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Original research article

Multiculturalism as a value in healthcare services in the Western Balkans

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Abstract
In this study, we aimed to examine the healthcare preferences and perspectives of citizens in the Western Balkans (namely Albania, North Macedonia, Kosovo, Montenegro, Serbia, and Bosnia and Herzegovina), as well as their trust toward medical professionals of various genders and ages. Almost 4,000 citizens (N = 3,789) of six countries in the Western Balkans (Albania, North Macedonia, Kosovo, Montenegro, Serbia, and Bosnia and Herzegovina) were surveyed using a self-reported questionnaire in this inter-country cross-sectional study.

Most of the participants state that their ethnicity (86%) or religion (89%) has no effect on receiving services in healthcare institutions when the doctor is from a different ethnicity or religion ($p < 0.05$). One-third of the study's participants stated that they don't necessarily prefer to be treated by medical doctors who approach all patients of different nationalities equally.

Finally, this article demonstrates that the majority of Balkan citizens had no disparities when receiving medical care from a medical doctor of a different ethnicity or religion. About one-third of the research participants nurture tolerance and diversity as a behavior culture and do not want to be treated by a doctor who discriminates against patients of different nationalities.

Keywords: Balkan; Citizens; Disparities; Healthcare; Multiculturalism; Trust

Introduction

Multiculturalism is a sociocultural situation in which different cultural identities coexist in a geopolitical space or in which the characteristics of disparate entities coexist in a culturally diverse society (Unah, 2021). Healthcare multiculturalism is widespread and growing due to numerous external factors, such as political instability, unemployment, educational needs, tourism, insecurity, and coping strategies to deal with these changes. The medical culture emphasizes the dismantling of patient life narratives and the reconstitution of patient concerns and experiences with illness, as well as the associated social context, into medically meaningful narratives that allow physicians to diagnose conditions and to formulate plans for therapeutic actions and procedures (Mojekwu et al., 2021).

Many factors influence healthcare outside of the traditional healthcare setting. While cross-cultural relationships can enrich our lives and provide us with tremendous benefits, they can also present challenges. Developing and delivering culturally competent care and services can lessen healthcare inequalities, which present both possibilities and difficulties for healthcare practitioners/providers, healthcare services, and health policy (Henderson et al., 2018). Education on cul-

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tural sensitivity and health tourism for healthcare providers can improve their knowledge and attitudes, reducing prejudice while producing better outcomes for patients' health (Yıldız et al., 2023). Additionally, diversity in quality of housing and access to healthy food and education are recognized as social determinants of health (Jackson and Gracia, 2018).

However, communication is one of the most difficult challenges in a culturally diverse healthcare setting. In fact, non-verbal communication is as important as verbal communication (Heer et al., 2016), and effective communication is required to ensure culturally acceptable communication because it increases client trust and promotes teamwork among members (Ioan et al., 2020; Javanmard et al., 2017). Thus, patients with different cultural and linguistic backgrounds experience numerous obstacles and use healthcare services less frequently than the host communities (Khatri and Assefa, 2022; WHO, 2018).

Furthermore, there are numerous cross-sectional studies demonstrating discrepancies in access to mental healthcare or treatment beginning among people of different races or ethnicities (Eken et al., 2021; Heun-Johnson et al., 2021). Difficulties with oral communication can result in poor patient assessment, diagnosis, and treatment management, and a lack of patient acceptance of all interventions (Wiener et al., 2013). There will inevitably be mistrust between healthcare professionals and patients from different cultural backgrounds, as well as challenges for both parties. The frustrations of healthcare practitioners will decline if they are well-educated or knowledgeable about the cultural issues of their patients (Dellenborg et al., 2012) despite the fact that patients and healthcare professionals might not recognize the importance of communication. Additionally, the quality of the working relationship, where mutual understanding is visible, is necessary for quality care in multicultural contexts (Sellevold et al., 2019).

Morin (2013) ranked Chad, Cameroon, Nigeria, Togo, and the Democratic Republic of Congo as the five most culturally diverse countries, but the Balkan region of Europe is also a diverse and multicultural region. Indeed, the Balkans are a mosaic – or sometimes an oil painting – of intertwined cultural traditions, beliefs, customs, and folkways, leading to difficulty in drawing straightforward borders that account for ethnic complexity. In fact, ethnic groups have been defined more often according to language or religion than to nationality (Akova and Demirkiran, 2013). Working as a healthcare professional in a community with such variation can easily lead to misunderstanding, behavioral adaptation barriers, and poor diagnoses, resulting in lower quality of care.

In this study, we aimed to examine the healthcare preferences and perspectives of citizens in the Western Balkans (namely Albania, North Macedonia, Kosovo, Montenegro, Serbia, and Bosnia and Herzegovina), as well as their trust toward medical professionals of various genders and ages.

Materials and methods

As indicated in Table 1 below, almost 4,000 citizens (N = 3,789) of six countries in the Western Balkans were surveyed using a self-reported questionnaire, which was administered electronically between July 25, 2021, and October 30, 2021, through the snowball sampling technique. We increased the first group of respondents to get a more representative sample. The data collection was done online, and there were no restrictions on who could participate in the study – other than being a citizen of the country and being between the ages of 18 and 70. This approach has enabled us to use the Exponential Non-Discriminative Sampling technique as a comprehensive alternative until we reach the target sample size. A Google Forms-based survey was utilized to collect data, and internal consistency of the questionnaire was determined to be acceptable (Maljichi et al., 2022). Since the questionnaire was originally written in Albanian, an identical version was translated using the double-forward-backward approach into Macedonian, Montenegrin, Serbian, and Bosnian for use in the respective nations (Bullinger et al., 1998).

During the drafting of the socio-demographic questions, we referred to the last census data for the respective countries to define the ethnicity and religion of the participants without providing any additional explanations or definitions. The ethical committee at Heimerer College approved the study protocol, and this study's methods adhered to the guidelines outlined in the Declaration of Helsinki regarding the inclusion of human subjects in research. Prior to participation, each participant provided informed consent electronically. A detailed methodology and study sample is explained elsewhere (Maljichi et al., 2022). To assess trust in healthcare institutions and medical doctors, or how much they agree with specific statements, we asked respondents to rate their agreement with statements (e.g., "How much do you trust…"). Responses were on a ten-point scale, with one (1) indicating "no trust at all or do not agree at all" and ten (10) indicating "a lot of trust or totally agree".

Table 1. Participants by country

Country	Participants
Serbia	809
Bosnia and Herzegovina	700
Kosovo	633
North Macedonia	624
Albania	601
Montenegro	422
TOTAL	3,789

The Statistical Package for the Social Sciences was used to analyze the data (SPSS version 21.0) (IBM, 2012). Frequencies and percentages were used to represent categorical variables, and the mean ± SD (standard deviation) was used to summarize continuous variables. The chi-square test and independent samples t-test were used to compare variables, and $p < 0.05$ was accepted as statistically significant.

Results

Most of the participants state that their ethnicity (86%) or religion (89%) has no effect on receiving services in healthcare institutions when the doctor is from a different ethnicity or religion ($p < 0.05$) (Chart 1). For instance, participants in Albania (95.8%), North Macedonia (83.3%), Kosovo (97.5%), Montenegro (93.6%), Serbia (96.9%), and Bosnia and Herzegovina (98.9%) all reported that ethnicity has no impact on their ability to receive healthcare services at facilities where the doctor is of a different ethnicity. Similar numbers, 97.3% in Albania, 84.3% in North Macedonia, 96.4% in Kosovo, 93.6% in Montenegro, 98.0% in Serbia, and 98.4% in Bosnia and Herzegovina, were reported with no impact on the patients' ability to receive healthcare services from a doctor of a different religion.

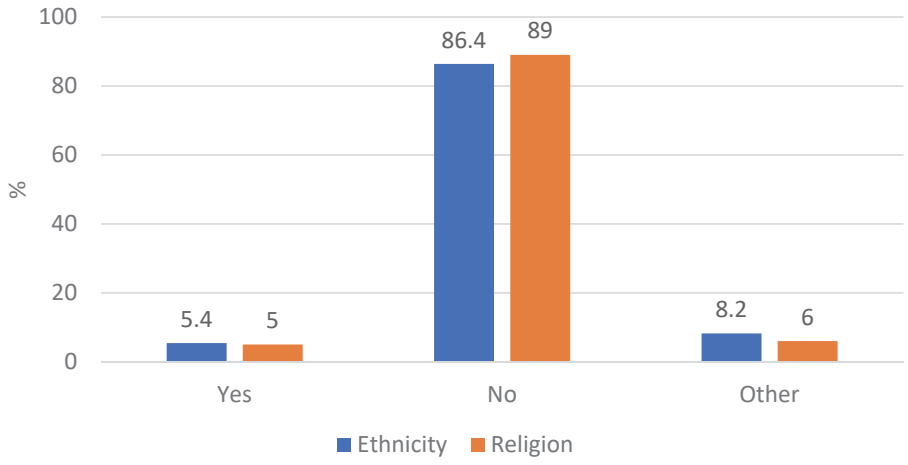


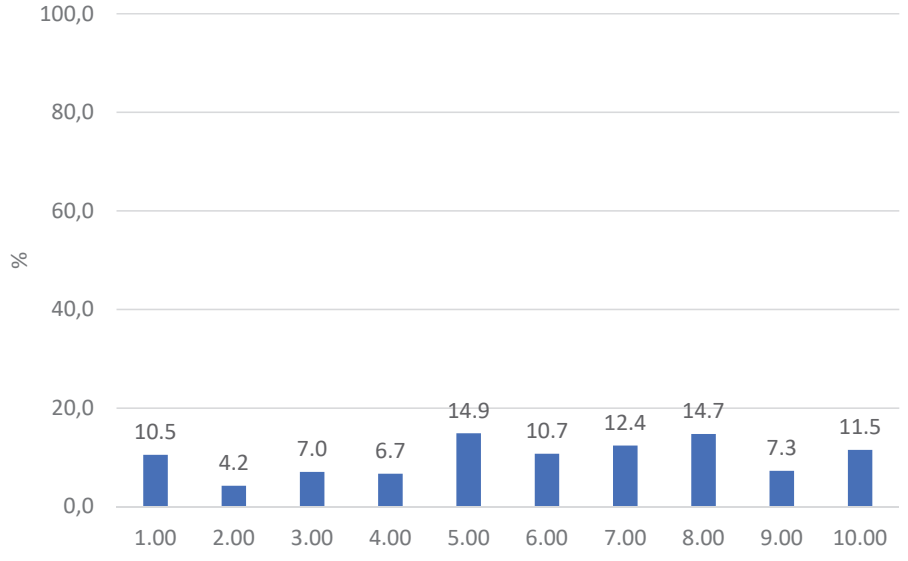
Chart 1. Impact on recieving health services

Approximately one-fifth of Balkan citizens noted that they would still receive healthcare services at an institution with or without trust in the healthcare institution (Chart 2a). More than one-half (55%) of participants stated that the minority community in their country can receive such services – when they want – at the same rate as the majority community (Chart 2b). One-third of the study's participants stated that they don't necessarily prefer to be treated by medical doctors who approach all patients of different nationalities equally (Chart 2c); one-fifth don't fully trust doctors' judgment about what treatment is best for them (Chart 2d).

More specifically, when we look at each country separately, we see that in North Macedonia, 22.1% of participants said they don't want to be treated by doctors who treat all patients of different nationalities equally, as do 25.7% in Albania, 34.1% in Kosovo, 35.0% in Serbia, 43.8% in Montenegro, and 50.1% in Bosnia and Herzegovina.

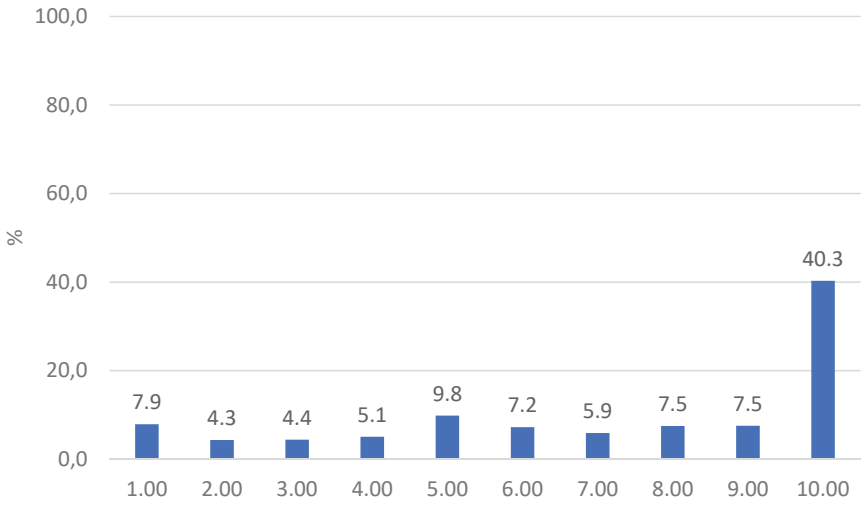
There was no statistically significant difference concerning the level of trust toward male ($\bar{x}$ = 7.1 out of 10) and female ($\bar{x}$ = 7.1 out of 10) doctors (t = –1.319, p = 0.187). However, females had higher trust in male ($\bar{x}$ = 7.2 out of 10) and female ($\bar{x}$ = 7.2 out of 10) doctors, compared to their male counterparts ($\bar{x}$ = 6.8 out of 10, and $\bar{x}$ = 6.9 out of 10, respectively) ($p < 0.05$).

Balkan citizens indicated higher trust in tertiary health institutions ($\bar{x}$ = 5.9 out of 10) compared to secondary ($\bar{x}$ = 5.4 out of 10) and primary ($\bar{x}$ = 5.7 out of 10) healthcare institutions ($p < 0.05$). Primary healthcare institutions had higher trust scores ($\bar{x}$ = 5.7 out of 10) compared to secondary healthcare institutions ($\bar{x}$ = 5.4 out of 10) ($p < 0.05$). Study participants declared less trust toward medical doctors aged 23–35, and most trust toward those aged 46–55 (Chart 3).



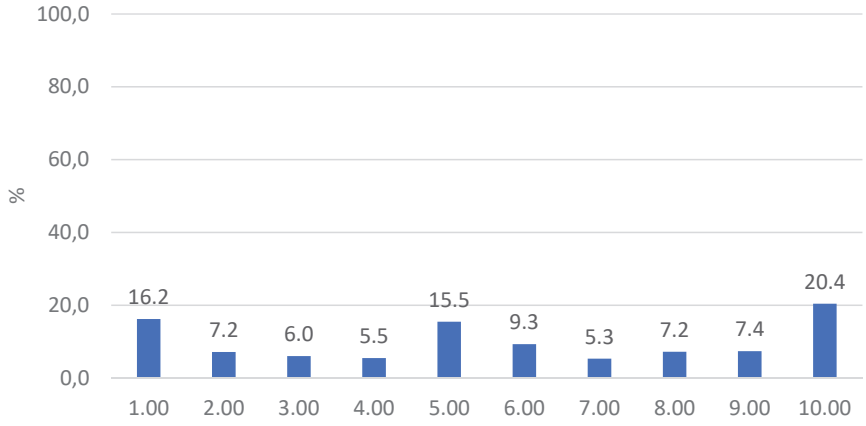
Legend: One (1) indicates "no trust at all" and ten (10) indicates "a lot of trust".

Chart 2a. The trust level towards the preferred health institution to receive health service



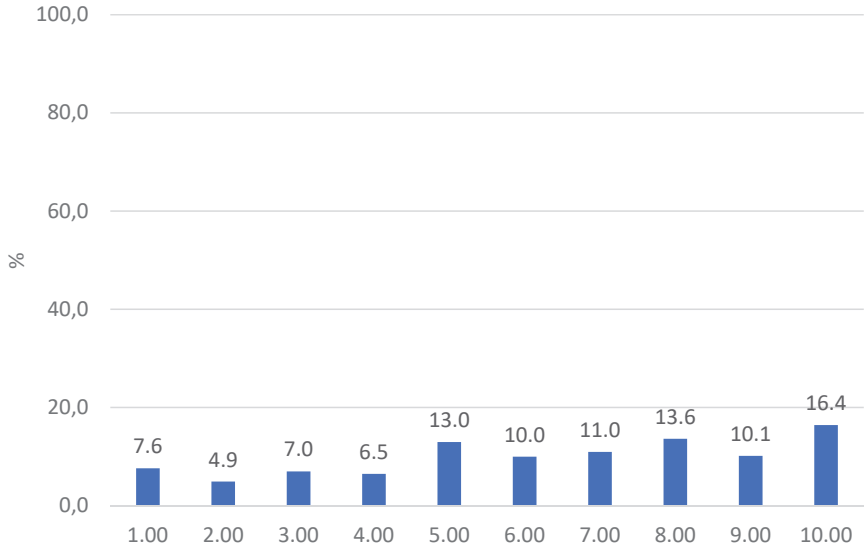
Legend: One (1) means "do not agree at all", while ten (10) suggests "completely agree".

Chart 2b. The minority community in your country can receive healthcare services when they want at the same rate as the majority community



Legend: One (1) means "do not agree at all", while ten (10) suggests "completely agree".

Chart 2c. You prefer to receive medical care from medical doctors who treat patients of all nationalities equally



Legend: One (1) indicates "no trust at all" and ten (10) indicates "a lot of trust".

Chart 2d. Trust in doctors' judgment for treatment choice

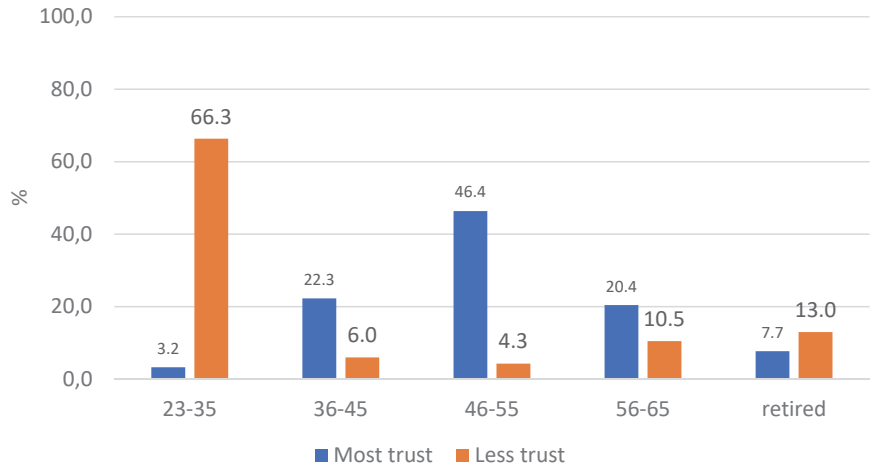


Chart 3. The level of trust towards medical doctors (MD) based on age group

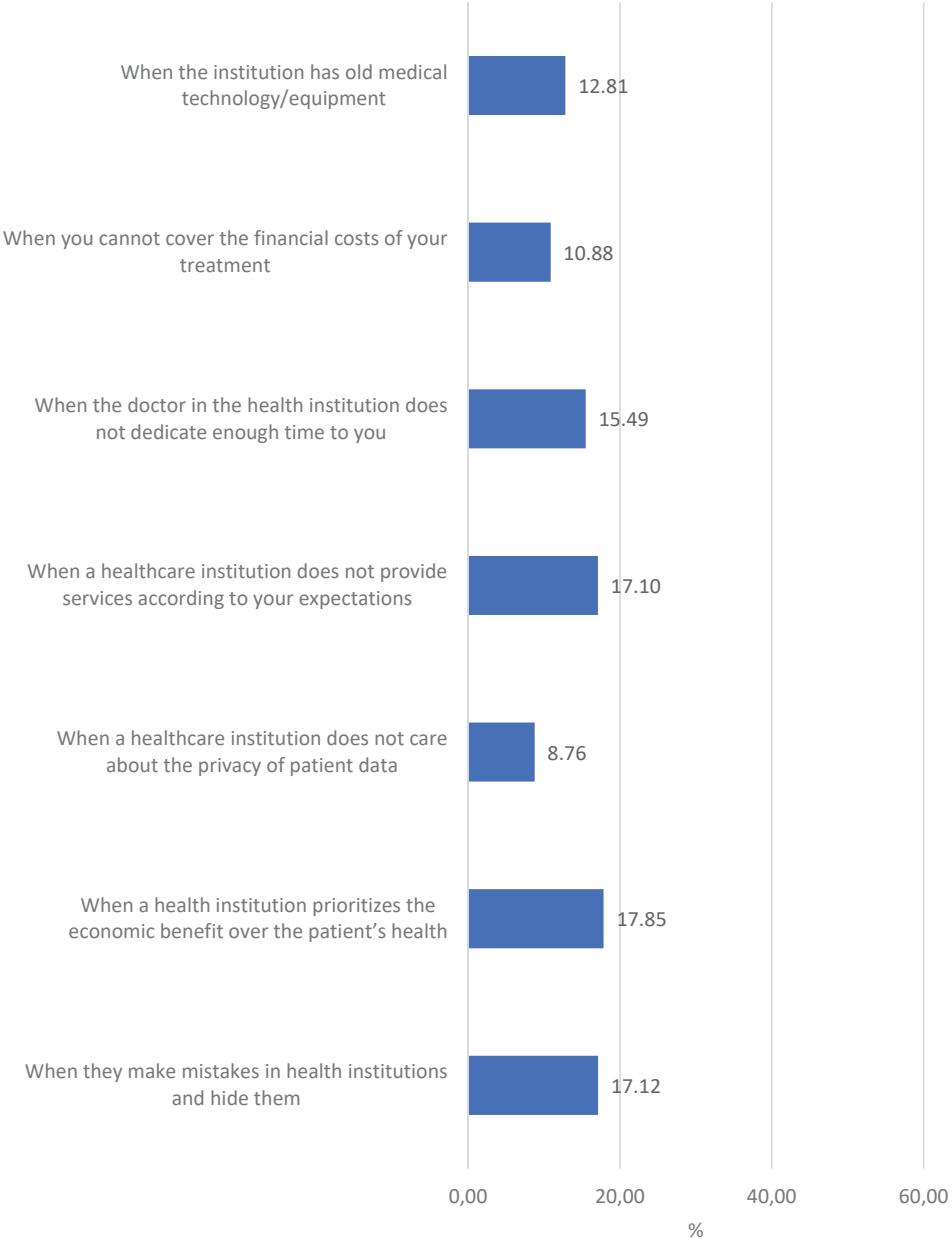


Chart 4. The reasons not to choose a health institution

As indicated in Chart 4, the first three reasons that Balkan citizens did not select a particular healthcare institution were:
(a) The healthcare institution prioritizes economic benefit over patients' health (17.8%).
(b) The healthcare institution makes and covers up mistakes (17.1%).
(c) The healthcare institution's services do not meet patients' expectations (17.1%).

As indicated in Chart 5, the first three reasons that indicated Balkan citizens' desire to choose a healthcare institution were:
(d) The healthcare institution is known for higher quality healthcare services (13.6%).
(e) The healthcare institution prioritizes patients' health (12.7%).
(f) The healthcare institution previously exceeded the patient's expectations (11.8%).

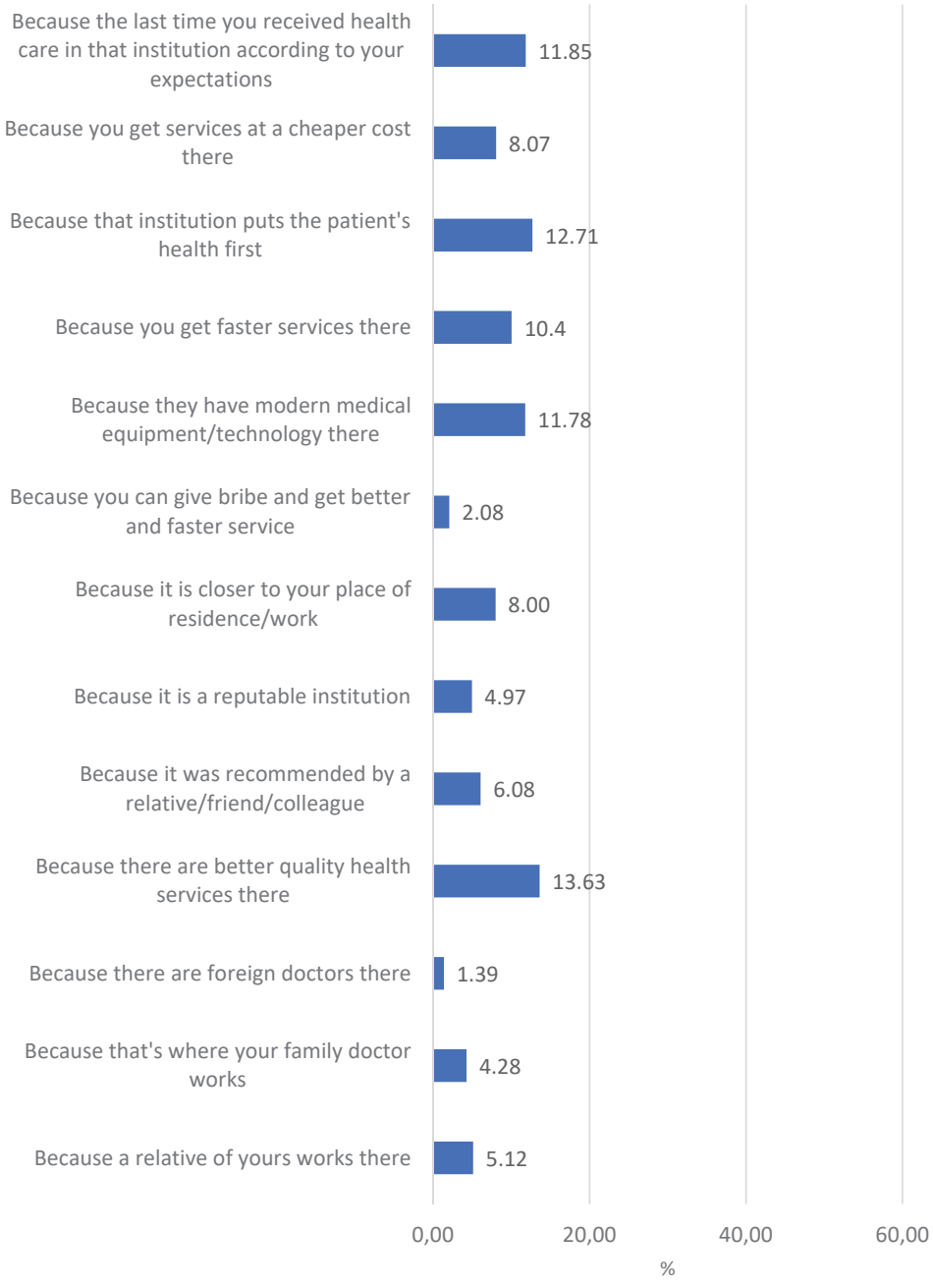


Chart 5. Which of the following reasons best indicates your desire to choose a healthcare institution?

Discussion

The primary finding of this paper indicates that the majority of participants feel that receiving medical care in facilities from a doctor of a different ethnicity or religion has no bearing on their access to those services. One-third of the study's participants stated they don't want to be treated by a doctor who discriminates against patients of different nationalities.

Due to the transferential interaction associated with racial and cultural differences, both patients and therapists may respond to attributes that are not specific to the individual, thus compromising the therapeutic relationship (Qureshi and Collazos, 2011). Additionally, clinicians may exhibit less empathy toward patients of diverse races and ethnic backgrounds and those belonging to low socioeconomic status (Roberts et al., 2021). In the Pollozhani et al. (2013) study conducted in North Macedonia, every third patient who was examined believed that his or her doctor or other medical staff did not understand his or her feelings and did not have the answers to all of his or her inquiries. Migrants and minorities living in a country may face linguistic and cultural challenges to accessing certain healthcare services, such as health promotion facilities, screening services, and specialized care, increasing their risk of poor health status due to a lack of (suitable) care (Dauvrin et al., 2012; Lebano et al., 2020; Pandey et al., 2021).

There are significant issues related to the healthcare services offered to non-dominant cultures in European contexts. According to Suurmond et al. (2010), who carried out studies in the Netherlands, immigrant patients with low Dutch-language proficiency and different illness perceptions and expectations exhibit inappropriate healthcare responses when they deviate from accepted professional default guidelines or norms representing appropriate healthcare. Moreover, the case of the Roma population in Europe shows that culture still presents an essential element connected to the status of one's ethnicity (Ioan et al., 2020). People of racial and ethnic minority groups were found to receive lower-quality healthcare than the majority population, even when they were insured to the same extent and had the same other healthcare access-related variables, such as the ability to pay for care (Beech et al., 2021; Landon et al., 2021). In medical facilities, there can also be a wide range of religious practices among medical doctors. Medical doctors in Indonesia are more influenced in their practice of medicine by their religious beliefs compared to those in India, the USA, Brazil, or Europe (Kørup et al., 2019).

It is known that the relationship between the patient and the healthcare professional is built upon their mutual trust, and this then influences the consistency in treatment and healing. As our community becomes increasingly diverse, communication about health issues may become more difficult; even though a balance between similarities and differences is frequently the secret to healthy, trusting relationships. Multicultural societies mean tolerance, exchange and collaboration, and cooperation among cultures that are present in a social environment, but also in the world, regardless of whether they are the same or different between them. Consequently, for healthcare providers to create a more sustainable multicultural environment, it is recommendable first to identify what types of sociocultural obstacles are present at the organizational level (whole hierarchy), structural (how each process is developed), and clinical level (which includes provider-patient interpersonal relations) (Betancourt et al., 2003).

We discovered that Balkan citizens' levels of trust in medical doctors of all ages and from various levels of healthcare facilities vary. Medical doctors in the 46–55 age group and at tertiary healthcare facilities received the greatest scores for trust. Compared to men, women reported a higher level of trust in medical doctors. According to a study conducted in Brazil by Dagostini et al. (2022), the majority of patients did not have a preference regarding the gender of their physicians; however, female patients were more likely to prefer the services of a same-gender physician than male patients.

Additionally, trust in healthcare organizations and professionals may vary depending on race and ethnicity. In the Schwei et al. study (2014), Mexican-Hispanics and African Americans reported lower institutional trust than whites. We think that the finding in our study that women have higher trust in doctors than males is due to cultural influences, whereas the higher degree of trust in tertiary care facilities stems from the low trust of Balkan citizens in doctors and the health system, as reported by Maljichi et al. (2022).

In this study, we found that Balkan citizens don't prefer to choose a healthcare facility when the facility places the economic benefit and not the patient's health on their priority list, and that they prefer to choose a healthcare facility when the facility offers higher-quality healthcare services. Kobayashi et al. revealed similar findings, demonstrating that patients favored public hospitals over other options and that the quality of the medical institution was thought to be the most crucial factor in choosing a medical institution (Kobayashi et al., 2013). In their article, Street et al. (2012) state that patient choices for healthcare should be taken into account while providing care and making clinical decisions. This complies with the ethical values of respect and autonomy and, in many situations, improves patient outcomes.

Furthermore, in their review, Hoşgör and Gündüz Hoşgör (2019) show that the first three reasons for patients' choice of health institutions are distance to the hospital, recommendation from the neighborhood, and their impression of price affordability. The reputation of a hospital, suggestions from family members and providers of outpatient services, personal experience with a hospital, and the distance from home were also important factors for German patients when choosing a hospital (de Cruppé and Geraedts, 2017). Another study by Palanisamy et al. (2021) showed that the customer's choice was affected by how applicable and pertinent the standardized model was in the healthcare environment, while the patient's gender and age had no bearing on the hospital they chose.

Conclusion

This article demonstrates that the majority of Balkan citizens had no disparities when receiving medical care from a medical doctor of a different ethnicity or religion. About one-third of research participants nurture tolerance and diversity as a behavior culture and do not want to be treated by a doctor who discriminates against patients of different nationalities. Integrating intercultural sensitivity into the training curriculum for healthcare workers can enhance their knowledge and attitudes, mitigate potential prejudices, and increase the quality of patient care.

Author's contributions

DM and *BT* led the conceptualization and design of the study. *DM* led the overall coordination of the study. All authors agreed on the focus of this paper and discussed the analysis approach. *BT* and *DM* led the authorship group, analyzed the data, drafted the first version of the paper, and undertook

final editing and submission. *GQ, IAT, TS, BL, DM, SSZ, AK, IAN*, and *MKO* contributed to the literature review. *GQ, BL, IAT*, and *DM* wrote the introduction. *DM, BL*, and *BT* wrote the methods section. *IAT, SSZ, IAN*, and *MKO* contributed to data interpretation. *GQ, IAT, SSZ, IAN, DM, TS* contributed to the discussion. *DM, BT*, and *GQ* supervised the drafting of this paper. All authors have read and agreed to the published version of the manuscript.

Availability of data

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Ethical aspects and conflict of interest

The authors declare no conflict of interest, financial or otherwise.

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