

Examining and Predicting Under-the-Table Payments for Health Care in Albania: An Application of the Theory of Planned Behavior¹

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The World Bank and the Albanian Ministry of Health report that the majority of Albanian citizens make illegal, under-the-table payments for health care. Qualitative studies have identified some factors associated with these informal payments, but the problem has not been systematically examined using established theoretical models. The purpose of this study was to examine and predict under-the-table payments using the theory of planned behavior (TPB). Self-administered surveys were completed by 222 Albanian citizens. The constructs of the theory explained 34% of the variance in intentions to make under-the-table payments, with attitude toward the behavior making the strongest contribution. Using the TPB to examine the practice of making under-the-table payments has indicated specific areas that can be targeted by policy interventions.

Informal payments to medical personnel in Albanian government health facilities are high, despite the country's stated policy of providing most health-care services free of charge. Using Living Standards Measurement Survey data from 2002, a World Bank study (Bonilla-Chacin, 2003) reported that 67% of people who had been hospitalized in the previous 4 weeks had made informal payments for health-care services. In a 2000 study, 80% of patients reported making informal payments in primary-care settings (Albania Ministry of Health, 2000).

While it is difficult to gather empirical data on informal payments because of their illegal or quasi-legal status, concerns about the potential negative

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effects of informal payments have led to an increase in research on the topic in the last few years (Ensor, 2004). Negative health effects of informal payments have been documented in numerous countries (Balabanova & McKee, 2002; Belli, Shahriari, & Curtio Medical Group, 2002; Ensor, 2004; Ensor & Savelyeva, 1998; Lewis, 2000; Thompson & Witter, 2000). Thompson and Witter noted the negative effect of informal payments on equity of service provision in central Asia, and researchers in Tajikistan (Falkingham, 2004) found that out-of-pocket expenditures, many of which were informal payments, were affecting access to care, as poorer people delayed seeking medical care or reported going into debt to pay for the care they needed.

Qualitative studies have been conducted in Albania, Bulgaria, and Georgia to gain a better understanding of people's views about under-the-table payments, why they make them, and how they perceive the consequences of giving or receiving informal payments (Albania Ministry of Health, 2000; Balabanova & McKee, 2002; Belli et al., 2002; Vian, Gryboski, Hall, & Sinoimeri, 2004). Some factors that seem to influence informal payments in these countries include a desire to get better quality care or faster service, a perception that government health systems are underfunded and medical personnel are underpaid, fear of being denied treatment, and a social norm to give a gift or tip to someone who provides a service.

In order to address the problem of informal payments, health-reform planners in many countries are promoting policies such as formalizing fees or increasing regulatory controls. Yet, these strategies for health reforms are based only on qualitative data about the factors influencing people's actions. To date, there has been little effort to systematically apply theoretical models to examine and predict behavior concerning informal payments.

Increased understanding of the relative influence of motivational factors is essential in order to change people's behavior. The current study is designed to examine how attitudes and beliefs affect the intentions and behaviors of Albanian citizens in making informal payments for health services in government health facilities.

Theory of Planned Behavior

In the present study, we use the theory of planned behavior (TPB), a behavioral decision-making model developed by Ajzen (1988; Ajzen & Madden, 1986), to help explain the practice of making informal payments. The TPB incorporates three directly measured constructs and three belief-based indirect constructs to describe and predict social behavior. Developed as an extension of the theory of reasoned action (Ajzen & Fishbein, 1980), the TPB begins with the premise that behavior is determined directly by intention.

According to the TPB, a person's *intentions*, or personal motivation to perform a behavior, are a function of his or her attitudes toward that behavior, subjective norms (i.e., the person's perceptions of what important others think about the behavior), and perceived behavioral control (PBC; i.e., the person's belief as to how easy or difficult the performance of the behavior is likely to be). Attitudes, subjective norms, and PBC, in turn, are influenced by a person's beliefs and the evaluation of those beliefs. The beliefs that influence attitudes are examined in terms of the subjective probability that performing a behavior will result in certain outcomes or consequences, as well as the evaluation of these outcomes/consequences. Subjective norms are influenced by *normative beliefs*; that is, the perceived beliefs of specific important individuals about performing or not performing the behavior, as well as motivation to comply with what others believe one should do. PBC is influenced by beliefs that have to do with the perceived presence of factors that may facilitate or inhibit performance of a behavior, such as confidence in one's ability to act, or perceived ease or difficulty in performing the behavior.

International Applications of the Theory of Planned Behavior

While the TPB has been used successfully to describe and predict a wide range of health-related, teaching, business, social, and ethical behaviors and to frame interventions to address these behaviors (Astrom, Jackson, & Mwangosi, 2000; Babrow, Black, & Tiffany, 1990; Beck & Ajzen, 1991; Boudreau, Godin, Pineau, & Bradet, 1995; Burak, 1994, 2002; Godin et al., 1996; Kurland, 1995; McCaul, Sangren, O'Neill, & Hinsz, 1993; Raats, Shepherd, & Sparks, 1995; Schifter & Ajzen, 1985; Sparks & Shepherd, 1992), it has been used less frequently in international settings and with minority or non-Western populations. International settings where the model has been applied include Benin (Hounsa, Godin, Alihonou, Valois, & Girard, 1993), Zimbabwe (Wilson, Zenda, McMaster, & Lavelle, 1992), Tanzania (Astrom, 2000; Masalu & Astrom, 2003), Taiwan (Lam, 1999), and immigrant subpopulations in Canada (Godin et al., 1996). Studies in these settings have shown that the model can be used successfully to predict intention, but that some adaptations may be needed. A review of the literature did not locate published studies in which the TPB was used to explain behavior or to predict intentions in countries with a transitional economy.

Predicting and Explaining Illegal Behavior

Testing the applicability of the TPB in the prediction of illegal payments for health care is an important step in understanding informal payment

behavior. Although there is limited literature on the application of the TPB to the intention to act illegally, there have been some studies of ethical decision making. Applying theory to business ethics decisions, Kurland (1995) tested whether the theories of reasoned action and planned behavior would predict the intentions of 144 U.S. insurance sales agents to disclose ethically relevant information about a product before recommending it to clients, even when this behavior might have conflicted with the agents' own self-interest. The study included a measure of *moral obligation*, which is defined as "the duty or obligation to the client that is sanctioned by one's conscience as right" (Kurland, 1995, p. 299). The modified TPB model, including perceived moral obligation, explained 58% of the variance, compared to 46% without the moral belief construct.

In their study of ethical decision making in the medical profession, Randall and Gibson (1991) predicted the intentions of 116 nurses to report colleagues for inadequate patient care. The study found that TPB variables explained 61% of variance in intention to report a colleague, with attitude having the strongest impact, followed by subjective norm. PBC had no significant impact, which the researchers attributed to instability of the variable or the volitional nature of the ethical decision being studied. The authors hypothesized that PBC might be more important where a strong unethical work climate exists, making people feel that they have little choice but to participate in unethical behavior.

Like Kurland (1995), Randall and Gibson (1991) included a direct measure of moral obligation to predict intention. Moral obligation was related significantly to intention, and significantly increased the explained variance. The researchers suggested that in applying the TPB to ethical decision making, it is wise to include a single variable measuring moral norms or to incorporate this as a behavioral belief (Randall & Gibson, 1991).

Beck and Ajzen (1991) used the TPB to predict intentions of 146 college students to engage in dishonest actions, such as cheating on a test, shoplifting, and lying. The TPB explained 62% to 69% of the variance in intention to engage in the dishonest actions. PBC was the only variable to be significant across all three types of actions. A measure of perceived moral obligation helped to improve the predictive accuracy of the model with statistical significance, but the improvement was modest (3%–7%).

While nominally illegal in Albania, the practice of informal payments is widespread and openly discussed. Currently, there are no punishments imposed on people who make informal payments. One assumption in using the TPB to predict intentions to make informal payments in Albania is that the behavior of giving an informal payment will not be seen as personally incriminating, and self-reports will not distort the results.

Method

Procedure

Study participants were a convenience sample of residents of Tirana, the capital of Albania. An effort was made to capture the diversity of the population of Tirana, so participants were recruited from 11 sites around the city. The sites covered all of the geographic areas of Tirana. In addition, the 11 sites included commercial and residential areas, urban and suburban/quasi-rural areas, economically disadvantaged areas, working-class areas, and more affluent areas.

Study participants were recruited in parks, cafés, market areas, public squares, a playground, a bus depot, and the grounds of a hospital. Albanian research assistants approached individuals in these areas and asked if they would be willing to complete a self-administered survey regarding the practice of giving under-the-table payments for health care in government facilities. The research assistants informed individuals that the survey was anonymous, and that there would be no way to identify study participants. The assistants also informed prospective participants that the survey would take 15 to 20 min to complete. Those who agreed were given a letter of informed consent and a survey to complete. Although the terms *under-the-table payment* and *government health facility* were defined in the survey introduction (as well as in the letter of informed consent), the research assistants also defined the terms orally and provided instructions for completing the survey. The research assistants then waited for the participants to complete the surveys and sealed the completed surveys in envelopes. Of the 275 people who were approached, 222 agreed to participate in the survey, resulting in a response rate of 80.7%.

Participant Characteristics

Questionnaires were completed by 222 individuals (117 male, 52.7%; 105 female). Participants ranged in age from 19 to 83 years, with a mean age of 40.3 years ($SD = 14.85$). The majority of participants were married ($n = 143$; never married, $n = 53$; widowed, $n = 14$; divorced or separated, $n = 8$; marital status not indicated, $n = 4$). Nearly half of the respondents ($n = 101$) reported being the heads of their families. Participants' educational level varied: 14.9% ($n = 33$) had completed primary school, 41.4% ($n = 92$) had completed high school, 36.0% ($n = 80$) had completed college/university, and 6.8% ($n = 15$) reported an educational level higher than college/university (2 participants did not indicate educational level). Self-reported

health status also varied and was distributed normally: 6.8% ($n = 15$) of participants reported excellent health, 24.3% ($n = 54$) indicated that their health was very good, 40.1% ($n = 89$) reported good health, 21.6% ($n = 48$) indicated fair health, and 6.8% ($n = 15$) reported poor health (1 participant did not indicate health status).

Measures

The components of the TPB were operationalized into a 64-item questionnaire that was constructed according to guidelines proposed by Ajzen and colleagues (Ajzen, 1988; Ajzen & Fishbein, 1980; Ajzen & Madden, 1986). The questionnaire was translated into Albanian and then back-translated into English to ensure the accuracy of the translation.

The dependent variable of the study—intention to make under-the-table payments for health care—was measured with three Likert-type items assessing participants' intentions to make under-the-table payments, and their likelihood to do so. For instance, the question "I intend to give an under-the-table payment the next time I go to a government health facility" was rated on a 5-point scale ranging from 1 (*completely disagree*) to 5 (*completely agree*). The question "How likely is it that you will give an under-the-table payment the next time you go to a government health facility?" was rated on a 5-point scale ranging from 1 (*very unlikely*) to 5 (*very likely*). The item scores were summed to form the intention score.

Attitudes toward giving under-the-table payments were measured with five items that were assessed via semantic-differential scales. These items assess whether study participants felt that giving under-the-table payments was *good–bad*, *important–unimportant*, *necessary–unnecessary*, *worthwhile–worthless*, and *beneficial–harmful*. The attitude score consisted of the sum of the five items.

Subjective norm was measured with two items asking participants to assess how important people in their lives would perceive their giving under-the-table payments. For instance, the question "People who are important to me think it is a good idea to give an under-the-table payment when I go to a government health facility" was rated on a 5-point scale ranging from 1 (*completely disagree*) to 5 (*completely agree*). PBC was measured with items that address the amount of control participants perceived regarding giving under-the-table payments. The question "How much does it depend on you whether you give an under-the-table payment when you go to a government health facility?" was rated on a 5-point scale ranging from 1 (*it doesn't depend on me at all*) to 5 (*it depends completely on me*). The three items were summed to form the PBC score.

The TPB posits that the antecedents of attitudes, subjective norms, and PBC are beliefs and evaluations of those beliefs. Outcome beliefs, normative beliefs, and control beliefs were derived from interviews that were conducted with Albanian citizens as part of a qualitative study conducted by Vian, Gryboski, Sinoimeri, and Hall (2006). The beliefs identified from the qualitative study that were included in the questionnaire were measured with Likert-type items. Beliefs regarding possible outcomes of giving or not giving under-the-table payments included being seen more quickly by medical personnel, improved quality of care, humiliation, feeling uncomfortable, and financial hardship. *Normative beliefs*, which are the perceived expectations of specific individuals or groups, addressed the beliefs of one's spouse, family, and friends. Control beliefs included the belief that one had sufficient money to pay the under-the-table payments and that one had relationships with medical staff that could facilitate not having to give under-the-table payments.

Researchers have found that the addition of a measure of moral obligation has improved the predictive ability of the TPB (Kurland, 1995; Randall & Gibson, 1991). Therefore, a measure of moral perspective was developed with five items that address the moral, ethical, and legal considerations of making under-the-table payments. Sample questions are "I believe that I am doing something illegal when I give an under-the-table payment at a government health facility" (reverse-scored) and "I believe that I am acting ethically when I give an under-the-table payment at a government health facility." The questions were rated on a 5-point scale ranging from 1 (*completely disagree*) to 5 (*completely agree*). The five items were summed to form a moral perspective score.

Additional questionnaire items include age, gender, education, health status, civil status, residence, and past behavior regarding under-the-table payments for health care. The instrument was field tested in the United States with 20 recent immigrants from Albania for clarity, readability, and fidelity of translation. The instrument was pilot-tested in Tirana, Albania, with 14 citizens. Feedback from the pilot test resulted in a minor revision to the wording of one item.

Results

Under-the-Table Payment Behavior

The majority of study participants (76.1%) reported having given under-the-table payments for health care in the past. More than one third (36.5%) indicated that they had made under-the-table payments within the past 30

days, and 64.9% of participants reported that they had made under-the-table payments at their last visit to a government health facility.

Intentions, Attitudes, Subjective Norms, and PBC

Table 1 shows mean scores of the major variables examined in the present study, and Table 2 shows the correlations among those variables. Scores for intention, attitude, and subjective norm hovered near the midpoint of the potential ranges. Approximately 20% of study participants *agreed* or

Table 1

Means for Theory of Planned Behavior Variables

Variable	<i>M</i>	<i>SD</i>	Possible range
Intention	8.34	2.76	3–15
Attitude	14.12	5.05	5–25
Subjective norm	5.15	2.54	2–10
PBC	6.83	2.40	3–15
Moral view	11.67	4.39	5–25
Belief-based attitude	100.98	21.49	35–147
Belief-based subjective norm	23.56	14.54	4–75
Belief-based PBC	12.45	6.91	2–35

Note. PBC = perceived behavioral control.

Table 2

Correlations Among Theory of Planned Behavior Variables

Variable	1	2	3	4
1. Intention	—			
2. Attitude	.480**	—		
3. Subjective norm	.386**	.355**	—	
4. Perceived behavioral control	-.185**	-.021	.116	—
5. Moral view	.128	.104	.187**	.081

***p* ≤ .01.

completely agreed that they intended to give and would give an under-the-table payment the next time they went to a health facility. Yet, when asked how likely it was that they would give an under-the-table payment, more than two thirds (66.7%) indicated that it was *likely* or *very likely*.

More than three quarters (77.5%) of respondents indicated that giving under-the-table payments at health facilities was *bad* or *very bad*; 55.4% indicated that giving payments was *harmful* or *very harmful*; and 43.7% believed that giving the payments was *worthless* or *very worthless*. Yet, 57.2% believed it to be *necessary* or *very necessary* to give under-the-table payments, and 52.8% of respondents indicated that making the payments was *important* or *very important*. Cronbach's alpha for the attitude measure was .77.

Less than one third of respondents *agreed* or *completely agreed* that the people who were important to them or the people they knew would want them to make under-the-table payments for health care. The reliability coefficient for the subjective norm measure was .86.

Mean scores for PBC were lower than the midpoint of the possible range, suggesting that study respondents felt that they had little choice in the matter of giving under-the-table payments at government health facilities. Indeed, 61.3% of participants responded that they do not have the possibility of choosing whether to give under-the-table payments, and 53.2% indicated that it would be *difficult* or *very difficult* to avoid giving the payments. Cronbach's alpha reliability coefficient for the PBC measure was .53.

Mean scores for moral view also were lower than the midpoint of the potential range, indicating that study participants did not view the practice of giving under-the-table payments as very ethical or right. Nearly 61% of respondents *disagreed* or *completely disagreed* that it was ethical to give under-the-table payments for health care, and 78.8% *agreed* or *completely agreed* that it was wrong to give under-the-table payments at government health facilities. The reliability coefficient for the measure of moral view was .41.

Prediction of Intentions

Regression analysis was used to predict intention to make under-the-table payments at government health facilities. Intention was regressed on attitudes, subjective norms, and PBC. The analysis yielded a multiple R of .58, and an R^2 of .336. The model was thus able to predict 33.6% of the variance in participants' intentions to give under-the-table payments at government health facilities. Each of the regression coefficients is significant

Table 3

Regression Coefficients for Theory of Planned Behavior

Variable	Unstandardized coefficients		Standardized coefficient	<i>t</i>	<i>p</i>
	<i>B</i>	<i>SE</i>	β		
(Constant)	5.358	.688	—	7.79	.000
Attitude	0.215	.034	.385	6.29	.000
Subjective norm	0.309	.067	.284	4.62	.000
PBC	-0.237	.067	-.204	-3.53	.001

Note. PBC = perceived behavioral control.

($p < .001$), with the attitude measure having the largest standardized coefficient. This suggests that attitude contributes the greatest weight in predicting intentions. Table 3 shows the regression coefficient table for the analysis.

The TPB maintains that attitude, subjective norm, and PBC are based on beliefs regarding possible outcomes of the behavior, the normative beliefs of specific referents, and beliefs about the resources and opportunities that could facilitate the behavior being addressed. Pearson correlation coefficients were calculated for the direct measures of the major variables and their indirect, belief-based measures. Significant correlations ($p \leq .001$) were found between each direct measure and its corresponding belief-based measure. The correlation between attitude and its indirect, belief-based measure was .31; the correlation between subjective norm and its indirect measure was .70; and the correlation between PBC and its indirect measure was .23.

The TPB posits that direct and belief-based measures of attitude, subjective norm, and PBC are alternative ways of assessing the same constructs. Regressing intention on individual beliefs resulted in an R of .57 and an R^2 of .33. Four beliefs contributed significantly to explained variance: two normative beliefs (“My spouse believes it’s a good idea for me to give an under-the-table payment when I go to a state health facility” and “My family believes it’s a good idea for me to give an under-the-table payment when I go to a state health facility”) and two behavioral outcome beliefs (“Giving an under-the-table payment when I go to a state health facility improves the quality of health care for me” and “Giving an under-the-table payment when I go to a state health facility is necessary because medical personnel look you

in the hands³). The item with the highest beta weight was the normative belief regarding the spouse.

Because accepting under-the-table payments is an illegal activity for Albanian health-care providers, participants' perspectives on the morality of the behavior were of concern. Therefore, a measure of moral perspective was added to the regression analysis to determine if it would make a unique contribution to the prediction of intention. The addition of the moral variable increased the R^2 to .357, thus contributing an additional 2.1% to the variance in intention. The F change, however, was not significant.

Individuals who are the heads of their families are likely to be the ones responsible for paying for health care for their family members. Thus, a regression analysis was conducted including only those individuals who reported that they were the heads of their families. When intention to give under-the-table payments was regressed on attitude, subjective norm, and PBC, the analysis yielded a multiple R of .642 and an R^2 of .412. Thus, for heads of families, the constructs of the TPB explained 41.2% of the variance in their intention to give under-the-table payments. Again, attitude had the largest beta weight.

External Variables

Ajzen and Fishbein (1980; Fishbein & Ajzen, 1975) contended that variables such as demographics and situational variables do not enter directly into the causal structure of the theories of reasoned action and planned behavior. These variables are considered influential in that they impact beliefs. However, because they are mediated by the theory's major variables, theoretically they should not contribute directly to variance in intention.

Consistent with the theory, the addition of age, education, and health status to the analysis did not contribute any significant additional variance in intention to give under-the-table payments at government health facilities. Contrary to the theory, however, the addition of the variable that addressed past behavior (i.e., giving an under-the-table payment at the last visit to a government health facility) contributed an additional 6.9% to the variance. Thus, with the addition of past behavior, the model was able to explain 42.6% of the variance in participants' intention to give under-the-table payments for health care, $F_{\text{change}}(1, 189) = 20.69, p = .000$. For heads of household, the addition of the past behavior variable to the model resulted in the explanation of 52.4% of the variance in intention. Table 4 shows the regression

³The term *looking in the hands* is a colloquial expression meaning that providers are looking at a person's hands, expecting money to be in them.

Table 4

Regression Coefficients for Theory of Planned Behavior With Additional Variables

Variable	Unstandardized coefficients		Standardized coefficient	<i>t</i>	<i>p</i>
	<i>B</i>	<i>SE</i>	β		
(Constant)	1.717	.988	—	1.73	.084
Attitude	0.218	.032	.404	6.89	.000
Subjective norm	0.295	.063	.277	4.65	.000
PBC	-0.140	.065	-.123	-2.16	.032
Moral view	0.051	.041	.070	1.24	.216
Past behavior	1.504	.331	.257	4.55	.000

Note. PBC = perceived behavioral control.

coefficient table for the analysis with the additional variables of moral view and past behavior.

Discussion

The purpose of the present study was to systematically examine the intentions of Albanians to make under-the-table payments for health care at government health facilities. An additional purpose was to test the applicability of the TPB in predicting intention to make said payments. The constructs of the theory predicted 34% of the variance in intention among study participants. When only heads of household were examined, the TPB's constructs predicted 41% of the variance in their intention to make under-the-table payments. Because nearly two thirds of participants reported making under-the-table payments at their last visit to a government health-care facility, this systematic examination of their intention and the predictive ability of the model may provide some important information that can inform policies and strategies for change.

Of some concern is the appearance of inconsistency in responses to individual items measuring intention. For example, only 20% of respondents *agreed* or *completely agreed* with the statements “I intend to give an under-the-table payment the next time I go to a government health facility” and “I will give an under-the-table payment the next time I go to a government

health facility.” But 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?” 67% of respondents said it was *likely* or *very likely*. After reviewing the questions again with the translator, we do not believe that this inconsistency was a result of weak linguistic equivalence in the translation, but it reveals that we did not achieve full cross-cultural equivalence.

A possible explanation for these results is that some Albanian citizens associate *intention* with having a choice, and the first two questions seem to be asking about a volitional behavior. In other words, Albanians may not believe that they can “intend” to do something if they are acting out of obligation, rather than personal choice or preference. The respondents who, after marking the response that they did not intend to make an informal payment, wrote comments in the margins including “I am obliged” and “I feel obliged” support this hypothesis. Thus, we believe that the intention question “How likely is it that you will give an informal payment . . . ?” may be a better translated measure of intention. Prediction of intention, however, was not significantly improved by removing any of the intention items from the analysis.

The rather poor Cronbach’s alpha reliability scores for the PBC and moral-view measures also concern us. With regard to PBC, it would appear intuitively that items asking individuals if they have a choice as to whether or not to give an under-the-table payment, if they feel that it depends on them whether or not they give an under-the-table payment, and if it is easy for them to give or not to give an under-the-table payment are similar, related, and measure the same construct. Similarly with the moral view construct, items that ask if one feels that giving under-the-table payments is wrong, if one feels that giving under-the-table payments is unethical, and if one feels that he or she is doing something illegal when giving under-the-table payments appear quite similar and appear to address the same construct. The fact that correlations among these items were very low, and often were not significant, may reflect an inability to achieve full cross-cultural equivalence with the survey translation. The low reliability scores may indicate that the regression analysis results reflect reliability differences, as well as contributions of the predictor variables.

Studies by Beck and Ajzen (1991), Kurland (1995), and Randall and Gibson (1991) suggested that the addition of a variable measuring moral belief might strengthen the predictability of the TPB. In this current study, the addition of the moral belief variable added only 2% additional variance in intentions. One explanation for this may be that moral beliefs are subsumed under attitudes, especially the attribute *good-bad*. Indeed, the correlation

between attitude and moral belief ($r = .38, p < .001$) suggests a collinearity that could account for the small increase in variance. Another explanation is that perhaps the survey did not capture the cultural equivalence of moral belief.

The addition of past behavior to the model increased the explained variance in intention to 52%. This is consistent with what Beck and Ajzen (1991) found in their study of dishonest behaviors in students, where prediction was better for behaviors with which respondents had had more experience. Ajzen and Madden (1986), however, suggested that beliefs about behavioral control might be based partly on past behavior. Because of past behavior's substantial contribution to variance in intentions, it was deemed useful to determine if the concept of PBC might have been a reflection of past behavior. When past experience was entered first into a regression analysis, the PBC variable added only a minimal amount to explained variance, and had a low regression coefficient. This finding supports Ajzen and Madden's suggestion that variables external to the theory are influential only in so far as they impact on the major predictor variables.

Attitudes made the most substantial contribution to predictions of Albanians' intentions to make under-the-table payments for health care. Surprisingly, PBC, though statistically significant, was not as important as attitudes in predicting intention. Ajzen and Madden (1986) added PBC, the concept that extends the theory of reasoned action into the TPB, to the model because it helps to explain nonvolitional behavior. The less substantial contribution of PBC in this study may mean that a segment of Albanian respondents saw giving under-the-table payments for health care as purely volitional. This was not what was expected, based on the qualitative data.

Although this study was limited by the fact that the sample was not randomly selected, and the study took place in only one Albanian city, the findings have implications for health planning and policy reform in Albania relating to informal payments. For example, more than 75% of respondents indicated that it was *very likely* or *likely* that making an under-the-table payment would result in their being seen more quickly, and more than 72% reported that it would result in improved quality of care. These motivations for giving under-the-table payments can be addressed directly through policy interventions that ensure prompt access to quality of care within government health facilities. This would reduce the pressure to make informal payments.

The current study shows that it is feasible to study ethical behavior systematically using a social psychology model in a non-Western country. Using the theory of planned behavior to examine illegal under-the-table payments in Albania has pointed to specific areas that can be targeted for

intervention. In this case, it appears that addressing attitudes and beliefs may be a starting point for interventional research.

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