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THE SOCIAL SECTOR AND TRANS-REGIONAL COLLABORATION AMONG SOCIAL SECTOR INSTITUTIONS IN BALKAN COUNTRIES IN TRANSITION - A CASE STUDY OF HEALTHCARE INSTITUTIONS IN ALBANIA

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Abstract
This article examines the situation, problems and priorities of trans-regional cooperation among public institutions in Balkan countries in transition and more specifically the health sector in Albania.
Since 1989 a dominant anti-state tendency has been adopted in the Balkan countries in transition, which in turn has led to a decline in the state and public sector of the economy. The main features of the healthcare systems in Balkan countries are privatization, decentralization, a decrease in public expenditure and, in general, the introduction of market elements in the health sector.
The collapse of economies, the increase in poverty and social and income polarization have led to a dramatic deterioration in healthcare systems since 1989. Before 1989, Albanian public health sector employees were rarely satisfied with the situation in this sector; however, they are comparatively more satisfied with the current situation and quite optimistic about the future. The greatest obstacles to the modernization of the system are the lack of resources, bureaucracy, corruption and the institutional framework. To confront these particular problems, trans-regional collaboration has been sought with corresponding institutions mainly of EU member countries and in particular neighbouring Balkan countries. This is due mainly to the strategic aim of Albania to become integrated into the EU as well as to benefit from the better level of EU member countries' healthcare systems.

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1. Introduction

In this article the situation and priorities of trans-regional collaboration between the public sector institutions of Balkan countries in transition and more specifically the healthcare institutions in Albania are examined.

More specifically this paper will try to look into the problems of the public sector in Balkan countries in transition and the resulting obstacles that affect their development and inter-Balkan economic cooperation, the changes that have taken place since 1989 in the healthcare sector in transitional countries and more specifically in Albania, the degree of employee satisfaction in Albanian healthcare units and their evaluation of the changes in the Albanian healthcare system, the attitudes of employees towards training and lifelong learning, the organisation and operation model of the healthcare sector in Albania, the obstacles which hinder its progress and the changes in the administrative field, as well as the existing collaboration and the priorities for future collaboration with the European Union and Balkan countries and the specific sectors for collaboration. The data analysed to explore these issues were drawn mainly from the primary research into "Modern Public Management - Healthcare Sector in Albania" that was conducted within the framework of the Community Initiative INTERREG II by the Federation of Public Employees' Organizations – regional branch of Thessaloniki - in cooperation with the independent Trade Union of Health Employees of Albania.

The research method was a structured questionnaire, which was completed during a personal interview of people selected from a random sample of 217 representatives of the managerial and trade-union executives of the health services in Albania, during the year 2000.The writer of this paper was the coordinator of the research team.

In addition an attempt will be made to look into the theoretical issues regarding the role of the state and the public sector in Balkan countries in transition.

2. Theoretical Approaches to the Role of the State

Along with the collapse of the U.S.S.R., came the collapse of the growth model which had made the state the 'guardian' of social values as well as the driving force for social and economic growth.

After 1989, with the beginning of the transitional phase in Balkan countries towards a market economy, the collapse of the planned economic system was accompanied by the decline of public institutions and a decrease in state control. The period during which the Balkan countries in transition aim to reconstruct the state and its institutions coincides with the start of discussions and the mapping out of important changes in the size and role of the state in former socialist countries as well as the developed countries of the West. According to the current consensus of opinion, the role of the state is in doubt. It must be taken into account that the state – "night watchman" of the19th century, which in turn became the welfare state in the 20th century -

was transformed into a 'state' – architect and instructor of reconstruction and overall growth during the first post-war decades"(Argiriadis, 1995, p.96).

The attack on the state, has in recent years had political and ideological consequences, aimed at reducing the governmental field of action, increasing privatization and promoting the decline of the welfare state, resulting in a dramatic increase in poverty.

At the same time, if the dispersion and weakening of political power advances beyond acceptable limits, it endangers the essential protection of individual rights and freedoms.

Taking this into account, it is not an exaggeration to say that the State of Justice, created during the Enlightenment, constitutes the protector and guarantor of human rights and freedom (Argiriadis, 1995, p.56).

State discord, however, does not mean its abolition. The state itself cannot be made to disappear, no matter how much its powers recede, and it must always maintain a strategic role.

With all the imperfections of a human institution, the bureaucratic state has helped in the creation of the State of Justice as well as the Welfare State. What is taking place today in most parts of the world is a weakening of the state in the name of a market economy, almost as if the state and the market were natural opponents. The international experience, on the contrary, proves that the state can play a positive role in the promotion of economic growth, while it pre-supposes the smooth operation of market forces (Argiriadis, 1995, p.48).

As regards the scope of public activities, especially in the service sectors such as health and, education, "the main argument supporting privatization is that the state is less effective. The response to the above mentioned argument is that private production cannot sufficiently reflect social targets" (Stiglitz, 1994, p.335).

The future of health economies depends heavily on how well health economists carry out two distinct, albeit related, missions: a) enhancing understanding of economic behaviour, and b) providing valuable input into health policy and health services research (Fuchs, 2000, pp. 141-157).

Alongside the anti-administration and anti-state tendency that substantially curbs the Welfare State, the open systems of the modern period have experienced a parallel movement developing out of the closed bureaucratic systems of the past. This movement allows a democratic constitution, which elevates the citizen, who is essentially the customer, to Administrative Services' user and taxpayer and the main object of concern to the State (Argiriadis, 1995, p.47).

"The state, and especially the State of Justice and the Welfare State having been set up with so much effort during the last two decades, are more necessary than ever. The state's structure and its mechanisms should be different in the next century in relation to the previous one. The modern state should be anti-bureaucratic and must

function as an open system... A state that respects the individual and his freedom, promotes personal freedom and responsibility and, in consequence, recognizes the role of a society of citizens" (Argiriadis, 1995, p.45).

3. The Public Sector in Balkan Countries in Transition

Since 1989, the Balkan states have acquired similar social and economic structures and institutions, but have simultaneously been characterized by large differences in their economic situation due to the economic crisis that has caused changes in the status quo. The main characteristics all of the reforms are the shrinking and reconstruction of the state sector and its institutions as well as the formulation of modern state structures according to the principles of the State of Justice. In Balkan countries, mainly during the first years of transition, attempts were made to reduce the size of the state sector before the necessary institutional frame had matured, putting ideological and political factors above the real interests of the economy. It was also taken into account that "reforms in a market economy do not mean the collapse of the state but the re-definition of its role"(Stiglitz, 1994, p. 17).

The Anglo-Saxon model has dominated the social policy field, by controlling the market economy and the remaining social protection model (Sakellaropoulos, 2001, p. 19).

The reduction in production and employment rates and the increase in deficits and public debt in combination with the implemented stability programmes aimed at shrinking the public and social sectors, led to a decrease in public expenditure on education, health and social protection resulting in an increase in poverty and the marginalization of great parts of the population.

Results from research carried out in Greece and the Balkan countries have shown that the role of the public sector and more generally the statutory mechanism is decisive in overcoming obstacles to growth and economic collaboration.

Research undertaken by the *Federation of Industries of Northern Greece (1998)*, investigated "the disincentives that face Greek enterprises that develop entrepreneurial activities in SECI countries" (South Eastern European Co-operative Initiative). The evaluation of the participants in the research concerning the degree of importance of each disincentive, leads to the following basic conclusions:

a. Political and economic instability is considered to be the most important disincentive to growth, followed by crime, lack of transparency, corruption, insufficient infrastructures, insufficient institutional framework and a negative business environment.
b. By analyzing the factors that make up the disincentives of growth, we see that most of them are related, either directly or indirectly, to state and public institutions. Significantly, the most important factors of disincentive (crime – lack of transparency – corruption) are the corruption of the statutory mechanism, the lack of transparency of public procedures and "paid protection" to organized crime

groups. The disincentives which constitute "insufficient infrastructures," are in the following order of importance: road networks, telecommunications, airports, railway networks, energy (infrastructures) and ports.

As regards the area of insufficient "institutional framework", the most important factor evaluated is the time-consuming process of customs clearance and cross-border distribution. This is followed by tariff legislation, the permanently altered institutional framework, tax legislation, the training of workers and executives and quality control.

With *regard to Greece*, research was undertaken of a representative sample of public and private institutions in the prefecture of Thessaloniki. Representatives of institutions in the sample were asked to evaluate the contribution of the public sector, businessmen and collective and social institutions to inter-Balkan economic collaboration up to the present day (Magoulios,2000,pp. 213-216). The main findings are as follows:

Fifty percent of the sample considered the contribution of the public sector to be insignificant, 39.5 percent considered it average and 11.7 percent thought it was important or very important. The average grade for the public sector is 39 (in a scale 0-100). The degree of correspondence, specifically of the state mechanism, in the promotion of inter-Balkan collaboration is considered high by 7 percent of the participants, average by 62.8 percent and low by 30.2 percent. In this estimate, the statutory mechanism is assessed as making an average contribution to inter-Balkan collaboration, without essential divergences from state institution and private sector representatives.

Up to now the areas of collaboration between institutions within Balkan countries have been, in order of priority: the exchange of information, community programs, advisory support, human resources, trade and science-technology, infrastructures, production, financing services and tourism. Other sectors mentioned are networks, joint-enterprises, culture and sports, humanitarian aid, energy, political relations, journalism and transport.

A Congress organized by the United Nations (Department of Economic and Social Affairs, Sector of Public Finances and Public Administration) (1999) on the subject of "Public Services under transition: Strengthening their roles, Professionalism, Moral Values and Models" took place in Thessaloniki in 1997 and involved the participation of Greece and all countries under transition.

During this congress the harmonization of these countries under the new conditions of an international environment and their future integration into the EU were examined. Three working groups discussed questions of critical importance and formulated findings, opinions and proposals. More specifically:

Apart from the conclusion reached that countries in transition are not all at the same stage of transition, it was generally recognized that during the initial phase of

transition, the political system collapsed and many institutions were abolished or even dissolved. In many countries, the adoption of a "minimalist state" approach gave the impetus to private initiative. However, simultaneously, it led to the worsening of the quality of important public services such as those of health and education and also led to the appearance of a black market economy.

The restrictions of the state budget, the continual changes of governments, programmes and top administrative managers as well as institutional instability, resulted in the main problems of a lack of stability and continuity and in the process of reorientation of these countries towards a slower rate of growth. Taking into consideration the fact that the countries are at different stages in the transition process, as well as the wide spectrum of potential problems that they have to face, it is maintained that "optimal" models or theories cannot be proposed for application. The adoption of a "pragmatic" approach is proposed so as to maintain the aim of the common objectives with feasible, realistic steps and in every case to take prevailing political and economic conditions into consideration.

Comparative studies or the exchange of experiences and information as well as closer collaboration between the countries in the region, will contribute to accelerating the transition process. It is stressed that comparing experiences of states that are at a similar stage of transition can be more beneficial than considering experiences of developed economies.

The common opinion is that the main problem is not the lack of professionalism in the public sector but the factors that prevent professionals being effective. Indeed, with minor exceptions, most of the countries agreed that the executives in the public sector are well prepared through education and experience, although they may require re-training. They are highly motivated and do the best that they can under difficult conditions. Major obstacles to their progress are:

(a) the framework within which they work. (Governments that often change are indecisive and have an unclear model of growth to follow).
(b) Economic difficulties, budget and workplace restrictions have decreased the attraction of the public sector while experienced managers have abandoned their job positions.
(c) The bureaucracy that continues to give greater priority to processes rather than results.
(d) Public services continue serving powerful interested parties and not the public.
(e) Public sector professionals have difficulty following the new changes due to lack of knowledge of foreign languages.

Pointing out that corruption and crime are generally common problems in all countries (not only in those in transition) a common approach was agreed upon for the reduction of this phenomenon in the public sector. The main elements that constitute this approach include:

(a) Ensuring that public servants, politicians and the public in general are better in-

formed on matters relating to moral values and standards.
(b) Cultivating the political will and dedication to the institutionalization and application of these models. To achieve this, the training of public sector workers as well as the promotion of values and models are considered essential
(c) Providing working conditions for public servants (recruitment, job security, wage scales, training and other factors) which would effectively limit "temptations".
(d) Encouraging the adoption of follow-up and control mechanisms of work, transparency in the process of decision-making, systems of public control.

It is concluded that the modernization of the public sector's institutional framework, a determination to deal with corruption, an increase in disposable resources, an upgrading of personnel and means as well as a reorientation of the public sector's role with regard to the real needs and particularities of each country, constitute the most important priorities in overcoming existing obstacles and will lead to a more effective contribution from the public sector and its institutions to the process of development in the region.

4. The Health Sector of Albania: The Structure, Organization, Evaluation and Priorities of Trans-Regional Collaboration

4.1 The development of the HEALTHCARE sector in the BALKAN countries in transition and more specifically in ALBANIA.

In the period before 1989, the healthcare systems in the Balkan countries were generally developed along the lines of the "Semashko model". Elements of the "Bismarck model" were also adopted with the basic elements being statutory financing, centralized structures and universal cover (National School of Public Health of Greece, 2000, p. 14).

After 1989, with the beginning of the process of transition towards a market economy, the health system reforms in the Balkan countries followed the tendencies that had prevailed in the USA and the EU, with the basic characteristics being privatization, decentralization, a reduction in statutory expenses and, in general, the introduction of market elements in the areas of healthcare.

Property ownership, the collapse of economies, the increase in poverty, social and income polarization also led to a dramatic deterioration in the healthcare systems. Besides, in Albania, the conflicts that followed the collapse of the system and the events of 1997 resulted in the destruction and the pillaging of many health centres and hospitals (Ministry of Health of Albania, 1997).

On the 'World echelon', included in the WHO Health report (2000), most of the Balkan countries in transition are located towards the lower end.

Albania's healthcare system is placed in 136th position as regards the expectations of the population, in 55th position for the overall operation of the healthcare system, in 149th position for *per capita* healthcare expenses and in 173rd–174th position for fair redistribution (WHO, 2000).

Its demographic growth was 1 percent annually from 1997 to 1999. Forty percent of the population is urban and 60 percent is rural, with the density of population per sq. km. in the rural regions being high (344), while in the countries of Europe and Central Asia the average is 123.

The number of births per woman was 3 in 1997 and 2 in 1998, while the corresponding demographic indicator in the countries of Europe and Central Asia was 2 on average.

According to the statistics for 1997/1998, life expectancy at birth is 72 years, three years more than the mean of European and Central Asian countries and five years lower than life expectancy in Greece (78).

The indicator of infant mortality in Albania is very high with 26 per 1000 births in 1997 and 25 per 1000 births (THE YEAR IS MISSING). In the same years, the mean of infant mortality in European and Central Asian countries is 23 and 22, while in Greece it is 7 and 6 (WDI database).

According to the findings of an international project coordinated by UNICEF and aimed at providing information about the development of appropriate policy responses at national and local levels and by the international community on health in south–eastern Europe, it is concluded that the business of improving health in south–eastern Europe is unfinished. The international donor community has given health in this region a low priority. Post–emergence development aid largely focused on infrastructure and neglected the need for a sustainable health sector; at the same time it put insufficient emphasis on increasing the healthcare sector or on increasing the capacity of public healthcare services(Rechel, Schwalbe, McKee, 2004, pp. 539-546).

The structure of the Albanian healthcare system is recorded in research assigned by the Albanian Ministry of Health to the International Medical Body entitled "Basic Units of Health" (Ministry of Health of Albania, 1999).

The first level of healthcare services is provided by the provision of medical advice centers (health posts) which usually function with a nurse, and health centers that have a general pathologist. The secondary level of the health system is the Regional Hospitals, 36 in total throughout the whole country. Regional hospitals provide emergency care, services for obstetrics, pediatrics and general surgery as well as hospitalization. There are also hospitals for patients with chronic diseases; most of them are psychiatric hospitals.

The third level of healthcare services is actually the Academic Hospital of Tirana. In the past 10 years, 40 small hospitals have been closed. This corresponds to 50 percent of all hospital beds. Twenty-eight thousand people work in the healthcare services, compared with 41,000 in 1990. There is one doctor for every 780 residents and 3 beds for every 1000 residents; this increased in 2002 to 3.3 beds per 1000 residents.

The overall *per capita* healthcare expenses in Albania, in 2000, was 63 US$, out of which 49 US$ went on public healthcare expenses and 14 US$ went on private healthcare expenses, constituting 3.5 percent of GNP (WHO, 2000 & 2002).

In 2002 the total expenditure on health constituted 3.7% of GDP, whilst 2.4 percent went on public healthcare and 1.3 percent of GDP went on private healthcare expenses. In the same year 64.6 percent of expenditure was public and 35.4 percent private, while overall per capita expenditure on health amounted to 48 US$ (World Bank 2002).

4.2 The findings of the PRIMARY RESEARCH into units of healthcare in ALBANIA (Magoulios et al, 2001).

The results from primary research on the evaluation of the healthcare units, in which the people surveyed were employees of the units, showed very low grades (on a scale of 1-100) regarding the level of computerization of services (average grade 29). Average grades were reported regarding the sufficiency of financing resources, as well as the sufficiency of equipment (average grades 43-42), and an average grade was reported (52) with regard to the condition of the building infrastructure of the healthcare unit. They declared adequate satisfaction (average grade 74) with regard to the efficiency and the qualifications of the personnel employed by the units.
They evaluated the effectiveness of the units' administrators as average (average grade 52) (Table 1).

Table 1. Please, assess your unit according to the following:
On a 1-5 scale (1=insignificant / 5=very important)

			insignificant >>> very important						
Serial number	FIELD	**N.A.**	**1**	**2**	**3**	**4**	**5**	**TOTAL**	**AVERAGE SCORE on a 0 - 100 scale**
1	Adequacy of	8	59	50	43	5	52	217	
	financial resources	*3.7*	*27.2*	*23.0*	*19.8*	*2.3*	*24.0*	*100.0*	***43***
2	Condition of building	7	36	38	55	32	49	217	
	Infrastructure	*3.2*	*16.6*	*17.5*	*25.3*	*14.7*	*22.6*	*100.0*	***52***
3	Adequacy of	7	51	59	42	13	45	217	
	Equipment	*3.2*	*23.5*	*27.2*	*19.4*	*6.0*	*20.7*	*100.0*	***43***
4	Condition of building	8	54	57	45	12	41	217	
	Equipment	*3.7*	*24.9*	*26.3*	*20.7*	*5.5*	*18.9*	*100.0*	***42***
5	Level of service	13	116	27	10	13	38	217	
	Computerisation	*6.0*	*53.5*	*12.4*	*4.6*	*6.0*	*17.5*	*100.0*	***29***
6	Adequacy of	9	18	11	37	39	103	217	
	personnel	*4.1*	*8.3*	*5.1*	*17.1*	*18.0*	*47.5*	*100.0*	***74***
7	Qualifications of	8	2	7	60	68	72	217	
	personnel	*3.7*	*0.9*	*3.2*	*27.6*	*31.3*	*33.2*	*100.0*	***74***
8	Efficiency of	19	37	38	42	33	48	217	
	Management	*8.8*	*17.1*	*17.5*	*19.4*	*15.2*	*22.1*	*100.0*	***52***

From the evaluation of the units with reference to three periods of time (before 1989, the present, and the anticipated future), the respondents declared themselves to be less satisfied with the condition of their healthcare unit before 1989, more satisfied with the present conditions and particularly optimistic for the future (average grades 33, 42 and 83 respectively) (Table 2).

Table 2. Assess the current situation of the unit (since 1989), the previous situation (prior to 1989) and the future situation according to your own personal estimate
On a 1-5 scale (1=very bad / 5=excellent)

			very bad >>> excellent						
Serial number	**Situation**	**N.A.**	**1**	**2**	**3**	**4**	**5**	**TOTAL**	**AVERAGE SCORE** *on a 0 - 100 scale*
1	Current	13	42	26	99	30	7	217	
	situation	*6,0*	*19,4*	*12,0*	*45,6*	*13,8*	*3,2*	*100,0*	***42***
2	Previous	13	66	60	40	20	18	217	
	situation	*6,0*	*30,4*	*27,6*	*18,4*	*9,2*	*8,3*	*100,0*	***33***
3	Future	24	3	5	26	55	104	217	
	situation	*11,1*	*1,4*	*2,3*	*12,0*	*25,3*	*47,9*	*100,0*	***83***

The respondents evaluated the institutional framework of public healthcare as "modern" or "conservative" in relation to eight parameters: Decentralization, efficiency, equal opportunities for both sexes, criteria of employment, criteria of personnel evaluation, meritocracy of personnel appointments, prospects of modernization and positive changes, adaptability to European data.

According to the evaluation of the respondents all parameters, apart from equal opportunities for men and women, that are ensured to a satisfactory degree (66 percent), appear to score below average on the actual institutional framework of public health (Table 3). From this point of view the institutional framework of public health in Albania could be characterized as "conservative" rather than "modern".

Obstacles to the modernization of the public health system in Albania, as noted by the respondents, are recorded in order of priority as follows: Lack of resources, bureaucracy, political divisions, corruption, institutional framework (Table 4).

The existing public health system does not seem to ensure the basic principle of modern public sector administration to a satisfactory degree. This refers to equal opportunities and respect for citizens' rights as well as effective services directed to-

wards the needs of the public services user. The framework of the operation of health services with regard to the users is evaluated with a mean of 41.5 (below average satisfaction) (Table 5).

Table 3. How would you rate the existing institutional framework for public health-care in your country according to the following parameters?
On a 1-5 scale (1=very bad / 5=excellent)

			very bad >>> excellent							
Serial number	FIELD	N.A.	1	2	3	4	5	TOTAL	AVERAGE SCORE on a 0-100 scale	ONLY TRADE-UNION EXECUTIVES
1	Decentralization	17	49	56	67	17	11	217		
		7,8	*22,6*	*25,8*	*30,9*	*7,8*	*5,1*	*100,0*	***36***	***34***
2	Efficiency	17	29	51	70	36	14	217		
		7,8	*13,4*	*23,5*	*32,3*	*16,6*	*6,5*	*100,0*	***44***	***47***
3	Equal opportunity for	16	21	13	46	56	65	217		
	both sexes	*7,4*	*9,7*	*6,0*	*21,2*	*25,8*	*30,0*	*100,0*	***66***	***58***
4	Personnel employment criteria	14	64	42	40	30	27	217		
		6,5	*29,5*	*19,4*	*18,4*	*13,8*	*12,4*	*100,0*	***39***	***47***
5	Personnel assessment criteria	17	56	48	52	27	17	217		
		7,8	*25,8*	*22,1*	*24,0*	*12,4*	*7,8*	*100,0*	***38***	***43***
6	Meritocracy in selecting	21	46	49	54	23	24	217		
	managerial cadres	*9,7*	*21,2*	*22,6*	*24,9*	*10,6*	*11,1*	*100,0*	***41***	***37***
7	Prospects for modernization	20	25	39	65	40	28	217		
	and positive changes	*9,2*	*11,5*	*18,0*	*30,0*	*18,4*	*12,9*	*100,0*	***51***	***52***
8	Adaptability to	16	43	60	55	28	15	217		
	the European reality	*7,4*	*19,8*	*27,6*	*25,3*	*12,9*	*6,9*	*100,0*	***39***	***44***

The most authoritative definition for quality of care was published by the Institute of Medicine in 1990, which defined quality of care as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Romano & Mutter, 2004, pp. 131-157). *The degree of participation of employees* involved in training programmes as well as their attitude to *lifelong education* was investigated in the primary research. The analysis of the answers to the questionnaires results in the following conclusions:

Table 4. Which do you consider to be the most important ostacles to the modernization procedure for the public healthcare system? **(define order of priority)**

Serial number	Obstacles	1st choice	2nd choice	3rd choice	4th choice	5th choice	6th choice	not included	TOTAL
1	Institutional framework	15	36	24	24	28	1	89	217
		6,9	*16,6*	*11,1*	*11,1*	*12,9*	*0,5*	*41,0*	*100,0*
2	Political affiliation	29	24	31	35	31	2	65	217
		13,4	*11,1*	*14,3*	*16,1*	*14,3*	*0,9*	*30,0*	*100,0*
3	Lack of resources	87	33	25	25	16		31	217
		40,1	*15,2*	*11,5*	*11,5*	*7,4*	*0,0*	*14,3*	*100,0*
4	Corruption	25	38	38	20	36	3	57	217
		11,5	*17,5*	*17,5*	*9,2*	*16,6*	*1,4*	*26,3*	*100,0*
5	Bureaucracy	30	41	38	26	23		59	217
		13,8	*18,9*	*17,5*	*12,0*	*10,6*	*0,0*	*27,2*	*100,0*
6	Other	3	3		1	1	16	193	217
		1,4	*1,4*	*0,0*	*0,5*	*0,5*	*7,4*	*88,9*	*100,0*

Table 5. How would you rate the existing institutional framework for public healthcare in your country in relation to the healthcare service users in the following areas? *On a 1-5 scale (1=very poor / 5=excellent)*

			very poor >>> excellent						
Serial number	FIELD	N.A.	1	2	3	4	5	TOTAL	AVERAGE SCORE on a 0 - 100 scale
1	Equal opportunities for	11	67	39	63	21	16	217	
	all citizens	*5,1*	*30,9*	*18,0*	*29,0*	*9,7*	*7,4*	*100,0*	**35**
2	Degree of coverage	13	32	51	81	27	13	217	
	of needs	*6,0*	*14,7*	*23,5*	*37,3*	*12,4*	*6,0*	*100,0*	**42**
3	Quality of the services	12	24	49	80	38	14	217	
	Provided	*5,5*	*11,1*	*22,6*	*36,9*	*17,5*	*6,5*	*100,0*	**46**
4	Service procedures	19	28	52	76	31	11	217	
	for the user	*8,8*	*12,9*	*24,0*	*35,0*	*14,3*	*5,1*	*100,0*	**43**
5	Participation of the	19	30	53	71	35	9	217	
	users	*8,8*	*13,8*	*24,4*	*32,7*	*16,1*	*4,1*	*100,0*	**42**
6	Respect for citizens'	9	49	50	54	35	20	217	
	rights	*4,1*	*22,6*	*23,0*	*24,9*	*16,1*	*9,2*	*100,0*	**41**

A significant percentage of workers in the healthcare units (68.7 percent) participated in training programs during the previous five-year period. Of the total number of participants in training programmes, 17.4 percent were educated in management, 61.1 percent in issues relating to Health, 20.1 percent in the use of new technologies and in computerization, 40.9 percent in issues relating to their specialization, 2 percent in the subject of economic management and 9.4 percent declared other areas. It appears that healthcare professionals from all the healthcare units such as prevention centres, health centres and hospitals participate in training programmes The particularly positive attitude of workers in the Healthcare sector with regard to lifelong training is recorded. A percentage of 90.8 expressed interest in continuous training. Women represent a higher percentage than men (95.5 percent and 82.5 percent respectively) when it comes to being more positive on training issues. The areas of interest for future training are in order of priority (Table 6) as follows: Subjects that concern the health sector, specialised subjects such as management, new technologies, financial issues.

Table 6. Mention those fields where there is need for additional education for each personnel category

Serial number	Personnel category	Management	New technologies - computerization	Financial management	Health	Other	N.A.	TOTAL
1	Administrative personnel	71 *32,7*	55 *25,3*	48 *22,1*	18 *8,3*	14 *6,5*	66 *30,4*	217
2	Medical personnel	25 *11,5*	62 *28,6*	33 *15,2*	101 *46,5*	21 *9,7*	33 *15,2*	217
3	Social workers - psychiatrists	14 *6,5*	17 *7,8*	13 *6,0*	39 *18,0*	40 *18,4*	105 *48,4*	217
4	Nurses	13 *6,0*	36 *16,6*	11 *5,1*	113 *52,1*	50 *23,0*	32 *14,7*	217
5	Assistants	17 *7,8*	27 *12,4*	25 *11,5*	45 *20,7*	54 *24,9*	72 *33,2*	217

The healthcare professionals questioned were asked to *evaluate* the existing organization of their unit and to express their opinion on the *model of organization* that they would wish to be applied to it on a 5-degree scale of eight parameters: operational rules, work description, rules of communication, administrative hierarchy, specialization of work, productivity criteria, stability of employment and decision-making processes.

From the evaluation of existing organizations and unit operations (Table 7), most parameters denote a balance. Differentiations are observed in two parameters:

Table 7. How would you grade your organization on the following scale?

Serial number	FIELD	*importance %*	1	2	3	4	5	*importance %*	FIELD	Respondents
1	Written rules of operation	***49,4***	42 *12,0*	31 *8,9*	57 *16,3*	20 *5,7*	50 *14,3*	***50,6***	Unwritten rules of operation	200 *92,2*
2	Detailed job Description	***50,1***	38 *10,9*	45 *12,9*	44 *12,6*	26 *7,4*	47 *13,4*	***49,9***	Vague job (duties) description	200 *92,2*
3	Written rules of Communication	***35,2***	25 *7,1*	25 *7,1*	34 *9,7*	36 *10,3*	78 *22,3*	***64,8***	Oral communication	198 *91,2*
4	Strict, clear distinction of administrative hierarchy	***44,9***	37 *10,6*	27 *7,7*	50 *14,3*	32 *9,1*	55 *15,7*	***55,1***	Unclear lines of hierarchy	201 *92,6*
5	Spécialisation, concrétisation of the job	***51,4***	36 *10,3*	48 *13,7*	49 *14,0*	23 *6,6*	43 *12,3*	***48,6***	Employees changing posts (enrichment of duties)	199 *91,7*
6	Clear productivity criteria	***42,9***	23 *6,6*	31 *8,9*	65 *18,6*	32 *9,1*	51 *14,6*	***57,1***	There are no clear productivity criteria	202 *93,1*
7	Fixed employment all the way through to retirement	***57,0***	68 *19,4*	25 *7,1*	38 *10,9*	31 *8,9*	37 *10,6*	***43,0***	Temporary employment, subject to evaluation	199 *91,7*
8	Concentration of power at the top of administration	***69,6***	79 *22,6*	42 *12,0*	46 *13,1*	17 *4,9*	14 *4,0*	***30,4***	Participation of employees in decision-making	198 *91,2*

- Rules of communication: oral communication rates highly with a 64.8 percent degree of importance.
- Decision-making processes: the evaluation of the existing model of decision-making rates highly with a 69.6 percent degree of importance.

According to the majority of the respondents in the sample, the most desirable model of organization of a unit appears to be more explicit and specific than the existing organizations, with a clear distinction of hierarchy, clear criteria of efficiency that clarifies the relationship between workers but allows participation in decision-making.

To date, there has been *trans-regional collaboration* developed between Albanian healthcare institutions and their counterparts in 5 out of the 15 EU countries. The first country, Italy (32.3 percent), shows a significant difference with the countries that follow; in second place is France (19.4 percent), in third place Greece (18 percent), in fourth place Germany (11.1 percent) and in fifth place Holland (10.1 percent). It is characteristic that the respondents declared that they have developed some form of collaboration, even on a very limited scale, with every EU country (Table 8).

The collaboration of Albania with EU countries in the healthcare sector has been developed in different areas, the most dominant being: information, personnel training and exchange of experiences in working practices.

Many healthcare units, totalling more than 50 percent of the sample, have participated in European programmes.

The countries with which the respondents reported collaboration in the implementation of Community programmes are Holland, Greece and Italy.

From the data in Table 9, concerning the categories of the EU country –member institutions with which trans-regional collaboration has been developed, results show that 69.6 percent are hospitals, 8 percent educational organizations and only 2.9 percent trade-union institutions. A higher frequency of collaboration with hospitals - more than the mean - is recorded with Greece, France, Italy and Germany. Collaboration with Educational Organizations has developed with 10 countries, while they have collaborated with trade-union institutions from 6 of the EU member countries.

Up to now their collaboration with EU countries has been evaluated as satisfactory (average grade 72). Their collaboration with Sweden, Belgium, Italy, Austria, Finland and Portugal has been evaluated more positively with rates higher than the average grades of satisfaction (Table 10).

They classify future collaboration with EU countries in order of preference in the following way (the classification includes the frequency of choices as well as first and second choice): Italy, Germany, United Kingdom, France, Greece and Denmark.

The areas proposed for the development of collaboration with EU countries are in the following order of preference: Exchange of experience in work practice, education – personnel training, exchanges of personnel – visits, studies – research, information, implementation of Community programmes and provision of services for users.

Table 8. With which of the following EU countries have you developed an interregional co-operation so far and in which fields?

Serial number	FIELD OF CO-OPERATION	N.A.	Information	Personnel training	Personnel exchange - visits	Studies - research	User servicing	Exchange of experience in work methods	Community programs	Other	TOTAL (*)
	COUNTRY	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
1	BELGIUM	1 *11,1*	3 *33,3*	1 *11,1*	 *0,0*	3 *33,3*	 *0,0*	1 *11,1*	 *0,0*	 *0,0*	**9** *4,1*
2	DENMARK	 *0,0*	4 *36,4*	2 *18,2*	1 *9,1*	6 *54,5*	1 *9,1*	1 *9,1*	 *0,0*	 *0,0*	**11** *5,1*
3	GERMANY	1 *4,2*	12 *50,0*	10 *41,7*	3 *12,5*	1 *4,2*	2 *8,3*	3 *12,5*	1 *4,2*	1 *4,2*	**24** *11,1*
4	GREECE	1 *2,6*	17 *43,6*	18 *46,2*	7 *17,9*	9 *23,1*	4 *10,3*	13 *33,3*	4 *10,3*	1 *2,6*	**39** *18,0*
5	SPAIN	 *0,0*	3 *75,0*	 *0,0*	 *0,0*	 *0,0*	1 *25,0*	 *0,0*	 *0,0*	 *0,0*	**4** *1,8*
6	FRANCE	 *0,0*	12 *28,6*	21 *50,0*	5 *11,9*	9 *21,4*	4 *9,5*	17 *40,5*	2 *4,8*	 *0,0*	**42** *19,4*
7	FINLAND	 *0,0*	3 *60,0*	1 *20,0*	1 *20,0*	 *0,0*	 *0,0*	2 *40,0*	 *0,0*	 *0,0*	**5** *2,3*
8	IRELAND	1 *16,7*	4 *66,7*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	1 *16,7*	 *0,0*	 *0,0*	**6** *2,8*
9	ITALY	2 *2,9*	21 *30,0*	24 *34,3*	11 *15,7*	8 *11,4*	8 *11,4*	28 *40,0*	7 *10,0*	6 *8,6*	**70** *32,3*
10	LUXEMBOURG	 *0,0*	3 *100,0*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	**3** *1,4*
11	HOLLAND	1 *4,5*	12 *54,5*	9 *40,9*	1 *4,5*	2 *9,1*	6 *27,1*	1 *4,5*	4 *18,2*	3 *13,6*	**22** *10,1*
12	AUSTRIA	 *0,0*	6 *46,2*	5 *38,5*	1 *7,7*	 *0,0*	3 *23,1*	4 *30,8*	1 *7,7*	1 *7,7*	**13** *6,0*
13	PORTUGAL	1 *20,0*	3 *60,0*	 *0,0*	 *0,0*	 *0,0*	 *0,0*	1 *20,0*	 *0,0*	 *0,0*	**5** *2,3*
14	SWEDEN	1 *16,7*	3 *50,0*	 *0,0*	 *0,0*	1 *16,7*	1 *16,7*	 *0,0*	 *0,0*	 *0,0*	**6** *2,8*
15	UNITED KINGDOM	1 *5,9*	9 *52,9*	4 *23,5*	1 *5,9*	2 *11,8*	1 *5,9*	5 *29,4*	1 *5,9*	1 *5,9*	**17** *7,8*
	TOTAL	10 *3,6*	115 *41,7*	95 *34,4*	31 *11,2*	41 *14,9*	31 *11,2*	77 *27,9*	20 *7,2*	13 *4,7*	**276**

Table 9. With which of the following EU countries have you developed inter-regional co-operation so far and with which bodies?

Serial number	BODY OF CO-OPERATION	N.A.	Hospital	Trade-union organ	Educational organization	Local Government	Enterprise	Other	TOTAL
	COUNTRY	0	1	2	3	4	5	6	
1	BELGIUM	4 *44,4*	5 *55,6*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	**9** *4,1*
2	DENMARK	3 *27,3*	5 *45,5*	3 *27,3*	1 *9,1*	*0,0*	*0,0*	*0,0*	**11** *5,1*
3	GERMANY	4 *16,7*	17 *70,8*	*0,0*	4 *16,7*	*0,0*	*0,0*	1 *4,2*	**24** *11,1*
4	GREECE	4 *10,3*	34 *87,2*	1 *2,6*	2 *5,1*	*0,0*	*0,0*	1 *2,6*	**39** *18,0*
5	SPAIN	3 *75,0*	1 *25,0*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	**4** *1,8*
6	FRANCE	3 *7,1*	34 *81,0*	1 *2,4*	4 *9,5*	*0,0*	*0,0*	3 *7,1*	**42** *19,4*
7	FINLAND	3 *60,0*	2 *40,0*	*0,0*	1 *20,0*	*0,0*	*0,0*	1 *20,0*	**5** *2,3*
8	IRELAND	3 *50,0*	2 *33,3*	*0,0*	*0,0*	*0,0*	1 *16,7*	*0,0*	**6** *2,8*
		7	57	1	4		1	4	**70**
9	ITALY	*10,0*	*81,4*	*1,4*	*5,7*	*0,0*	*1,4*	*5,7*	*32,3*
		2	1						**3**
10	LUXEMBOURG	*66,7*	*33,3*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	*1,4*
11	HOLLAND	3 *13,6*	12 *54,5*	1 *4,5*	1 *4,5*	*0,0*	3 *13,6*	3 *13,6*	**22** *10,1*
12	AUSTRIA	4 *30,8*	7 *53,8*	*0,0*	2 *15,4*	*0,0*	*0,0*	2 *15,4*	**13** *6,0*
13	PORTUGAL	2 *40,0*	1 *20,0*	*0,0*	1 *20,0*	*0,0*	1 *20,0*	*0,0*	**5** *2,3*
14	SWEDEN	3 *50,0*	3 *50,0*	*0,0*	*0,0*	*0,0*	*0,0*	*0,0*	**6** *2,8*
15	UNITED KINGDOM	4 *23,5*	11 *64,7*	1 *5,9*	2 *11,8*	*0,0*	*0,0*	1 *5,9*	**17** *7,8*
	TOTAL	52 *18,8*	192 *69,6*	8 *2,9*	22 *8,0*	0 *0,0*	6 *2,2*	16 *5,8*	**276**

Table 10. With which of the following EU countries have you developed an inter-regional co-operation so far? (rate your experience on a 1-5 scale)

			negative >>> very positive						
serial number	EXPERIENCE RATING	N.A.	1	2	3	4	5	TOTAL	AVERAGE SCORE on a 0 - 100 scale
1	BELGIUM	4 44,4	0,0	0,0	0,0	2 22,2	3 33,3	9 100,0	**90**
2	DENMARK	5 45,5	0,0	3 27,3	1 9,1	1 9,1	1 9,1	11 100,0	**50**
3	GERMANY	6 25,0	2 8,3	1 4,2	3 12,5	6 25,0	6 25,0	24 100,0	**65**
4	GREECE	8 20,5	4 10,3	2 5,1	11 28,2	10 25,6	4 10,3	39 100,0	**56**
5	SPAIN	3 75,0	0,0	0,0	1 25,0	0,0	0,0	4 100,0	**50**
6	FRANCE	12 28,6	1 2,4	0,0	5 11,9	15 35,7	9 21,4	42 100,0	**76**
7	FINLAND	4 80,0	0,0	0,0	0,0	1 20,0	0,0	5 100,0	**75**
8	IRELAND	5 83,3	0,0	0,0	1 16,7	0,0	0,0	6 100,0	**50**
9	ITALY	13 18,6	1 1,4	1 1,4	9 12,9	24 34,3	22 31,4	70 100,0	**79**
10	LUXEMBOURG	3 100,0	0,0	0,0	0,0	0,0	0,0	3 100,0	-
11	HOLLAND	7 31,8	0,0	0,0	6 27,3	6 27,3	3 13,6	22 100,0	**70**
12	AUSTRIA	7 53,8	0,0	0,0	1 7,7	3 23,1	2 15,4	13 100,0	**79**
13	PORTUGAL	3 60,0	0,0	0,0	1 20,0	0,0	1 20,0	5 100,0	**75**
14	SWEDEN	4 66,7	0,0	0,0	0,0	0,0	2 33,3	6 100,0	**100**
15	UNITED KINGDOM	7 41,2	1 5,9	0,0	2 11,8	3 17,6	4 23,5	17 100,0	**73**
	TOTAL	91 33,0	9 3,3	7 2,5	41 14,9	71 25,7	57 20,7	276 100,0	**72**

With regard to the *inter- Balkan collaboration* of Albanian healthcare units, to date, it has been developed mainly with Greece, followed by Turkey. Collaboration between Albania and the Balkan countries as a whole has been developed to a limited degree.

This collaboration between the Balkan countries and Albania has been developed in different areas, the most prevalent being: information, personnel training and exchange of experience in working practices. (Table 11).

Table 11. With which of the following Balkan countries have you developed inter-regional co-operation so far and in which fields?

Serial number	FIELD OF CO-OPERATION	N.A.	Information	Personnel training	Personnel exchanges - visits	Studies - research	User servicing	Exchange of experience in work methods	Community programs	Other	TOTAL (*)
	COUNTRY	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	
1	ALBANIA	*0,0*	4 *36,4*	1 *9,1*	2 *18,2*	1 *9,1*	3 *27,3*	2 *18,2*	1 *9,1*	*0,0*	**11** *5,1*
2	BULGARIA	1 *6,3*	6 *37,5*	2 *12,5*	1 *6,3*	1 *6,3*	*0,0*	1 *6,3*	2 *12,5*	6 *37,5*	**16** *7,4*
3	GREECE	3 *5,4*	20 *35,7*	17 *30,4*	8 *14,3*	6 *10,7*	5 *8,9*	11 *19,6*	3 *5,4*	7 *12,5*	**56** *25,8*
4	FRY	1 *7,1*	7 *50,0*	2 *14,3*	1 *7,1*	2 *14,3*	*0,0*	3 *21,4*	1 *7,1*	4 *28,6*	**14** *6,5*
5	FYROM	2 *18,2*	6 *54,5*	1 *9,1*	1 *9,1*	1 *9,1*	*0,0*	4 *36,4*	*0,0*	*0,0*	**11** *5,1*
6	ROMANIA	*0,0*	9 *56,3*	3 *18,8*	2 *12,5*	1 *6,3*	*0,0*	1 *6,3*	2 *12,5*	2 *12,5*	**16** *7,4*
7	TURKEY	1 *2,9*	11 *32,4*	9 *26,5*	3 *8,8*	3 *8,8*	8 *23,5*	4 *11,8*	2 *5,9*	8 *23,5*	**34** *15,7*
	TOTAL	8 *5,1*	63 *39,9*	35 *22,2*	18 *11,4*	15 *9,5*	16 *10,1*	26 *16,5*	11 *7,0*	27 *17,1*	***158***

The data in Table 12, concerning the categories of institutions in Balkan countries with which it has developed trans-regional collaboration, show that 49.4 percent are hospitals, 7 percent educational organizations, 2.5 percent enterprises and only 1.3 percent trade-union institutions.

The evaluation of its collaboration with Balkan countries is perceived as satisfactory (average grade 68). Its collaboration with the Former Republic of Yugoslavia

(FRY), Bulgaria and Turkey has been evaluated more positively and with more than average grades of satisfaction. Up to now its collaboration with Greece has shown a rate of satisfaction of 62 percent (Table 13).

Future collaboration with Balkan countries is classified in order of preference (the frequency of choices as well as first and second choice, is included in the classification,) as follows: Greece, Turkey, Romania, Bulgaria, FRY and FYROM.

The areas in which Albanian healthcare units give priority for the growth of collaboration with Balkan countries are in the following order of preference: Exchange of experience in work practices, education – personnel training, exchanges of personnel – visits, information, studies – research, implementation of EU programmes, provision of services for users.

No differences have been established regarding the collaboration of existing and future sectors of healthcare units in Albania with those in EU and Balkan countries.

Table 12. With which of the following Balkan countries have you developed interregional co-operation so far and with which bodies?

Serial number	BODIES OF CO-OPERATION	N.A.	Hospital	Trade union organ.	Educational organization	Local Government	Enterprise	Other	TOTAL
	COUNTRY	**0**	**1**	**2**	**3**	**4**	**5**	**6**	
1	ALBANIA	3 *27,3*	5 *45,5*	 *0,0*	1 *9,1*	 *0,0*	2 *18,2*	 *0,0*	**11** *5,1*
2	BULGARIA	4 *25,0*	5 *31,3*	 *0,0*	2 *12,5*	 *0,0*	 *0,0*	6 *37,5*	**16** *7,4*
3	GREECE	12 *21,4*	37 *66,1*	 *0,0*	3 *5,4*	 *0,0*	 *0,0*	6 *10,7*	**56** *25,8*
4	FRY	5 *35,7*	4 *28,6*	1 *7,1*	1 *7,1*	 *0,0*	 *0,0*	4 *28,6*	**14** *6,5*
5	FYROM	4 *36,4*	4 *36,4*	 *0,0*	1 *9,1*	 *0,0*	 *0,0*	3 *27,3*	**11** *5,1*
6	ROMANIA	3 *18,8*	6 *37,5*	1 *6,3*	1 *6,3*	 *0,0*	 *0,0*	6 *37,5*	**16** *7,4*
7	TURKEY	7 *20,6*	17 *50,0*	 *0,0*	2 *5,9*	1 *2,9*	2 *5,9*	7 *20,6*	**34** *15,7*
	TOTAL	38 *24,1*	78 *49,4*	2 *1,3*	11 *7,0*	1 *0,6*	4 *2,5*	32 *20,3*	***158***

Table 13. With which of the following Balkan countries have you developed inter-regional co-operation so far? (rate your experience on a 1-5 scale)

			negative >>> very positive						
Serial number	RATING OF EXPERIENCE	**N.A.**	**1**	**2**	**3**	**4**	**5**	**TOTAL**	**AVERAGE SCORE** *on a 0 - 100 scale*
1	ALBANIA	5 *45,5*	*0,0*	*0,0*	2 *18,2*	*0,0*	4 *36,4*	11 *100,0*	**83**
2	BULGARIA	5 *31,3*	*0,0*	*0,0*	2 *12,5*	7 *43,8*	2 *12,5*	16 *100,0*	**75**
3	GREECE	17 *30,4*	2 *3,6*	3 *5,4*	13 *23,2*	16 *28,6*	5 *8,9*	56 *100,0*	**62**
4	FRY	5 *35,7*	*0,0*	*0,0*	1 *7,1*	6 *42,9*	2 *14,3*	14 *100,0*	**78**
5	FYROM	9 *81,8*	*0,0*	*0,0*	2 *18,2*	*0,0*	*0,0*	11 *100,0*	**50**
6	ROMANIA	4 *25,0*	*0,0*	2 *12,5*	6 *37,5*	4 *25,0*	*0,0*	16 *100,0*	**54**
7	TURKEY	12 *35,3*	1 *2,9*	*0,0*	3 *8,8*	12 *35,3*	6 *17,6*	34 *100,0*	**75**
	TOTAL	57 *36,1*	3 *1,9*	5 *3,2*	29 *18,4*	45 *28,5*	19 *12,0*	158 *100,0*	**68**

5. Conclusions

The dominant anti state-tendency which has been adopted in Balkan countries in transition due to the implementation of "stability programmes" has led to a decline in the state and public sectors of the economy.

Since 1989 and the start of the transitional phase to a market economy, the main features of the Health Systems in the Balkan countries have been privatization, decentralization, the decrease in public expenses and generally the introduction of market elements into the healthcare sector. The collapse of economies, the increase in poverty and social and income polarization have led to the dramatic deterioration of Health Systems. These problems have been experienced with greater intensity in the healthcare sector of Albania.

The international donor community has given health in this region a low priority. Post–emergence development aid largely focused on infrastructure and neglected the need for a sustainable health sector; at the same time it put insufficient emphasis on

increasing the healthcare sector or on increasing the capacity of public healthcare services.

Healthcare sector employees in Albania were less satisfied with the situation in this sector before 1989, more satisfied with the present situation and quite optimistic about the future. The institutional framework of public health is evaluated as being rather "conservative". In the 'employees' opinion, the largest obstacles to the modernization of the system are bureaucracy, corruption, the lack of resources and the institutional framework.

The existing public healthcare system in Albania seems unable to secure to a satisfactory degree the objectives of equal opportunities, social rights of citizens as well as the effective provision of services oriented to the needs of users of public services.

The main factors contributing to the modernization of the public health sector in Albania seem to be: the improvement of the ratio of healthcare personnel to population, the increased number of doctors, nursing and administrative personnel, the training of healthcare personnel, the modern decentralized organization and management of resources and human potential accompanied by the increase of resources, the improvement of infrastructures and the effective use of new technologies.

To confront these particular problems, trans-regional collaboration with their counterparts in EU member countries and mainly neighbouring Balkan countries is sought by Albanian healthcare institutions. This is due mainly to the strategic aim of Albania to be integrated into the European Union as well as the better level of healthcare systems in EU member countries. In order of precedence, the sectors of existing as well as desired collaboration are: information, personnel training and the exchange of experience in work practices. In any case the improvement of the healthcare system in Albania depends firstly on the general economic and social development of the country, and secondly, on the use of experience, know-how and the contribution of trans- regional European and Balkan co-operation.

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