

1. Structural organization

1.1 Main national stakeholders involved in the planning, production, management and regulation of human resources for health:

<i>Organization</i>	<i>Functions</i>
Ministry of Health	Planning, monitoring and developing HRH policies
Ministry of Education and Science	Designing curricula and leading the education process
Health professional education institutions	Delivering HRH education
Ministry of Finance	Budget planning and financing of MoH and MoE projects
Health Insurance Institute	Financing services provided by primary health care staff
Institute of Public Health	Postgraduate training for public health specialists, in collaboration with the Faculty of Medicine
National Centre for Quality, Safety and Accreditation of Health Institutions	Trains monitors and supervisors of service quality
Professional associations	Participate in development of ethical standards and clinical protocols

1.2 Coordination between the ministries of health and education in relation to the planning, production, management and regulation of human resources for health: Responsibility health professional education lies with the Ministry of Education, while the responsibility for HRH licensing, employing, and planning lies with the MoH.

Analytical comment on the effectiveness of the organizational arrangements for HRH and collaboration between stakeholders, key issues and challenges: Collaboration is difficult, slow and bureaucratic. The lack of exchange of data on HR makes analysis and judgment difficult. The rapidly changing health service environment, characterized by the growth of privatization, demands much clearer separation between the planning, policy-making and executive functions to enable the ministry to respond quickly to newly emerging issues. Stakeholder involvement is weak in many respects - for example, the professional associations do not negotiate pay or influence education policy, although MoH policy expects that professional bodies will be involved in and influence HRH planning and continuing professional development.

2. Policy framework

2.1 Explicit national human resources policy/strategy: There is no HRH strategy.

2.2 Main strategic objectives of the human resources for health policy: There is a general long-term strategy (2008-2013) to be approved in 2008 which, among other things, outlines some HRH objectives:

- Collaboration with the donor community to design and implement a robust training programme for health services managers will be sought. Links will be established with the international projects dedicated to professional training.
- While this training programme is put in place, at least four key health managers will be sent abroad every year to train in internationally recognised public health schools (at least 20 people in five years).

Analytical comment on the effectiveness of the policy, main issues and challenges: The health sector overall lacks policies and strategies, while priorities compete. Policy development faces many challenges: the MoH structure does not enable adequate separation between the policy, planning and executive functions. Employment practices have not been modernized, and current practices inhibit the development of a modern health service. Information on vacancies and staff mobility is either not available or not assembled in a form that enables planners and decision-makers to make consistent decisions on HRH deployment.

3. HRH planning in state-provided public services

3.1 HRH planning in state-provided public services: HR planning does not exist as a formal or regular process, while HR management is addressed in terms of personnel functions which do not include a strategic view of HR development. The concept of proactive management is not yet accepted. The HR information system does not support improved planning and management. HR performance objectives are not established in most institutions.

3.2 Planning time-frame: To date this has been rigid and short term, but demographic changes are driving moves towards greater flexibility and responsiveness.

3.3 Decentralization in HRH planning: Decentralized planning occurs only in primary health care. Staffing in health centres has been reorganised and strengthened to improve services through a single financing source. Staffing norms and standards were determined for the health centres, within the framework of health insurance financing, but the centres have some autonomy - each can determine its own staffing levels, with the director controlling recruitment in consultation with a board comprising the director of the Public Health Directorate of the district, one representative of the local health Insurance and one representative from local government. Concerning the hospital and public health services the planning is completely centralized, although funding of HRH through health insurance is being piloted in the hospital sector. In the pilot hospital funded by the health insurance scheme, the hospital board plans HRH, while other hospitals funded directly from the state budget present their plans to the MoH, which has the final say.

3.4 Staffing norms/standards (such as number of nurses per physician, or per facility type according to levels of care): Only for the PHC such norms are determined at national level, based on the analysis of certain indicators including population size, type of service, geography, morbidity, and bed occupancy rate. They are then related to staff/population ratios: for example, in rural areas there should be one doctor for 1700 inhabitants, and one to 2000 in urban areas. These are only for doctors. There is nothing written for nurses.

3.5 HR distribution between different levels of care (primary care, secondary care, tertiary care, etc): There are imbalances between PHC and hospitals, which are oversupplied with doctors and nurses.

3.6 Geographical balance of the distribution of HR: There are marked regional imbalances; the variations are highest for medical specialists. The relatively smaller variation in general practitioner coverage appears to reflect concerted government efforts to change the ratio of GPs to specialist doctors, and to improve GP salaries, especially for those working in remote rural areas. Many health professionals have migrated to urban areas. The MoH is working to establish the right balance using the following mechanisms: salary differentiation based on place of work;

staff deployment in line with population coverage; and contractual arrangements to ensure that doctors from urban areas move to rural areas where they are most needed.

3.7 Personnel categories in which there are shortages or surpluses: There are too many medical specialists in all specialties to allow new graduates to choose their preferred specialization.

Table 3.7.1: Staff shortages and surpluses

Category/specialty	Shortage	Surplus
Physicians	Public health, pathology, intensive care	Hospitals; gynaecology (especially in Tirana and Durres)
Nurses	Generalised, including hospitals. There is lack of specialisation, For example paediatrician nurse.	-

Analytical comment on the effectiveness of HRH planning, the key issues and the main challenges: HRH planning is currently ineffective. The challenge is to correct the skewed geographical distribution over time, as part of an overall HRH plan, and to strengthen services in the regions. The failure to balance supply and demand results in discrepancies.

4. HRH stock and distribution

Table 4.1: Numbers and distribution

Note: this table gives data from a variety of sources, as indicated. These are international databases produced by the WHO Regional Office for Europe, the Organisation for Economic Cooperation and Development, and the European Commission, supplemented with data from official sources at country level. The indicators used here are those employed by the WHO Health for All Database (see <http://data.euro.who.int/hfadb> for full definitions). Extreme caution must be used in interpreting this data, as each database may use different assumptions, definitions, and time frames for data collection. The data are rarely directly comparable across these different sources.

Indicator	Value	Range	WHO Europe average (2004w)	EU 25 average (2003-4w)
Employment in health sector as % of total employment	3% (2003c)			EEA 7% (2002o)
Physicians Total number	4100w (2002)			
Physicians per 100 000 population (PP)	132,9 w (2003)		353	348
Physicians per 100 000 (FTE)	N/A			
GPs per 100 000 (PP)	51		66	99
Medical specialists per 100 000	50		115	121
Surgical specialists per 100 000	7		42	38
Gynaecologists per 100 000	6		19	14
Paediatricians per 100 000	5		27	15
Other specialists per 100 000	24			
% of physicians working in the hospital sector	44%			
% of physicians in active employment	N/A			
% of physicians working in the private sector	N/A			
Dentists Total number	1035			
Dentists per 100 000 (PP)	33		51	63
Dentists per 100 000 (FTE)	N/A			
% in active employment	N/A			
% working in the private sector	N/A			
Nurses Total number	12 746			
Nurses per 100 000 (PP)	406			719
Nurses per 100 000 (FTE)				

% working in the hospital sector	48%			
% in active employment				
% working in the private sector				
Midwives Total number	912			
Midwives per 100 000 (PP)	29		44	36
Feldshers Total number	No longer exist			
Pharmacists Total number	1173 (state)			
Pharmacists per 100 000	38		51	78
Public health specialists Total number	132			
% in active employment				
Non-medical professionals Total number	2468			
% in active employment				
Managers Total number	82			
Support workers Total number	2772			
Other indicators	10:13			
Female:male ratio among physicians				
Male:female ratio among active physicians				
Male:female ratio among nurses	2:7			
Male:female ratio among active nurses				
Ratio nurses to physicians	7:2		2:1 (2000w)	

Sources: c = country sources; e = Eurostat; o = OECD Health Data; w = WHO European Health for All Database (Note: year cited relates to year database accessed or year for which most recent figures available, and not necessarily to year when data collected in country).

4.2 HRH age pyramid: The health care workforce is quite young, with an average age under 45, and with distinct gender patterns. Nurses, midwives, pharmacists, and dentists are overwhelmingly female, while specialist physicians are overwhelmingly male. General practice appears to be the best balanced profession in terms of gender, although the younger cohort of GPs has a higher proportion of men, unlike the older cohorts which are predominantly female. Physicians are much older on average than the other professions, with 25% of GPs and 27% of specialists being 50 or older. This compares with 19% of pharmacists, 15% of dentists, and 17% of nurses and midwives. The retirement age recently increased to 60 for women and 64.5 for men.

Table 4.2.1: Age distribution of HRH– males (MoH 2003)

	< 30	30-40	40-50	50-55	55-60	60-65	Totali
Physicians							
Specialists	110	380	450	250	98	45	1333
GPs	55	345	275	150	35	10	860
Dentists	45	180	245	75	35		580
Pharmacists	28	75	102	55	18		278
Nurses	65	890	920	54	20		1949

Tabela 4.2.1:-- Age distribution of HRH– females (Mohr 2003)

	< 30	30-40	40-50	50-55	55-60	60-65	Totali
Physicians							
Specialists	55	130	165	45	30		425
GPs	35	190	380	180	55	12	852
Dentists	40	350	250	65	25		730
Pharmacists	60	260	420	110	40		890
Nurses	780	4245	3865	1860	354		11109

Midwives	215	1245	895	250	120		2725
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Analytical comment on the total stock of human resources, and on trends in HR supply in the last 10-15 years; comparisons with the rest of the region; closeness to policy objectives; main issues and challenges for the future: Although the health sector's share of total paid employment has risen since 2002, it still constitutes a relatively modest 3% of the total. Low health service utilization rates do not imply an HRH oversupply, because there have been periodical reductions in HRH numbers. Physician and nurse densities are similar to those of other lower-middle-income countries, but are the lowest and fourth lowest respectively in the European Region. There is only one psychiatrist per 78 000 people. GP density is higher, reflecting the government's efforts to improve access to primary care. In some remote areas there are some shortages in GP and specialists. The physician workforce is overspecialized, but the skill level of many specialists is low compared to elsewhere in Europe. There is now an evident need to adapt postgraduate medical courses to more general branches like internal medicine and emergency care. The relatively high ratio of nurses to physicians is the result of a relatively low density of physicians rather than an oversupply of nurses. There is considerable scope for substituting nursing time for physician time and clerical staff for nursing staff in hospitals in the medium to longer term. However, there is a shortage of nurses, particularly in hospitals. Albania is relatively better endowed with dentists and pharmacists; both professions have largely been privatized. The main challenge is the regulation of the labour market in the health sector. More health professionals are needed at all levels, especially for those areas where there are shortages, keeping in mind the age pyramid.

5. HRH management and performance

5.1. Health professional salaries:

Table 5.1.1: Average salary by type of institution (x 1000 Lek) 2003

Provider type	Physicians	Nurses	Low medical personnel	Admin staff	Technical	Support
All providers						
Tirana	21.8	16.7	16.6	32.6	13.4	12.9
Outside Tirana	21.0	16.3	16.0	26.3	13.4	12.9
University hospital	23.7	17.5	17.9	44.0	13.4	12.9
Other hospitals	21.7	16.8	16.8	23.9	13.4	12.9
Polyclinics	20.0	15.9	15.0	28.6	13.4	12.9
Health centers*	42.8	15.9	15.0		n/a	12.9
Health posts*	26.1	15.9	15.0		n/a	12.9
Other MOH of which		16.2	15.6	31.5	18.5	12.9
IPH			15.2	27.7	13.4	12.9

National Drug Center			16.2	28.1	13.4	12.9
Gov. Medical Service Cent				24.6	13.4	12.9
National Blood Center					13.4	12.9
Biomedical workshop		16.2		22.7	13.4	12.9

Source: MOH. *Physicians salaries for health centers and health posts are from HII

Health sector wages have tended to lag behind other parts of the public sector and are significantly behind the education sector, often used as a benchmark in other countries. Only construction and agriculture have lower average wages.

Hospital sector wages have recently grown faster than other health sector wages. Polyclinics and health centres have the lowest growth rates, at around 10% per year (the national rate of inflation was 3.8 % in 2007). Salaries vary little except. The Director of the Hospital University Center, Tirana, earns €810 (Euro) gross a month; a surgeon €380; a physician €360; a nurse €270. A district hospital director earns €70; a surgeon €320; a physician €310; a nurse €240. Some professions have supplements that may greatly increase their overall earnings. For example, nurses may earn service increments (2% a year), as well as for shift work, on call, and specific functions. There are more opportunities to access these additional payments in urban areas. Deductions include social and health insurance (11%) and tax (10%).

5.2 Comparison of the average general practitioner salary to that of a hospital medical specialist: GPs/family doctors are paid more than hospital specialists. A government salary review may shift this balance. There are salary differentials based on qualifications as financial incentives for GPs working in remote areas.

5.3 Special incentives (financial or non-financial) to encourage health professionals to work in remote or otherwise underserved areas: Only physicians' salary structures explicitly recognize regional differences, reflecting the government's policy of encouraging GPs to remain in rural areas. GP remuneration has been structured to allow for significant location premiums, in addition to capitation supplements to the basic salary. These factors can lead to substantial differences: for example, the minimum salary for a young physician with a normal patient load (1700) in a non-remote commune is about 32 000 lek per month, while the same physician would earn about 21 000 in a central municipality and 61 000 in a remote mountainous commune. These policies appear to be quite effective and are likely to explain the relatively narrower range of distribution of GPs compared to other health professions. Moreover, as seen in the table below, higher salaries are paid in areas that are relatively underserved. In PHC, 5% of the budget may be paid as a bonus to health centres that achieve indicators defined in the contract

Table 5.3.3: Urban and rural salaries

	Minimum salary	Maximum salary	Average salary
GP urban area	25	42	33
GP rural area	35	60	47
Premium for rural	40.0%	42.9%	42.4%
Specialist urban/rural	19.3	20.8	20
Nurse urban/rural	14.5	17.3	15.9

Source Ministry of Health

5.4 Average hours worked by physicians and nurses in hospital and outpatient settings: The normal working week is six days, 40 hours a week. Health centres are open for 12 hours a day, meaning two shifts. Physician productivity is low; on average, a GP sees only about eight patients per day.

5.5 Procedure for licensing health professionals: The Order of Physicians and Order of Pharmacists are responsible bodies that recognize and certify professional qualifications, on the basis of notarised copies of professional diplomas and documentation. Any doctor, dentist, pharmacist or nurse, Albanian or foreign, who wishes to practise in the private health sector must obtain a licence from the Ministry of Health, which accepts requests and prepares documentation for the Special Commission on Licensing. The individual professional licence serves as recognition of qualification to practise when specific criteria are met, including proof of registration and extract of the registration of the business with the National Registration Center and proof of membership of the Order of Physicians (physician and dentist) or Order of Pharmacists (pharmacists). Under a new law, health professionals after finishing training will have to undergo a mandatory year's practice and then take an examination before a panel of MoH, medical faculty and Order of Professionals. They will then be licensed to have the right to practise independently. Relicensing will be required after 5 years (probably linked with continuing education credits).

5.6 Estimated unemployment rates among health professionals: Not known. The official general unemployment rate is about 14%.

5.7 Public-private sector dynamics: There is insufficient information on private sector activities in the health care system and the capacity to monitor such activity is largely absent. Although still relatively small, private provision of outpatient services is growing. Dental care and the pharmaceutical sector are largely privatized. Some private services are financed and organized by foreign NGOs, private agencies and religious bodies. The Hospital Act allows for establishment of private inpatient facilities. Private facilities are concentrated in the two largest cities, Tirana and Durres. About 4300 professionals work in the private health care sector, with dentists and pharmacists accounting for about a third and 45% respectively. Employment is growing in the private health sector, but not at the direct expense of the public sector. There is a trend towards working in the private sector after completing regular working hours in the public sector, which has implications for the control of quality and potential abuse of working hours in the public sector. Newly qualified doctors prefer to work in the private sector, especially in Tirana, than in the public sector outside the capital where they are contracted. But although the private sector offers better working conditions and salaries, working in the state sector creates a

feeling of more security. There are advantageous opportunities to work in the private sector, but HRH policies are lacking; there is a need to regulate the drift of HRH from the public to the private sector. It is hoped to increase HRH public sector salaries by 20% each year.

Analytical comment on the effectiveness of HR management; whether the incentives encourage behaviour that contributes to policy objectives; the main issues and challenges: There are no incentive mechanisms to encourage HRH to achieve the objectives. Key challenges to avoid a brain drain of HRH abroad or to private settings, and to curb informal payments, include introducing recruitment processes based on documented knowledge, skills and experience and not political influence; introduction of financial mechanisms to encourage employment in rural and remote areas; introduction of performance-related pay; define HRH career pathways; increase salaries; and introduce annual staff appraisal.

6. Migration

6.1 Overall trends in migration: The trend is to leave the country, especially nurses, where in addition to individual initiative there are institutional requests from other countries. This trend depletes the system.

6.2 Estimated number of foreign professionals in the health workforce: 30.

6.3 Estimated annual outflow of human resources by category: The phenomenon exists but there is no information.

Analytical comment on whether migration trends favour or harm the health system; main issues and challenges: Migration trends may harm the health care system and challenge its sustainability, especially the impact on reducing the already understocked nursing workforce.

7. Education of health professionals

7.1 Educational institutions: There are several medical faculties, public and private. The private faculty at Kristal University teaches, pharmacy and nursing, while the Lady of Good Counsel University teaches medicine, pharmacy, dentistry, nursing and physiotherapy.

Table 7.1.1: Number of educational public institutions by type of training programme, 2001-3

Profession	Institution
Physicians	U of Tirana
Dentists	U of Tirana
Pharmacists	U of Tirana
Nurses	Vlore
	Tirane
	Elbasan
	Korçe
	Shkoder
	Gjirokaster

Source: INSTAT

Table 7.1.2: Training courses in 2008

Occupation	Duration of course (years)	Number of programmes
Specialist doctor	4	28
GP/Family Physician	2	1
Doctor	6	1
Dentist	5	1
Pharmacist	5	1
Nurse, midwife Laboratory and radiology technician	3+ 2	Nursing Faculty includes six programmes (nurse, midwife, laboratory and radiology technician, physiotherapist, logopedist)

7.2 Student numbers

Table 7.2.1: Number of admissions and graduates

Indicator	Annual student intake (2006-2007c)	Annual number of graduates (2007c)	Graduates per 100 000 population	WHO Europe – graduates per 100 000, average (2003w)
Physicians	250	200	6.7	10
Nurses	975	1166 ¹	32	31
Midwives	208	60	2	3
Pharmacists	100	80	2.6	3
Dentists	100	100	3.3	2

Note 1: This is the first year that nurses graduate at the end of the three-year system (according to Bologna system 3+2). The last nurses of the old four-year system graduated in the same year.

The number of physician graduates declined dramatically - almost 50% since 1997 - but rose after 2003 due to the opening of private faculties. The number of nurses qualifying has increased, but there is high wastage from outmigration. Dentists and pharmacist graduate numbers fluctuated. Compared to the existing workforce, the number of graduates is exceedingly low for nurses and pharmacists, but has risen for physicians and dentists.

Table 7.2.2: Total graduates by year, 1997-2003

	1997	1998	1999	2000	2001	2002	2003
Doctors	336	239	153	150	144	172	188
Nurses		117	140	164	188	245	
Dentists	57	44	27	32	68	67	77
Pharmacists	39	30	19	32	12	32	36

Source :Database 'Health for All' www.who.dk/hfadb

Table 7.2.3: Graduates per 100 practising professionals by year, 1997-2003

	1997	1998	1999	2000	2001	2002	2003
Doctors	7.8	6.8	3.5	3.5	3.5	4.2	4.6
Nurses	0.0	0.9	1.1	1.3	1.6	2.1	0.0
Dentists	4.2	3.2	1.9	2.5	5.4	5.2	6.0
Pharmacists	3.1	2.4	1.5	2.6	1.0	2.6	2.9

Source :Database 'Health for All' www.who.dk/hfadb

7.3 Health professional education and the Bologna process: Albania has signed up to the process. The nursing faculty programme in Tirana is based on the Bologna 3+2: in the first three years there is an obligatory basic, general curriculum, and continuation to a specialised level in the last two years. Medical, pharmaceutical and dentistry education does not conform to the process.

7.4 Accreditation and licensing of educational institutions: All public and private universities, including training clinics, must be licensed by the MoE. There are no available data to check the accuracy of the licensing and accreditation process and training standards. The MoH is planning a professional development system with three components: a centre for HRH continuing education; a staff certification/validation system; and an accreditation system for training programmes. The MoH, through the National Centre of Accreditation of Health Institutions, has started to develop standards for accreditation of health institutions (hospitals, primary health care, laboratory, dentistry and pharmacy standards). Once these standards are approved by MoH and the law of accreditation is in place, the process of accrediting health institutions will begin.

7.5 Proportion of educational institutions that are accredited/licensed: All.

7.6 Structure and duration of education:

Basic education programmes for doctors, dentists, pharmacists, nurses and midwives are supervised by the Ministry of Education. The table shows current intakes and outputs of basic education. Post-basic training is provided for doctors, pharmacists and dentists.

7.7 Training in family medicine: This is a recognized specialty. Following basic medical education, after which a doctor is called a 'general practitioner', a two-year postgraduate education programme is required to become a family doctor. Most doctors working in PHC have not done any specialist training, so the MoH, and Pro Shendet project funded by USAID, is conducting a short training course for all those contracted by the health insurance institute.

7.8 Other professional training:

(a) Public health: a three-year programme.

(b) Health management: Within the framework of a World Bank Project, the first course on health management and planning started in 2000 at the Institute of Public Health. It provides training for directors and specialists in public health, and Health Insurance Institute regional directors. By 2007, 130 had been trained. The course lasts five months. It is also planned to send at least four managers abroad every year for management training at internationally recognised schools.

7.9 Continuing professional development (CPD) for all health professionals: There is no structured continuing education; it is provided occasionally based on priority needs. A Swiss cooperation project implemented through a Swiss-Canadian consortium aims to create a stable and sustainable process for accreditation of all training courses. The MoH is planning a professional development system that will comprise a Centre for Continuing Education of Health Staff (CCEHS); an accreditation system for the training programmes; and an HRH certification/validation system. The centre will identify and assess HRH training needs; propose priorities for CPD; provide technical assistance to the development of a national CPD plan; and coordinate programmes and activities in line with the plan. The accreditation system will outline the credits to be awarded after each programme, and ensure the quality of training programmes. The certification/validation will be linked to recognition of CPD activities through a system of credits on the basis of course attendance or completion of prescribed hours of continuing education, aiming at periodic relicensing necessary for practice, promotion and other benefits.

7.10 Postgraduate specialization for physicians: There are 30 specialties.

Analytical comment on the quality of health professional education; alignment to HR planning; leverage used; main issues and challenges: Postgraduate specialization needs are identified annually by districts and linked to national and local specified goals and objectives. The emerging needs include:

- A well-structured system for postgraduate specialization, attuned with the real needs of health services (especially family medicine, internal medicine and emergency services);
- strengthening of university teaching capacities;
- increased responsibility during hospital practical sessions; and
- improvement of family medicine curricula.

8. Regulatory systems

8.1 Health professional education: For the professional education of doctors, dentists, pharmacists, nurses, midwives and laboratory technicians, the following procedure is followed: after finishing high school, the candidate competes in the public faculties according to criteria and procedures established by the MoE. The planned number of admissions is defined by the Council of Ministers. The winners are selected through a national list. Admission to private universities is based on criteria defined by the universities themselves.

<i>Type of regulation</i>	<i>Responsible agency</i>	<i>Comments</i>
Law for university education	Ministry of Education	No Bologna process

8.2 Employment: Recruitment in health institutions under the MoH is based on competition in line with unified criteria. There is a public announcement of each vacancy and open applications. Selection is made by the directorate of the institution, based on the institution's criteria and the interview with the candidate.

<i>Type of regulation</i>	<i>Responsible agency</i>	<i>Comments</i>
National Code of Labour	MoH	Regulates terms of employment in the private sector, based on individual contract between employer and employee.
Law 8549: Civil Servant Status	Public Administration Department	All civil service posts, e.g. MoH, are filled by open competition. Candidates work a probation year.

8.3 Standards of professional practice and conduct:

<i>Type of regulation</i>	<i>Responsible agency</i>	<i>Comments</i>
Code of Ethics and Medical Deontology	Order of Physicians	

8.4 Migration: Foreign citizens who intend to work as doctors, dentists and pharmacists must obtain an equivalent diploma recognized by the Ministry of Education and membership of the Order of Physicians or Pharmacists, and demonstrate acceptance and application of codes of conduct and all regulations governing the health service.

<i>Type of regulation</i>	<i>Responsible agency</i>	<i>Comments</i>
Law	MoE/MoH	

Analytical comment on the effectiveness of these regulatory systems; how, and how well, they are enforced; main issues and challenges: These regulations are enforced.

9. Finance

9.1 HRH wage bill as a proportion of total health expenditure: 42%.

9.2 Financing of undergraduate education of health professionals: The public education institutions for health professionals are funded by the state. At the beginning of each study year all students must pay a registration fee of €250. Students in the public faculties may receive a state scholarship for board and lodging according to criteria set by the Council of Ministers. There are also scholarships for those who have achieved high results during high school and undergraduate studies. In private faculties the fees are paid by the students themselves, and range from €3000 to €4500.

9.3 Funding of continuing professional development: There is no structured CPD; it is provided ad hoc according to priority needs. Funding is a mix of provision from the state and donors.

Analytical comment on the effectiveness and adequacy of these funding mechanisms, main issues and challenges: The 6% of GDP that Albania spends on health care is in line with the average for lower middle-income countries, but its public sector consumes a below-average share of this expenditure. As a result of low public-sector spending, out-of-pocket expenditure at the point of service accounts for almost 60% of sectoral funding. Better negotiation and coordination with donors is needed for fundraising. Earmarked budgets are needed for CPD.

10. Data sources used in this profile

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