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Beliefs about informal payments in Albania

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Informal payments for health care are a growing concern in Albania and other transitional economy countries. Recent international studies have shown that informal payments can have negative effects on health care access, equity and health status by causing people to forgo or delay seeking care, or sell assets to pay for care. Many countries are putting in place reforms meant to reduce informal payments. In order to be successful, such policies need to consider people's attitudes and beliefs about the practice. This study collected data from 222 citizens in Albania regarding intentions, past behaviours, attitudes and beliefs about informal payments. Comparing people who intend to make informal payments with people who do not intend to make payments, the study found differences in attitudes as well as beliefs about the consequences of making informal payments, in perceptions about what others think and in control beliefs, but no difference in moral beliefs or demographic characteristics. People who intend to make informal payments the next time they seek care are more likely to believe they will get faster and better quality care than non-intenders, but also think they must pay to receive any care at all. People who do not intend to make informal payments are more likely to report that they have connections with medical personnel, which may be substituting for informal payments. The study has implications for educational campaigns accompanying policy reforms. Campaigns which focus on anti-corruption messages are unlikely to be effective, as moral beliefs do not appear to influence intention.

Key words: health care financing, informal payments, beliefs, behaviour, government health facilities, transition economies

Introduction

Informal payments for health care are a growing concern in many transition economy countries (Balabanova and McKee 2002; Ensor 2004; Gaal and McKee 2005). While some patients give informal payments willingly for reasons such as to express gratitude or expedite care, other patients feel compelled to make these 'unofficial' payments to get quality services or even any care at all. Informal payments can have negative effects on the health and well-being of citizens and the growth of democracy (Ensor 2004; Allin et al. 2006). From both a health and a governance point of view, countries are eager to reduce the incidence of informal payments in government health facilities.

Medical personnel in Albanian government health facilities are paid a salary by the government, and are prohibited from accepting payment from patients. Yet, informal payments in the Albanian health sector are still common: recent studies have estimated 45–67% of patients make informal payments when seeking care at government health facilities (Bonilla-Chacin 2003; Hotchkiss et al. 2004). As reported in other countries where informal payments are prevalent, official user fee policies are often not enforced, and providers appear to be substituting informal fees for formal ones (Gotsadze et al. 2005).

Researchers have applied economic principles and anti-corruption theory in suggesting possible approaches to the problem of informal payments (Ensor 2004; Vian 2005). Yet these theoretical frameworks provide limited socio-cultural insight into the motivations underlying the practice, a prerequisite for effective policy design and implementation. This article reports on a study which examined the role of beliefs and attitudes in predicting intention to make under-the-table payments in Albania. Our findings using behaviour science theory to predict intention to make informal payments are reported elsewhere (Burak and Vian, forthcoming). This article describes people's intentions, past behaviours, attitudes and beliefs about informal payments. In particular, we wanted to see if people who intend to make informal payments in the future are different from people who do not intend to make informal payments, in terms of their beliefs, attitudes, past behaviours and demographic characteristics. The term 'intention' in this sense captures future expectation to perform an act, both in the case where the action is volitional and when the person feels obliged. Analysis of the detailed beliefs helps illuminate the reasons behind people's intentions.

Background

Albania, a nation of 3.1 million, is one of the poorest countries in Europe, with per capita GDP of $4584

(adjusted for purchase power parity) in 2003. Total health care expenditures are very low: public and private spending amounted to only 3% of GDP in 2000 (Nuri 2002). Out-of-pocket expenditures account for 70% of total spending, higher than most other Balkan countries (Bonilla-Chacin 2003).

The health care system has roots in the Soviet 'Semashko' model; through the early 1990s, the Ministry of Health operated and regulated all services. In 1995, a social health insurance programme was put in place which allowed covered individuals to obtain discounted drugs and free outpatient consultations from general practitioners, family doctors and (in the capital of Tirana) some specialists (Bonilla-Chacin 2003). In 2003, 63% of residents in Tirana reported being enrolled in the plan. Most health care services are delivered through government facilities, including approximately 51 hospitals, 564 primary health care centres and 1582 health posts (Nuri 2002). The private sector includes 750 private pharmacies, as well as dentistry services, diagnostic facilities and some specialized outpatient clinics, mostly located in urban areas (Nuri 2002). At the time of this study in 2004, there were no private hospitals.

Conceptual framework

The determinants of informal payments have been considered through multiple lenses. Using an economic model, Ensor (2004) categorized informal payments as contributions toward the cost of care (closing the 'budget-cost gap'), payments for additional services (beyond the 'essential package' guaranteed by government), and misuse of power or market position (corruption). Ensor analyzed the failures of government which can promote informal payments, including failure to provide adequate funding for essential care packages and failure to regulate, which creates room for additional service payments or abuse of power. Gaal and McKee (2005) add other important dimensions to the conceptual framework of informal payment motivations, examining motivation from a legal-ethical and socio-cultural viewpoint, as well as economic factors. Legal-ethical drivers include lack of accountability and low moral standards, while socio-cultural dimensions relate to expressing gratitude, tipping and resistance to change.

In designing reforms to reduce informal payments, policies which consider current attitudes and beliefs about informal payments are more likely to be successful. For example, examining evidence from Poland, Chawla et al. (1998) note that reforms to provider payment systems must convince physicians to give up the high revenue they earn through informal channels, and patients must be convinced that they will still be able to access care and receive quality services without making informal payments. The authors comment that, 'In a system where both physicians and patients have come to understand the advantages of informal payments, any change therein may require many attitudinal adjustments'. Similarly, Ensor (2004) notes that a newspaper in Kazakhstan printed the results of informal payment surveys, naming the hospitals involved. Ensor cautions that in order for such a policy of public disclosure to work as a disincentive to informal payments, 'payments must be seen by consumers to be unambiguously a bad thing'. If, on the other hand, people are making informal payments as a way to receive faster care or better quality, they may actually prefer to go to the hospitals that accept informal payments. Rather than reducing under-the-table bribes, such a policy might actually increase them (Ensor 2004).

By applying a theoretical framework, we can begin to understand the contribution of different beliefs, norms and perceptions to the practice of informal payments. The research team used expectancy-value theory as a guide in designing the study (Janz et al. 2002). In explaining and predicting motivation and behaviour, expectancy-value theories posit that people perform behaviours in response to their beliefs and values, and the behaviours are undertaken to achieve some end. Fishbein and Ajzen's theories of reasoned action and planned behaviour identify beliefs as the antecedents of attitudes, intentions and behaviours (Ajzen and Fishbein 1980). According to the theories, the beliefs that underpin behaviour include beliefs about the outcomes of the behaviours in question (beliefs about consequences), perceived beliefs of referent individuals about the behaviours (social beliefs), and beliefs about resources, opportunities and cooperation of others (control beliefs) (Ajzen and Madden 1996). Others have expanded the constructs of this theory to include moral beliefs as well (Randall and Gibson 1991; Kurland 1995).

In applying behavioural theory to the practice of informal payments, we are not denying the important role organizational level factors and governance play in facilitating or hindering informal payments. On the contrary, such factors can influence people's intention to make informal payments by affecting beliefs about consequences, social beliefs or perceived behavioural control, as we discuss later in the paper.

Finally, we decided to restrict the study to informal payments given in a non-gift context, and in government health facilities. As in other Eastern European countries, Albanian citizens and policy makers are more tolerant of 'gratitude payments', or informal payments that are meant to be gifts indicating gratitude (Gaal and McKee 2005). To clarify the focus of our study, therefore, we instructed respondents that the study was only about 'cash or in-kind payments for services that were supposed to be offered free of charge' at government health facilities, and not about 'gifts given freely to express thanks or gratitude'. We explained that under-the-table payments were usually given before or during the health services. As the private sector was very small at the time of the study (including mainly dentist clinics and pharmacies), virtually all respondents were users of government health facilities.

Methods

The research team conducted an anonymous, convenience survey of 222 respondents in the Albanian capital city of Tirana. The research was conducted in June 2004 with funding from Boston University School of Public Health and Bridgewater State College, Massachusetts, USA. We recruited participants from 11 sites around the city that were purposely chosen to be socio-demographically diverse, including commercial and residential areas, urban and suburban areas, working class and more affluent areas. Study participants were recruited in parks, cafes, market areas, public squares, a playground, a bus depot and the grounds of a hospital.

We drew on recent qualitative research on this topic in Albania to develop questions in the 64-item survey instrument (Vian et al. 2006). Following the process and format commonly used for questionnaire development in the theory of planned behaviour research, we included questions about intention, attitudes, beliefs about consequences, social norms and normative beliefs (grouped under the heading 'social beliefs'), perceived behavioural control and beliefs about resources ('control beliefs'), and moral view or perspective ('moral beliefs'). Other questions addressed history of care-seeking behaviour, and past behaviour related to giving informal payments. We also measured a limited number of demographic characteristics including age, gender, education, health status, civil status and residence. We did not collect information on income or occupation.

To measure intention, we asked respondents about their reported likeliness to give an informal payment the next time they went to a government health facility. People who stated they were likely or very likely to give were put in one group ('intenders'), while those who said they were unlikely or very unlikely to give comprised a second group ('non-intenders'). Respondents who were undecided fell into a third group.

Attitudes were assessed via five-point semantic differential scales, measuring directionality in each contrasting pair of adjectives (e.g. good versus bad) as well as intensity of association. We measured whether informal payments were perceived to be good/bad, necessary/unnecessary, important/unimportant, worthwhile/worthless or beneficial/harmful. Using factor analysis, researchers have shown that these bipolar adjectives are consistently reliable measures of attitude (Osgood et al. 1957). Beliefs were assessed using yes/no items and Likert-type items expressing agreement or disagreement on a five-point scale from strongly agree to strongly disagree.

The questionnaire was translated into Albanian, and then back-translated into English to ensure the accuracy of translation. We field tested the instrument in the US with 20 recent immigrants from Albania. The instrument was pilot tested again in Tirana, with 14 citizens.

Albanian research assistants approached individuals and asked if they would be willing to complete a self-administered survey regarding the practice of giving informal payments for health care in government facilities. The research assistants told individuals that the survey was anonymous and would take 15–20 minutes. Those who agreed were given a written explanation of informed consent and a survey to complete. The research assistants orally defined some terms such as 'informal payment' (*shpërblim nën dorë*) and 'government health facility' (*qendër shëndetësore shtetërore*) and instructed respondents that the term 'informal payment' did *not* include gifts (*dhuratat*) given freely to express thanks or gratitude. The research assistants then waited for the participants to complete the surveys and sealed the completed surveys in envelopes. Of the 275 people approached, 222 agreed to participate in the survey, resulting in a response rate of 80.7%.

In analyzing the data we compared demographic characteristics of intenders versus non-intenders, looking at gender, age, marital status, education and self-assessed health status. We also compared past experience with seeking care and informal payments. In addition, we calculated average scores for attitudes and beliefs by item, with 5 = strongly agree and 1 = strongly disagree. Negative beliefs (e.g. those capturing the disadvantages of informal payments or less in favour of informal payments) were reverse scored. For example, the belief that informal payments are humiliating was reverse scored: a response of 'strongly agree' was scored 1, whereas strongly disagree was scored 5. Item scores were also calculated by category of belief (with the exception of control beliefs, as explained in the results section). A lower score indicated less positive beliefs, while a higher number indicated more positive beliefs.

For attitude and belief scores, we calculated mean scores of intenders and non-intenders and compared them looking for significant differences. Looking in detail at attitudes, we analyzed the distribution of responses for each attitude item measured. We also examined individual beliefs about consequences, and moral, social and control beliefs, comparing intenders with non-intenders and performing the chi square test of independence.

In a separate analysis, we used multiple regression analysis to predict intention to make under-the-table payments at government health facilities. As described in an earlier paper, our analysis found that constructs of the theory explained 34% of the variance in intentions to make informal payments, with attitude toward the behaviour making the strongest contribution (Burak and Vian, forthcoming).

Results

Of the 222 participants who filled out the questionnaires overall, 47.3% were female. Forty-six per cent of all respondents were heads of household, while 65.3% of all

respondents were married. Education levels were relatively high, with 43% having attained college or graduate education and an additional 41.6% having finished high school. Over two-thirds of participants reported being in good to excellent health, while less than one-third reported fair to poor health. About 42% of respondents had sought care at a government health facility within the last month.

Intention

In response to the question 'How likely is it that you will give an informal payment the next time you go to a government health facility? [very likely = 5, very unlikely = 1]', 67% of respondents said it was very likely or likely they would give an informal payment (intenders), while 23% thought it was very unlikely or unlikely (non-intenders). Ten per cent of respondents were undecided.

Analyzing intenders versus non-intenders, we found no significant differences in demographic characteristics between those who said they were likely to give an informal payment versus those who were not likely to give. In addition, there were no significant differences in past care-seeking behaviour (see Table 1).

There were, however, significant differences between intenders and non-intenders in past behaviour regarding informal payments (Table 2). Respondents who had made an informal payment before were significantly more likely to report they intended to give an informal payment in the future. As noted earlier, respondents were instructed not to consider gifts when answering questions, so these informal payments include only fee-for-service payments and not 'gratitude' payments. Intention to make an informal payment is significantly correlated with past experience making informal payments ($P < 0.01$).

Table 1. Demographic characteristics of sample

	Total	Intenders	Non-intenders
Gender			
Male	52.7%	53.4%	41.1%
Female	47.3%	46.6%	52.9%
Mean age (range 19–83)	40.3	38.5	44.7
Marital status			
Married	65.3%	66.4%	62.3%
Never married	24.2%	24.6%	21.6%
Widowed	6.4%	4.7%	9.8%
Divorced	3.6%	4.1%	3.9%
Head of family	53.4%	53.7%	50.1%
Education			
Grade school	15.4%	14.1%	17.6%
High school	41.6%	46.6%	31.3%
University	36.2%	33.8%	37.2%
More than university	6.8%	5.4%	11.8%
Health status			
Excellent	6.8%	6.7%	3.9%
Very good	24.4%	22.9%	25.4%
Good	40.3%	39.9%	43.1%
Fair	21.7%	23.6%	19.6%
Poor	6.8%	6.1%	7.8%
Last sought care at government health facility			
<1 month ago	41.9%	42.3%	43.1%
>1 month ago	55.4%	57.6%	56.8%

Attitudes and beliefs

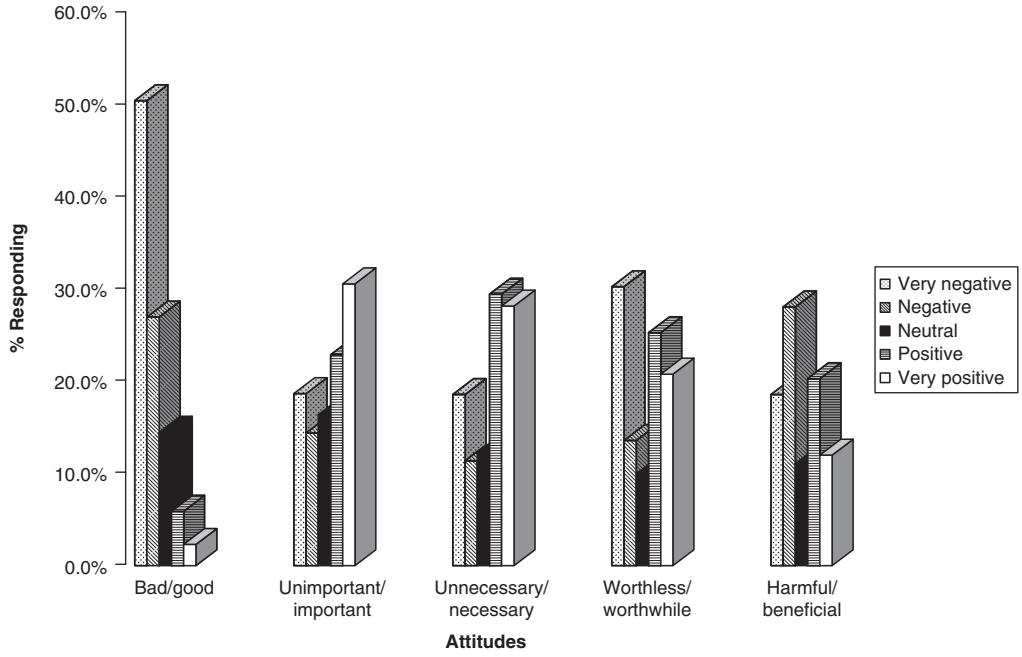
As mentioned above, we used five bipolar adjectives that other researchers have found to be consistently reliable measures of attitudes about a wide range of things from smoking to cheating on tests or buying organic vegetables. In this study, the internal consistency reliability of attitude measures was good (Cronbach's alpha 0.77). The reliability coefficient for the eight beliefs about consequences was similar ($\alpha = 0.78$) and the coefficient for the five social beliefs was also high ($\alpha = 0.89$). Internal consistency was lower for the five moral beliefs ($\alpha = 0.41$). The individual items measuring control beliefs and perceived resources or opportunities to make informal payments did not comprise a single construct. The reliability coefficient for all seven control belief items was 0.29, therefore we have not analyzed differences between intenders and non-intenders for control beliefs as a whole, but present findings for individual items.

Table 3 shows the mean attitude and belief scores for intender respondents compared with non-intenders. People who intended to make an informal payment the next time they sought care at a government health facility had more positive attitudes about informal payments than people who were unlikely to give (15.02 vs. 12.22, $P \leq 0.001$). They also had more positive beliefs about the consequences of making an informal payment and more positive social beliefs, both significant at the $P \leq 0.001$ level. There was no significant difference in moral beliefs between people who intended and who did not intend to make informal payments. Those who intend to make informal payments and those who do not intend to make informal payments have similar beliefs about the rectitude of this practice, and views about whether the practice is illegal or unethical do not seem to influence people's intention to make an under-the-table payment.

Figure 1 shows the distribution of responses to the attitude items on the questionnaire. The graph shows the range of responses to each attitude pair, from very

Table 2. Informal payment-making history of intenders vs. non-intenders

	Intenders (n = 147)	Non-intenders (n = 50)	χ^2 P value
Have ever given informal payment at government health facility			
Yes	91.2%	42.0%	0.000
No	8.8%	58.0%	0.000
Gave informal payment at last visit to government health facility			
Yes	80.8%	29.8%	0.000
No	19.2%	70.2%	0.000
Gave informal payment in last 30 days (if sought care in last 30 days)			
Yes	74.2%	26.7%	0.000
No	25.8%	73.3%	0.000



Note: Attitudes are assessed on scale from very negative to very positive. For example, for 'Bad/good' attitude, 50.5% of respondents responded that making an informal payment is 'very bad'; 27% 'bad'; 14.5% 'neither good nor bad', 5.9% 'good', and 2.3% said 'very good'.

Figure 1. Attitudes on making informal payments in government health facilities

Table 3. Mean attitude and belief scores of intenders vs. non-intenders

	Total	Intenders	Non-intenders
Attitudes (range 5–25)	14.12 (sd = 5.05)	15.02 (sd = 5.08)*	12.22 (sd = 4.20)
Beliefs about consequences (range 8–38)	25.94 (sd = 4.54)	27.06 (sd = 3.94)*	22.76 (sd = 4.96)
Moral beliefs (range 5–25)	11.68 (sd = 3.81)	11.65 (sd = 3.96)	11.48 (sd = 3.58)
Social beliefs (range 4–25)	10.91 (sd = 5.47)	11.64 (sd = 5.77)*	8.68 (sd = 4.08)

*$P \leq 0.001$.

negative (e.g. very bad, very unimportant, very worthless) to very positive (e.g. very good, very important, very worthwhile). Attitudes toward informal payments were consistent with the exception of 'good/bad'. While fewer than 10% of respondents said making an informal payment was good or very good, close to 60% of respondents thought making informal payments was necessary or very necessary. About a third of respondents thought making informal payments was beneficial or very beneficial.

Beliefs about consequences

We measured eight beliefs about consequences, including two positive beliefs – that informal payments lead to faster care and better quality care – and six negative beliefs: if you do not give an informal payment you will not get any medical attention at all, informal payments are a financial burden, making informal payments is humiliating, making informal payments feels uncomfortable, informal payments are necessary because doctors 'look you in the hands' (as explained by Vian et al. 2005, this statement captures the belief that providers expect payment from patients), and that not giving an informal payment makes people feel afraid.

Individuals who intend to make informal payments subscribe to both the positive as well as the negative outcomes of giving informal payments, as shown in Table 4. They believe they will get quicker and better care, but they also believe that they must pay in order to get medical attention, and they feel uncomfortable and afraid.

Compared with intenders, non-intenders are less likely to believe informal payments will have positive consequences. For example, 53.1% of non-intenders agreed that making an informal payment results in faster care,

Table 4. Beliefs about making informal payments at government health facilities by intenders vs. non-intenders

Beliefs	Intenders			Non-intenders			χ^2
	Strongly agree or disagree	Total	Percentage of intenders	Strongly agree or disagree	Total	Percentage of non-intenders	*P* value
Beliefs about consequences: Making informal payments...							
Improves quality of care	123	148	83.1	25	50	50.0	0.000
Results in being seen more quickly	128	148	86.5	26	49	53.1	0.000
Is required in order to get any attention	125	148	84.5	34	50	68.0	0.020
Is a financial burden	131	148	88.5	39	50	78.0	0.093
Is humiliating	85	148	57.4	34	50	68.0	0.172
Feels uncomfortable	122	147	83.0	38	50	76.0	0.300
Is required because medical personnel 'look you in the hands'	126	148	85.1	28	50	56.0	0.000
Not making an informal payment makes me afraid	119	147	81.0	21	50	42.0	0.000
Moral beliefs: Making informal payments...							
Is wrong	123	147	83.7	37	50	74.0	0.157
Is illegal	113	147	76.9	35	50	70.0	0.349
Is ethical	46	146	31.5	11	49	22.4	0.200
Makes me feel guilty	59	145	40.7	23	50	46.0	0.514
I feel guilty NOT giving informal payments	46	147	31.3	13	50	26.0	0.467
Social beliefs:							
People I know think I should make informal payments	53	147	36.1	7	50	14.0	0.000
People important to me think I should make informal payments	55	148	37.2	7	50	14.0	0.000
My spouse thinks I should make informal payments	30	113	26.5	4	32	12.5	0.044
My family thinks I should make informal payments	21	148	14.2	2	50	4.0	0.004
My friends think I should make informal payments	46	148	31.1	4	49	8.2	0.000
Control beliefs:							
The decision to make informal payments is up to me	47	148	31.8	25	50	50.0	0.023
I can choose whether or not to make informal payments	43	146	29.5	29	50	58.0	0.000
I don't have to give informal payments if I don't want to	85	146	58.2	33	49	67.3	0.244
Making informal payments is easy for me to do	74	148	50.0	17	50	34.0	0.042
It is easy for me to avoid making an informal payment	25	148	16.9	28	50	56.0	0.000
The money I have to live is enough	40	146	27.4	19	50	38.0	0.172
I have relationships with medical personnel	38	145	26.2	22	50	44.0	0.024

compared with 86.5% of intenders. Likewise, non-intenders are less likely to believe in some of the negative consequences of informal payments; 42% of non-intenders would be afraid if they did not make an informal payment, compared with 81.0% of intenders. Slightly more than half of non-intenders (56.0%) believe that informal payments are necessary because medical personnel 'look you in the hands', compared with 85.1% of intenders.

Moral beliefs

The majority of respondents see the practice of informal payments as morally problematic. For example, about three-quarters of all respondents agreed that it is wrong and illegal to give informal payments in government health facilities, and only 29% agreed they are acting ethically when they give an informal payment. Moral beliefs is the only category of beliefs where we did not find statistically significant differences between intenders and non-intenders, as shown in Table 4.

Respondents did not feel much guilt over the practice of informal payments. Less than half of respondents agreed that they felt guilty giving informal payments; even fewer (28%) felt guilty *not* giving informal payments. Qualitative research suggested that people might feel obliged to make informal payments to contribute to the cost of their care, because medical staff of government health facilities are not well paid.

Social beliefs

Less than one-third of all respondents agreed that people they know or people important to them think they should make informal payments. At the same time, there were significant differences between intenders and non-intenders, as illustrated in Table 4. For example, over 37% of intenders reported that people who are important to them want them to make informal payments, compared with only 14% of non-intenders. Friends seem to be an important influence on social norms: 31.1% of intenders agreed that friends want them to make informal payments, compared with 8.2% of non-intenders ($P<0.001$).

Control beliefs

Most non-intenders agree that they do not have to give an informal payment if they do not want to (67.4%), that they can choose whether or not to make an informal payment (58.0%), and that it is easy for them to avoid making an informal payment (56.0%). Some beliefs about resources related to informal payments seem to influence intention. Qualitative research findings from Albania (Vian et al. 2006) have suggested that medical personnel are less likely to ask for informal payments from people they know and with whom they have social relationships, and our findings support this. For example, non-intenders are more likely to agree that they have relationships with medical personnel (44.0%, versus 26.2% for intenders). Having friends or kin who are medical personnel may enhance perceived control over the decision to make an informal payment.

On the other hand, intenders believe it is difficult to opt out of the practice of informal payments. Only 16.9% agreed or completely agreed that it would be easy to avoid making an informal payment, while less than a third of respondents reported they could choose whether or not to make an informal payment.

Discussion

Similar to findings from other studies of out-of-pocket expenditures in Albania, the results of this study show that a majority of respondents have made informal payments for health care in the past (77%), and most intend to make informal payments in the future (67%). Our study is unique in that we specifically asked respondents not to include gifts, or gratitude payments, when considering informal payments. Gaal and McKee (2005) note that it is important to separate these two kinds of payments, as policy interventions to address each of them may differ. In addition, our study's focus on socio-cultural motivations provides several observations which are useful for policy debate, as described below.

Drivers of informal payments

First, the study found no significant differences in demographic characteristics between intenders and non-intenders. Study respondents' intention to make an informal payment does not appear to be affected by whether they are young or old, male or female, educated or uneducated, healthy or unhealthy. This is somewhat surprising, as one might expect that young people who have spent more of their adult years in a market economy might be more inclined to make informal payments, or that people with higher education might be less inclined to make informal payments because they are more aware of their entitlements as citizens or have connections (discussed further below). The study also found that intention to make an informal payment is unaffected by whether or not the respondent recently sought care at a government health facility. One might have expected that people with recent care-seeking experience would have a better appreciation of the high prevalence of informal payments in current medical practice, and might therefore be more inclined to make an informal payment in the future. To safeguard confidentiality, the study did not collect demographic information on income and occupation. Future research should explore ways to collect information about these potentially moderating variables without increasing reticence of respondents.

Our study did find that beliefs about the consequences of informal payments, as well as social beliefs and some individual control beliefs, are related to intention. Looking specifically at the beliefs about consequences, the findings suggest that the practice of informal payments in Albania is driven by two kinds of factors: informal

payments which are given to obtain a benefit or privilege ('positive gain informal payments'), and informal payments given because the patient perceives that informal payments are obligatory in order to receive care ('compulsory informal payments'). People who intend to make informal payments in the future are more likely to believe they will get faster and better quality care. They appear willing to pay for this perceived advantage through 'positive gain informal payments'. At the same time, several negative beliefs are also significant. As has been documented in Hungary, fear plays an important role in motivating informal payments as patients try to 'alleviate their overwhelming defenselessness with money' (Antal cited in Gaal and McKee 1991). Thus, Albanian respondents who intend to make informal payments are more likely to report that they would be afraid if they did not make them, and to believe that they will not get any medical attention unless they make informal payments. When seeking care at government health facilities, respondents with these beliefs are likely to make 'compulsory informal payments'.

The paradox of 'bad' but 'important'

The combination of these two motivational forces creates a paradoxical result: although most respondents perceived the practice of informal payments as 'bad', 'wrong' and 'illegal', over half of respondents thought informal payments were 'important' and 'necessary', and a third felt they were 'beneficial' and 'worthwhile'. This leads us to the second important observation in our study: beliefs about the propriety of making informal payments do not seem to matter. Moral beliefs had no influence on intention to make informal payments.

Yet, public education campaigns to combat informal payments in Albania have appealed in large part to these moral beliefs: for example, some non-governmental organizations have distributed posters to hospitals with messages such as 'Bribes are corruption'. A similar approach has been used in Australian media campaigns to combat movie piracy. Based on the assumption that people do not realize that buying pirated movies is wrong, the Australian campaign promotes the message that 'Piracy is illegal' in trying to curb the practice. Yet, the findings of this study suggest that people already believe that informal payments are wrong; thus, trying to convince people that informal payments are corruption will have little effect in reducing the practice.

Instead, behaviour change strategies might be better focused on breaking the chain of belief that says you must make informal payments to get good care, and you will suffer if you do not. This would involve convincing people that medical personnel in government health facilities are adequately paid through official channels, that people can get quality care without making informal payments, and that medical staff will be punished for having their hands out to extort further payment from patients.

Regarding compensation of personnel, many have argued that low salaries can cause informal payments to flourish (Soeters and Griffiths 2003; Ensor 2004; Gaal 2006). Qualitative data from Albania show that people may feel obliged to make informal payments because staff are inadequately paid, as indicated by this quote:

> 'The government should increase the doctors' salaries. After that, it will be the people's turn to say 'no' to these payments. The salary doctors get is not enough.' (Vian et al. 2004)

While our study did not explicitly ask people about beliefs related to provider payment, such beliefs may be influencing observed attitudes, perceived control and intention. Evidence from Cambodia (Soeters and Griffiths 2003; Akashi et al. 2004; Barber et al. 2004), Colombia and the Czech Republic (Vian 2005) and Kyrgyz Republic (McEuen 2004) suggests changes in payment systems, including increased salaries, can decrease informal payments. The Albanian government has plans to reform provider payment systems (Fairbanks 2004; Cook et al. 2005). Given that policies are already in place in Albania to allow official user fees, including the ability for a facility to retain revenue and share it with individual providers, the problem may be more one of effective implementation.

For the second premise, publicized quality improvement programmes with transparent reporting could help to convince patients that they will get quality care without making informal payments. Albania is working on health reforms in this area, as well.

Finally, there must be consequences for physicians who insist on informal payments. If people know that a doctor can be punished for accepting informal payments, they are likely to feel more in control over the decision to give an informal payment or not.

It's who you know

Another important implication of this study concerns control beliefs. We were surprised to find that intention to make an informal payment was not significantly related to perceived financial means, suggesting that people who perceive they can afford informal payments are no more likely to make informal payments than people without adequate financial resources. Instead, we found that perception of relationships with medical personnel – a control belief – was significant. You are less likely to make an informal payment if you know someone: 44% of non-intenders reported that they had relationships with medical personnel, compared with only 26% of intenders ($P < 0.05$). This finding is in line with other research which has identified the importance of informal connections in care-seeking behaviour in Russia (Brown and Rusinova 1997) and in exemption from formal user fees in Cambodia (Soeters and Griffiths 2003). Connections with doctors or other medical staff could be a substitute for making informal payments, perhaps because networks

of reciprocal obligation will provide an equivalent benefit to medical personnel later, or because medical personnel are ashamed to ask for informal payments from patients who know them socially (Vian et al 2004). If true, a health policy promoting use of family doctors who are well known and perceived as friends and allies – and adequately paid – could help to reduce the practice of informal payments. At the hospital level, it is not clear whether a patient referred by her family doctor might benefit from a connection between the referring doctor and the hospital specialist. Further research is needed on the topic of connections and their role in informal payments.

More methodological work is needed to improve the construct of control. Although the questions meant to capture respondents' perceived behavioural control appear to be measuring the same thing (i.e. 'the decision to make informal payments is up to me', 'I can choose to make informal payments', 'I don't have to give if I don't want to', 'making informal payments is easy', and 'it is easy for me to avoid making informal payments'), we may not have achieved full cross-cultural equivalence in the survey translation of the questions.

This study has several limitations. The convenience sampling methodology does not allow us to generalize findings within or outside of Tirana. Beliefs and intentions of rural patients or patients from smaller cities may be different. The study also was not designed to solicit opinions of medical personnel, whose perspectives are likely to be different yet equally influential. Finally, although researchers made special efforts to put respondents at ease and to assure them that they could not be identified, some respondents may have been reticent. Still, the findings support many beliefs identified previously through qualitative research.

Conclusion

There are no records of informal payments, only memories, a fact which complicates policy analysis and makes the pursuit of evidence-based reform strategies difficult. Our most important tools for conducting policy research on informal payments involve surveys and interviews, as we cannot easily use administrative data to measure prevalence and explore causes. Using a confidential survey research approach, this study has attempted to shed some light on basic assumptions about what motivates people to give or not to give. Changing policies may be easier than changing beliefs: yet both are essential steps in curbing the practice.

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