/conditions-membership_en.

36. Health Consumer Powerhouse. Euro Health Consumer Index 2018. Sweden: Health Consumer Powerhouse Ltd.; 2019.

37. Government of the Republic of Serbia. Employment and Social Reform Programme in the Process of Accession to the European Union Serbia; Belgrade (Serbia): Government of the Republic of Serbia; 2016.

38. Krstic K, Janicijevic K, Timofeyev Y, Arsentyev EV, Rosic G, Bolevich S, et al. Dynamics of Health Care Financing and Spending in Serbia in the XXI Century. Frontiers in public health. 2019;7:381.

39. Mitrasevic M, Radovanovic S, Radevic S, Maricic M, Macuzic IZ, Kanjevac T. The Unmet Healthcare Needs: Evidence from Serbia. Iranian Journal of Public Health. 2020;49(9):1650.

40. Petrović D, Bukvic R. European Migrant Crisis (2014-2018) and Serbia. In: Janev I, editor. Serbia: Current Political, Economic and Social Issues and Challenges. New York: Nova Science Publishers, Inc; 2019. p. 125-42.

41. Rašević M. Migration and development in Serbia. Switzerland: International Organization for Migration; 2016.

42. Regional Coorporation Council. Regional overview of the Western Balkan economies regarding the European Pillar of Social Rights. Sarajevo: Regional Coorporation Council, European Union; 2020.

43. Mizik R, Karajicic S. Serbia: Brief health system review [Internet]. Health Policy Institute 2014 [cited September 2021] Available from: http://www.hpi.sk/en/2014/01/serbia-brief-health-system-review/.

44. Bredenkamp C, Gragnolati M. Sustainability of health care financing in the western Balkans: an overview of progress and challenges. South East Europe Review. 2008;11(2):151-84.

45. Bjegovic-Mikanovic V, Vasic M, Vukovic D, Jankovic J, Jovic-Vranes A, Santric-Milicevic M, et al. Serbia: health system review. Copenhagen (Denmark): European Observatory on Health Systems and Policies; 2019. ISBN: 1817-6119 Contract No.: 3.

46. OECD. Government at a Glance: Western Balkans. Paris (France): OECD Publishing; 2020. DOI: https://doi.org/10.1787/a8c72f1b-en

47. Mackenbach JP, Karanikolos M, McKee M. The unequal health of Europeans: successes and failures of policies. The Lancet. 2013;381(9872):1125-34.

48. OECD, European Union. Health at a Glance: Europe 2020 State of Health in the EU Cycle. Paris (France): OECD Publishing; 2020. DOI: https://doi.org/10.1787/23056088

49. European Commission. Eurostat: Life expectancy across EU regions [Internet]. Eurostat News 2020 [cited September 2021]. Available at: https://eceuropaeu/eurostat/web/products-eurostat-news/-/edn-20200930-1.

50. World Health Organization. World Health Organization Global Health Expenditure database: Out-of-pocket expenditure [Internet]. World Bank 2018 [cited November 2021]. Available from: https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=RS.

51. Buch Mejsner S, Eklund Karlsson L. Informal payments and health system governance in serbia: A pilot study. Sage Open. 2017;7(3):2158244017728322.

52. Giannouchos TV, Vozikis A, Koufopoulou P, Fawkes L, Souliotis K. Informal out-of-pocket payments for healthcare services in Greece. Health Policy. 2020;124(7):758-64.

53. Tomini S, Groot W, Pavlova M. Informal payments and intra-household allocation of resources for health care in Albania. BMC Health Services Research. 2012;12(1):1-12.

54. Tambor M, Pavlova M, Golinowska S, Sowada C, Groot W. The formal–informal patient payment mix in European countries. Governance, economics, culture or all of these? Health Policy. 2013;113(3):284-95.

55. Bjegovic-Mikanovic V, Vasic M, Vukovic D, Jankovic J, Jovic-Vranes A, Santric-Milicevic M, et al. Towards equal access to health services in Serbia. Eurohealth. 2020;26(1):25-8.

56. Bradby H, Humphris R, Newall D, Phillimore J. Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Refugees and Asylum Seekers in the European Region. Copenhagen (Denmark): WHO Health Evidence Network Synthesis Reports; 2015. ISBN 978 92 890 5110 1

57. Hannigan A, O'Donnell P, O'Keeffe M, MacFarlane A. How do variations in definitions of" migrant" and their application influence the access of migrants to health care services. Copenhagen (Denmark): World Health Organization. Regional Office for Europe; 2016.

58. Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Copenhagen (Denmark): World Health Organization. Regional Office for Europe; 2016. ISBN 978 92 890 5165 1

59. De Vito E, de Waure C, Specchia ML, Ricciardi W. Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Undocumented Migrants in the European Region. Copenhagen (Denmark): WHO Health Evidence Network Synthesis Reports; 2015. ISBN 978 92 890 5111 8

60. Simon J, Kiss N, Laszewska A, Mayer S. Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Labour Migrants in the European Region. Copenhagen (Denmark): WHO Health Evidence Network Synthesis Reports; 2015. ISBN 978 92 890 5109 5

61. Lukić V. Understanding transit asylum migration: Evidence from Serbia. International migration. 2016;54(4):31-43.

62. World Health Organization. Serbia: assessing health-system capacity to manage sudden large influxes of migrants. Belgrade (Serbia) and Copenhagen (Denmark): The Ministry of Health of Serbia and the WHO Regional Office for Europe; 2015.

63. Pusztai Z, Severoni S, Puthoopparambil SJ, Vuksanovic H, Stojkovic SG, Egic V, et al. Refugee and migrant health: improving access to health care for people in between. Public health panorama. 2018;4(02):220-4.

64. Verrept H. What are the roles of intercultural mediators in health care and what is the evidence on their contributions and effectiveness in improving accessibility and quality of care for refugees and migrants in the WHO European Region? Copenhagen (Denmark): WHO Regional Office for Europe; 2019.

65. UNHCR. Applying for asylum in Serbia [Internet]. Help Serbia 2021 [cited October 2021] Available from: https://help.unhcr.org/serbia/applying-for-asylum-in-serbia/.

66. Lilyanova V. The Western Balkans - Frontline of the migrant crisis. Strassbourg (France): European Parliamentary Research Service, European Union; 2016. PE 573.949

67. Arsenijevic J, Pavlova M, Groot W. Shortcomings of maternity care in Serbia. Birth. 2014;41(1):14-25.

68. Bartlett W, Bozikov J, Rechel B. Health reforms in south-east Europe: New York (USA): Springer; 2012.

69. Rašević M. Serbia: The migration issue in key national strategies. In: Bobić M, Janković S, editors. Towards Understanding of Contemporary migration - Cause, Consequences, Policies, Reflections (pp131-150). Publisher: Belgrade: Institute for Sociological Research Faculty of Philosophy University of Belgrade, Serbian Sociological Society. Belgrade: Institute for Sociological Research; 2017.

70. Arsenijevic J, Pavlova M, Groot W. Out-of-pocket payments for public healthcare services by selected exempted groups in Serbia during the period of post-war

healthcare reforms. The International journal of health planning and management. 2014;29(4):373-98.

71. Arsenijevic J, Pavlova M, Groot W. Out-of-pocket payments for health care in Serbia. Health Policy. 2015;119(10):1366-74.

72. Transparency International. What is Corruption? [Internet]. Transparency international 2021 [cited October 2021] Available from: https://www.transparency.org/en/what-is-corruption.

73. Transparency International. Glossary corruption offences [Internet]. Transparency International 2021 [cited October 2021] Available from: https://www.transparency.org/en/glossary.

74. Aasland A, Grødeland ÅB, Pleines H. Trust and Informal Practice among Elites in East Central Europe, South East Europe and the West Balkans. Europe-Asia Studies. 2012;64(1):115-43.

75. Khodamoradi A, Ghaffari MP, Daryabeygi-Khotbehsara R, Sajadi HS, Majdzadeh R. A systematic review of empirical studies on methodology and burden of informal patient payments in health systems. The International journal of health planning and management. 2018;33(1):e26-e37.

76. Vian T, Burak LJ. Beliefs about informal payments in Albania. Health policy and planning. 2006;21(5):392-401.

77. Pyone T, Smith H, van den Broek N. Frameworks to assess health systems governance: a systematic review. Health Policy Plan. 2017;32(5):710-22.

78. Dodgson R, Lee K, Drager N. Global Health Governance, a conceptual review: Routledge; 2017.

79. Balabanova D, Mills A, Conteh L, Akkazieva B, Banteyerga H, Dash U, et al. Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. The Lancet. 2013;381(9883):2118-33.

80. Bigdeli M, Rouffy B, Lane BD, Schmets G, Soucat A, Bellagio Group. Health systems governance: the missing links. BMJ Glob Health. 2020;5(8).

81. Brand H. Good governance for the public's health. European Journal of Public Health. 2007;17(6):541.

82. Savedoff WD, Hussmann K. Why are health systems prone to corruption. In: Kotalik J, Rodriguez D, editors. Global Corruption Report 2006. Berlin (Germany): Transparency International; 2006. p. 4-16.

83. Kickbusch I, Gleicher D. Governance for health in the 21st century. Copenhagen (Denmark): WHO Regional Office for Europe; 2012. ISBN 978 92 890 0274 5

84. Cockerham WC. The social causes of health and disease. New York (USA): John Wiley & Sons; 2021.

85. Whitehead M, Dahlgren G. Concepts and principles for tackling social inequities in health: Levelling up Part 1. Copenhagen (Denmark): WHO Regional Office for Europe. 2006;2:460-74. WHOLIS E89383

86. WHO Commission on Social Determinants of Health. Closing the gap in a generation: health equity through action on the social determinants of health: Commission on Social Determinants of Health final report. Geneva (Switzerland): World Health Organization; 2008.

87. World Health Organization. The World health report: 2004: changing history. Geneva (Switzerland): World Health Organization; 2004.

88. Global Health Europe. Inequity and Inequality in Health [Internet]. Global Health Europe, Maastricht University 2009 [cited October 2021] Available from: https://globalhealtheurope.org/values/inequity-and-inequality-in-health/.

89. Siddiqi S, Masud TI, Nishtar S, Peters DH, Sabri B, Bile KM, et al. Framework for assessing governance of the health system in developing countries: gateway to good governance. Health policy. 2009;90(1):13-25.

90. Cockerham WC, Hamby BW, Oates GR. The social determinants of chronic disease. American journal of preventive medicine. 2017;52(1):S5-S12.

91. Labonté R. Health systems governance for health equity: critical reflections. Revista de salud pública. 2010;12:62-76.

92. Ecorys. Updated study of corruption in the health sector. Final Report. Luxemborg: European Commision: Publications Office of the European Union; 2017.

93. Jain A, Nundy S, Abbasi K. Corruption: medicine's dirty open secret. British Medical Journal Publishing Group; 2014.

94. World Bank. Combatting corruption [Internet]. World Bank: Understanding poverty governance 2020 [cited November 2021] Available from: https://www.worldbank.org/en/topic/governance/brief/anti-corruption

95. Sommersguter-Reichmann M, Wild C, Stepan A, Reichmann G, Fried A. Individual and institutional corruption in European and US healthcare: overview and link of various corruption typologies. Applied health economics and health policy. 2018;16(3):289-302.

96. Pourtaleb A, Jafari M, Seyedin H, Behbahani AA. New insight into the informal patients' payments on the evidence of literature: a systematic review study. BMC health services research. 2020;20(1):1-11.

97. TNS Opinion & Social. Special Eurobarometer 502 - Corruption. Brussels (Belgium): Directorate-General for Communication, European Commission; 2019.

98. TNS Opinion & Social. Special Eurobarometer 470 - Corruption. Brussels (Belgium): Directorate-General for Communication, European Commission; 2017.

99. Williams CC, Horodnic AV. Explaining informal payments for health services in Central and Eastern Europe: an institutional asymmetry perspective. Post-Communist Economies. 2018;30(4):440-58.

100. Svendsen GLH, Svendsen GT. Trust, social capital and the Scandinavian welfare state: Explaining the flight of the bumblebee: Edward Elgar Publishing; 2016.

101. Fidrmuc J, Gërxhani K. Mind the gap! Social capital, East and West. Journal of Comparative Economics. 2008;36(2):264-86.

102. Ecorys. Study on corruption in the healthcare sector. Luxembourg: European Commission: Publications Office of the European Union; 2013.

103. Gaal P, McKee M. Informal payment for health care and the theory of 'INXIT'. The International journal of health planning and management. 2004;19(2):163-78.

104. Hirschman AO. Exit, voice, and loyalty: Responses to decline in firms, organizations, and states. Cambridge, MA: Harvard university press; 1970.

105. Marlow S, Swail J, Williams CC. Entrepreneurship in the Informal Sector: an institutional perspective. London (UK): Routledge; 2017.

106. Williams CC, Horodnic IA. Explaining the prevalence of illegitimate wage practices in Southern Europe: an institutional analysis. South European Society and Politics. 2015;20(2):203-21.

107. Kolasa K, Kowalczyk M. Does cost sharing do more harm or more good?-a systematic literature review. BMC Public Health. 2016;16(1):1-14.

108. International Organization for Migration. Glossary on migration [Internet]. IOM: Our work 2019 [cited November 2021] Available from: https://www.iom.int/glossary-migration-2019.

109. Huddleston T, Bilgili Ö, Joki A-L, Vankova Z. Migrant integration policy index 2015: integration policies, who benefits? Barcelona (Spain): Barcelona Center for International Affairs and Migration Policy Group; 2015.

110. International Organization for Migration. IOM Handbook on Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse. Switzerland: International Organization of Migration; 2019.

111. Kristiansen M, Razum O, Tezcan-Güntekin H, Krasnik A. Aging and health among migrants in a European perspective. Public Health Reviews. 2016;37(1):1-14.

112. Scholz N. The public health dimension of the European migrant crisis. European Parliament Briefing, Members' Research Service; 2016. PE 573.908

113. WFP; IOM. Populations at risk: Implications of COVID-19 for hunger, migration and displacement – An analysis of food security trends in major hotspots. Switzerland: World Food Programme; International Organization for Migration; 2020.

114. European Comission. European Pillar of Social Rights [Internet]. European Commission, 2017 [cited June 2021] Available at: https://ec.europa.eu/info/sites/default/files/social-summit-european-pillar-social-rights-booklet_en.pdf

115. World Health Organization. Report on the health of refugees and migrants in the WHO European Region: No public health without refugees and migrant health. Copenhagen (Denmark): WHO Regional Office for Europe; 2018.

116. United Nations. International covenant on economic, social and cultural rights. New York (USA): United Nations; 1966.

117. World Health Organization. Health of migrants: the way forward: report of a global consultation, Madrid, Spain, 3-5 March 2010. Geneva (Switzerland): World Health Organization; 2010. Report. No.:9241599502.

118. World Health Organization. Strategy and action plan for refugee and migrant health in the WHO European. Copenhagen (Denmark): WHO Regional Office for Europe; 2016 (Regional Committee for Europe 66th session; EUR/RC66/8 + EUR/RC66/Conf.Doc./4).

119. Van Mol C, De Valk H. Migration and immigrants in Europe: A historical and demographic perspective. Integration processes and policies in Europe. New York (USA): Springer; 2016. p. 31-55.

120. European Commission. Asylum Statistics: European Comission [Internet]. European Commission 2021 [Available from: https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Asylum_statistics.

121. Apt W. Demographic changes and migration. Final report. Berlin (Germany): VDI/VDE Innovation + Technik; 2017.

122. Winters M, Rechel B, de Jong L, Pavlova M. A systematic review on the use of healthcare services by undocumented migrants in Europe. BMC health services research. 2018;18(1):1-10.

123. Norredam ML, Nielsen AS, Krasnik A. Migrants' access to healthcare. Dan Med Bull. 2007;54(1):48-9.

124. Duncan GF. Refugee healthcare: Towards healing relationships. Canadian Social Science. 2015;11(9):158-68.

125. Peterson P, Sackey D, Correa-Velez I, Kay M. Building trust: delivering health care to newly arrived refugees. Connecting Health in Communities (CHIC) Chronic Disease Initiative: Brisbane (Australia); 2011.

126. Venables E, Whitehouse K, Spissu C, Pizzi L, Al Rousan A, Di Carlo S. Mental health and psychosocial support, Data and displacement, Missing migrants. In chapter Roles and responsibilities of cultural mediators. Forced Migration Review; 2021.

127. Padovese V, Egidi AM, Melillo Fenech T, Podda Connor M, Didero D, Costanzo G, et al. Migration and determinants of health: clinical epidemiological characteristics of migrants in Malta (2010–11). Journal of Public Health. 2014;36(3):368-74.

128. Bhopal RS, Gruer L, Cezard G, Douglas A, Steiner MF, Millard A, et al. Mortality, ethnicity, and country of birth on a national scale, 2001–2013: A retrospective cohort (Scottish Health and Ethnicity Linkage Study). PLos medicine. 2018;15(3).

129. DG Sante. The State of Health in the EU: Companion Report 2019. Brussles (Belgium): European Commission, OECD and the European Observatory on Health Systems and Policies; 2019.

130. King R, Lulle A, Sampaio D, Vullnetari J. Unpacking the ageing–migration nexus and challenging the vulnerability trope. Journal of Ethnic and Migration Studies. 2017;43(2):182-98.

131. Malmusi D, Borrell C, Benach J. Migration-related health inequalities: showing the complex interactions between gender, social class and place of origin. Social science & medicine. 2010;71(9):1610-9.

132. Brinkmann S, Tanggaard L. Kvalitative metoder, tilgange og perspektiver. Kvalitative metoder: En grundbog. Copenhagen (Denmark): Hans Reitzels Forlag; 2020. p. 15-29.

133. Lindseth A, Norberg A. A phenomenological hermeneutical method for researching lived experience. Scandinavian journal of caring sciences. 2004;18(2):145-53.

134. Birks M, Mills J. Grounded theory: A practical guide. Thousand Oaks, CA (USA): Sage; 2015.

135. Charmaz K. Constructing grounded theory. Thousand Oaks, CA (USA): Sage; 2014.

136. Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M, et al. Guidance on the conduct of narrative synthesis in systematic reviews. A product from the ESRC methods programme Version. 2006;1:b92.

137. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. BMC medical research methodology. 2008;8(1):1-10.

138. Merleau-Ponty M, Smith C. Phenomenology of perception. London (UK): Routledge; 1962.

139. Mays N, Pope C. Qualitative research: rigour and qualitative research. Bmj. 1995;311(6997):109-12.

140. Brannen J. Combining qualitative and quantitative approaches: an overview. Mixing methods: Qualitative and quantitative research. 2017:3-37.

141. Snyder H. Literature review as a research methodology: An overview and guidelines. Journal of business research. 2019;104:333-9.

142. Webster J, Watson RT. Analyzing the past to prepare for the future: Writing a literature review. MIS quarterly. 2002:xiii-xxiii.

143. Haddaway N, Woodcock P, Macura B, Collins A. Making literature reviews more reliable through application of lessons from systematic reviews. Conservation Biology. 2015;29(6):1596-605.

144. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. International journal of social research methodology. 2005;8(1):19-32.

145. Pluye P, Hong QN. Combining the power of stories and the power of numbers: mixed methods research and mixed studies reviews. Annual review of public health. 2014;35:29-45.

146. Sandelowski M, Voils CI, Barroso J. Defining and designing mixed research synthesis studies. Research in the schools: a nationally refereed journal sponsored by the Mid-South Educational Research Association and the University of Alabama. 2006;13(1):29.

147. Britten N, Campbell R, Pope C, Donovan J, Morgan M, Pill R. Using meta ethnography to synthesise qualitative research: a worked example. Journal of health services research & policy. 2002;7(4):209-15.

148. Jones K. Mission drift in qualitative research, or moving toward a systematic review of qualitative studies, moving back to a more systematic narrative review. Qualitative Report. 2004;9(1):95-112.

149. Husserl E, Panzer U. Logische Untersuchungen, Husserliana. Edmund Husserl. 1984.

150. Pluye P, Robert E, Cargo M, Bartlett G, O'cathain A, Griffiths F, et al. Proposal: A mixed methods appraisal tool for systematic mixed studies reviews. Montréal (Canada): Department of Family Medicine, McGill University; 2011.

151. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implementation science. 2010;5(1):1-9.

152. Daudt HM, van Mossel C, Scott SJ. Enhancing the scoping study methodology: a large, inter-professional team's experience with Arksey and O'Malley's framework. BMC medical research methodology. 2013;13(1):1-9.

153. National Insitute for Health and Care Excellence. Methods for the Development of NICE Public Health Guidance. London (UK): NICE; 2012.

154. Page MJ, Moher D, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. PRISMA 2020 explanation and elaboration: updated guidance and exemplars for reporting systematic reviews. bmj. 2021;372.

155. Lewin S, Glenton C, Munthe-Kaas H, Carlsen B, Colvin CJ, Gülmezoglu M, et al. Using qualitative evidence in decision making for health and social interventions: an approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). PLoS Med. 2015;12(10):e1001895.

156. Glaser B, Strauss A. The Discovery of Grounded Theory: Strategies for Qualitative Research. Mill Valley, CA (USA): Sociology Press; 1967.

157. Clarke AE. Situational analysis: Grounded theory after the postmodern turn. Thousand Oaks, CA (USA): Sage Publications, Inc.; 2005.

158. Bowers B, Schatzman L. Dimensional Analysis. In: Morse J, Noerager Stern, P., Corbin, J., Bowers, B., Charmaz, K., Clarke, A, editor. Developing grounded theory: The second generation. Walnut Creek, CA (USA): Left Coast Press; 2009. p. 88-127.

159. Leaning J. Ethics of research in refugee populations. The Lancet. 2001;357(9266):1432-3.

160. Ford N, Mills EJ, Zachariah R, Upshur R. Ethics of conducting research in conflict settings. Conflict and health. 2009;3(1):1-9.

161. Seagle EE, Dam AJ, Shah PP, Webster JL, Barrett DH, Ortmann LW, et al. Research ethics and refugee health: a review of reported considerations and applications in published refugee health literature, 2015-2018. Conflict and health. 2020;14(1):1-15.

162. Rousseau C, Kirmayer LJ. From complicity to advocacy: The necessity of refugee research. The American Journal of Bioethics. 2010;10(2):65-7.

163. Ellis BH, Kia-Keating M, Yusuf SA, Lincoln A, Nur A. Ethical research in refugee communities and the use of community participatory methods. Transcultural psychiatry. 2007;44(3):459-81.

164. Zwi AB, Grove NJ, Mackenzie C, Pittaway E, Zion D, Silove D, et al. Placing ethics in the centre: Negotiating new spaces for ethical research in conflict situations. Global public health. 2006;1(3):264-77.

165. Uslaner EM. Corruption and inequality: WIDER Research Paper; 2006.

166. Biswas D, Kristiansen M, Krasnik A, Norredam M. Access to healthcare and alternative health-seeking strategies among undocumented migrants in Denmark. BMC public health. 2011;11(1):1-11.

167. CeSID; UNDP Serbia. Corruption Benchmarking–Serbia: Perception of corruption at the household level. Serbia: UNDP Serbia and CeSID Opinion Polling Agency; 2015.

168. World Health Organization. Primary health care on the road to universal health coverage: 2019 monitoring report: Executive summary. Geneva (Switzerland): World Health Organization; 2019.

169. Bredenkamp C, Mendola M, Gragnolati M. Catastrophic and impoverishing effects of health expenditure: new evidence from the Western Balkans. Health policy and planning. 2011;26(4):349-56.

170. Tomini S, Groot W, Pavlova M. Paying informally in the Albanian health care sector: a two-tiered stochastic frontier model. The European Journal of Health Economics. 2012;13(6):777-88.

171. Vian T, Grybosk K, Sinoimeri Z, Hall R. Informal payments in government health facilities in Albania: Results of a qualitative study. Social science & medicine. 2006;62(4):877-87.

172. International Organization for Migration. IOM Handbook on Protection and Assistance for Migrants Vulnerable to Violence, Exploitation and Abuse. Geneva (Switzerland): IOM; 2019.

173. Verrept H. Notes on the employment of intercultural mediators and interpreters in health care. Inequalities in health care for migrants and ethnic minorities. 2012;2:115-27.

174. Lewis M. Informal Health Payments in Central and Eastern Europe and the Former Soviet Union: Issues, Trends and Policy Implications. In: Mossialos E, Dixon A, Figueras J, Kutzin J, editors. Funding Health Care: Options for Europe. 2002: 184-205.

175. Polese A. Informal payments in Ukrainian hospitals: On the boundary between informal payments, gifts, and bribes. Anthropological Forum; 2014: 381-395.

176. Stepurko T, Pavlova M, Gryga I, Groot W. Empirical studies on informal patient payments for health care services: a systematic and critical review of research methods and instruments. BMC Health Services Research. 2010;10(1):1-13.

177. Belli P, Gotsadze G, Shahriari H. Out-of-pocket and informal payments in health sector: evidence from Georgia. Health Policy. 2004;70(1):109-23.

178. Ensor T, Savelyeva L. Informal payments for health care in the Former Soviet Union: some evidence from Kazakstan. Health Policy and Planning. 1998;13(1):41-9.

179. Ensor T. Informal payments for health care in transition economies. Social science & medicine. 2004;58(2):237-46.

180. Grødeland ÅB. Public perceptions of corruption and anti-corruption reform in the Western Balkans. Slavonic & East European Review. 2013;91(3):535-98.

181. World Health Organization. Together on the road to universal health coverage. A call to action. Geneva (Switzerland): World Health Organization; 2017.

182. Uslaner EM. Trust and corruption. In: Lambsdorff GJ, Taube M, Schramm M, editors. The new institutional economics of corruption. London (UK): Routledge; 2005. p.76-92.

183. Chiu Y-C, Smith KC, Morlock L, Wissow L. Gifts, bribes and solicitions: print media and the social construction of informal payments to doctors in Taiwan. Social Science & Medicine. 2007;64(3):521-30.

184. Thompson R, Witter S. Informal payments in transitional economies: implications for health sector reform. The International journal of health planning and management. 2000;15(3):169-87.

185. Van Lerberghe W, Conceicaõ C, Van Damme W, Ferrinho P. When staff is underpaid: dealing with the individual coping strategies of health personnel. Bulletin of the World Health organization. 2002;80:581-4.

186. Sundell A. Understanding Informal Payments in the Public Sector: Theory and Evidence from Nineteenth-century Sweden. Scandinavian Political Studies. 2014;37(2):95-122.

187. Gaál P, Jakab M, Shishkin S, Kutzin J, Cashin C, Jakab M. Strategies to address informal payments for health care. Implementing health financing reform: lessons from countries in transition Copenhagen (Denmark): World Health Organization. 2010:327-60.

188. Baji P, Pavlova M, Gulácsi L, Zsófia HC, Groot W. Informal payments for healthcare services and short-term effects of the introduction of visit fee on these payments in Hungary. The International journal of health planning and management. 2012;27(1):63-79.

189. Moderniseringsstyrelsen, Landsforening K, Regioner D. God adfærd i det offentlige; 2017. ISBN: 87-7956-490-9.

190. Miller K, Vian T. Strategies for reducing informal payments. Anticorruption in the Health Sector: Strategies for Transparency and Accountability Sterling, VA (USA): Kumarian. 2010.

191. Uslaner EM. Trust but verify: Social capital and moral behavior. Social Science Information. 1999;38(1):29-55.

192. Cypress BS. Rigor or Reliability and Validity in Qualitative Research: Perspectives, Strategies, Reconceptualization, and Recommendations. Dimensions of Critical Care Nursing. 2017;36(4):253-63.

193. Leung L. Validity, reliability, and generalizability in qualitative research. Journal of family medicine and primary care. 2015;4(3):324.

194. Lub V. Validity in qualitative evaluation: Linking purposes, paradigms, and perspectives. International journal of qualitative methods. 2015;14(5):1609406915621406.

195. Davies D, Dodd J. Qualitative research and the question of rigor. Qualitative health research. 2002;12(2):279-89.

196. Bornø Jensen A, Vallgårda S. Forskningsmetoder i folkesundhedsvidenskab. Copenhagen (Denmark): Munkgaard; 2021.

197. Newington L, Metcalfe A. Factors influencing recruitment to research: qualitative study of the experiences and perceptions of research teams. BMC medical research methodology. 2014;14(1):1-11.

198. Reiss K, Dragano N, Ellert U, Fricke J, Greiser KH, Keil T, et al. Comparing sampling strategies to recruit migrants for an epidemiological study. Results from a German feasibility study. The European Journal of Public Health. 2014;24(5):721-6.

199. Jensen NM, Rahman A. The silence of corruption: identifying under-reporting of business corruption through randomised response techniques. London (UK): Routledge; 2014.

200. Budak J, Rajh E. Corruption survey in Croatia: survey confidentiality and trust in institutions. Društvena istraživanja: časopis za opća društvena pitanja. 2012;21(2 (116)):291-313.

201. Fête M, Aho J, Benoit M, Cloos P, Ridde V. Barriers and recruitment strategies for precarious status migrants in Montreal, Canada. BMC medical research methodology. 2019;19(1):1-14.

202. Ingleby D. European research on migration and health. Migration Health Research Portal. Geneva (Switzerland): International Organization for Migration; 2009.

203. Gabriel P, Kaczorowski J, Berry N. Recruitment of Refugees for Health Research: A qualitative study to add refugees' perspectives. International journal of environmental research and public health. 2017;14(2):125.

204. Plumridge G, Redwood S, Greenfield S, Akhter N, Chowdhury R, Khalade A, et al. Involving interpreters in research studies. Journal of health services research & policy. 2012;17(3):190-2.

205. Murray CD, Wynne J. Researching community, work and family with an interpreter. Community, Work & Family. 2001;4(2):157-71.

206. Campbell R, Pound P, Pope C, Britten N, Pill R, Morgan M, et al. Evaluating meta-ethnography: a synthesis of qualitative research on lay experiences of diabetes and diabetes care. Social science & medicine. 2003;56(4):671-84.

207. Sandelowski M, Barroso J. Handbook for synthesizing qualitative research. New York (USA): springer publishing company; 2006.

Appendix 1: Map of Western Balkan countries

Appendix 2: Interview guide for the pilot study

The below questions were posed as overall questions, whereas probing questions were asked depending on the answer of respondents.

Public health officials and primary care doctors

1. What are your general tasks at this institute?
2. Let me start by asking you about what do you know about primary health care?
3. What is your opinion in general on the primary health care system? Do you believe it functions well or not so well?
4. So, in line with this, what is your opinion on how the primary health system delivers health care to the public in Vojvodina?
5. Next, we will talk about informal practice and behaviour. So, first off, how would you define informal payments?
    a. What are the wrongs and rights?
    b. Is it a part of the system?
    c. Do you see logic in informal payments? Why people do it?
    d. What is your opinion in using personal relationships to benefit professionally?
    e. Do you believe that citizens perceive government officials and providers in general to go by rules and regulations?
6. When I say the word corruption, what do you think? What is the first thing that comes to mind?
    a. Are you familiar with the Anti-corruption strategy?
    b. How are the policies in place to fight corruption? –What makes you answer that?
    c. What could be done to fight corruption?
7. Next we will talk about how you think people trust government officials and PHC. So how do you believe the trust level generally is towards health care providers and other government officials?
    a. What makes you answer that?
    b. Democracy. What is democracy to you? How would you describe the level of democracy in Serbia? (Inclusion of civil society in decision-making, transparency, citizen's voice etc.)
8. So now we are going to go a bit back to health care services. Do you believe that people in Vojvodina feel they have equal access to health care services? – Why? If **No**, whom do you believe doesn't?
9. Finally, I will ask, what is your perspective on the functioning of the separation of primary, secondary and tertiary care?
10. *Closing questions, thank you.*

Appendix 3: Transcription codebook

Characters inserted into the transcript	**Meaning**
[00:00]	Time indication inserted every 10. minutes
--	Missing or unrecognizable words
(…)	longer break
(Traffic noise)	Write in parentheses when outside noise disturbs the speakers voice.
(R interrupts)	Simultaneous speech: Write in parentheses and then write sentences as they are spoken e.g; M2: xxx R: xxx
(crying)	Write feeling and expressions in parentheses
Speakers are stated as either a migrant (e.g. M2), a civil servant (e.g. N2), Translator (T), Research assistant (R2) and researcher (R)	
Files are saved as NAME.DATE.FILETYPE, for example M2.030918.m4a	
Commas are inserted for understanding, not for correct punctuation	
Abbreviations and numbers under 10 are written as text	
Repeated words are deleted, for instance '*I,I,I believe*' to only *'I believe*'	
When interpreters and migrants are talking it is written in italic, for example: *T speaking in farsi with M2 and M2 replies*	

Appendix 4: Interview guide for the main qualitative study

The below questions were posed as overall questions, whereas probing questions were asked depending on the answer of respondents.

Asylum-seeking migrants

- I would like to know about your background and who you are. So, can you tell me where you are from and what your daily activity is here in Serbia?
- Can you tell me about your situation in Serbia? (living-, working conditions, asylum)
- Do you have any family members with you? (map family aspects)
- I think it would be interesting to hear what you believe health is, so could you tell me, when do you believe someone is healthy?
- Tell me about an experience, that made an impression on you, with the local/public health care clinics, hospitals or such in Serbia?
- In your last experience with the health care system, what impression did you get of the health care providers? Why you think so?
- *Closing questions, thank you.*

Civil servants

- I would like to know about your background and who you are. Can you briefly tell me what is your profession and what work you have done within migrant's health?
- Now let's move on to talk about your views on migration in Serbia. What do you think is the greatest challenge in terms of (non-western) migrants in Serbia?
- What are the challenges or facilitators of migrants in accessing health care? (residence, income, gender, ethnicity, religion, language)
- Let's talk about your thoughts about the political system in Serbia. So, what can you say about your view on the Serbian politicians in general? (views on anti-corruption and the existing policies concerning migrants' entitlement in health)
- *Closing questions, thank you.*