

ATTRIBUTES FOR EFFECTIVE MANAGEMENT OF PACIFIC HEALTH SERVICES IN NEW ZEALAND

COUNTIES MANUKAU DISTRICT
HEALTH BOARD
A Community Partnership

LeVa
Pasifika within Te Pou

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FOREWORD

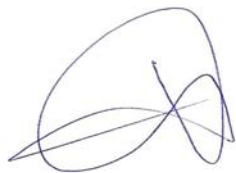
The area of Pacific health management has always interested me, mainly because Pacific health managers have an important role to play in influencing outcomes for Pacific people, yet within New Zealand they are a relatively small workforce. I was presented with an opportunity through my Masters programme to explore this interest further and was surprised to find that this area had not been extensively researched. Therefore, with guidance from my supervisor Dr Rod Perkins, I decided to replicate a study that was conducted in the Asia–Pacific region to explore attributes for effective management within a Pacific health service.

Whilst this study was part of my Masters programme, a number of people showed interest in it and requested that I make the findings available. I gave these people assurances that the findings would be disseminated, so I hope that this document (a streamlined version of my dissertation) honours that obligation.

I am optimistic that my work will make some meaningful contribution to the development of the Pacific health manager workforce, but more importantly will add to the limited body of knowledge on Pacific health management.

Finally I would like to add a disclaimer; I am not the font of all knowledge pertaining to Pacific health management and this study should not be viewed as the definitive perspective on Pacific health management. However, it does provide us with some information that will encourage further analysis and work in the area of Pacific health management.

I look forward to future discussion.



Kirkpatrick Mariner

ABSTRACT

This study identifies and explores key attributes that are considered to be desirable by Pacific health managers for the effective management of Pacific health services in New Zealand. It replicates Phase I of the study undertaken by Boldy, Chen and Jain *Attributes of Effective Managers and Implications for Health Care Management Education in the Asia-Pacific Region* (1994) (the Boldy study).

The Boldy study is part of the International Project on Culture and Management (IPCaM). The aim of IPCaM is to explore the role of national culture in managerial behaviour and effectiveness. The project has three distinct phases and overall covers in excess of 60 countries worldwide. Phase I of the Boldy study aimed to identify desirable managerial qualities of effective managers in particular cultures. Eleven countries in the Asia-Pacific region participated. Based on a questionnaire survey, managers and students from the participant countries were asked to provide their perceptions of attributes that are desirable for effective management. The study then discussed the broad implications of these findings for health care management education. Phase II of IPCaM will assess the effectiveness of the culturally desired managerial qualities in the respective cultures. Phase III will focus on the development of culturally appropriate management education.

Findings from the current study show that Pacific health managers and participants in the Boldy study held similar views on some desirable attributes, such as nurturing constructs and social/behaviour theory (as a key component of training), and the requirement for political and classical management skills. The Pacific health managers also rated the personality constructs of high spirited/extrovert, assertiveness and humility, general knowledge and history of organisation as desirable and essential. The concept of collective responsibility, and relationships were also considered fundamental to being an effective manager within a Pacific health service in New Zealand. The participants in the current study also perceived cultural attributes as central to effective management.

DEDICATION

To my parents

Pepe Filisita Pulotu and Leuo Pauli Patrick Mariner

who put their hopes and dreams on hold

so we can live ours

– forever indebted

My parents are ‘remarkable people who have endured the unremarkable’ for us.

They are migrants from Samoa, who arrived in New Zealand with basically nothing but a determination that establishing a life in New Zealand will not beat them, whilst always dreaming about the return home [Samoa]. Thirty years later, they have succeeded, helping to establish a life for myself, my brothers and sister, providing us with opportunities and experiences that we may not have had back in Samoa. Currently my parents are in the process of realising their dreams back in Samoa.



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- Maiava Carmel Peteru for her wonderful cultural oversight
- and Kathleen Samu.

Supporters of this study:

- Counties Manukau District Health Board, in particular Philip Grady, Pacific Health Division and Te Kahui Ora
- Le Va, in particular Dr Monique Faleafa
- School of Population Health, in particular Dr Paul Brown
- Professor Duncan Boldy
- Health Research Council.

My Pacific Colleagues:

- Natalie Leger
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- Dr Tamasailau Suaalii-Sauni
- Dr John Huakau
- Philip Siataga
- Levaopolo Seupule Tiava'asu'e
- Dr Francis Agnew
- Pulotu Laifai Bruce Levi
- and all the participants.

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RECOMMENDATIONS

Based on participant responses, this study has identified key attributes that are considered important for the effective management of Pacific health provider organisations.

An essential component of who Pacific health managers are and how they manage Pacific health services is the recognition that Pacific values and models (ethnic specific and pan Pacific) are incorporated into Pacific health care management education and practice in the work place. There is strong participant support for the development of a Pacific focused health care management training and education programme.

The broad implications arising out of this study, with respect to a range of related areas in the Pacific health sector, include:

- providing the basis for ongoing research in this area of Pacific health management
- contributing to developmental work on cultural management approaches
- encouraging Pacific people to undertake management health studies
- developing a framework to support potential managers and current managers of Pacific health services within New Zealand
- assisting organisations to understand key attributes for managerial effectiveness within Pacific health services and Pacific non-health services.

Consistent with the three phases of the Boldy study, and in order to bring this study to a satisfactory completion, it is recommended that based on the aims in the Boldy study (but adapted to meet the needs of Pacific health environments), Phases II and III from this current study be implemented. A proposed approach is:

- Phase II – assess the effectiveness of the attributes identified in Phase I within Pacific ethnic-specific health services and pan Pacific health services
- Phase III– complete a discussion paper to inform the development of Pacific management education resources and programmes, to complement mainstream management courses and programmes
 - develop and pilot a Pacific management education programme.

INTRODUCTION

Background

There is a growing awareness among managers and management educators worldwide that management theories, methods and practices which are highly successful in one particular culture may not be appropriate for another culture. (Boldy et al, 1994)

Historically, the provision of health services for Pacific peoples has been facilitated within 'mainstream' health organisations. The past decade in particular has seen increasingly high use of health services by Pacific people, far outweighing the numbers of trained Pacific health professionals. Fewer Pacific people still are employed in management roles.

Language, cultural beliefs and socioeconomic circumstances are some of the key barriers for many Pacific peoples desiring to access mainstream health services. As an obvious solution, there is a greater need for by-Pacific-for-Pacific health services with Pacific health managers. This approach has an impact on the type of training and skills development required for building this workforce.

In recent years there has been a gathering interest by Pacific peoples in undertaking training and study in health management roles. Many see this as an opportunity to influence and facilitate processes within the health system, as a means of:

- minimising barriers to accessing health services
- ensuring that delivery to, and treatment of, Pacific peoples is culturally appropriate and clinically safe.

While this is encouraging, problems occur where Pacific health managers are expected to negotiate their way through Western models of management practices in an environment that is driven by ethnic specific or pan Pacific values and expectations.

Limitations

A positive approach is the hope that, with respect to current paucity of literature in this area, this study might be counted as minimising this limitation by one. An area that requires further research is the re-examination of the term Pacific/pan Pacific in terms of understanding ethnic specific. In focusing on Pacific, without addressing the values of ethnic specific groups, not only are ethnic specific communities rendered invisible, but also the myth of convenience that Pacific peoples are homogenous is perpetuated. Where information is predominantly non-Pacific, there is always the risk that the opinion of non-Pacific writers reflecting issues for ethnic groups becomes a 'guest' authority for all ethnic groups. A recommendation has been made to remedy this situation in Phases II and III.

LITERATURE REVIEW

This literature review focused on identifying and gathering evidence on national and international management theories and models, which can be applied within a range of Pacific health management environments.

A. UNIVERSALISTIC AND CONTINGENT APPROACHES

Two approaches were identified as possible models for providing effective management:

- universalistic
- contingent.

The universalistic approach argues that there is a generalised criterion for managerial effectiveness, which can be applied in any context. In contrast, the contingent approach takes into account the need to understand context as a key driver to managerial effectiveness.

Universalistic Approach

House and Aditya (1997) looked at managerial effectiveness in Britain and America. They contended that effective leadership behaviours are universal and can be applied to all situations, including organisations, industries and cultures. Their overall findings showed that there is strong compatibility between Britain and America in what are considered to be successful management traits.

Hamlin's study (2002) identified a set of criteria for managerial effectiveness with front line and middle management within a National Health Service trust hospital in Britain. The results suggested the existence of generalised criteria of effective management, which supports the concept of the universally effective manager. Hamlin stated that his findings support the current drive towards establishing universal evidence-based management approaches within the health sector.

Contingent Approach

Between 1987 and 1989, Boldy, Chen and Jain collected data from 2,276 managers and 4,941 students in the Asia-Pacific region. They looked at the way in which students in health administration programmes in the region construed effectiveness in terms of managerial and cultural specific qualities. The eleven participant countries were arranged into four cultural cluster groups:

- Western: USA and Australia
- Chinese: Hong Kong, China, Taiwan and Singapore
- Indian: India and Bangladesh
- South East Asian: Indonesia and Malaysia.

The findings of this study show that, with the exception of Australia and the USA, each country identified a distinctive combination of qualities in its managers. In the case of Australia and the USA, there was an indication that a number of synergies between the two countries existed and that this was perceived as advantageous for effective management.

Further, the study's findings challenged the assumption that the participant countries would be influenced by the dominant country within their cluster grouping. This gave validation to the view that what may be considered to be of importance within one country's cultural context may not necessarily be the situation

within the context of those countries within the same cluster group and across different cluster groups. This created a dilemma for those Asia–Pacific countries that sent students to the USA and Australia to undertake health management studies. A crucial consideration was that students from the Asia–Pacific region being trained overseas were likely to find that their newly acquired skills were inappropriate and difficult to apply within a local context.

In its report (1994), the Boldy study proposed that management characteristics that are highly successful in one particular culture may not be appropriate for another culture. Further, growing evidence suggested that management education is being tailor-made to accommodate the nuance of ethnic cultures.

An Australian study undertaken by Boldy, Jain and Harris (1990) looked at identifying what was considered to be the most important attributes for an effective Australian manager. The study compared the perceptions of 284 Australian health service and general managers, as well as 211 health service and general management students. There were some significant differences identified between the health care and general management groups. Overall, however, they shared similar perceptions of what desirable attributes contributed to developing an effective Australian manager. For example, all groups perceived the skills dimension to be the most desirable attribute of an effective Australian manager, with decision-making and planning/evaluation rated as the more important skills. Similarly, both managers and students perceived effective managers as being open-minded, energetic, supportive and self-confident. These findings identify the existence of a set of cultural preferences for an ideal effective Australian manager that is shared by members of the same cultural group even when located within different organisational contexts.

In 1993, Boldy and Jain studied student perceptions of managerial effectiveness in Sweden, Germany, Spain and Belgium. Findings showed that despite some similarities, cultural differences were likely to affect management effectiveness in these countries. They concluded that the development of culturally appropriate management education was important.

A study undertaken by Jain and Abubaker (1993) explored the question of whether Sudanese and American students perceived the ideal manager differently. The study found that Sudanese and American students held significantly different expectations of senior managers in all four areas of managerial attributes. Again cultural background was cited as the primary reason for the difference in their respective expectations.

Flanagan and Spurgeon’s study (1996) supported the view that management and leadership effectiveness is context dependant. Their study of managerial effectiveness in the National Health Service in Britain further proposed that managerial effectiveness was best understood as a construct with three distinct but interrelated dimensions: the person, the job and the organisation. The model they developed to measure managerial effectiveness identified characteristics related to the individual and the individual’s competencies; the job to be performed and its requirements; and the context (referred to in their model as ‘The organisation’) in which the job was being performed (refer Figure 1).

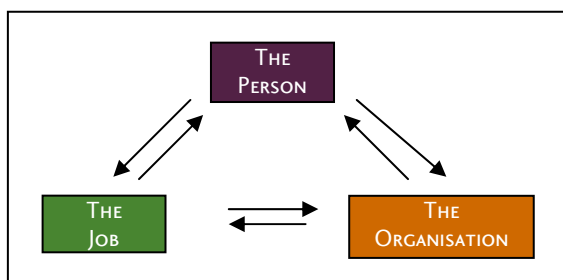


Figure 1: Flanagan and Spurgeon’s model of managerial effectiveness

Based on this model, The Person both influences The Organisation (or context in which the job is performed) and is also influenced by it. Likewise, there is a dynamic relationship between The Person and The Job, and The Job and The Organisation.

Perkins' PhD study (2003) on managerial effectiveness in the New Zealand health system identified that the ways in which people construe effectiveness change over time and as the context in which management takes place changes.

Overall, studies from the literature review indicate that:

- i. underlying cultural values do differentially inform perceptions about what constitutes an effective manager
- ii. perceptual similarity or difference in describing the desirable attributes of effective managers is also related to cultural distance (Boldy, Jain & Chen, 1996).

B. CULTURE

The task of attempting to define a view on culture within the context of managing health services raises many challenges. Questions on how culture impacts on health management and the need to recognise diversity of interpretations across multiple contexts and diverse ethnic communities must be taken into account. The Asia–Pacific study, for example, settled on each participant country as representing a unit of culture to enable '...ease of operation and because there (was) little agreement on the definition of culture'.

The current study adopts the definition of culture by Saldana (2001) cited by Suaalii-Sauni and Samu (2005):

...[Culture] refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

Hofstede's (1984) concept of culture resonates with the definition offered by Saldana. He made the comparison between culture as a series of integrated patterns of human behaviour and culture as a collective programming of collectively held values:

... The collective programming of the human mind that distinguishes the members of one human group from those of another. Culture in this sense is a system of collectively held values.

Hofstede argued that there was a need among managers to understand culture; how culture determines value systems and how it influences management approaches from one country to another. Hofstede (1993) further added that the concept of a universal management theory does not exist because the formula to managerial effectiveness will vary from one cultural context to another. As a means of promoting managerial effectiveness, managers need to understand how culture influences and affects management processes.

Hofstede has identified five value dimensions that underpin differences between countries. These dimensions help understand managerial practice as reflected within a cultural context. The five dimensions are:

<p>POWER DISTANCE INDEX (PDI) (VERSUS EQUALITY)</p> <p>Looks at the scale of inequality that exists among people, which the population of a country considers as normal. That is, the extent to which the less powerful members of organisations and institutions (like the family) accept and expect that power is distributed unequally.</p>	<ul style="list-style-type: none"> ▪ Degree to which society is equal or hierarchical (Japan – high power distance/hierarchical) ▪ Low power distance: where the low employee can speak naturally or even yell at the boss of a company (U.S.).
<p>INDIVIDUALISM (IDV) (VERSUS COLLECTIVISM)</p> <p>The extent to which people believe that they need to look after their own self-interests versus the interests of their families or groups that they belong to. On the individualist side are societies where the ties between individuals are loose: everyone is expected to look after him/herself and his/her immediate family. On the collectivist side, are societies in which people from birth onwards are integrated into strong, cohesive in-groups. The word 'collectivism' in this sense has no political meaning: it refers to the group, not to the state.</p>	<ul style="list-style-type: none"> ▪ Degree to which society encourages individual or collective achievement and relationships (U.S.). ▪ Collectivism: prize success of group achievement (Japan).
<p>MASCULINITY (MAS) (VERSUS FEMININITY)</p> <p>The degree to which a culture leans to dominance, forcefulness and materialism versus a culture which is more conducive to people, feelings and the quality of life.</p>	<ul style="list-style-type: none"> ▪ Degree to which society reinforces traditional male work role/achievement, control, and power (Japan). ▪ Feminine society: male/female roles equal, either sex can be traditional 'breadwinner' (Scandinavian countries). ▪ U.S. would rank somewhere in the middle.
<p>UNCERTAINTY AVOIDANCE INDEX (UAI) (VERSUS RISK TAKERS)</p> <p>The predilection of a structured versus unstructured framework/infrastructure. UAI deals with a society's tolerance for uncertainty and ambiguity; it ultimately refers to people's search for truth. It indicates to what extent a culture programmes its members to feel either uncomfortable or comfortable in unstructured situations. Unstructured situations are novel, unknown, surprising, and different from the usual.</p> <p>Uncertainty avoiding cultures try to minimise the possibility of such situations by strict laws and rules, safety and security measures, and on the philosophical and religious level by a belief in absolute truth; 'there can only be one truth and we have it'. People in uncertainty avoiding countries are also more emotional, and motivated by inner nervous energy.</p> <p>The opposite type of culture, uncertainty accepting cultures, are more tolerant of opinions different from what they are used to, try to have as few rules as possible, and on the philosophical and religious level are relativist and allow many currents to flow side by side. People within these cultures are more phlegmatic and contemplative, and not expected by their environment to express emotions.</p>	<ul style="list-style-type: none"> ▪ Societal lack of tolerance of uncertainty, ambiguity and unstructured situations (Japan), versus a society accepting change, risks and varieties of opinions. ▪ Risk takers: thrive on potential payoff of high-risk situations (U.S.).

LONG-TERM ORIENTATION (LTO) (VERSUS SHORT-TERM ORIENTATION)

Long-term values lean towards the future, versus short-term values, which lean towards past and present e.g. respect for tradition and fulfilling social obligations. This fifth dimension was found in a study among students in 23 countries around the world, using a questionnaire designed by Chinese scholars. It can be said to deal with virtue regardless of truth. Values associated with long-term orientation are thrift and perseverance; values associated with short-term orientation are respect for tradition, fulfilling social obligations, and protecting one's 'face'. Both the positively and the negatively rated values of this dimension are found in the teachings of Confucius, the most influential Chinese philosopher who lived around 500 B.C. However, the dimension also applies to countries without a Confucian heritage.

- Degree to which society embraces long-term commitments, and values tradition, with typically a lower tolerance for 'outsiders' (Japan).
- Short term: enjoy new relationships, outsiders accepted faster (U.S.).

The dimensions of power distance (small¹), collectivism, femininity, uncertainty avoidance (weak²), and long-term orientation, as well as short-term orientation, have similar aspects to the theoretical and philosophical approaches described in the Agnew (2004) report, which attempts to articulate Pacific models of mental health service delivery in New Zealand.

Critics of Hofstede's work question the validity of his findings based on a lack of vigor in his research method. McSweeney (2002) argues that Hofstede treats each nation as an absolute without recognising the fact that subcultures exist within a culture/nation. Popper (2006), in support of McSweeney's view, also believed that Hofstede's presentation on his perception of treating countries as defining cultures was misleading. In defense of his work, Hofstede responded in a paper, 'Dimensions Do Not Exist: A reply to Brendan McSweeney' (2002). In principle, Hofstede and McSweeney agreed on the fact that cultural differences existed within countries. However, in his attempt to dispel the view that one size fits all from one country to another, Hofstede's failure to provide an appropriate methodology led to challenges to his method of ascertaining cultural differences.

The collective Pacific concept of health is based on the view that the spiritual, mental, physical and psychological realms of a person are interdependent. Similarly, there are interdependent relationships between people, between people and their environment, and people and their divinities. Hofstede's value dimension of collectivism assists with placing a collective Pacific understanding of 'collectivism' within a Pacific management model. With regards to work on developing a Pacific approach, and taking into account the critical comments about Hofstede's methodology, the Hofstede model does offer a plank for ongoing thinking around a philosophical framework in all five dimensions

¹ Small power cultures expect and accept power relations that are more consultative or democratic. People relate to one another more as equals regardless of formal positions. Subordinates are more comfortable with, and demand the right to contribute to and critique the decision-making of those in power.

² A weak uncertainty avoidance ranking indicates that the country has a high tolerance for uncertainty and ambiguity.

C. PACIFIC HEALTH MANAGEMENT

This study adopts the concept of health cited in Tupu Ola Moui, (2004)

...Pacific constructs of health are holistic, reject notions of mind – body dualism, and emphasise health as the property of the (extended) family rather than representing a purely individual attribute. (Lang and Mitaera 1994); (Scott et al 1999)

The Pacific population comprises 6.9 per cent of the total New Zealand population. Of this, 60 per cent are New Zealand born (Statistics New Zealand, 2006). For many Pacific peoples, New Zealand is now considered home (Suaalii-Sauni and Samu 2005).

Pacific peoples migrated to New Zealand – the land of milk and honey – during the economic boom years of the 1950s, 60s and early to mid-70s. They came to find employment and to undertake education, as a means to build significant capital and equity with which to establish their new lives in New Zealand and to assist their families in their island homes. ‘Throughout the boom years, Pacific peoples enjoyed average incomes, high employment and participation rates in the labour market.’ (Tupu Ola Moui, 2006-2010)

As a developing concept, Pacific health management emerged in response to the dramatically changing needs of Pacific populations affected by trends in New Zealand’s social and economic environment. ‘Economic deregulation in the late 1970s and 1980s and benefit reforms in the 1990s contributed to the legacy of low socioeconomic status. Its impact on health status that many Pacific people live with today continues to prevail.’ (Ibid)

Pacific health management is one area of Pacific health that must be addressed to ensure that the cultural values and beliefs of Pacific peoples are taken into account in health care provision. It is especially important in planning for provider and workforce development that workforce capability includes both a practical and critical understanding of Pacific ethnic specific values.

Developing Pacific Health Management

The Pacific population is not a homogenous group. It is comprised of 22 different ethnic groups, with each ethnic group having its own culture, language and history. The main ethnic groups are Samoan, Cook Island, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan.

The term ‘Pacific peoples’, was an attempt to encapsulate a group of people by using a pan identity group construct (Anae, 1998). Mila-Schaaf writes, ‘...The term Pacific peoples is an ‘umbrella’ term that is used to encompass a variety of Pacific Island nations and communities who are linguistically, culturally, and geographically distinctive from each other. Pacific Peoples (as opposed to ‘Pacific People’) is used to accentuate plurality and acknowledge the many Pacific nations and territories that are grouped together when this term is used. Other words that are used in a similar fashion include Pacific Islanders, Pasifika Peoples, Tagata Pasefika, and Pacificans.’ (Health Research Council of New Zealand, 2005)

As an established population within New Zealand society, there are concerns about the welfare of Pacific peoples, particularly in the area of health. ‘Pacific peoples have poorer health status, are more exposed to risk factors for poor health and experience barriers to accessing health services.’ (Tupu Ola Moui, 2004). The reasons for the relatively poor health of Pacific peoples in New Zealand are numerous and complex.

In his paper, Novak (2006) highlights the impact on people's health and the increasing health inequalities that occur when Pacific peoples engage with a health system that has different worldviews and perceptions of health (mainstream). Novak states that where differences exist between two cultures to the way in which health is valued and perceived, there are implications. These include:

- service users may choose not to access services for fear of being misunderstood or disrespected
- providers may miss opportunities for screening or assessment because they are not familiar with the prevalence of conditions among Pacific populations
- providers may fail to take into account differing responses to medication, treatment or care options;
- providers may lack knowledge about traditional remedies, leading to harmful drug interactions or incomplete care planning to take account of other therapies or services being used
- service users may not adhere to medical advice because they do not understand or do not trust the provider.

As a way forward to improving health outcomes for Pacific peoples, the Ministry of Health (2002) developed strategies focusing on community participation, developing provider services, workforce capacity and capability and addressing issues of access. The strategies included to:

- promote greater engagement with Pacific communities through high-quality support
- develop Pacific health services through the Pacific Provider Development Fund
- increase the Pacific health workforce by encouraging more Pacific peoples into the health professions
- increase the access to and use of Pacific health providers
- promote early intervention by helping Pacific peoples access mainstream health services as well as Pacific services, by addressing financial constraints and ensuring the new primary health care package is effectively meeting this need
- encourage the growth and development of the Pacific Health Research workforce, and use of evidence to support actions to improve Pacific health.

The introduction of the Pacific Provider Development Framework in 1995 was the Ministry of Health's attempt to resolve some of the above mentioned issues. The framework was set up to support the viability and sustainability of Pacific health providers. Its intention was to deliver high-quality services to its Pacific communities.

Programmes crucial to the development of a quality workforce (and therefore service) included the Pacific leadership development programme and the Pacific health workforce awards (under these awards, Pacific students were supported to enter into health management studies). Both programmes looked at approaches to developing the capacity and capability of managers and leaders within the Pacific health sector. Anecdotal feedback from past students however, suggested that the programmes leaned more towards understanding business acumen and not the attributes required for effective management within a Pacific health service.

The Annandale and Richards study (2007) explored the viability of workforce infrastructure and organisational development for the Pacific mental health and addictions sector. They concluded that recruitment of Pacific senior health managers was difficult because of capacity and capability issues. They further noted that organisational investment and an appropriate infrastructure would greatly assist Pacific health managers develop into good managers.

Despite the development of several initiatives, it would appear that workforce development activities for Pacific health managers have not been as successful as intended. Initiatives for Maori health managers, however, are proving to be effective and an exploration of Maori developmental models would be of benefit to Pacific workforce planning.

Maori Health Management

Over the past 168 years, land and physical resource claims by iwi and hapu are historical events that continue to affect the lives of all New Zealanders, and in particular Pacific peoples. There is a strong correlation between the historical losses of land and Maori taonga through colonisation, and their present day poorer health, social and economic status. This is an established pattern for all indigenous nations with a history of colonisation throughout the world.

In the area of health, the growing movement among Maori to have services for Maori provided within a framework that is responsive to Maori came about as a response to Maori people having on average, the poorest health status of any ethnic group in New Zealand. It has been advocated that through developing Maori services, where service delivery frameworks are distinctively Maori, some of the health inequalities experienced by Maori would be addressed. As a result there are estimated to be over 240 Maori health providers throughout New Zealand delivering health and disability services to Maori and non-Maori populations.

With the emergence of more Maori providers and commercial opportunities arising for Maori, there is an increasing number of Maori entering into managerial roles within the private and public sector. This is evidenced by the increased numbers of Maori business interests and iwi³ participation throughout the private and public sector, e.g. Tainui and Ngai Tahu. This in turn has led to the resurgence of a concept called 'Maori management', which is fast becoming an emerging discipline in mainstream management circles. Suffice to say, the concepts have been around long before colonisation. Essentially the concept of Maori management is the integration of two paradigms (Maori and Western), which complement each other without compromising identity and which honour the historical context for Maori.

The Maori management concept is closely aligned to the work of Colvill (1998), Kingi (2004) and Tapsell (1997). The key themes identified in their work suggest that effective management for Maori is based on the following elements:

- comprehension of te Tiriti o Waitangi⁴ and its relevance in the past, present and future
- respect for people
- relationships in terms of face-to-face, looking and listening, and developing an understanding of the context
- reciprocity
- benefit community and iwi
- the ability to integrate Western business acumen and skills with tikanga⁵
- being active participants in design, development, implementation, evaluation and decision-making of service provision and commercial interests.

³ Maori tribe, the largest social group within Maoridom. Iwi were divided into hapu (sub-tribe), which in turn are made up of whanau (households).

⁴ A broad agreement involving reciprocal guarantees and obligations signed between representatives of the British Crown and tangata whenua, circa 1840.

⁵ Traditional logic and common sense associated with a Māori worldview.

In addition, whanau ora⁶ was identified and should not be understated as a key element to managerial effectiveness in health (Informant, 2007).

Cram's paper (2001) is informed by Maori researchers such as Moana Jackson, Mason Durie and Linda Smith. Cram suggests that these themes are underpinning concepts that should apply in any area concerning Maori interests, not just health and business.

Management technical skills such as accounting, finance, and marketing are considered to be important for Maori. It is equally important that Maori concepts of management and business are equally valued as part of the skills package. Education institutions such as the University of Auckland and Massey University offer courses that include Maori approaches to management, governance, decision-making, leadership, innovation, human resource management, communication, information and strategic planning, consultation and commercial interests, to name a few.

There are strong similarities and synergies between Maori and Pacific peoples in terms of:

- health and social disparities
- cultural colonisation
- cultural and social views.

It could be argued that Maori and Pacific peoples have a different experience of loss, cultural alienation and displacement. This would suggest that Maori and Pacific health managers require an appreciation of the above concepts, both in a historical and current context:

...acknowledge that where Maori and the diverse Pacific populations experience comparable social, economic and cultural disparities, Pacific research contributes to the empowerment of Pacific populations and their families by addressing the factors that bring about and perpetuate social, economic and cultural disparities...(Health Research Council of New Zealand, 2005)

⁶ Collective wellness.

METHOD

Aim

The aim of this study is to identify and explore the perceptions of Pacific health managers in New Zealand regarding those attributes that are desirable for effective management of Pacific health services.

Significance

It is anticipated that this study will:

- identify specific areas of skills and training required within workforce development initiatives focused on Pacific health management
- provide a methodology for ongoing research in this area
- encourage Pacific people to undertake management health studies
- provide Pacific and mainstream health service providers with information on what cultural and non-cultural attributes have been identified as appropriate for effective management
- support the development of a framework to support potential and current managers of Pacific Health services within New Zealand
- assist organisations to understand key attributes identified for managerial effectiveness within Pacific health services.

Participant Selection Criteria

Criteria for participation was determined by people who had experience in managing a Pacific health service in New Zealand, including those currently managing a service and those who had previously managed a Pacific service.

Methods of Recruitment

Pacific health networks were used to recruit study participants from throughout New Zealand. Potential participants were approached individually and in settings where managers of Pacific health services congregate e.g. at conferences.

Approaches to potential participants included:

- face to face
- phone calls
- email, using an existing Pacific network list.

Participants were also recruited using a snow-balling technique.

Types of Pacific Health Services

A Pacific health service is a service that provides services to a community or population that is predominantly made up of Pacific peoples. These services include, for example, primary care, older person services, child and youth services, mental health, alcohol and drug services and health promotion services. The staff is predominately made up of many ethnicities from the Pacific.

Regions

The majority of the services represented in the data come from district health board districts in Auckland, Wellington and Christchurch.

Questionnaire

The questionnaire used by Boldy, Chen and Jain as part of the 1987 International Project on Culture and Management was adapted to the New Zealand Pacific context⁷. It was administered anonymously.

The questionnaire contained 75 questions covering the following domains.

- personality characteristics (30 items)
- knowledge and learning (10 items)
- skills (15 items)
- beliefs and values (20 items).

Participants were asked to rate their views as to whether attributes would help or hurt effectiveness within the above domain areas according to the following five point Likert scale.

- | | |
|---|----|
| 1. Will greatly help managerial effectiveness | +2 |
| 2. Will help | +1 |
| 3. Will neither help nor hurt | 0 |
| 4. Will hurt | -1 |
| 5. Will greatly hurt | -2 |

Control variables included age, gender, educational status and major field of study.

The questionnaire also contained space for study participants to make observations and comments, a feature that the Boldy, Chen and Jain (1994) questionnaire did not appear to have.

The questionnaire took approximately 15 to 20 minutes to complete.

Statistical Analysis

The results were analysed using the Statistical Package for Social Sciences for Windows (Version 15). Factor analysis was also used to explain interrelationships among the responses and develop constructs that provide an understanding of the data. Principle component analysis was used because of the sample size.

⁷ To access a copy of the questionnaire used for this study please contact Kirkpatrick Mariner, Pacific Health Division, Counties Manukau District Health Board, Auckland, New Zealand.

PARTICIPANT FINDINGS

Table 1 shows the demographics of the 71 participants in this study.

Table 1: Demographics

CHARACTERISTIC		%
GENDER	Female	53
	Male	45
	No response	2
AGE	25–34 years	21
	35–44 years	31
	45–55 years	31
	56+ years	14
	No response	3
ETHNICITY	Samoaan	46
	Tongan	13
	Niuean	7
	Cook Island	6
	NZ European	6
	Mixed	13
	No response	9

Management Experience and Educational Status

Of the total group, 31 per cent of participants have health management experience of 10 years or more, and 38 per cent of participants have less than five years of health management experience. Across these two groups, four per cent have health management qualifications.

In terms of educational status of participants, 84 per cent had undergraduate degrees, with 43 per cent of these participants also having Masters degrees or higher qualifications. However, the types of qualifications varied. 24 per cent of all participants had a health-related qualification. Seven per cent of participants reported they had specific health management qualifications. Three per cent of all participants identified health management as their professional background.

The Four Domains

The results of this study are described using the headings in the Boldy, Chen & Jain (1994) study. Boldy (2008) states that there was no 'definition' as such and therefore the constructs used are labels that help summarise the findings within each factor (see table in Appendix One).

Personality

The desired personality attributes of an effective manager within a Pacific health service are described as nurturing, extroverted, high spirited, entrepreneurial, assertive, authoritative and humble. Acknowledging that humility is important, study participants did not identify modesty as a construct of the effective manager. Likewise, although being assertive is viewed favourably, 'being hard driving is not'.

Knowledge and Learning

Participants believe Pacific health managers should have an understanding in areas such as general knowledge and history of the organisation, be familiar with social-behavioural theory, and have an appreciation of managerial theoretical frameworks.

Skills

Pacific health managers require a working application of classical management theory with an emphasis on administrative skills, human relations theory in particularly behavioural management and political management skills.

Beliefs and Values

Beliefs and values included the importance of relationships. Participants saw people as basically good. Materialism and a mechanistic view of human organisation were also considered important.

Comparing results in the current study with those in the Boldy study, some important similarities and differences emerged.

Participants in the current study were the only group to believe that ‘people are basically good’. However, current study participants and Taiwanese respondents in the Boldy study shared the belief that subordinates should have a strong voice in decision-making.

With the exception of Australia, Bangladesh, China and the USA, groups from all the other countries in the Boldy study believed that ‘employees should be treated as ones own children’.

The following beliefs and values featured predominantly in factor two for Pacific health managers. In contrast, none of the participant countries in the Boldy study regarded these as important to managerial effectiveness, and a few believed that some of these attributes were undesirable.

- ‘Money is everything’ – all of the participants in the current study disagreed with this belief.
- ‘Taking risks is unwise’.
- ‘Subordinates must be closely supervised’.
- ‘Trust nobody but yourself’.
- ‘Each person should place self-interest above all considerations’ – in the Boldy study, Indonesia, South Korea, Taiwan and the USA did not believe this helps effectiveness. However, this may be about interpretation.
- ‘Trade unions are important only in poorly managed organisations’.

Additional Attributes

Additional attributes were identified by study participants as contributing to effective management. Study participants identified respect, honesty and integrity (within personality), cultural awareness, (within knowledge and learning), and knowledge of Pacific language(s) (within skills), valuing family and collectivism (within beliefs and values) as important attributes of the effective Pacific health manager. (Further observations of participants are included on page 24.)

Table 2 contains a series of constructs or desirable attributes, which when combined, give a picture of what it means to be an effective manager in a Pacific Health organisation or within a mainstream organisation offering services to Pacific peoples.

Table 2: Pacific constructs of an effective manager of a Pacific health service

	PERSONALITY	KNOWLEDGE AND LEARNING	SKILLS	BELIEFS AND VALUES
FACTOR ONE	Nurturing (thoughtful, caring, supportive, tolerant, patient, practical) Approachable (friendly, open minded, courteous, practical) Extroverted / high spirited (lively, energetic, cheerful, fun-loving) <i>Distant and impulsive (won't help effectiveness)</i>	General knowledge History of the organisation Familiar with social-behavioural theory Managerial theoretical frameworks	Classical management Human Relations Political	Subordinates should have a strong voice in decision-making Happy employees are productive employees People are basically good
FACTOR TWO	Entrepreneurial			Collective Materialism Mechanistic view of human organisation
FACTOR THREE	Assertive (forceful, authoritative)	Scientific and technological developments		Information is power
FACTOR FOUR	Humility (modest, reserved, informal) <i>Hard driving and like self (won't help effectiveness)</i>			Taking risks is unwise
ADDITIONAL CONSTRUCTS	Respect Integrity and honesty	Cultural awareness	Self-awareness A Pacific language	Family and relationships Collective responsibility

Participant Comments on Additional Attributes

Respect

Participants felt that respect was understated in the questionnaire and that the word ‘courtesy’ was not sufficient to hold the concept and value of respect from a Pacific worldview. One participant expressed that respect should always be viewed in the context of relationships.

The value of respect defines protocol and etiquette that are needed to maintain good relationships. If a Pacific manager did not portray respect they would find themselves outside the relational arrangements and isolated from staff and ultimately community.

Integrity and Honesty

Study participants would use integrity and honesty interchangeably and saw this as an important part of effective management within a Pacific health service. One participant observed that:

Integrity is something that managers should have and perhaps value highly for effective management, in my case, it is about accountability to the 'self' It is about honouring my thoughts, my word[s], my actions and behaviour, my performance. In summary, it's walking the talk.

Cultural Awareness

The participants stated that an effective manager within a Pacific health service required an understanding of Pacific Island paradigms and knowledge of the diverse cultural relationships. As a result of this, the manager would become more cognisant of the issues facing Pacific peoples in New Zealand.

Understanding Pacific nuance and context is essential to managing appropriate service provision. To ignore this and its impact in health management would be viewed as irresponsible.

Self Awareness

Within skills, participants identified self-awareness as an effective attribute meaning managers should have the ability to identify their own self-efficacy, including deficits within decision-making and skill sets. Participants commented:

I think 'self awareness' is important, knowing what your strengths and weaknesses are and acknowledging it!! Not try and hide it and also admit when you've made a mistake and likewise celebrate achievements.

Acknowledging yourself as a learner and acknowledging expertise within the team.

Pacific Language

Participants expressed that proficiency in a Pacific language was desirable and considered this as a key component of cultural competency.

Family and Relationships

Participants highlighted that the concept of family and relationships should be a key feature to the psyche of managers. Team culture was also considered important, and the comments appeared to be underlined by the principle of collective responsibility, which would also underpin the concepts of family and relationships,

Pacific organisations work together like a family rather than individuals within the organisations.

Valuing the 'we' there is no 'I' in 'We'.

Comparisons on the findings of Pacific participants and participants from the Boldy study (1994) have been included in Appendix 1.

DISCUSSION AND CONCLUSION

Pacific research in the area of Pacific health management is relatively new and therefore not as advanced as studies undertaken by Boldy et al (1994) and other international scholars. From this study, however, there are indications that Pacific management model(s) are likely to be significantly distinctive to those in the Asia-Pacific region. Reasons for this may include influences within the New Zealand management environment; the multi-ethnic composition of the Pacific population; multiple realities and experiences of a diverse Pacific population; un-factored influences from within the Pacific region, and Pacific peoples own efforts to find a place of inclusion for their values and beliefs.

Information provided by the participants indicates that there is a wealth of untapped, and in some cases unharnessed, knowledge and information. An initial comment on the findings from this study is the belief by participants that there needs to be ongoing work undertaken towards the development of Pacific health management and health care education models.

The study findings suggest that effective management within Pacific Health services requires a critical understanding of ethnic specific worldviews and issues such as migration and generational change. A wide appreciation of the social complexities that impact on the lives of Pacific peoples suggests that a component of the health care education and training resource should be multi-disciplined.

An opinion as to whether a Pacific model would fall into a contingent or universalistic approach should be considered with caution. Ethnic specific contexts are culture specific, however, as migrants to New Zealand, an added context would probably be environment. A preliminary guess would be that the contingent and universalistic approaches, as singular and combined methods depending on factors related to ethnic specific views, would benefit a Pacific approach.

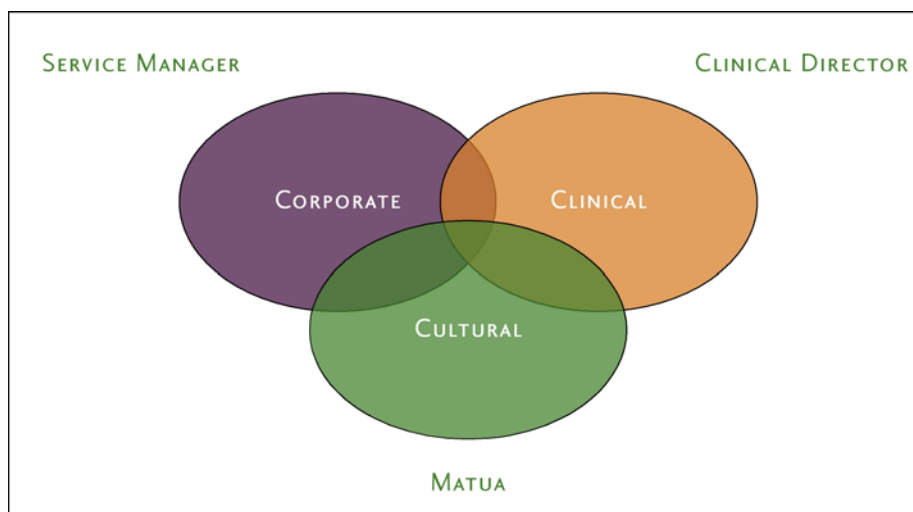
As a tool for measuring, for example social and economic 'distances/differences' between Pacific values and societal norms, the Hofstede 5 value dimensions would add value to this work. Exploration into how this tool has been used by ethnic communities internationally and the degree of effectiveness would inform potential areas of weaknesses and strengths.

While there are aspects of Western models that can be considered within the context of developing a Pacific model, the Maori management model would be the most immediate and relevant point of reference in terms of its cultural value base and multi-pronged experiences with mainstream businesses and providers.

A Model of Pacific Health Management

A Pacific health management approach called the 3C Model provides an insight into how culture and management values can work together. This model is used within the Pacific mental health and addiction services of Waitemata District Health Board, Auckland, New Zealand.

This diagram illustrates the relationship between three key roles and how they determine who responds to what area. The matua for example, will front cultural and community issues and will be supported by the service manager and the clinical director where appropriate. Similarly, there is corresponding support for the clinical director for any clinical issues and the service manager for any business issues. This relationship demonstrates collective responsibility at management level and (despite the service manager holding overall formal accountability) this model of working has been well received by all staff maximising ownership, productivity and morale.



It is important to note that this model recognises that the cultural component is perceived equally with management and clinical as an essential component towards effective management, suggesting that this approach may be effective to manage the tensions between context and content within a Pacific health management setting. Although further work is required to test this model in Pacific Health settings, there is also recognition that this model may not be suitable for all Pacific health services given the resource constraints

Summary

The approach to Pacific health management in New Zealand requires articulation in a model that understands the diverse realities of Pacific culture and the New Zealand management system. The acknowledgement that tensions do exist between these worldviews also needs further exploration suggesting that Pacific health management in New Zealand is about getting the balance right - 'negotiating the space between both paradigms'.

The literature and findings suggest that Pacific health management models should consider context (cultural) and content (technical) in determining an appropriate framework that will lead to effective management within Pacific health services in New Zealand.

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APPENDIX 1

Key Attributes for Effective Management – Pacific People

FACTOR ONE	PERSONALITY		KNOWLEDGE AND LEARNING		SKILLS		BELIEFS AND VALUES	
	Open-minded	0.83	Social forces impacting the organisation	0.76	Decision-making	0.86	Happy employees are productive employees	0.55
	Thoughtful	0.83	Pertinent technical knowledge	0.72	Planning and evaluating	0.86	People are basically good	0.51
	Supportive	0.82	History of the organisation	0.67	Conflict resolution	0.84	Subordinates should have a strong voice in decision-making	0.42
	Caring	0.78	Management theories and techniques	0.63	Public relations	0.83		
	Courteous	0.78	Theories of social and political behaviour	0.63	Negotiation	0.83		
	Tolerant	0.76	Socioeconomic-political developments	0.63	Problem solving	0.82		
	Friendly	0.73	General knowledge	0.58	Attracting resources	0.82		
	Lively	0.73	Scientific and technological developments	0.48	Interpersonal relations	0.76		
	Practical	0.73	Developments in other countries	0.46	Organising	0.68		
	Cheerful	0.72			Forecasting	0.67		
	Energetic	0.7			Diplomacy	0.67		
	Intuitive	0.7			Public speaking	0.65		
	Patient	0.69			Conducting meetings	0.6		

	Self-confident	0.65			Directing	0.59		
	Fun-loving	0.57			Politicking	0.43		
	Ambitious	0.48						
	Likes self	0.44						
	Modest	0.37						
	Impulsive	-0.36						
	Distant	-0.53						
FACTOR TWO	PERSONALITY		KNOWLEDGE AND LEARNING		SKILLS		BELIEFS AND VALUES	
	Proud	0.61					Rules must always be obeyed	0.72
	Businesslike	0.5					Money is everything	0.72
	Competitive	0.49					Work must come before everything else	0.7
	Idealistic	0.45					Employees should be treated as ones own children	0.62
	Hard-driving	0.35					A manager's first concern should be productivity	0.57
							Trust nobody but yourself	0.57
							Subordinates must be closely supervised	0.53
							Trade Unions are important only in poorly managed organisations	0.51
							Each person should place self-interest above all considerations	0.45

							Taking risks is unwise	0.45
							An effective organisation should run like a machine	0.43
							An effective manager should be popular with employees	0.39
FACTOR THREE	PERSONALITY		KNOWLEDGE AND LEARNING		SKILLS		BELIEFS AND VALUES	
	Risk-taking	0.49	Scientific and technological developments	0.45			Information is power	0.35
	Forceful	0.4						
	Authoritative	0.37						
	Modest	-0.38						
FACTOR FOUR	PERSONALITY		KNOWLEDGE AND LEARNING		SKILLS		BELIEFS AND VALUES	
	Reserved	0.6					Taking risks is unwise	0.46
	Impulsive	0.38						
	Modest	0.36						
	Informal	0.35						
	Hard-driving	-0.37						
	Likes self	-0.43						

APPENDIX 2

Comparisons between the Pacific and the Boldy, Chen and Jain Study

Personality (Factor One)

Both studies agreed on caring, courteous, open minded, patient, practical, supportive, thoughtful and tolerant.

Pacific participants also identified three attributes – intuitive, proud and reserved. No other country in the Boldy, Chen and Jain study rated these as part of their construct towards effective management. Bangladesh, China, India, and Malaysia found the attribute of being proud undesirable. Taiwan also found both being proud and intuitive ineffective. Hong Kong found being reserved is a disadvantageous personality trait.

There was strong agreement within both studies that being cheerful, patient and supportive would help managerial effectiveness. Self-confidence was also a highly rated attribute. Both studies agreed that being impulsive and distant was not helpful.

Knowledge and Learning

Pacific health managers considered training towards effective management should include general knowledge and the history of the organisation. All of the 11 participant countries in the Boldy, Chen and Jain study did not recognise this as a prerequisite of learning.

Participants of both studies agreed that socioeconomic political developments (factor one) and theories of social and political behaviour (factors one and two) were considered important. This was followed by management theories and techniques (excluding China and India), and developments (excluding India and Bangladesh).

Skills

The Pacific study participants considered that all skills (factor one) listed in the questionnaire are highly important for effective management. Hong Kong (factor one, two and three) and USA (factor one and two) agreed on some of the skills as being useful. All the participant countries agreed that conducting meetings, public speaking (excluding Malaysia), and diplomacy (excluding Indian) would support managerial effectiveness. With the exception of South Korea, USA and Pacific participants, the remaining participant countries viewed the skill of politicking non-essential. Other skills such as conflict resolution, problem solving and attracting resources did not feature highly for a number of countries, particularly Taiwan.

Of the four domains, Pacific managers rated the skills section more highly than the other domains. This suggests that Pacific health managers would use an eclectic mix of political, classical, administrative and human relations management skills and adapt them to whatever situation arises to maximise effective management.



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