CHAPTER ONE

MANAGEMENT WORK

Health is often pursued through a variety of health programs and projects. For example, when a young adult achieves academic success and starts a promising career after overcoming a drug addiction, an effective treatment program may deserve much of the credit for the turnaround. When a person with type 2 diabetes leads an active and productive life, her health improvements may well be attributed to a program that helps her understand the disease and take an active role in controlling it. When a county health department mounts a project to enroll children in an innovative insurance plan, the impact on those children may be felt throughout a lifetime of better health.

One of the distinguishing characteristics of successful programs and projects is how well their managers perform. This book is about the work these managers do. This chapter provides an overview of management work in health programs and projects, as well as some key definitions and concepts, all of which serve as a framework for the remainder of the book. Management work is described in terms of the core activities–strategizing, designing, and leading–managers undertake in performing this work. After reading this chapter, the reader should be able to do the following:

- Define health, health programs and projects, and management
- Understand the core and facilitative activities of managers' work

- Understand the roles managers play as they do management work
- Appreciate the underlying skills and competencies used by managers in doing management work
- Understand the importance of applying well-developed personal ethical standards in doing management work

As a backdrop for considering management work, it is important to know that three distinct types of work occur in health programs and projects (Charns and Gittell 2000). *Direct work* entails the actual provision of services or creation of products for which a program or project exists. This type of work is done by counselors, nurses, therapists, physicians, health educators, and others who form what Mintzberg (1983) terms the "operating core" of a program or project.

A second type of work done in health programs and projects is *support work*. This work is a necessary and facilitative adjunct to the direct work. In health programs and projects, people performing support work are involved in such activities as fund raising and development, recruiting patients for a clinical trial, providing legal counsel, marketing a program or enhancing public relations for a project, or providing accounting and financial services.

The third type of work done in health programs and projects is *management work*. This work involves establishing–often with the direct participation of others–the results a program or project is intended to achieve and creating the circumstances through which the direct work, aided by support work, can lead to the desired results.

An example will clarify the different types of work. A manager may establish the desired result of a project as enrolling one thousand children in an innovative insurance plan. The act of enrolling children in the plan is the direct work of the project. The manager may also arrange for publicity about the plan to increase awareness and encourage enrollment. The provision of publicity is support work. Establishing the desired result, assigning and training project staff to help parents or guardians enroll children, and arranging for publicity is management work.

As we will see in this chapter, there are two basic ways to assess and study management work. It can be approached in terms of the *activities* managers engage in as they do their work and in terms of the *roles* they play in performing this work. We will examine management work from both perspectives. We will also discuss the *skills* and *competencies* needed to do management work well. Before considering management work, however, it will be useful to define key terms such as *health, health programs and projects,* and *management.*

Health and Health Determinants

The World Health Organization (http://www.who.int.htm) provides a long-standing definition of *health* as the "state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organization 1948, p. 100). Another version of this definition views health as a state in which the biological and clinical indicators of organ function are maximized and in which physical, mental, and role functioning in everyday life are also maximized (Brook and McGlynn 1991). The state of health in human beings is a function of many variables, or *health determinants,* as they are often called. The wide variety of determinants means that health programs and projects have an enormous range of possible foci.

Health determinants for individuals or populations include the physical environments in which people live and work; their behaviors; their biology (genetic makeup and the physical and mental health conditions acquired during life); a host of social factors that include economic circumstances, socioeconomic position in society, income distribution, discrimination based on factors such as race/ethnicity, gender, or sexual orientation, and the availability of social networks and social support; and the health services to which they have access (Evans, Barer, and Marmor 1994; Berkman and Kawachi 2000). Health programs and projects can be focused on any of these determinants, as well as on combinations of them.

Health Programs and Projects as Logic Models and as Organizations

The most useful way to get a clear picture of what a program is and does is to think of it as a *theory* (Patton 1997; Weiss 1998) or *hypothesis*. Like all theories, the theory of a program or project is simply a plausible, sensible model of how it is supposed to work (Bickman 1987). The way a program or project is intended to work can be described as a theory or hypothesis by developing a series of *if, then* statements about it. For example, a particular program or project can be characterized as follows: *If* resources a, b, and c are assembled; and *then* processed by doing m, n, and o with the resources; and *if* the processing is done well, *then* the results will be x, y, and z. Using its underlying theory or hypothesis as a guideline, any program or project can be described in terms of the inputs available for

it to use, the processes it undertakes with the resources, and the results it achieves by processing the resources.

Implicit in the hypothesis or theory of a program or project is its underlying rationale or logic (Renger and Titcomb 2002). In fact, for any program or project, it is possible to draw a logic model of how it is supposed to work (W. K. Kellogg Foundation 2001). A logic model presents a schematic picture of the relationships among the inputs or resources available to a program or project, the processes undertaken with the inputs, and the results the program or project is intended to achieve. Figure 1.1 depicts a basic logic model for a program or project.

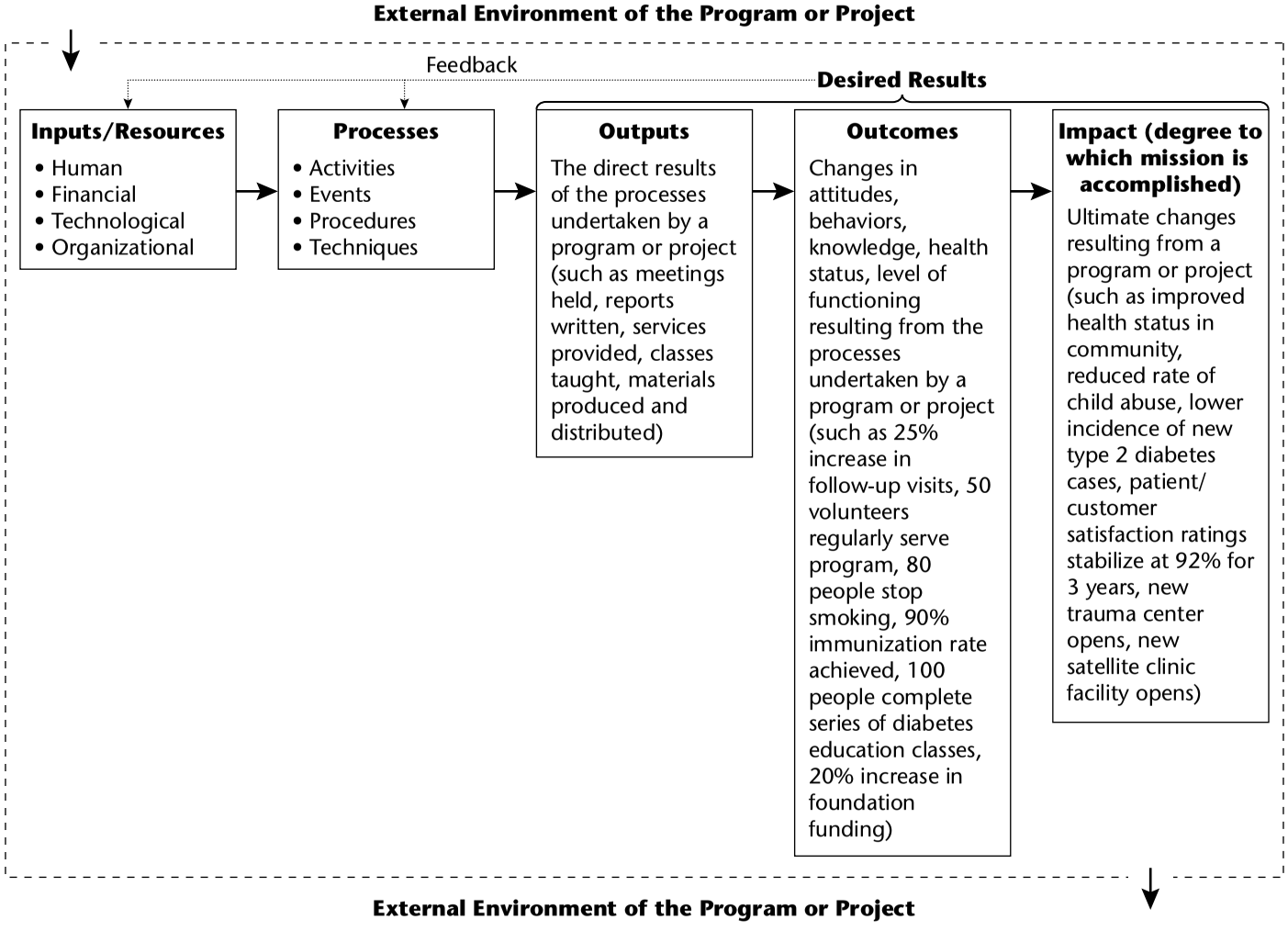
This logic model shows how *inputs* and *resources* are *processed* in attempting to accomplish the program or project's desired results in the form of *outputs, outcomes,* and ultimately *impact*. In effect, the logic model provides a road map of how a program or project is intended to work. There is a feedback loop from desired results to inputs and resources and processes indicating that adjustments will be necessary in them in an ongoing program or project. Very importantly, it shows the program or project existing within a larger *external environment*.

The external environment of a program or project includes many variables that can influence its performance. These are illustrated in Figure 1.1 by the arrow that flows from the environment into the program or project's logic model. These external variables include everything from the cultural milieu of the community in which the program or project is undertaken to its physical climate. It also includes economic conditions, the state of health of the population the program or project might serve, housing patterns, demographic patterns, political environment, background and experiences of program participants, media influence, public policies, and the priorities and resources of the larger organization in which a program or project may be embedded.

External variables can influence almost everything about a program or project including whom it seeks to serve, the extent of recipients' needs for the program or project's services, the resources available to the program or project, the quality of its staff and volunteers, how smoothly implementation occurs, and the pace at which results are seen. A program or project cannot be completely separated from its external environment. All programs and projects are affected by and affect their external environments.

The results of a program or project flow out into its external environment. This is shown in Figure 1.1 by the arrow that flows outward into the external environment. This arrow means that the outputs, outcomes, and impact of a program or project flow outward and affect the individuals and populations that it serves. The concept of the logic model of a program or project will be useful throughout this book, beginning with how we think about programs and projects as organizations.

FIGURE 1.1. THE LOGIC MODEL OF A PROGRAM OR PROJECT.



A program or project cannot exist as a theory or hypothesis. Actual programs and projects take the form of groups of people and other resources formally associated with each other through intentionally designed patterns of relationships in order to pursue some pre-established results. That is they exist as *organizations,* albeit rather small ones. Organizations can be very large, involving thousands of participants. Expansive integrated health care systems or state health departments, for example, are large organizations. Even though programs and projects are typically much smaller than such organizations, they meet the definition of organizations. Programs and projects can be defined as groups of people and other resources formally associated with each other through intentionally designed patterns of relationships in order to pursue desired results.

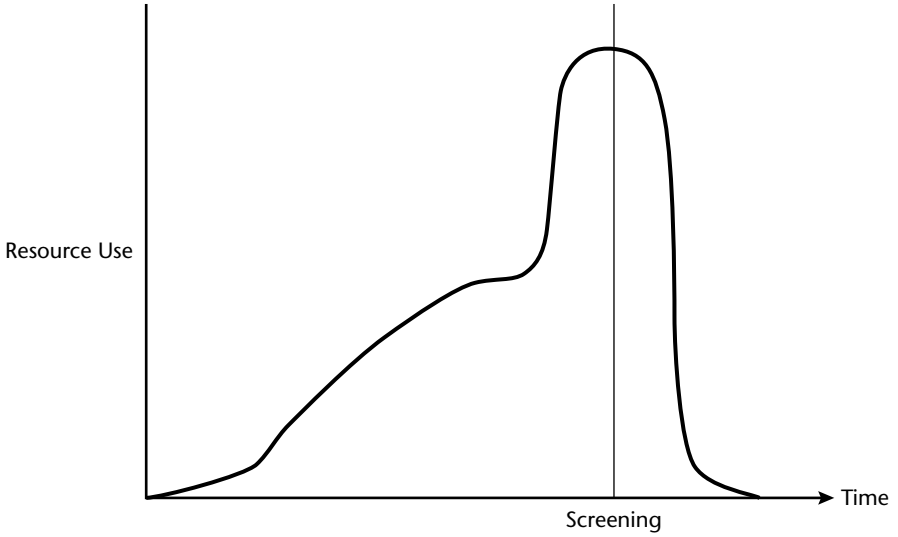
Programs or projects that pertain to any of the determinants of health noted previously are *health programs or projects.* Thus health programs and projects address some aspect of the physical environments in which people live and work, as well as their behaviors, their biology, the social factors that affect them, and health services.

Programs and projects differ in only one major respect, although this difference is important in managing them. Projects are a subset of programs that are time-limited. That is, a project has a *pre-determined life cycle,* and a program has an *indeterminate life cycle.* The duration of a project is scheduled at its beginning, although some run for longer or shorter durations than originally planned because of changing circumstances. Projects have specific beginning and ending points (Frame 2003). Programs have indeterminate life expectancies in that they are expected to go on indefinitely.

Figure 1.2 graphically *depicts a project life cycle.* Assume that the project is intended to conduct diabetes screenings at an annual health fair. The curve reflects the consumption of human, financial, and material resources during the life cycle of the project. A gradual build up of activity during which arrangements are made for the conduct of the screenings precedes the peak of activity when the actual conduct of the screenings occurs. The peak is followed immediately by the project's conclusion and termination.

Examples of *health programs* include those in cancer care, cardiac rehabilitation, data and statistics, geriatrics, health education, home care, palliative care, prevention, promotion, research and development, substance abuse, wellness, and women's health. Less obvious examples of health programs include housing programs, job training, or programs to clean up the physical environment, as well as programs aimed at reducing ignorance, discrimination, or poverty. These less obvious examples are also health programs because they also address one or another health determinant. Appendix A provides a brief description of a health program embedded in the Glendale Adventist Medical Center, Hearts N' Health. Note the ongoing nature of this program reflected in the final paragraph of the description.

FIGURE 1.2. A PROJECT'S LIFE CYCLE.



Examples of *health projects* include research or demonstration projects pertaining to a health determinant, as well as projects to promote seat belt use, healthier eating, or safe sex practices. Projects also may be designed to achieve some specific physical or intellectual purpose within a larger program or organization, such as designing and equipping a laboratory, training staff members in a new protocol or how to use some new technology, designing an information system, or developing a strategic plan or a new accounting system. Appendix B provides a brief overview of a project embedded in the Office of Minority Health, U.S. Department of Health and Human Services, to develop a set of national standards for culturally and linguistically appropriate health services. Note that the project terminated with the publication of the standards as reflected in the final paragraph of the overview.

Typically, health programs and projects are embedded within larger organizational settings or homes, such as health departments, hospitals, health plans, nonprofit organizations or agencies, long-term care organizations, or large integrated health systems. Both the program and the project illustrated in Appendices A and B are embedded in larger organizations; one is embedded in a public health agency of the federal government and the other in a private health care

organization. It is possible for a program, however, to be freestanding from any other organization, perhaps having its own governing board. When health programs and projects are embedded within larger organizations like departments and other sub-divisions of the larger organizations, it is useful to think of these programs and projects as *organizations within organizations.*

Program and Project Management

Program or project management is defined as the activities through which the desired outputs, outcomes, and impact of a program or project are established and pursued through various processes using human and other resources. Following the basic logic model of a program or project shown in Figure 1.1, it can be seen that managers, often with help from other participants in a program or project, seek to accomplish the following:

- Determine a program or project's desired outputs, outcomes, and impact
- Assemble the necessary inputs and resources to achieve the desired results
- Determine the processes necessary to accomplish the desired results and ensure that the processes are carried out effectively and efficiently
- Do the things noted previously while analyzing variables in the program or project's external environment, assessing their importance and relevance, and responding to them appropriately

In performing management work, managers engage in an interrelated set of *activities* and play a mosaic of interconnected *roles,* both of which are facilitated by possession and use of certain *skills* and *competencies*. The activities in which managers engage as they manage and the roles they play as they perform management work are considered in the next section.

The Work of Managers: Activities and Roles

This book is organized and presented around the *activities* that managers engage in as they manage. Focusing on activities is sometimes called a functional approach to the work of managers. In addition to performing sets of interconnected activities, managers also play certain *roles* as they do management work. In performing activities or playing roles, managers rely upon certain *skills* and *competencies* to do their work well.

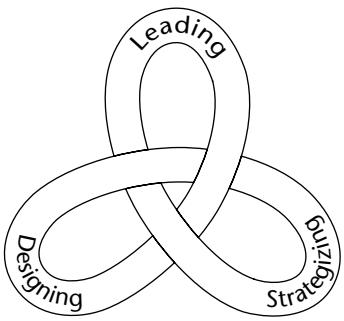
This section introduces the activities managers engage in as they perform management work, the roles played in doing this work, and the skills and competencies needed to do this work. Throughout this section and in the more in-depth discussions to follow in the book, the descriptions of and the prescriptions and recommendations about the activities that managers engage in as they perform management work reflect *evidence-based management*. Practicing evidence-based management means that managers, like clinicians practicing evidence-based medicine, base their professional work on empirical evidence from management research (Kovner, Elton, and Billings 2000; Walshe and Rundall 2001).

The Core Activities in Management Work

All health program and project managers engage in three core activities as they perform management work: *strategizing, designing,* and *leading* (Zuckerman and Dowling 1997). In performing these core activities, managers also engage in other activities that facilitate and support accomplishment of the core activities. These facilitative activities are briefly discussed later in this chapter; a subsequent chapter is devoted to each of the activities. The core strategizing, designing, and leading activities of management work are shown in Figure 1.3 and are discussed briefly in the following sections. More detailed discussions of these activities follow in subsequent chapters.

Strategizing. The work that managers do when establishing the outputs, outcomes, and impact desired for their programs and projects–and when conceptualizing the means of accomplishing them–is *strategizing*. Although the relative degree of complexity may vary, managers of all programs and projects engage

FIGURE 1.3. THE CORE ACTIVITIES IN MANAGEMENT WORK.



in strategizing activities as part of performing management work. This activity also helps managers adapt their programs and projects to the challenges and opportunities presented by their external environments (Ginter, Swayne, and Duncan 2002).

The aim of strategizing is to achieve an integrated set of direct, support, and management work sufficient to establish and achieve the results envisioned for a program or project. Effective *strategizing* lays the foundation for *designing* effective relationships among people and other resources necessary to achieve desired results. It also provides the blueprint managers use in *leading* others in contributing to their achievement.

There are a number of reasons why strategizing activities are so crucial to the success of health programs and projects. Perhaps none is more important than the simple fact that this activity focuses attention on desired results. Good strategizing yields statements of intended outputs, outcomes, and impact, and conceptualizes the means through which these can be achieved. In this way strategizing contributes to the coordination and integration of the actions of all participants in a program or project toward shared purposes.

Another reason strategizing is important is that it helps offset the pervasive uncertainty that health programs and projects face. When managers think about the future in systematic ways and plan for contingencies that can be imagined or foreseen, they greatly reduce the chances of being caught unprepared. Uncertainty cannot be eliminated, but it can be prepared for through strategizing. Conditions of uncertainty require that programs and projects be adaptable and flexible, which makes strategizing critical.

A third reason strategizing is important is that it enhances efficiency and effectiveness. It facilitates the substitution of coordinated and integrated effort in place of random activity, controlled flow of work in place of uneven flow, and careful decisions in place of snap judgments. As demands increase for programs and projects to be operated efficiently and effectively, the value of strategizing increases.

Finally, strategizing in health programs and projects is important because it facilitates managers' efforts to assess and control results in their programs or projects. Controlling relies upon comparing actual results with some predetermined desired result and taking corrective actions when actual results do not match desired results. Good strategizing yields statements of desired results against which actual results can be compared.

Control techniques are based upon the same basic elements regardless of whether quality, cost, participant or patient and customer satisfaction, or some other variable is being controlled. Controlling, wherever it occurs, involves four steps: (1) establishing standards or desired results, (2) measuring performance, (3) comparing actual results with standards or desired results, and (4) correcting deviations from standards or desired results when they occur.

Designing. *Designing* is the work managers do when establishing the initial logic models of their programs and projects and subsequently reshaping them as circumstances change. Managers are also designing when they establish the intentional patterns of relationships among human and other resources within their programs and projects and when they establish the relationship of the program or project to its external environment, including, when relevant, to the larger organizational homes in which it is embedded.

Guided by the requirements of a program or project's logic model, designing activities permit managers to design and build an organizational structure. This includes assembling the necessary inputs and resources for the program or project. Because human resources are a key resource in all programs and projects, designating individual positions and aggregating or *clustering* these positions into the work groups, teams or other subunits of a program or project is a critical aspect of a manager's designing activity. The number and type of individual positions are typically determined by how a program or project's work is divided and specialized.

In larger programs or projects, designing activity may also include clustering work groups into divisions or other units, as well as determining how the various work groups and clusters of work groups are integrated and coordinated. Depending upon circumstances, designing may also involve relating a program or project to a larger organizational home. For example, a program embedded in a county health department must fit within its larger organizational home. A program manager in such a setting may report to a superior in the larger organizational home.

The pattern of relationships among the human and other resources that results from designing activities is called the *organization design* of a program or project. *Staffing* involves the specific activities of attracting and retaining people to occupy the positions in an organization design, and is thus a vital part of organizing a program or project. In addition to relying upon paid staff, some programs or projects use volunteers.

In practice, organization design proceeds from individual positions through a clustering of positions into work groups, which may serve as subunits of a program or project, or may be the entire program or project. For programs and projects embedded in larger organizations, clustering of work groups forms the organization design of programs, projects, departments, and the larger subdivisions of the organization. Eventually, clustering produces an entire organization and perhaps even a system of inter-connected organizations.

Successful designs in health programs and projects, as well as in larger organizations, depend upon appropriate distributions of *authority* and *responsibility* as the organization is built up through successive rounds of clustering. Authority is the power one derives from a position in an organization design. Responsibility can be thought of as the obligation to execute work, whether it is direct,

support, or management work. All participants in programs and projects have responsibilities as a result of their positions. The source of responsibility is one's organizational superior in the organization design. By delegating responsibility to an organizational subordinate, the superior creates a relationship based on mutual obligations between superior and subordinate.

Effective organization designs achieve a balance between authority and responsibility. When responsibility is given to a participant, that person must also be given the necessary authority to make commitments, use resources, and take the actions necessary to fulfill the responsibility.

Depending upon the circumstances of a program or project, a challenge for its design can be the degree of *coordination* required among participants. There is a correlation between the degree to which a program or project's work is divided and the need for attention to coordination among participants. The more differentiated the work is, the more important–and often more difficult–the coordination task is likely to be. For example, in the project to enroll children in an innovative health plan described previously, the work would not be highly differentiated. In contrast, a large program in women's health would involve many different people performing highly differentiated work. Coordination would be more of a challenge in the latter case.

Health programs and projects, and certainly the larger organizations in which many of them are embedded, are often characterized by considerable division of work into a number of professional and technical jobs. The work done in these settings is so often performed by such a variety of workers that very significant coordination problems arise. In addition, the direct, support, and management work in most programs and projects are highly interdependent. This condition of functional interdependence makes achieving coordination an important aspect of the organization design of a program or project.

Another key to successful health program and project organization designs is the inclusion of features that minimize and resolve *conflict* among participants. Individuals participating in programs or projects may perceive missions or objectives differently or may favor various pathways to their fulfillment. Conflict may arise between and among any of the various participants in a program or project, as well as with others outside the program or project.

Conflict involving two or more individuals within a program or project, as well as conflict between a program and its organizational home or other entities, may arise. In fact, both forms of conflict should be anticipated and can be addressed at least partially through organization design. Even such low levels of conflict as those evidenced by some participants disliking other participants or having difficulty in getting along with others can reduce performance in a program or project. Thus, the prevention or resolution of conflict is an important

aspect of successful organization designs; effective designs for programs and projects facilitate the management of conflict.

In combination, a program's logic model and its organization design provide a comprehensive snapshot of the program, what it intends to accomplish, and how it intends to accomplish its desired results. The snapshot provides guidance for the third core activity managers engage in as they do management work, leading.

Leading. The work managers do when influencing other participants to contribute to the performance of their programs or projects is *leading*. No matter how well a manager strategizes and designs, a program or project's success also depends upon the manager effectively leading.

In leading the other participants in a program or project, managers seek to instill in them a shared vision of a program or project's logic model, and stimulate determined efforts to make the model work. As leaders, managers focus on the various decisions and actions that affect the entire undertaking, including those intended to ensure the program or project's survival and overall well-being. Leading also requires managers to help participants be *motivated* to contribute to the program or project.

Leading successfully in any setting is a challenge. It is especially so in programs and projects where leaders must satisfy diverse constituencies. Not only must the needs and preferences of a program or project's patients/customers, which themselves are not likely to be homogeneous in their needs and preferences, be taken into account, but so must the needs and preferences of other participants. Only rarely are the needs and preferences of all participants in a program or project in harmony.

As Figure 1.3 illustrates, the core activities of managers are interrelated. Leading is not done in isolation from designing and strategizing. How well managers engage in one of the core activities affects their performance in the others. In addition to these core activities of management work, managers engage in a number of other activities that support and facilitate their performance of the core activities. These facilitative activities are considered next and permit us to create a more complete mosaic of the activities that make up management work.

The Facilitative Activities in Management Work

Managers engage in *decision making* and *communicating* as they perform the core activities of strategizing, designing, and leading. Increasingly, managers of programs and projects also engage in *managing quality* and *marketing* as they seek to assure the success of their programs and projects. Thus, Figure 1.3 can be

expanded into a more complete picture of the activities performed in management work. Figure 1.4 shows the *facilitative activities* of decision making, communicating, managing quality, and marketing intertwined with the *core activities* of management work.

Decision Making. Decision-making activities permeate all management work, facilitating a manager's performance of the core activities of strategizing, designing, and leading. Managers make decisions when desired results are established in a program or project's logic model through strategizing, or when alterations are made in a program or project's organization design or logic model. In fact, not only are designs subject to change, but all management work is performed in a dynamic context that requires continual decision making to modify such variables as results, means, tasks, technologies, and people.

Decision making is simply making a choice between two or more alternatives. The myriad decisions that program and project managers face can be divided into two subsets: problem-solving decisions and opportunistic decisions (DuBrin 2003). Problem-solving decisions are made in order to solve existing or anticipated problems. Opportunistic decisions are typically sporadic and arise with opportunities to advance accomplishment of a program or project's intended results.

Communicating. Just as decision-making activities permeate all management work, communicating activities are also ubiquitous in facilitating a manager's performance of the core activities of strategizing, designing, and leading. For example, managers who can effectively articulate and communicate their ideas and

FIGURE 1.4. THE CORE AND FACILITATIVE ACTIVITIES IN MANAGEMENT WORK.

preferences have a distinct advantage in leading a program or project's participants. If participants are to be involved in designing logic models and organization designs, communicating is vital, and if these designs are to be understood by those affected by them, details of the designs must be effectively communicated. Communicating is essential in developing strategies for a program or project and in sharing the strategies with stakeholders inside and outside the program or project.

Communicating involves senders (who can be individuals, groups, or organizations) conveying ideas, intentions, and information to receivers (who can also be individuals, groups, or organizations). Communication is effective when receivers understand ideas, intentions, or information as senders intend. Managers in health programs and projects must be concerned with communication on two levels. They concern themselves extensively with communicating with internal stakeholders in their programs or projects, as well as with communicating between the program or project and other stakeholders in its external environment.

Managing Quality. In successfully managing health programs and projects, managers are heavily involved in *managing quality*. Not only is quality obviously important to those to whom services are provided, it is also important to the people who work in programs and projects. For example, it has been shown that working in environments characterized by efforts to continuously improve quality yields higher levels of satisfaction with work for participants (Berlowitz and others 2003).

In what we will call a *total quality (TQ) approach* in this book, managers are guided by the application of three principles as they seek to manage quality: focusing on the patients/customers of their program or project, striving for continuous improvement, and fostering teamwork (Dean and Bowen 1994). A patient/customer focus means identifying what a program or project's patients/customers need and want and then developing and delivering services that satisfy those needs and wants. Continuous improvement means making a commitment to continuous efforts to examine the processes through which services are provided in search of better ways to provide them. Teamwork is emphasized in a TQ approach because quality is a collective responsibility of all those involved in a program or project.

Marketing. The boundary between a program or project and its external environment is important territory for its manager. Managers use *marketing* to effectively cross these boundaries. The purpose of marketing is to bring about voluntary exchanges of values with others for the purpose of achieving the program or project's objectives. Others in the external environment that can be

reached through marketing activities include potential direct patients/customers for a program or project's services, as well as people who can influence patients/customers. Engaging in exchanges with patients and customers is critical to the success of most programs or projects, especially when services for sale are offered.

In addition to patients/customers, successful programs and projects engage in voluntary exchanges with physicians and other health care providers who are in a position to refer patients or consumers, and with insurers and health plans who may permit or limit use of a program or project's services by their subscribers or members. Similarly, voluntary exchanges are made with potential employees and perhaps with donors, volunteers, and organizations in which a program or project is embedded. All of these exchanges are supported and facilitated through marketing.

It is important to stress the interdependence among the full set of activities shown in Figure 1.4, including the core activities of management work (strategizing, designing, and leading) and the facilitative activities of decision making, communicating, managing quality, and marketing. Although it is convenient to separate activities for purposes of discussion or description, the danger in doing so is that it may seem that managing is a series of separate activities, perhaps performed in a particular sequence. In practice, managers do not perform the activities noted earlier separately–and certainly not in a fixed sequence.

The mosaic of core and facilitative activities that managers engage in as they do management work as shown in Figure 1.4 guides the outline for the remaining chapters of this book as follows:

Chapter Two	Strategizing the Future
Chapter Three	Designing for Effectiveness
Chapter Four	Leading to Accomplish Desired Results
Chapter Five	Making Good Management Decisions
Chapter Six	Communicating for Understanding
Chapter Seven	Managing Quality–Totally
Chapter Eight	Commercial and Social Marketing

As subsequent chapters are read, it may be useful from time to time to revisit Figure 1.4 to review how the activities being described fit together into the mosaic of activities that make up management work. Before examining the activities that make up management work in detail, however, it will be useful to consider this work from another vantage point–the roles managers play as they perform management work.

Roles Played by Managers: The Mintzberg Model

Although it was conducted decades ago and did not focus specifically on managers of health programs or projects, an important study of management work has direct applicability to considering the work of managers in programs and projects. Henry Mintzberg (1973; 1975) observed a sample of managers over a period of time, recorded and analyzed what they did, and concluded that management work can be described meaningfully in terms of three categories of interrelated roles that all managers play. Thus, another way to examine the work of managers is to think about the different roles they play.

Roles are the typical or customary sets of behaviors that accompany particular positions. Teachers play identifiable roles in schools, quarterbacks play defined roles on football teams, and managers play roles as they perform management work. Mintzberg concluded that managers, simply because they are managers, must adopt certain patterns of behavior when doing management work.

He saw the work of managers as a series of three broad categories of roles–interpersonal, informational, and decisional–with each category composed of a number of separate and distinct roles as summarized in Figure 1.5.

FIGURE 1.5. THE MANAGER'S ROLES.

- **Interpersonal Roles**
  - Figurehead
  - Influencer (leader)
  - Liaison
- **Informational Roles**
  - Monitor
  - Disseminator
  - Spokesperson
- **Decisional Roles**
  - Entreprenuer
  - Disturbance handler
  - Resource allocator
  - Negotiator

Interpersonal Roles. In Mintzberg's view, all managers play *interpersonal roles* as figurehead, influencer or leader, and liaison. The figurehead role is played as managers engage in ceremonial and symbolic activities such as presiding over the opening of an additional site for a program or giving a speech to a graduating class of speech pathology students. Managers play their influencer or leader roles when they seek to inspire or help others to be motivated to higher levels of performance or when they set examples through their own behavior. Liaison roles involve managers making formal and informal contacts inside their program or project and also with external stakeholders. Managers usually pursue liaison roles in order to establish relationships that will help them achieve the program or project's mission and objectives.

Informational Roles. As Figure 1.5 illustrates, Mintzberg also ascribes a category of *informational roles* to managers in which they serve as monitors, disseminators, and spokespersons. In their monitor roles, managers gather information from their networks of contacts–including those established in their liaison roles–filter the information, evaluate it, and choose how to act as a result of the information. Their disseminator roles grow out of access to information and their ability to choose what to do with the information they obtain. In dissemination, managers have many choices about whom, inside and outside their programs or projects, they route information to. The third informational role, the spokesperson role, is related to managers' figurehead roles. As spokespeople, managers communicate information about their programs or projects to internal and external stakeholders.

Decisional Roles. The third category of roles managers play in Mintzberg's model, *decisional roles,* includes entrepreneur, disturbance handler, resource allocator, and negotiator roles. In their roles as entrepreneurs, managers function as initiators and designers of changes intended to improve performance in their programs or projects. When playing this role, managers are acting as change agents. In their disturbance handler roles, managers decide how to handle a wide variety of disturbances (for example problems or issues) that arise as they carry out their daily work routines. A program manager may face disturbances created by participants, by a regulatory agency, or by the actions of a competitor. Even a heavy snowfall that makes it impossible for key participants to come to work can be a significant disturbance. The ability to handle disturbances is an important determinant of managerial success in programs and projects.

In playing the resource allocator role, managers must allocate human and other resources among alternative uses. As resources become constrained,

decisions about resource allocation become more difficult and more important. In their negotiator roles, managers interact and bargain with participants, suppliers, regulators, customers or patients, and others who have some relationship to their program or project. Negotiating includes deciding what objectives or outcomes to seek through negotiation, as well as deciding what techniques will be used in conducting the negotiations they enter.

The ten managerial roles shown in Figure 1.5 cannot really be neatly separated. In practice, they are closely intertwined into a *gestalt,* or an integrated whole. Management work is not merely the algebraic sum of these ten roles, but is much more. When the interconnected roles are each played well, the result is synergistic. Being a good negotiator makes a manager a better disturbance handler. Playing the informational roles effectively improves performance in the decisional roles because this provides managers with better information upon which to base their decisions.

Most, if not all, of the activities managers engage in as they manage their programs and projects can be categorized into one or more of the core or facilitative activities depicted in Figure 1.4. Similarly, the roles managers play are comprehensively summarized in Figure 1.5. However, descriptions of these activities and roles say very little about the *skills* or *competencies* needed to perform the activities or play the roles well. Thus, another important element in understanding management work is to understand the skills and competencies upon which successful managers rely.

Skills and Competencies That Underpin Management Work

Katz (1974) has identified three types of skills effective managers use: technical, conceptual, and human or interpersonal. The *technical skills* of managers, like the technical skills of a physical therapist or a nurse, are apparent as they do their work. A manager's work to counsel a participant in a program about performance, or develop a budget for a project requires technical skills. *Human or interpersonal skills* are the abilities of managers to get along with other people, to understand them, and to lead them in the workplace. *Conceptual skills* reflect the mental abilities of managers to visualize the complex interrelationships that exist in a workplace. For example, relationships may exist between and among a program and other departments or units in its organizational home. Relationships may also exist between participants in a program and other components of the external environment. Conceptual skills permit managers to understand how factors in particular situations fit together and interact with one another. Conceptual skills are

clearly reflected in the quality of a program or project's logic model and organization design.

Managers Use Different Mixes of Skills. Not all managers use conceptual, technical, and human skills to the same degree or in the same mix, although every manager relies on all three types of skills in performing management work. For example, the management work that takes place in a very large program providing health education services could require three different levels of management and three different mixes of technical, human, and conceptual skills. The program manager would be vitally concerned about the overall performance of the program and how it fits within its larger environment. If this program were housed in a hospital, for example, the manager would be concerned about how the program fits into the total picture of the hospital and its plans, including how the program might grow in the future. Such concerns would require a heavy dependence on conceptual skills.

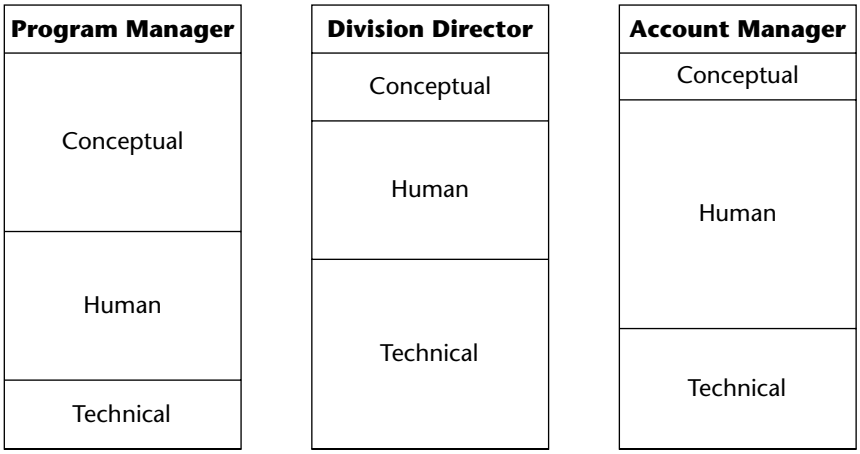
The large health education program might have major subdivisions (such as one that focuses on services offered to individual clients and another to provide services to employers for their employees), each with its own division director. These middle-level managers would rely more on their technical skills than on conceptual or human skills, although like all managers they would use all the skills to a degree. In this program the division managers spend much of their time troubleshooting the health education services provided by their division; they may be required to constantly make decisions on the basis of technical knowledge.

In contrast to the program manager and the two division directors, a health educator who is the account manager in charge of a team providing services to a single employer might use a considerable amount of technical skill because in addition to being a first-level manager, this individual must provide health education services. However, this manager would also be required to use human skills on the job more than either the program manager or the division directors, because almost all of this person's work involves direct contact with the other educators on the team. This variation in the mixes of these three types of skills used in management work can be seen in Figure 1.6.

Competencies Needed to Manage Effectively

Longest (1998a) extends the Katz model of skills required of managers to a broader set of what are called *competencies,* which he defines as clusters of knowledge and skill in using the knowledge. In this somewhat broader approach, with

FIGURE 1.6. RELATIVE MIXES OF SKILLS NEEDED FOR EFFECTIVE MANAGEMENT WORK IN A LARGE PROGRAM.



some overlap with the Katz model, the competencies useful to program and project managers are as follows:

- Conceptual
- Technical (managerial and clinical)
- Interpersonal and collaborative
- Political
- Commercial

Governance is also a useful competency for those whose programs or projects are freestanding rather than embedded in larger organizations.

Conceptual Competency. In all settings, managers must be able to envision the places and roles of their programs or projects within their larger contexts. This may mean envisioning places and roles in the larger society, as well as in the organizational home in which a program or project is embedded. This competency also allows managers to visualize the complex interrelationships in their workplaces–relationships among participants within a program or project, as well as relationships of the program or project to other units of an organization or

external entities with which it interacts. In short, adequate conceptual competency allows managers to identify, understand, and interact with their program or project's myriad external and internal stakeholders. *Conceptual* competency also enhances a manager's ability to comprehend the culture and historically developed values, beliefs, and norms present in the program or project, and to visualize its future.

Technical (Managerial and Clinical) Competency. The cluster of knowledge and associated skills that make up *technical* competency pertains to management work as well as to the direct work performed in a program or project. In health programs and projects, direct work often involves clinical activities such as conducting a health education session, performing a screening test, conducting a physical therapy session, or counseling a patient. The technical aspects of management work, such as planning for a new service or facility or developing a program or project budget, are also crucial to the program or project's success. Knowledge and relevant skills in using or applying the knowledge in both clinical and management areas make up technical competency for health program and project managers.

Interpersonal and Collaborative Competency. An important ingredient in managerial success is the cluster of knowledge and related skills about human interactions and relations by which managers lead others in pursuit of a program or project's mission and objectives. A survey of managers to determine competencies most important to success in management performance in ambulatory health services settings found interpersonal skills rated most highly (Hudak, Brooke, Finstuen, and Trounson 1997). *Interpersonal* competency incorporates knowledge and skills useful in effectively interacting with others. It enables managers to help participants achieve higher levels of motivation and handle conflicts among participants.

The core elements of traditional interpersonal competence expand considerably when programs or projects must interact with other organizational entities. This requires *collaborative* competency, which facilitates synergistic interaction among programs, projects, and various other organizational units. Collaborative competency is exercised when, for example, two programs are successfully merged, or when a joint venture among programs is created and operated to better serve a particular population. This competency relies upon a manager's ability to build trust among programs, projects, and other organizational units, and to effectively form partnerships with other units to achieve certain purposes. It also is reflected in the ability to build effective coalitions and alliances.

Political Competency. *Political* competency, defined as the dual capability to accurately assess the impact of public policies on the performance of a program or project *and* to influence public policy making at state and federal levels (Longest 1996; 2002), is an increasingly important competency for program and project managers. Managers can influence public policy at many points in the policy-making process. For example, they can help define problems that policies can address; they can help create solutions to the problems; or they can help establish the political circumstances necessary to advance solutions through the policy-making process (Kingdon 1995).

Program and project managers are often in excellent positions to know firsthand about particular health problems because they deal with them daily. Similarly, by permitting their program or project to serve as a demonstration site (for assessing possible solutions), they can play important roles in identifying feasible solutions to problems.

Based on their knowledge and expertise in addressing particular health issues, managers can participate in drafting legislative proposals and testify at legislative hearings. They can also influence rule making. Procedurally, rule making typically precedes and guides the implementation of public policies and is designed to include input in the form of formal comments on proposed rules from those who will be affected by them.

Commercial Competency. In any setting, *commercial* competency is the ability of managers to establish and operate value-creating situations in which economic exchanges between buyers and sellers occur. Value in health services has a specific meaning. It requires that buyers and sellers think about both *quality* and *price*. Value is quality divided by price. Value in the services produced by most health programs or projects is created when services have more of the quality attributes desired by buyers than competitors offer. Value is also created when a program or project can produce and sell a set of quality attributes at a lower price than its competitors. The commercial success of health programs and projects may be essential for their survival. This success requires managers to possess commercial competency.

Governance Competency. When programs and projects are embedded in larger organizations, the organization's governing board is relevant to the program or project in the same way it is relevant to other units in the organization. Managers of such programs or projects may have little need for *governance* competency. However, when health programs and projects exist as freestanding entities they may have their own governing boards. In these situations, governance competency is also important for their managers.

The governing board, in concert with the manager, is responsible for establishing a clear vision for the program or project, for fostering a culture that supports the realization of the vision, for assembling and effectively allocating the resources to realize the vision, for leading the program, project, or organization through various challenges in its external environment, and for ensuring proper accountability to multiple stakeholders (Orlikoff and Totten 1996).

When programs and projects have governing boards of their own, the knowledge and associated skills that make up governance competency are important for their managers for three reasons. First, in freestanding programs and projects, managers often participate directly in the governance function as members of its governing body. Second, at the top level of a program or project it is difficult to separate what occurs under the rubric of governance from what occurs as management work. Consequently, effective managers must be knowledgeable about management *and* governance. Third, managers can help those with direct governance responsibilities to do a better job by arranging educational activities for board members or by providing appropriate information to help with governance.

The work of managers has been viewed from the perspective of the activities managers engage in as they do their work (see Figure 1.4), and from the perspective of the managerial roles they play in doing management work (see Figure 1.5). Each perspective contributes to an understanding of management work. In addition, it is also important to consider the ethical aspects of management work.

Managing Programs and Projects Ethically

The beginning of an appreciation for the extent to which ethics affects management work rests in the recognition that all decisions and actions in health programs and projects include ethics dimensions, whether they are clinical or managerial decisions, or some combination. Managers, if they are to behave ethically, must first recognize ethical issues and then act on them.

Managers routinely make decisions and take actions that have consequences for their programs or projects, as well as for their internal and external stakeholders. As a foundation for their decisions and actions, managers need well-developed personal ethics standards, which must be applied in the context of the philosophy and culture of the program or project, and in many instances in the context of the philosophy and culture of the organization in which it is

embedded. Compatibility between the personal ethics standards of managers and those of the programs, projects, and organizations within which they work is important, and both sets of standards should be built upon four key ethics principles: respect for persons, justice, beneficence, and nonmaleficence.

Respect for Persons

The principle of *respect for persons* has four elements: autonomy of persons, truth telling, confidentiality, and fidelity. The concept of autonomy recognizes that individuals have the right to their own beliefs and values and to the decisions and choices that further these beliefs and values. Specifically, autonomy pertains to the rights of individuals to independent self-determination regarding how they live their lives; autonomy also pertains to the rights of individuals regarding what happens to them in health care situations.

In health programs or projects, honoring the autonomy of patients/customers means following their wishes about their care and letting them be involved in their care to the extent they choose to be. It also means that when its patients/customers are children or are adults of diminished competence through physical or mental condition, the program or project has special procedures for surrogate decision making or substituted judgments.

The principle of respect for persons is especially important in its effect on consent and use of confidential patient information in health programs and projects. Respect for persons as autonomous beings implies honesty in relationships with them. Closely related to honesty in such relationships is the element of confidentiality. Confidences broken will impair the performance of management work.

A fourth element of the respect for persons is fidelity. This means doing one's duty and keeping one's word. Fidelity is often equated with promise keeping. When managers tell the truth, honor confidences, and keep promises, they are behaving in an ethically sound manner.

Decisions and actions that reflect the principle of respect for persons can sometimes be better understood in contrast to its opposite—paternalism. Paternalism implies that someone else knows what is best for other people. Decisions and actions guided by a preference for autonomy limit paternalism. One of the most vivid examples of the application of this principle in health care is the 1990 Patient Self-Determination Act (Public Law 101-508). This public policy is designed to give individuals the right to make decisions concerning their health care, including the right to accept or refuse treatment and the right to formulate advance directives regarding their care. These directives are a means by which competent individuals

give instructions about their health care that are to be implemented at some later date should they lack the capacity to make these decisions. In concept, this policy gave people the right to exercise their autonomy in advance of a time when they might no longer be able to actively exercise the right.

Justice

A second ethics principle of significant importance to managers and their work in programs and projects is *justice*. The concept of justice impacts directly on management work because justice, in the context of ethics, is defined as fairness (Rawls 1999). The principle of justice also includes the concept of desert: justice is done when a person receives that which he or she deserves (Beauchamp and Childress 2001). The key ethical question in many of the decisions and actions of managers, deriving from attention to the principle of justice, is, of course, "What is fair in this situation?"

The principle of justice provides much of the underpinning for ethically sound decisions and actions regarding the allocation of resources. Decisions about resource allocation that adhere closely to the principle of justice are made under the provisions of a morally defensible system and are not arbitrary or capricious. The application of justice in activities of making decisions in health programs and projects, as well as in other settings, is in part ensured by the existence of the legal system. This system serves as an appeals mechanism for those who believe they have been done an injustice.

Beneficence and Nonmaleficence

Two other ethics principles have direct relevance to managers in health programs and projects: beneficence and nonmaleficence. *Beneficence* means acting with charity and kindness. This principle is incorporated into acts through which services or products are provided that are beneficial to people, including the services of health programs and projects. However, the principle of beneficence also includes the more complex concept of balancing benefits and harms, which may require using the relative costs and benefits of alternative decisions and actions as one basis upon which to choose from among alternatives.

The growing emphasis on cost-effectiveness in health care will increasingly call into play the principle of beneficence in the conduct of management work in health programs and projects. Managers who are guided by the principle of

beneficence feel a positive duty to contribute to the welfare of patients/customers. This is rooted in the Hippocratic tradition and has a long and noble history in the health professions and in health care settings, including health programs and projects.

Nonmaleficence, a principle with deep roots in medical ethics, is exemplified in the dictum *primum non nocere,* which means, first, do no harm. Managers who are guided by the principle of nonmaleficence try to make decisions that minimize harm. Harm can be mental as well as physical and can be caused through such acts as violating the privacy of patients/customers. While beneficence is a positive duty involving taking action to do good, nonmaleficence involves refraining from doing something that harms. The principles of beneficence and nonmaleficence are reflected in actions and decisions to assure the quality of the services of a program or project. These principles are also reflected in managers' exercise of their fiduciary duties, use of confidential information, and resolution of conflicts of interest.

Supporting Ethical Behavior in Health Programs and Projects

Health programs and projects, by their nature, frequently involve health professionals providing health services. In these situations, the professionals face a set of ethical obligations that stem from their roles as professionals. These obligations have been described by Bayles (1989) and are summarized in the following categories:

Obligations to make services available	This obligation requires equality of opportunity in access to professional services. Ethical issues arise in the form of access problems such as what to do about patients/customers who cannot pay for services.
Obligations between professionals and patients/customers	"The fiduciary model presents the best ethical ideal for the professional-client relationship" (Bayles 1989, p. 100). In this model, the professional is honest, candid, competent, loyal, fair, and discreet in relationships with patients/customers.

Obligations to third parties	In many health programs and projects, other people or organizations (for example parents or other family members, employers, teachers, insurance plans) have interests in the professional-patient or professional-customer relationship. The ethical issues that arise from these obligations usually involve issues of confidentiality and the protection of privacy. These issues often involve complying with laws such as the Health Insurance Portability and Accountability Act (HIPAA).They may also involve responding to court orders. HIPAA, enacted by Congress in 1997, includes privacy provisions that generally limit the use or disclosure of protected health information to a minimum necessary standard (Harris 2003, pp. 108–120). It also gives patients the right to see and receive copies of their records, request amendments to their records, and learn details about disclosures of their records.
Obligations between professionals and their employers	Obligations exist between professionals and the health programs and projects that employ them. In some cases, these obligations also exist between professionals and the larger organizational homes in which programs or projects are embedded. Ethical issues that arise from these obligations involve due process, confidentiality, and professional support. Professionals, as participants, have obligations to their employers that include being honest, candid, competent, loyal, fair, and discreet.

Obligations to the profession	The professionals who work in health programs and projects have obligations to their professions that include advancing knowledge, reforming the profession, and respecting the profession. These obligations "rest on the responsibilities of a profession as a whole to further social values" (Bayles 1989, p. 179).

A number of codes of ethics have been developed for individual professions, as well as for various health care organizations. For example, the American Hospital Association has produced a prototype code of ethics for hospitals. It includes sections on the community roles and responsibilities of these institutions, on patient care in them, and on organizational conduct. The American Medical Association adopted the first version of its *Principles of Medical Ethics* at its founding in 1847. The American Nurses Association has developed a code for nurses. The American College of Healthcare Executives has produced a code of ethics to guide members on ethical issues. Similarly, other health professions have developed codes. In fact, a code of ethics is a hallmark of any profession. Beyond these codes, many individual health care organizations develop their own codes. These often provide very visible evidence of the commitment of organizations to ethical behavior; programs and projects embedded in such organizations can also use these codes of ethics.

In addition to relying upon codes of ethical behavior developed by others, a program or project-specific code of ethical behavior can provide specific guidelines for participants to follow. Managers can support ethical behavior in other ways as well. They can develop cultures within their programs or projects that minimize ethical ambiguity and continuously remind participants to make ethical decisions and take ethical actions. They can reward ethical behavior and create climates in which people are free to challenge standards or practices they consider unethical. Finally, they can encourage ethical behavior by providing training in applied ethics in order to increase awareness of the ethical dimensions of decisions and actions, encourage critical evaluations of values and priorities, and help participants integrate ethical considerations into their decisions and actions.

Managers and the Success of Programs and Projects

To conclude this introductory chapter, it is important to emphasize the significant impact that managers can have on their programs and projects. Health programs and projects are not random groups of people assembled by chance interactions. Instead, they are consciously formed around a logic model. From this fact stems the overarching purpose of all management work in a program or project, which is to facilitate the achievement of its intended results, whether expressed as outputs, outcomes, or impact.

The contributions managers make to the degree to which desired results are successfully accomplished can be measured along many dimensions. Measuring their overall contributions to success may involve measuring a program or project's *outputs* in terms of counts of services and productivity levels, quality of services, and patient/customer satisfaction. For example, the number of services rendered can be counted and compared to established targets. Productivity can be measured in terms of resources used per unit of service. Quality of the services provided by a program or project can be measured in terms of clinical outcomes achieved, as well as process measures such as adherence to protocols and input measures such as the credentials of staff. Patient/customer satisfaction levels can be measured by surveys and by loyalty demonstrated by continued use of services.

In addition to outputs, a manager's contributions to a program or project's success can also be measured in terms of *outcomes,* such as changes in the attitudes, behaviors, health status, or level of functioning in patients/customers. Finally, managers' contributions can be measured in terms of *impact* of the program or project on overall health status in a community, for example, or on the enhanced capacity of a health care organization in which a program or project is housed to respond to unmet service needs in a community.

There is no universally accepted formula by which managers maximize their contributions to program and project effectiveness. However, there is a correlation between a program or project's success and how well its manager performs the core activities of designing, strategizing, and leading. Similarly, the manner in which a manager makes decisions, communicates, manages change and quality, and markets the program or project may have a direct bearing on success.

There is also a correlation between the use of appropriate mixes of conceptual, human or interpersonal, and technical skills by managers and the degree to which desired results are attained. Similarly, performance is affected by a program or project manager's possession and use of appropriate conceptual, technical (managerial and clinical), interpersonal and collaborative, political,

commercial, and governance competencies. Finally, there is a correlation between how well managers play their interpersonal, informational, and decisional roles and the levels of performance their programs and projects attain. Effective managers, by creating conditions that are conducive to superior performance, make vital and unique contributions to the programs and projects they manage. The remaining chapters in this book are intended to help managers maximize their contributions to successful programs and projects.

Summary

Definitions of health, health programs and projects, and management are provided in this chapter. Following the World Health Organization's view–and more contemporary interpretations of it–health is defined as a state in which the biological and clinical indicators of organ function are maximized and in which physical, mental, and role functioning in everyday life are also maximized.

Health is a function of a number of health determinants, which for individuals or populations include the following:

- The physical environments in which people live and work
- Peoples' behaviors
- Peoples' biology (genetic makeup and physical and mental health problems acquired during life)
- A host of social factors that include economic circumstances, socioeconomic position in society, and income distribution
- Discrimination based on factors such as race or ethnicity, gender, or sexual orientation
- The availability of social networks and social support
- The health services to which people have access

The variety of health determinants means that health programs and projects can have a wide array of foci.

Health programs are defined as discrete sets of interrelated people and other resources arranged in designs that facilitate accomplishment of pre-established results. Health projects are a subset of programs that tend to be more time-limited than other programs and are often supported by project-specific grants. The usefulness of considering a program and project in terms of its logic model, which shows how inputs and resources are processed to accomplish the program or project's outputs, outcomes, and ultimately its impact, is emphasized. Viewing programs and projects as organizations is also discussed.

Program or project management is defined as the activities through which the desired outputs, outcomes, and impact of a program or project are established and pursued through various processes using human and other resources. Following the basic logic model of a program or project (see Figure 1.1), managers, often with the help of others accomplish the following:

- Determine a program or project's desired outputs, outcomes, and impact
- Assemble the necessary inputs and resources to achieve desired results
- Determine the processes necessary to accomplish the desired results and ensure they are carried out effectively and efficiently
- Relate the program or project to its external environment

The work of managers is considered in terms of the core activities that all managers engage in as they do management work: strategizing, designing, and leading. Consideration of this work is extended to include the facilitative activities managers engage in as they perform management work, including decision making, communicating, managing quality, and marketing. The entire set of core and facilitative activities in management work is presented graphically in Figure 1.4. The core and facilitative activities of management work form the chapter outline for the remainder of this book.

As an adjunct to the discussion of the activities in management work, Mintzberg's model of the roles that managers play in doing management work is also presented. Figure 1.5 summarizes these roles in interpersonal, informational, and decisional categories. There is also a discussion of the conceptual, technical, and human skills that are useful to managers in doing their work, as well as the conceptual, technical (managerial and clinical), interpersonal and collaborative, political, commercial, and governance competencies that can be useful in performing management work.

The chapter acknowledges the growing impact that ethical considerations have on all actions and decisions in health programs and projects in both the clinical and management spheres of activity. The ethical principles of respect for persons, justice, beneficence, and nonmaleficence are discussed as the basis for the construction of a personal and professional ethic for managers.

The chapter concludes by noting the correlation between a program or project's success and how well its manager performs the core and facilitative activities of designing, strategizing, leading, decision making, and communicating. A program or project's success is also affected by how well its manager manages quality and markets the program or project.

Chapter Review Questions

1. Define health, health programs and projects, and management.
2. Discuss how the determinants of health shape the focus of health programs and projects.
3. Briefly describe the core activities of management work.
4. Briefly describe the facilitative activities of management work.
5. Discuss the skills that are useful to managers in performing their work, including the different mixes of skills that would be appropriate in different circumstances.
6. Discuss the competencies managers need if they are to do their work well.
7. Discuss the Mintzberg model of the roles managers play in doing their work.
8. Why is it important for managers to develop personal ethical standards of conduct? Discuss the principles upon which such standards should be based.
9. Discuss the overall contributions managers make to the success of the health programs and projects they manage.