1. INTRODUCTION

The goal of the current health care reforms in Russia is to establish a sustainable and equitable health care system compatible with new societal realities. Major problems have been created by the current economic situation, which makes it very difficult to raise revenues for health care. Consequently, it is especially important to maximize the efficiency and effectiveness of the current system.

Health sector reforms have been focused principally upon changing organizational structures and financial flows for health care. However, it is unlikely that these reforms will be successful without improved and more effective management. This becomes even more important in that the main trend in state policy toward health services is to increase institutional freedom with respect to operational issues.

In the Russian health care system, the public sector has traditionally played a leading role; thus making developments that are taking place in public administration especially important. However, these developments are not now central to Russian health care because presently health services are managed by physicians, many of whom have no managerial training. Given the changing conditions of Russian health care, and the increasing role of management in carrying out health care reforms, the present system of educating health managers needs to be improved. Health managers need training in the new skills that are required to implement successfully these reforms.

Since medical universities have a monopoly in educating doctors, these universities also have succeeded in monopolizing the delivery of health management (HM) education and training. While some medical universities have started to develop HM programs, they have been slow in responding to the emerging needs for highly trained health care managers. In addition, most medical universities lack experience in teaching management disciplines.

Public administration (PA) schools have the potential to educate health managers – and, in fact, some do offer programs in health management as one area of specialization. However, with the doctors’ monopoly of the health care sector, such programs are unlikely to have much influence and they will not gain popularity without the cooperation of the medical profession. PA faculties must change the situation by raising awareness among doctors as to the importance of management science and of interdisciplinary knowledge for the effective management of health care systems.

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2. COUNTRY PROFILE AND PUBLIC ADMINISTRATION OVERVIEW

Russia is a vast country of about 144 million inhabitants. It is a federation of 89 regions. Recently, Russia has gone through difficult reforms aimed at creating a democratic society based on a market economy. The transformation of society impacts upon every aspect of national life, including the growing public sector. The system of public administration in Russia is undergoing serious changes as a part of the market-oriented reforms occurring in the country. The role and effectiveness of the state – what the state should do, and how it should do it – is at the center of a more general discussion about the role of the state in economic and social development. Thus, the efficiency and effectiveness of the public sector – and how it is managed – are on the political agenda of the country’s national and regional governments.

Despite wide-scale privatization in Russia, the public sector is still very significant in scope. Indeed, about 37% of employed individuals still work in the public sector. Nevertheless, the major policy trend in Russia has been the minimization of the role of the state – especially as a direct provider of social services (including health) and increasing the efficiency of the state administration. Government is to focus on core public activities and to develop incentives to enable public officials to do their jobs better. Russian scholars and policy makers are well-acquainted with the discussions on these issues carried out in the international arena, including by such international organizations as OECD and the World Bank. With Russian reforms though, often the rhetoric is not reflected in practical measures: implementation has always been a weak point of the Russian policy process.

One of the major problems in the Russian public sector is coordination – both in terms of vertical relationships between different levels of government and horizontal relationships between various ministries and departments. Another major problem is the dispersion of authority, especially in the financial field. Although new tax and budget codes were adopted in the late 1990s, the power of the regions to raise money to carry out their functions – so-called fiscal federalism – is not yet clearly defined. Regional disparities in social and economic development are substantial, and the federal government faces the problem of creating effective mechanisms for the redistribution of resources between regions.

In Russia, "public administration" refers to both the civil service and to the state-owned organizations that are widespread in the social sector. In fact, the distinction between public administration and management in Russia is rather blurred, especially in practice, although the word "administration" is more often used to denote management in the public sector, while management tends to refer to "management in the private sector.” Nevertheless, it is common to find the position of manager in public sector organizations. This distinction is probably more strictly followed in educational programs.

Managing a public bureaucracy in Russia is a very challenging task because of:

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2 The basic legislation that regulates the activities of civil servants is the Fundamentals of the Civil Service, adopted in 1995.
• low financing (state organizations are usually underfinanced in terms of both the planned budgetary appropriations and the actual amounts received during the fiscal year); and
• low salaries (in practice, this means low morale), because there is a special salary scale for staff of state organizations.

Presently, the government is promoting reforms that would reintroduce separate salary scales for each government branch (i.e., education, health care, science, etc.). Civil servants are in a slightly better position, since they are entitled to certain privileges, e.g., better pensions. Currently under discussion is a proposal that people working in state organizations in the social sector (e.g., doctors, teachers) should be treated as civil servants and thus obtain the privileges of civil servants.

The issue of corruption is very acute for Russian public administration. There is a general belief that low salaries in the public sector make bribes attractive to public administrators. In open debates, a number of remedies have been offered; however, the problem still persists and Russia is frequently characterized as one of the most corrupt countries in the world.

3. PUBLIC ADMINISTRATION EDUCATION

Russia has many faculties and programs where students can obtain a master’s degree in public administration or public management (MPA/MPM) or a PA/PM-equivalent bachelor’s degree. In general, the structure of PA education in Russia is the same as in other humanitarian/social science specialties. In Soviet times, students studied in the university for five years to get a graduate degree. At present, higher education in Russia is being reformed along Western lines: bachelor’s degrees (four years) and master’s degrees (one or two years more, for a total of five or six years) are being introduced everywhere. Postgraduate education includes doctoral degrees (Ph.D.) and retraining courses to improve skills in areas often unrelated to the area of the basic degree. Business management education is now much more popular in Russia than PA/PM, however, primarily because working in the private sector is more prestigious and financially rewarding for young people.

Public administration/public management is taught at:
• faculties of public (and municipal) management/administration which offer degrees in PA; and
• chairs at other, mostly MBA-type, faculties which offer degrees in management with a public management specialization.

Among the most popular educational institutions in the field of PA education are Moscow State University (Faculty of Public Administration) and the Academy of Management in Moscow (Faculty of Public/Municipal Administration). They both offer undergraduate and postgraduate training in PA. Other important schools are, for example, the Higher School of Economics in Moscow (Faculty of Public Administration); Piatigorsky State University in Pyatigorsk (Faculty

3 In Russia, there are two doctoral degrees – Candidat nauk and Doctor nauk.
of Civil Service and PA); and Pomorsky State University in Arkhangelsk (Faculty of Management).

The best-known PA/PM chairs are at the Diplomatic Academy (Moscow) – chair of PA and IT; the Russian Economic Academy named after Plekhanov (Moscow) – chair of PA in the Faculty of Management; the Russian University for International Friendship (Moscow) – chair of public and municipal management in the Faculty of Humanitarian and Social Sciences; St. Petersburg State University – chair of PA in the Faculty of Management; Siktivkarsky State University (Siktivkar) – chair of PA in the Faculty of Management; Tomsky State University (Tomsk) – chair of PA in the Faculty of Management; and Cheliabinsky State University (Cheliabinsk) – chair of theory and practice of PA. It is impossible to describe fully the country’s various PA/PM programs, but this small sample shows that there are different institutional approaches to delivering PA/PM education.

The leading role in postgraduate retraining in PA belongs to the State Academy of Civil Service, established under the auspices of the Office of the President. It issues special certificates in PA for people working as public administrators but holding graduate degrees in other disciplines. The State Academy of Civil Service is based in Moscow and has branches in several Russian regions. At present, this is the most popular form of staff development in the public sector. It enables people to improve their managerial capabilities and adopt new information technology, and, in so doing, also improve significantly their career prospects. This type of education also is more efficient in that graduates of retraining programs return to their work while no one is certain about the careers of students graduating from PA faculties. The other important training institution is the Academy of National Economy, under the government of the Russian Federation – it is the faculty for top public administrators. There also are many other training centers, but they are too numerous to list, given the scale of the country.

A strategic aim of PA education in Russia is to change public sector bureaucrats who are spending public money into cost-conscious managers who are accountable for results. Russia is following the actions taken in developed countries by emphasizing the importance of management development in the public sector. Although PA education in Soviet times was not well-established in the classical Western sense, Russian educational programs in the field are now highly influenced by Western analogues, and lecturers often have undergone training in Western universities. But this is where the contradiction arises between Western-based theories and practices and Russian reality. The Russian educational tradition tends to favor more academic knowledge, while in managerial training there is a need to take a more practical approach and use case studies. As a result, many Russian PA education programs have a stronger policy than management component. A major problem in analyzing the successes and failures of PA education in Russia, however, is the difficulty, given the very large number of new programs, of assessing the quality of teaching.
4. HEALTH CARE IN RUSSIA: FROM THE SEMASHKO MODEL TO COMPULSORY HEALTH INSURANCE

The problems discussed above generally apply to state health services which, as a result of past history, are the predominant majority of Russian health services. When Russia was an integral part of the USSR, almost all health care was financed and provided by the state (the so-called Semashko model), with the private practice of medicine the rare exception. While significant achievements of this earlier system are generally recognized, major drawbacks are also well known. The Semashko model showed positive outcomes in times when the principal aim of health care was to fight infectious diseases but it could not ensure the proper level of treatment of chronic illnesses. Thus, chronic illnesses constituted an increasing share in the morbidity structure. The health care system continued to expand and become broader (e.g., setting up new polyclinics and hospitals, training more professionals). However, Soviet leaders and researchers did not give adequate attention to the problems associated with increasing the health care system’s efficiency when the resources allocated by society to health care decreased due to slowdowns in economic growth (Korchiagin 1990; Preker and Feachem 1994; Sheiman 1995; Stains 1999).

The transition to a market economy and the decentralization of decision-making inevitably led to reform in health care. This reform has been strategically carried out through the introduction of compulsory health insurance (CHI) and the decentralization of health care financing and management. The principles of CHI and the mechanisms of its implementation were articulated in legal documents that include the 1991 Law on CHI. The following was introduced:

- universal CHI coverage;
- health insurance contributions paid by employers, with local administrations paying for the unemployed;
- a basic CHI program of compulsory medical insurance (CMI), including a minimum set of medical services provided by the CMI system, adopted at the federal level - with regional programs having a similar scope as the federal one;
- individuals and organizations could participate in voluntary health insurance; and
- the system of CHI funds – the federal fund of CHI and the regional funds of CHI – were to be set up as independent state non-commercial credit and monetary agencies committed to comprehensive CHI, social justice and equality, and the financial stability of the system. The CHI funds were to accumulate contributions and transfer these resources to health services either directly or via special health insurance companies (HICs) (as independent non-profit organizations). The main functions of HICs were to conclude contracts with health services (e.g., hospitals, polyclinics); to reimburse them for medical services provided for the insured; to defend the interests of the insured; and to control the quality of health care.

By the year 2000, the federal CHI fund, 90 regional CHI funds (with 1,129 branches), and 362 HICs had been set up in Russia. At present, CHI funds are regionally based in two respects: first, regional CHI funds are independent bodies but not branches of the federal CHI fund, as is the
case, for example, with the Pension Fund. Second, CHI funds collect contributions from both employers and regional administrations. The employers' CHI contribution is fixed at 3.6% of payroll, divided between the federal CHI fund (0.2 percent) and a regional CHI fund (3.4 percent) covering only the employees and not including their dependents. The CHI contributions of regional authorities cover medical treatment for those not employed (e.g., children, pensioners).

By the end of the 1990s, it had become apparent that CHI had failed to bring about clear positive results, especially improvement in access to and/or quality of medical services. In fact, the quality and scope of medical services, as well as the health status of the population, had continued to decline. Hospitals and polyclinics suffered from a lack of equipment and medications. People had the same problems of access to and quality of medical services. Facilities, in many cases, needed major renovations and new equipment. In many hospitals, patients had to provide medication, food, and even bed linen for themselves.

The CHI itself had encountered serious problems. First, there was the grave problem of using insurance policies issued by a regional fund to get medical treatment outside the fund’s area. Moreover, by 2000 only about 30%, or 8,210 health services that included 5,649 hospitals, 1,900 primary care/policlinics and 661 dental clinics, had joined the CHI system.

As a result, three CHI models have emerged during the course of health care reform. In some Russian regions, reforms have developed as planned by the relevant legislation. Regional CHI funds accumulate resources and conclude contracts with HICs, which act as insurers and directly provide health services. However, in 15 regions, the only CHI funds that function are those that collect money and act as insurers. HICs have not been set up and health services receive money from the CHI or their branches directly. In the rest of the regions, a combined system has evolved, with CHI funds and their branches, as well as HICs, acting as insurers. Their shares vary substantially, though, depending on the region.

A second serious problem encountered in the development of the CHI concerns the collection of payments. Enterprises, as well as regional administrations, often do not fulfil their commitments. In many regions, health authorities are unwilling to make contributions for the economically non-active population. According to the federal fund data, the share of payments by employers amounts to about 60% of all CHI receipts, whereas contributions for the unemployed are about 26%.

At present, on average, more than 65% of the resources to cover health care needs come from the budgets of different levels, including 80% from local budgets, with the remaining resources (close to 35%) being CHI’s share. There are substantial regional variations in CHI’s share of total health care expenditures; percentages fluctuate from 2% in the Saratov region to nearly 78% in the Samara region.

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4 Social funds in Russia include four out-of-budget funds: The Pension Fund, The Employment Fund, The Social Security Fund and funds of CHI.

5 In accord with the new Tax Code, starting in 2000 CHI contributions are collected by tax inspectors as a share of a new unified social tax.
The reforms in health care have not been accompanied by relevant organizational changes. In fact, new structures – the CHI funds – were simply embedded into the old administrative system, which remained practically intact. Understandably, this has led to conflict between various players in the health care field, including the Ministry of Health, regional health authorities, the federal CHI fund, regional CHI funds, health insurance companies, and health services. This conflict has added to the ineffectiveness of health care reform.

Relations between the CHI agencies and the regional and local health authorities have not developed smoothly. Both sides have been fighting for supremacy in the health care system and they often cannot come to a mutual understanding or achieve compromise. The structure of the health care system itself has not improved: the number of excess beds, a target of criticism from the Soviet model, has not, in fact, substantially lessened, and no significant improvement in primary health care has occurred.

The number of medical personnel, mainly nurses, has, however, declined, primarily due to the fact that wages/salaries in the health care system are still among the lowest in the country. The average wages for health care personnel amounted to about 60% of the average nominal wage in the national economy in 2000, while that of doctors amounted to about 80%. As a result, many medical professionals have to occupy two positions simultaneously. This enables them to get two salaries but definitely leads to work overload and poor quality medical treatment. Such a situation also leads to the widespread practice of giving “gratitude” payments to medical staff in Russia.

The main reform innovation in primary health care has been the introduction of the general practitioner (GP). At present, this is said to be the major development in the organization of health care in Russia. Despite the positive experiences with GPs in other countries, its introduction in Russia is likely to bring about many problems, the solution of which will require considerable additional investments.

The main problem with the health reforms underway in Russia is that they were not well thought through conceptually, and there was inadequate preparation for their implementation (Grigorieva 1998; Nazarova 2000). For example, regional administrators are entitled to define the amount of their contributions, taking into account the structure of the regional population and its health status. At the same time, contributions by enterprises and organizations are fixed by federal legislation, and a fine is imposed for non-payment. Although the dependency ratio is increasing, the contribution from regional authorities is only 31% of that paid by employers. Regional administrators have been, in practice, cutting down expenditures on health care by paying CHI contributions for unemployed individuals from their health budgets, thus simply redistributing budget funds.

As a result, even the proponents of CHI recognize the necessity to introduce changes into the health care system. It is not clear, though, what will happen as different proposals are discussed. One proposal, for example, has promoted the idea of combining social and health insurance by merging the CHI funds and the Social Insurance Fund. In addition, the Pension Fund is strongly
lobbying to manage the CHI funds for pensioners, and it is very likely to succeed. But whatever proposal is successful, it is likely to support the general trend of developing CHI in Russia.

5. HEALTH MANAGEMENT AND POLICY EDUCATION

Today the importance of health management education is acknowledged by virtually all of the relevant actors in Russia. Statements made by various health officials – from members of the State Dumas (Lower Chamber of the Russian Parliament) to the Minister of Health and heads of CHI funds – stress the need to improve the organization and management of health care services as they provide a vital link in the efficient delivery of quality care. Such statements result from increased recognition that competent management is essential in organizations and programs at every level. Thus, changes in the organization and financing of health care have created a need for well-qualified people who can manage health services in the new environment and who are trained in cost containment, quality assurance and strategies of access to health care. However, similar pressure concerning health policy knowledge and skills generally does not exist. This produces a gap in the education system, which as reflected in the discussion that follows, focuses entirely on health management education.

At present, there are about four million people working in health care in Russia in the system overseen by the Ministry of Health. This includes 680,000 doctors and 1.6 million nurses and other medical staff, or 45 doctors and 100.2 other medical staff per 10,000 population (a ratio of 1:2.5). Traditionally, people who occupy managerial positions in the health care system are almost all doctors. In fact, the health care system in Russia is managed by physicians. There is a very strong belief in the medical profession that only doctors can manage health services. It is reinforced by the fact that the Minister of Health, other senior health officials and members of Parliament who work in the Health Committee are all doctors. As a result, the dominant culture of health services has been static for years.

Most doctors work in the public sector and are salaried state employees. The salary of health administrators depends on the size of the institution, which is determined by the number of beds for hospitals of various types and the number of doctors’ positions for policlinics and other primary care health services. There are five qualification groups. Doctors working in dangerous conditions are entitled to extra payments; for example, doctors working in tuberculosis wards are entitled to an extra 15% payment; in psychiatric wards, 25%; and in leprosariums, 30%.

Health service administrative/management positions include:

- chief physicians (heads);
- deputy chief physicians;
- senior nurses; and
- heads of departments, laboratories, and units.

Health management (HM) education in Russia occurs in both medical universities/faculties and in non-medical universities/faculties. Both types of institutions offer graduate and postgraduate degrees in what is traditionally understood as HM education. Because top-level administrators in the health services delivery system are MDs, most health management programs are physically
and organizationally located in medical schools, under the administrative control of the Ministry of Health.

In general, medical education is under the strict control of the medical profession. There are 59 medical institutes, universities and academies in Russia, all controlled by the Ministry of Health. In cooperation with the Ministry of Education, the Ministry of Health develops the curriculum. A special higher medical and pharmaceutical education group (UMO, the teaching and pedagogical unit) in the Ministry of Education adopts medical education standards.

The three basic stages of medical education in Russia are
- graduate degree (six years of study);
- postgraduate professional training (two years either ordinatura or internatura) and postgraduate studies to apply for a research degree (Ph.D.) (aspirantura); and
- professional retraining (often in a new speciality).

Every year about 100,000 people graduate from medical universities. Beginning in 1994, the admission rate has been fixed in accordance with planned needs for doctors with various specialities – about 21,200 every year in total, including 19,800 full-time doctors. There is also a system of so-called targeted admissions for specific regions and programs; this involves a separate competition. Overall, the competition to enter medical universities is quite high – about five people per place, on average.

In addition to medical schools, several universities traditionally have had medical faculties (e.g., the Moscow State University named after Lomonosov, and the university named after Patrice Lumumba in Moscow). Medical faculties also exist in other Russian universities (e.g., Petrozavodsk, Chebiksari, Nalchick, Saransk, Yakutsk, Tula, Novgorod) – altogether there are 20 medical faculties in non-medical universities. But these medical faculties mostly offer biological specializations, psychology, social work in health, and (to a limited extent) health economics and management.

The Ministry of Health uses its authority to insure the leading positions of doctors in health management. For example, it issued a special decree (n337/1999) stipulating the medical qualifications that managers need to have in order to be appointed to administrative/management positions in health services. These are:

<table>
<thead>
<tr>
<th>Administrative/Management Position</th>
<th>Medical Qualification Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief doctor</td>
<td>Social hygiene and organization of health care* (or any clinical speciality)</td>
</tr>
<tr>
<td>Deputy chief doctor</td>
<td>Social hygiene and organization of health care* (or any clinical speciality)</td>
</tr>
<tr>
<td>Head of department</td>
<td>Clinical speciality of the department</td>
</tr>
</tbody>
</table>

**“Social hygiene and organization of health care” includes therapy, surgery, trauma and orthopaedics, endocrinology and physiotherapy.**
In spite of the dominance of medical schools in educating health managers, at present a number of non-medical universities – both general and polytechnic – offer health management programs. It is virtually impossible to tell how many such programs exist, although the general view is that the number of such programs is likely to grow. There are two basic types of health management programs, according to the degrees awarded:

- graduate (bachelor’s, master’s) degrees; and
- postgraduate degrees.

Graduate training in health services administration is a relatively new phenomenon in Russia. In fact, until the mid-1990s there was no graduate program in health management for people to be appointed as health managers. Doctors usually had no special managerial training, except that they were required to take retraining courses – as are all state employees – every five years.

The first degree-granting health management program in a medical university was established in 1996 at the Faculty of Health Management in the Moscow Medical Academy named after Sechenov (MMA). It is equivalent to a two-year ordinatura, for the training of health managers. The faculty also provide retraining courses for health managers and lecturers in health management. The program actively uses funds provided by international organizations (e.g., TACIS).

Health management programs offered by non-medical universities are designed along the standard lines for humanities/social sciences education programs (see the earlier section on PA education). Health management is offered as a specialization for managers focused upon public and municipal administration or management in the social sector.

One major problem is that medical universities do not grant management degrees. Students graduate as “social hygiene and organization of health care” specialists and the curriculum is definitely dominated by medicine-related disciplines. This is apparently done to stress that the graduates are doctors first. The Ministry of Health plans to introduce a new degree in public health and management. With regard to non-medical universities, the situation seems to be the opposite. They usually introduce health management as a specialization within management and/or public administration degrees. This means that students graduate, first of all, as managers and do not have any training in medicine.

These factors, together with the weak state standards for educational management, lead to a situation in which universities have much freedom in developing a health management curriculum. For example, the Moscow Medical Academy program includes a six-month placement with one of the health services or a local health administration. The curriculum includes courses in public health, health policy, health economics and statistics.

A number of postgraduate/retraining courses are designed for those who currently hold administrative positions. A major advantage of these courses is that most who finish this training will return to work at their original institutions. At present, these courses are mostly offered by specialized retraining centers affiliated with medical universities. They provide students with
formal certificates that are valid for a five-year retraining cycle. Currently, it appears that retraining courses developed by non-medical universities are mostly informal – people obtain new knowledge but receive no formal certificates, or at least none that are recognized by the health care authorities.

Changes in health management have produced a good opportunity for nurses to increase their status within the Russian health care system. After graduating from nursing colleges, they now can study at medical universities for four years and receive graduate degrees in management. In 2000, 22 Russian medical universities offered students such a degree (full-time, part-time and distant learning format). Graduates from Russian medical universities during the period 1996 to 2000 included 947 graduate nurses (managers); every year about 250 nurses (managers) receive degrees. About 748 nurses (managers) are working for health authorities and in health services. However, graduate nurses (managers) are not able to take administrative positions in the doctors' managerial hierarchy; rather, they can work as chief nurses or directors of nursing homes or hospices, or (subject to having five years of work experience) can move up the hierarchy within nursing.

Finally, it is important to note that there is a clear lack of cooperation between medical and non-medical universities in training health managers. Moreover, neither side seems to be willing to promote such cooperation. The medical profession considers any attempts by other professionals to develop education in health management as a threat to its dominance in health care.

6. CONCLUSIONS: MAIN DILEMMAS IN HEALTH MANAGEMENT EDUCATION

Effectively managing the changes resulting from new and emerging public policies will be the most significant future responsibility of health services managers. This will require a broad knowledge of issues and options, as well as new approaches to management.

Having doctors serve as managers makes it difficult to reconcile managerial and professional cultures. Doctors have always regulated access to health care; they have always made the decisions as to whether patients should be treated and with what level of intervention. “Clinical freedom” assumes that doctors make decisions in the best interests of the patients. Professionals are guided in their activities, first of all, by the interests of their clients, while managers must think about the interests of the organization as a whole, and often society at large. In health care, this “conflict" is even more evident, since there is a need for both professional and managerial expertise when making decisions that affect quality, access and efficiency.

Russian health managers are usually medical professionals who perform management functions. This means that they typically perform clinical work – from the Minister of Health, who travels on a regular basis from Moscow to St. Petersburg to operate on patients in the St. Petersburg military hospital, to heads of the departments or units in hospitals or policlinics. These individuals have had to combine general managerial tasks with the management of clinical activities and physicians.
Normally, physicians have had little, if any, management training prior to assuming this responsibility. Their expectations are established by means of an education that is hospital, technology and specialty centered. Thus, balancing managerial and professional functions puts additional pressure on physicians. For example, a study on the social profile of health managers in Krasnoyarsk showed that health administrators often lack knowledge about how to deal with people.

Professional and managerial careers are interlinked in the Russian health care system. To a large extent, an administrative position is a form of recognition of a doctor’s talents and qualifications. Doctors are salaried employees of a state-run organization, and a managerial position means that the doctor is moving up the career ladder. Today, administrators not only need specific managerial knowledge, but also the ability to be proactive and risk-taking. By becoming managers, doctors get a higher salary and more prestige, but on the other hand, they often need to change some of their approaches to people and work.

It would be too strong to state that doctors are incapable of managing health services. But a number of reservations need to be considered in resolving this doctor-manager dichotomy:

- Professional and managerial cultures differ. Doctors focus on treating patients, while managers are concerned with institutional sustainability.
- Cost considerations also are important. It is much more expensive to train a doctor than a manager. Therefore, diverting doctors from performing their primary tasks is quite expensive for a society that lacks adequate resources for health care.
- The lack of formal managerial education makes the life of a doctor-manager difficult. He or she has to learn from their mistakes without having access to the vast experience in the field accumulated elsewhere.

There currently are four major dilemmas in health management education in Russia. First, there is the tension between the doctors' monopoly on health administration, on the one hand, and, on the other, the promotion of a new culture that emphasizes the increased role of effective management in the new environment of decentralization and, in so doing, promotes and raises the status of managers. This raises the issue of the need for physician-managers as opposed to full-time general managers/public administrators with no clinical functions. Here, economic considerations should be taken into account, since it might be more efficient and effective in terms of time, money, and quality of service to use doctors to perform their original tasks rather than employing them as managers.

The complexity of the challenges facing, and the consequences for, communities requires that there be purposeful preparation for a career in health services management. Previous training in medicine or nursing is useful, but not sufficient. Individuals with clinical backgrounds need an in-depth knowledge of management and social sciences as they are applied to health. Those with management training need a systematic knowledge of medicine and health. As a rule, medical schools do not teach management, and management schools do not teach health. The solution might be to establish partnerships between medical schools and management schools in training managers for health care. But at present this is a challenging task, as the medical profession tries to preserve its ultimate control in health care.
In fact, PA schools – if they want to continue to offer health management education, whether for prestige and/or money, need to lead the process of establishing effective cooperation with the medical profession in educating health managers. Useful starting points might be new domains in education that are now gaining popularity (as well as moral and financial support from state authorities) which include

- joint training of doctors and social workers to promote interdisciplinary work with socially vulnerable groups of the population; and
- retraining personnel for CHI bodies.

Second, the state monopoly in health care – both in financing and delivery – is being seriously questioned in Russia. There are already numerous private clinics in the country, and their number is increasing. Charging fees for service has also become quite common, even in the state health services; which means that patients who can pay are likely to be favored. What model of management, public or private, should Russia adopt in promoting health management education? Or, should health management education be diversified according to the needs of a particular organization? Regardless, programs should combine the content that is essential to successful management in the health sector.

Third, there are different layers of health management – e.g., Ministry of Health, chief doctors, heads of departments. Thus, it makes sense to have different health management degrees. At this stage, health management education should also address the needs of health policy makers, since there is no other opportunity for them to gain any health policy making knowledge other than through health management programs. Unfortunately, public health policy is not popular with faculties of political science, and thus health management programs are able to raise their status by introducing health policy components. Moreover, including health policy may help promote professional health management programs.

Fourth, in order to further develop health management education it is first necessary to have relevant information about its current state in Russia. However, at this stage it is very difficult, if not impossible, to evaluate the quality of teaching and to follow graduates’ careers. The diverse health management courses offered by various higher education institutions, as well as the lack of communication and experience-sharing among these institutions, suggest that the quality of programs, in terms of structure and content, may not fully comply with international standards. On the other hand, it is unclear whether health management program graduates have an opportunity to use their knowledge at their workplaces and whether they really occupy managerial positions in health services.

To conclude, managing health care in modern Russia poses challenges to all parties concerned; including public administrators and the medical profession. Regardless of the challenges, however, it is clear that, given the complexity of the health care system, health care reforms are unlikely to be successful without the development of well-established health management and policy education and training opportunities.
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