

**Review of the
Ministry of Health
Hauora Māori
Scholarship Programme**

A report prepared for the Ministry of Health and
the Health Research Council of New Zealand

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Hauora Māori
Scholarship Programme

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LIST OF ABBREVIATIONS

APC	Annual Practicing Certificate
AUT	Auckland University of Technology
CTA	Clinical Training Agency
DHB	District Health Board
DHBNZ	District Health Boards New Zealand
EEO	Equal Employment Opportunities
FTE	Full Time Equivalent
HFA	Health Funding Authority
HMSP	Hauora Māori Scholarship Programme
HRC	Health Research Council of New Zealand
HWAC	Health Workforce Advisory Committee
MAPAS	The Māori and Pacific Admissions Scheme
MAPO	Māori Coordinated Care and Co-Purchasing Organisations
MDO	Māori Development Organisations
MHDW	Māori Health and Disability Workforce
MoH	Ministry of Health
MPDS	Māori Provider Development Scheme
NCNZ	Nursing Council of New Zealand
NZQA	The New Zealand Qualifications Authority
PECT	Post Entry Clinical Training
PHO	Primary Health Organisation
RHA	Regional Health Authority
TEC	Tertiary Education Commission
Te ORA	Te Ohu Rata o Aotearoa

EXECUTIVE SUMMARY

Introduction

Māori rates of participation in tertiary health field education programmes are low relative to non-Māori (Ministry of Education, 2005), and Māori are under-represented across almost all health professions, particularly in front line clinical roles. There are clear rationale for initiatives to strengthen the participation of Māori at all levels and in a range of roles within the health and disability workforce. Those rationale relate to: the Treaty of Waitangi; projected excess health and disability workforce demand overall; New Zealand's changing demographic profile and increasing demand for Māori health professionals; wide and enduring inequalities between the health status of Māori and non-Māori; evidence of treatment disparities; the positive health impact of ethnic concordance between practitioners and patients; and, the likely wider intergenerational and socio-economic benefits. These rationale are also consistent with the Government's vision and direction for the coming decade of economic transformation; making life better for families, young and old; and building our national identity. A representative and culturally competent national health and disability workforce is best placed to ensure optimal health outcomes for all New Zealanders as the basis for a healthy workforce overall to drive the transformation of our economy. Reducing inequalities in health between Māori and non-Māori will be critical to the achievement of a better life for whānau, and this will rely in part on the development of Māori health and disability workforce (MHDW) capacity and capability in order that the health sector is best equipped to facilitate health gain for Māori. The Māori identity is fundamental to New Zealand's national identity and, like other elements of our national identity, should be nurtured and reflected in all domains including in health settings. A strengthened MHDW will facilitate the provision of culturally sound health services which support Māori to be healthy as Māori and contribute fully to the New Zealand national identity.

Increasing and maintaining an appropriately qualified MHDW will rely upon the recruitment of Māori into tertiary health field programmes from secondary school students and second-chance learners, as well as the retention and ongoing skill development of the current professional MHDW. As well, community health workers and voluntary workers should have the opportunity to gain tertiary level qualifications that will support their effectiveness in their role, and some may choose to move into other health sector roles.

There has been a recent proliferation of workforce development planning and interventions across the sector, consistent with comprehensive Government policy frameworks that support health and disability workforce development. In early 2006, the Ministry of Health published Raranga Tupuake Māori Health Workforce Development Plan 2006 in an effort to facilitate a more co-ordinated and managed approach to MHDW development. The Māori Health Scholarship Programme, now renamed the Hauora Māori Scholarship Programme, is a longstanding MHDW development initiative established in the early 1990s. The Hauora Māori Scholarship Programme (HMSP) is a national initiative that aims to strengthen the MHDW, and

thereby contribute to improved health outcomes for Māori. The Programme provides financial assistance for students undertaking a tertiary health-related programme of study who are committed to Māori health and have whakapapa and/or cultural links with Māori. Since 2000, Te Kete Hauora, the Māori Health Directorate of the MoH has managed the Māori Provider Development Scheme (MPDS). HMS is one of the four funding categories within the MPDS⁶.

The overall aim of this report is to review the HMSP in terms of its contribution to MHDW development. It is intended that the findings of the research will further clarify the Programme's intervention logic, assess the impact of the Programme in terms of student outcomes and MHDW capacity and capability, provide an indication of the extent to which the Programme complements other MHDW initiatives, identify aspects of Māori workforce development initiatives in other sectors that may be transportable to the health sector, and provide recommendations for Programme improvement. The scope of the project did not allow for cost analysis or in-depth analysis with regard to funding prioritisation.

Research approach and methods

The research is located within a Māori inquiry paradigm. An inquiry paradigm guides the conceptualisation of problems, selection of research methods, data analysis and the standards by which quality of research is assessed. While a Māori inquiry paradigm has not yet been articulated in the literature, a number of themes have been identified in the Māori health research literature as providing an indication of the essential features of a Māori inquiry paradigm. These themes are; interconnectedness, Māori potential, Māori control, collectivity, and Māori identity, and together are used to provide the theoretical framework for this project. It is the themes, rather than particular methodologies, that are the key to the Māori health research approach used in this study.

The research incorporated both quantitative and qualitative components and used multi-methods that included: literature review; review of Ministry of Health information; twenty-nine key informant interviews with stakeholders; a survey of 593 scholarship recipients; matching of scholarship recipient names on professional councils and registration boards databases; review of workforce development interventions; and surveys of Māori health tertiary students and the current MHDW.

Research findings

Intervention logic

The core intervention logic for the HMSP is to contribute to ensuring equitable Māori participation within the health and disability workforce through strengthening the capacity and capability of the MHDW, and thereby facilitating improved health outcomes for Māori. The provision of financial assistance through scholarships to

⁶ In 2007, the HMSP fund and administration transferred as part of the MPDS from Te Kete Hauora, the Māori Health Directorate to the Sector Innovation and Capability Directorate in the Ministry of Health

eligible Māori secondary school students with an interest in pursuing a career in health and Māori health field tertiary students is intended to address affordability as a barrier to Māori accessing tertiary health-related education. The concept of access includes entry into, success in, and completion of programmes. In the context of evidence of affordability as a major barrier to Māori participation in tertiary health field education, ongoing marked under-representation of Māori within the health and disability workforce, wide ethnic disparities in health, and the Government's direction for the coming decade, the Programme intervention logic remains sound.

Programme complementarity

MHDW recruitment and retention initiatives to support capacity and capability building are varied and include discipline specific interventions (e.g. Te Rau Puawai), multidisciplinary approaches (e.g. Hauora.com), pre-entry support (e.g. Whakapiki Ake Project), and post-entry training (e.g. Clinical Training Agency funded initiatives). Generally, the HMSP is unique in its focus as the only national multidisciplinary Māori health scholarship programme and as such complements other MHDW development initiatives. However, there are two potential areas of overlap. The mental health field is an area where relatively high and consistent levels of funding are being invested with good workforce outcomes through Te Rau Matatini and Te Rau Puawai. Te Rau Puawai offers comprehensive support, including scholarships, to Māori students seeking university qualifications in mental health-related fields, though the focus is on one university. The second area is with regard to post-entry training. Approximately one third of surveyed scholarship recipients were already working in the sector at the time they were awarded the scholarship. Other options for funding post-entry health field study include Clinical Training Agency funding, employer support, and Māori Provider Development Scheme funding and other Māori Provider Development Scheme funding.

Success factors in other sectors

A range of assistance is offered in other sectors to develop the Māori workforce. Nine best practice characteristics of selected interventions offered in other sectors that may be transported to the health sector were identified. Those factors are:

1. specific targeting of Māori;
2. well resourced marketing strategies that raise the profile of initiatives;
3. levels of scholarship funding that minimise costs to learners and therefore cover, for example, full tuition fees, other course costs and living expenses;
4. strong links between courses offered and workforce supply and demand;
5. opportunities to study in a variety of geographical and institutional locations;
6. courses at varied skill levels are supported;
7. programme links to Māori stakeholders developed;
8. assistance to transition from study to work; and,
9. the provision of broad based support including pastoral care.

Student outcomes

Findings from the research indicate that the Programme has been successful in terms of contributing to student outcomes. Positive outcomes are reported for surveyed

recipients with regard to entry into and retention in tertiary health-related programmes of study, and qualification completion rates.

Surveyed recipients were carrying out study across a wide range of health-related disciplines in areas in which Māori are under-represented in the workforce. The majority of surveyed recipients indicated that the scholarship influenced their decision to enrol in a health-related course. One in four survey respondents stated that receiving a scholarship had played a significant role in their decision to reconsider pulling out of their course and continuing their studies. A large proportion of respondents indicated that the scholarship provided significant support to enable them to commit to completing their qualification and to go on to graduate. While just over half of respondents were still completing the course of study for which they were awarded a scholarship, almost all of the remaining recipients had successfully completed their course, and some had also gone on to do further study. This demonstrates a very high completion rate among surveyed recipients. Most of the recipients surveyed had completed an undergraduate degree or a postgraduate qualification. According to over half of respondents, receiving a scholarship had been 'very' or 'extremely' significant in supporting them to pass their course work each year, to achieve higher grades, and to complete their course of study within the minimum timeframe.

Impact on MHDW

The data presented in this report clearly indicates that the Programme has made a substantial contribution to the MHDW in terms of both capacity and capability through reducing financial barriers to tertiary study and contributing to positive student outcomes.

Over half of respondents indicated that receiving a scholarship impacted significantly in encouraging them to work in the health field, and more specifically in the Māori health and disability sector. Of the 390 survey respondents that were not employed in the health sector at the time of receiving the scholarship, one third are now employed in health. The percentage of total respondents now working in the health and disability sector has increased from one third to just over half. Of those respondents who had completed their qualification, more than three quarters are now working in the health sector. Data on recipient registration and annual practicing certificate status from professional council and registration boards supports findings that there are substantial numbers of scholarship recipients who are active within the MHDW. Further, at the time of the survey there were an additional 284 respondents still completing qualifications, which within a relatively short timeframe will strengthen the MHDW.

Approximately one third of surveyed recipients were already working in the sector in a range of professions and employment settings at the time they were awarded a scholarship. The majority of these respondents were enrolled at the undergraduate degree or postgraduate level. The Programme has provided assistance to the existing MHDW to the extent that 189 respondents have increased their capability through upskilling as just over half of this group had completed the qualification that they were enrolled in at the time of completing the survey questionnaire.

Of those who were already in the MHDW at the time they received the scholarship, the majority have remained in the health sector. A high proportion of respondents indicated that receiving a scholarship had at least some significance in their decision to continue to work in the health and disability sector. More than half of all respondents anticipate that they will work in the health sector for more than 10 years. The implication is that the Programme positively influences MHDW retention.

There is evidence that the Programme has been successful in contributing to strengthening the Māori health provider workforce. Thirty percent of the practicing nurse respondents who received a scholarship are working in a Māori health provider setting, and this equates to the largest number from any of the professional categories to work in this setting. The greatest percentage of scholarship recipients by occupation now working in a Māori health provider setting include health managers, social workers, public health workers and nurses.

Strengths of the Programme

Eight best practice characteristics of the Programme were identified in this research as:

1. a history of governance-level champions;
2. a clear Programme intervention logic;
3. targeting of Māori and an evidence-based Programme rationale;
4. consistency with Government policy;
5. an interdisciplinary and multi-level focus;
6. the complementary nature of the Programme;
7. provision of financial support to address the barrier of affordability of tertiary education; and,
8. the way in which the Programme has been administered.

Recommendations

Overall, within the scope of this project the data indicates that the HMSP is well administered by Te Kete Hauora and has been effective in contributing to improved outcomes for Māori health field tertiary students, and increasing the capacity and capability of the MHDW. The following recommendations are intended to strengthen what is already a successful MHDW development initiative.

Programme patrons

Much of the momentum and status of the Programme was originally derived from Māori and non-Māori leaders driving its development. This has to some extent been eroded, possibly as a result of the transfer of the Programme between health funders and the implementation of an effective, but largely mechanical, administration process. Continued evolution of the Programme and its political durability, would be enhanced by the involvement of eminent leaders as Programme patrons.

It is recommended that:

Programme patrons be appointed to enhance the mana and status of the Programme, and support its ongoing development and positive contribution to MHDW development. The role of Programme patrons would include the provision of input into high level decision-making, support in raising the profile of the Programme, and endorsement and representation of the Programme at public events.

Eligibility criteria

There are evidence-based rationale for targeting the Programme to Māori through whakapapa-based eligibility criteria, as a mechanism to enhance equitable representation of Māori within the workforce. Findings of this research reinforce those rationale, and highlight the major contribution of the Programme to MHDW capacity and capability building.

It is recommended that:

The Programme continue to build on its strengths, and reinstate whakapapa-based eligibility criteria for all recipients alongside a demonstrated commitment to Māori health.

Resource issues

There are indications that the Programme could be further improved through increasing the level of scholarship funding available to individual recipients to better reflect growing costs of tuition fees and other study-related expenses. Interventions reviewed in other sectors tended to fund a higher proportion of student costs than the HMSP. However, specific recommendations with regard to changes to the level of funding will require a cost analysis that takes into account the variable costs of study programmes and differences in the extent of increases over time and across programmes.

Although largely outside the scope of this study, there is also a need to consider prioritisation of scholarship funding in order to ensure the best return on investment and to manage expectations if available funding does not meet demand for scholarships or adequately cover increasing costs of health field tertiary study. Identified possible areas of funding overlap may be further explored (such as the mental health field and post entry training), alongside consideration of whether a stronger emphasis on undergraduate level study may result in greater returns in terms of supporting increased Māori entry into the workforce. Further consideration of the

health professional roles that are most likely to impact directly on Māori health outcomes should also inform prioritisation.

It is recommended that:

Cost analysis be undertaken to determine the extent to which increases in the level of scholarship funding to individual recipients is justified due to increasing tuition fees and other study-related costs, and the formula by which funding levels may be increased if advisable.

Additional analysis be undertaken in order to ensure prioritisation of scholarship funding that facilitates the best return on investment and greatest impacts on Māori health outcomes.

Marketing

Marketing of the Programme has been minimal, and has tended to focus on directly targeting students with information and application forms through their institutions. Data indicates that there are substantial numbers of eligible individuals who are either not aware of or have inadequate knowledge of the Programme.

It is recommended that:

A more comprehensive HMSP marketing strategy be developed that utilises both mainstream and Māori media. Additional resources should be provided to meet the costs of marketing the Programme. The level of resources should be benchmarked against successful education-related marketing campaigns such as those for TeachNZ Scholarships and Te Mana.

As part of the marketing strategy, the Ministry of Health facilitates increased communication between the health, education, and employment sectors with regards to the Programme in order to raise Programme awareness among stakeholders across sectors.

All eligible applicants in a given year are automatically sent application forms in the following year (both successful recipients and those who were declined), and the Programme work with tertiary providers to encourage a process by which all new Māori students who enrol in health-related courses are sent Programme application forms.

That particular attention is paid to increasing Programme awareness among Māori Year 12 and 13 secondary school students and second chance learners considering entry into foundation courses and programmes for health field auxiliary staff.

Application process

There were limited suggestions as to how the Programme's application process could be improved, and generally comments related to increased support for completing application forms.

It is recommended that:

An on-line application process be developed.

Consideration be given to additional measures to facilitate applicants access to information to assist in completing application forms, including for example the establishment of an 0800 telephone number for enquiries, and that there is a named individual as the contact point for enquiries.

Information issues

Within the sector generally, insufficient work has been carried out to profile the health and disability workforce and clarify future supply and demand issues in order to facilitate fully informed planning. This information should be available to inform all health and disability workforce development initiatives, including the HMSP to strengthen the link between Programme planning and MHDW supply and demand, particularly in relation to scholarship categories and the numbers of scholarships provided in various categories. There are also opportunities for the Programme to enhance its contribution to MHDW development through increased sharing of information and data gathered for HMSP internal planning and accountability purposes. This may include Programme specific data as well as wider analysis.

Since the Programme's establishment, the most important piece of work to inform Programme planning was the needs analysis completed in 2001. While regular needs analysis would be useful, this should be balanced against the fact that Māori are under-represented in almost every health professional group and therefore the need for MHDW development is so widespread across professions that support within any professional group will be beneficial.

Also with regard to information issues, to facilitate future Programme planning, greater attention is required to maintaining Programme databases. This includes electronic databases of scholarship recipients and unsuccessful candidates.

It is recommended that:

Information collected that relates to MHDW supply including programme needs analysis and evaluation reports, be made available to Māori workforce development stakeholders to support Māori workforce development in the health and other sectors and to improve accountability and transparency.

Greater attention be paid to ensuring the accuracy and completeness of Programme databases, including electronic databases of scholarship recipients and unsuccessful candidates to facilitate Programme planning.

That Programme development be further informed by data on MHDW supply and demand which draws on, for example, secondary school NCEA data, Ministry of Education undergraduate and postgraduate uptake trend information, and NZHIS workforce data.

John McLeod Scholarships

A further area for improvement relates to the John McLeod Scholarships. The original intent behind the establishment of the John McLeod Scholarships had been to provide an excellence award for the highest achieving Māori scholars in medicine and nursing as recognition of academic excellence, to encourage postgraduate research, and as an incentive for Māori academic success. While the broadened scope, to include the range of health disciplines, is sensible in terms of seeking to recognise the highest performing scholars it appears that the prestige of the John McLeod scholarships has become somewhat diluted. It would be timely to reassess the criteria for the John McLeod Scholarships in consultation with the McLeod whānau in order to better meet the original intent of the award in terms of recognising Māori academic excellence. The awarding of a coveted scholarship that is held in the highest regard has the potential to support Māori health leadership development, promote the value placed on Māori academic excellence in health, and provide an incentive for the highest Māori health academic achievers.

It is recommended that:

The criteria for the John McLeod Scholarships is reviewed in consultation with the McLeod whānau in order to better meet the original intent of the award in terms of recognising Māori academic excellence.

INTRODUCTION

He Korowai Oranga (Ministry of Health, 2002a) is the Government's overarching policy framework for Māori health. One of the four pathways for action identified in He Korowai Oranga is to increase Māori participation in the health and disability sector, including the objective of increasing the number and improving the skills of the Māori health and disability workforce (MHDW) at all levels. The Ministry of Health Hauora Māori Scholarship Programme (HMSP) is consistent with the stated Government commitment to strengthen the MHDW. The Programme's development began in the early 1990s, and it has been administered by the Ministry of Health (MoH) since 1999.

The purpose of the Scholarship Programme is to encourage more Māori into health fields in areas where Māori are under-represented as health professionals and over-represented in terms of health need, through the provision of scholarships to Māori secondary school students with an interest in health and Māori tertiary students enrolled in health-related fields. In 2004, the MoH forecasted a budget commitment of \$927,000 to the Scholarship Programme making 564 scholarships available.

This research has been commissioned by the MoH and the Health Research Council of New Zealand (HRC) as part of the Māori Health Joint Venture, a joint initiative between the two parties. The Māori Health Joint Venture is a component of the HRCs Partnership Programme. The Joint Venture aims to strengthen the links between policy and practice and facilitate an evidence-based approach in key areas of need, in this instance MHDW development.

Project aim and objectives

The overall aim of the project is to evaluate the HMSP in terms of its contribution to MHDW development. It is intended that the findings of the research will further clarify the Programme's intervention logic, evaluate the impact of the Programme on the MHDW, identify aspects of Māori workforce development initiatives in other sectors that may be transportable, and provide evidence-based recommendations for Programme improvement. The research will therefore provide direction for the MoH to maximise the Programme's contribution to developing a MHDW of optimum size, configuration and quality, thereby improving Māori health outcomes.

The objectives of the research are to:

1. Document the intervention logic for the HMSP;
2. Identify the student outcomes (study, recruitment, and retention in the health workforce) from those who received funding from the Programme;

3. Identify strengths and weaknesses of the HMSP in achieving the outcome of greater participation in the health and disability workforce by Māori;
4. Assess how the Māori health scholarships complement other Māori health workforce development initiatives and usefulness to stakeholders (students, whānau, iwi, hapū, District Health Boards [DHB], providers);
5. Assess the impact that the HMSP has had on the MHDW and its skill level;
6. Identify Programme improvements to further assist the development of the MHDW; and,
7. Identify the assistance offered in other sectors to develop the Māori workforce and describe the key success factors of these programmes which could be transported.

Theoretical framework

The research is located within a Māori inquiry paradigm. An inquiry paradigm guides conceptualisation of problems, selection of research methods, data analysis, and the standards by which the quality of research is assessed. While a Māori inquiry paradigm has not yet been articulated in the literature, a number of themes have been identified in the literature as providing an indication of the essential features of a Māori inquiry paradigm and together can be used as a theoretical framework for Māori health research (Ratima, 2003). Those themes are; interconnectedness, Māori potential, Māori control, collectivity, and Māori identity. The themes provide the theoretical framework for this research project. It is the themes, rather than particular methodologies, that are the key to the Māori research approach used in this project. The implications of each of those themes for this research project are identified in Table 1.

Table 1. Themes of a Māori inquiry paradigm and implications for the research

Themes	Implications for the research
Interconnectedness (Cunningham, 1998; M. H. Durie, 1996; Royal, 1992)	<ul style="list-style-type: none"> • links to Māori development emphasised • recognition of determinants of Māori under-representation in the workforce • structural causes of inequality such as unequal power relations and institutional racism are acknowledged
Māori potential (Bishop, 1994; Cram, 1995; A. Durie, 1998; M. H. Durie, 1996; Te Awekotuku, 1991)	<ul style="list-style-type: none"> • contribute to MHDW development • lead to positive health outcomes for Māori • non-deficit approach
Māori control (Bishop, 1994; M. H. Durie, 1998; Pomare et al., 1995; Tuhiwai Smith, 1996)	<ul style="list-style-type: none"> • research led and controlled by Māori • project consistent with Māori defined priorities • research outputs will contribute to increased Māori control over their own health development
Collectivity (Pomare et al., 1995)	<ul style="list-style-type: none"> • return information in accessible form to Māori collectives • produce positive outcomes for Māori collectives • Māori human, indigenous and Treaty of Waitangi rights are recognised
Māori identity (Pomare et al., 1995)	<ul style="list-style-type: none"> • consistency with Māori cultural processes • Māori cultural competencies valued • Māori identity recognised as central to health as Māori

Research methods

The research incorporated both quantitative and qualitative components and used multi-methods that included literature review and review of MoH information, key informant interviews, scholarship recipients' survey, database matching, MHDW project surveys, and a review of relevant Māori workforce development interventions.

Literature review and MoH information review

International and local literature was reviewed in order to clarify the Programme context, including evidence relating to the value of scholarships in influencing recruitment, retention and success in tertiary health-related fields of study for Māori. Search questions linked directly to research objectives and databases searched included PubMed, Medline, Index New Zealand, EMBASE, AMED.

Available MoH documentation and data relating to the HMSP was reviewed. Issues such as Programme intervention logic, eligibility criteria, categories and levels of funding, marketing strategies, assessment processes, and reporting were explored.

This information was supplemented by informal discussions with key stakeholders, in particular those who had been or were currently involved in the development and/or administration of the Programme. The review provided the basis for documentation of the Programme's intervention logic, and informed assessment of Programme strengths and weaknesses, complementarity with other MHDW development initiatives, and potential Programme improvements.

Key informant interviews

In-depth open-ended key informant interviews were carried out using an interview schedule (Appendix 1) developed with input from the Advisory Group, information sheets for participants (Appendix 2), and consent form (Appendix 3). The advantages of using in-depth open-ended interviews as a data source are that they are able to focus directly on the topic of interest, and provide insight as to informants' perceptions of the Programme.

The sampling technique employed was purposeful sampling (Patton, 1990), and therefore interviewees selected were considered to be rich sources of information about the Programme. The Advisory Group provided input into the selection of key informants. Twenty nine face-to-face (n=19) and telephone (n=10) key informant interviews were conducted by the researchers with stakeholders covering the following range of groups: scholarship recipients; Māori community informants; career advisors; tertiary education providers; health service providers; professional bodies and networks; programme administrators; and, other stakeholder agencies (e.g. Ministry of Education and District Health Boards).

The qualitative data management software package NVivo (Version 2 www.qsrinternational.com) was used in the project, and data was analysed by two researchers using thematic analysis. The results from the key informant interviews have been integrated into the document rather than being reported in a separate section. This approach has been taken to avoid duplication between sections as the findings from the key informant interviews were mostly consistent with findings from the MoH information review. Key informant interview findings are reported in the section 'Hauora Māori Scholarship Programme Development and Administration'.

Scholarship recipients' survey

The Scholarship Recipients' Survey provided the primary quantitative data for the project. A survey questionnaire was developed based on the research objectives, literature review, and findings from key informant interviews. The main areas covered in the questionnaire were; Programme administration and marketing, student outcomes, and relevant current employment issues.

In collaboration with the MoH, the Research Team prepared a list of scholarship recipients' names, contact details, scholarship category and year(s) in which they were awarded a scholarship. A survey pack was prepared containing a letter inviting scholarship recipients to participate (Appendix 4), an information sheet (Appendix 5), a consent form (Appendix 6) and a survey questionnaire (Appendix 7). A survey pack was mailed to scholarship recipients for whom contact details could be secured in October/November 2005. Those who had not sent in a response after two weeks were mailed another survey pack. Those who had still not responded after a further

two weeks were sent one last survey pack and were also given the option of completing the survey on-line.

As the nursing category had the largest group of scholarship recipients, the research team endeavoured to elicit further responses with the assistance of the Nursing Council of New Zealand (NCNZ). A search of the NCNZ on-line register was conducted by the Research Team for the 218 nursing category non-respondents. A list of 56 scholarship recipients in the nursing category identified as registered with the NCNZ was created and forwarded to the Council. These recipients were sent another survey questionnaire on behalf of the Research Team by the NCNZ as contact details were considered to be the most up-to-date available. This elicited a further 11 responses.

Survey data was entered into electronic databases which were reviewed, cleaned and collated into a single database. The final database was imported into SPSS statistical software (SPSS Inc. www.spss.com) for summarisation and analysis. For key issues of concern the results were stratified into scholarship categories to identify any differentials across groups. Chi-square test statistics were utilised to measure for any association between factors.

Matching databases

Registration boards were contacted to confirm scholarship recipients official registration and, where relevant, whether a current annual practicing certificate was held for all scholarship recipients on the MoH database. This data provided an indication of recipients that had completed their qualification and gained their professional health registration. The practicing status for registered health professionals is renewed on an annual basis and indicates whether the recipient is actively part of the MHDW. The fourteen registration boards listed below were contacted to seek information on the practising status of scholarship recipients.

- Nursing Council of New Zealand
- Midwifery Council of New Zealand
- Medical Council of New Zealand
- The Physiotherapy Board of New Zealand
- Dental Council of New Zealand
- Pharmacy Council of New Zealand
- New Zealand Optometrists and Dispensing Opticians Board
- New Zealand Chiropractic Board
- New Zealand Dietitians Board
- Podiatrists Board of New Zealand
- New Zealand Medical Laboratory Science Board
- New Zealand Medical Radiation Technologists Board
- New Zealand Psychologists Board
- Occupational Therapy Board of New Zealand

Māori health and disability workforce project surveys

Questions related to the HMSP were included in a national survey of Māori tertiary students enrolled in health-related field courses at Level 5 and above of the New Zealand Qualifications Authority (NZQA) Framework, and a national survey of the MHDW. The surveys were carried out as part of a separate MoH and HRC funded research project undertaken by Taupua Waiora entitled, 'Rauringa raupa recruitment and retention of Māori in the health and disability workforce'. The surveys were completed in 2006.

In the Māori tertiary students survey researchers sought to include a mix of respondents in terms of geographical location, disciplinary spread, and undergraduate versus postgraduate enrolment status. Two hundred and eighty-five eligible participants were recruited through Māori health and education networks, with assistance from a wide range of stakeholders including tertiary institutions, Māori professional bodies, DHBs, and Māori and mainstream health service providers.

In the MHDW survey, 449 participants were recruited through Māori and health networks. Participants in each survey were asked if they were aware of the HMSP and whether they had applied for a scholarship. Those who were aware of the Programme, but had not applied, were asked why they had not applied.

Data from each survey was entered into electronic databases in the same manner as for the Scholarship Recipients' Survey. The database was imported into SPSS statistical software for summarisation and analysis. Qualitative data was analysed manually using thematic analysis.

Review of relevant Māori workforce development interventions

Māori workforce development interventions in other sectors were identified in the literature review, key informant interviews and surveys. A small number of relevant interventions for which programme information was available were identified. Selected interventions; TeachNZ, Rangatahi Maia, and Te Ohu Kaimoana's 'Fish Fingers' were assessed to identify success factors that were transportable and could inform strategies for improved Māori participation in the health and disability workforce. The assessment took into account the complex nature of workforce recruitment and retention, barriers and facilitators to Māori participation in tertiary health-related field programmes of study (as identified in the project 'Rauringa raupa recruitment and retention of Māori in the health and disability workforce') and the likely applicability of assistance mechanisms to the health sector.

THE PROGRAMME CONTEXT

Māori participation in the health and disability workforce and tertiary education

Health professional councils and registration boards and the New Zealand Health Information Service are the main sources of regularly collected information on registered health practitioners, though data quality and particularly ethnic data is variable across professions (Health Workforce Information Programme Steering Group, 2005; Ministry of Health, 2006e). However, based on available data, in 2001 the Health Workforce Advisory Committee (HWAC) stocktake of New Zealand health workforce capacity estimated a total of 100,000 health workers (Health Workforce Advisory Committee, 2002b). Of the 100,000, approximately 67,000 were registered health practitioners, 30,000 were support workers, and 10,000 were alternative or complementary health workers (Health Workforce Advisory Committee, 2002b). Of the registered health practitioners, approximately 40% were nurses and 25% were medical practitioners. More recent 2004 data from the New Zealand Institute of Economic Research (NZ Institute of Economic Research, 2005) estimated an increased size of the health workforce at 130,000. The Institute's health care workforce demand projections to the year 2021 (NZ Institute of Economic Research, 2004) show an excess in workforce demand of between 28-42% depending on the method of calculation.

The HWAC stocktake concluded that there were shortages in both the regulated and unregulated Māori health workforce. Although Māori made up around 15% of the New Zealand population (Statistics New Zealand, 2002), they comprised only 5% (n=3211) of the regulated health workforce at that time (Health Workforce Advisory Committee, 2002b). Māori were under-represented across almost all health professions, particularly in front line clinical roles (Health Workforce Advisory Committee, 2002b). For example, Māori make up 3% of the medical workforce (Medical Council of New Zealand, 2003), 6% of nurses (Nursing Council of New Zealand, 2004), 2% of dentists (Thomson, 2004), 4% of psychologists, 3% of physiotherapists, 2% of occupational therapists, and 2% of medical radiation technologists (New Zealand Health Information Service, 2005). In a number of other regulated professions, Māori comprise less than 2% of the workforce. For example, there are five Māori dietitians (1.6% of the workforce), six Māori medical laboratory technologists (0.8%), only one Māori dispensing optician (1.1%), and three Māori optometrists (0.7%) (New Zealand Health Information Service, 2005).

Increasing and maintaining an appropriately qualified MHDW will rely upon the recruitment of Māori into tertiary health-related programmes from secondary school students and second-chance learners, as well as the retention and ongoing skill development of the current professional MHDW. Community health workers and voluntary workers should have the opportunity to gain tertiary level qualifications that

will enable them to be more effective in their role, and some may choose to move into other health sector roles.

Although tertiary education enrolments, including Māori enrolments, have increased overall (largely due to the growth of wānanga) Māori rates of participation in the health sciences remain relatively low (Ministry of Education, 2003a). Ten percent of Māori enrolments in tertiary education in 2004 were in health-related fields, less than the overall proportion of all tertiary students enrolled in health related courses of 13% (Ministry of Education, 2005). The profile of Māori tertiary students differs from that of non-Māori. In 2004, the majority of Māori students were enrolled at institutes of technology and polytechnics (39%) and where wānanga (35%), with only 14% of total Māori enrolments at universities (Ministry of Education, 2005). Māori are more likely to be mature students and to be studying at sub-degree level (85% of Māori enrolments at sub-degree level compared to 65% for Asian and European), and are less likely to be enrolled at bachelors and postgraduate levels (Ministry of Education, 2005). The proportion of Māori students studying at the bachelors' level (16%) is relatively small compared with the overall average of 28% of all tertiary students.

Rationale for Māori health workforce development

There are strong rationale for increasing the participation of Māori within the New Zealand health and disability workforce, which relate to; the Treaty of Waitangi, projected excess health and disability workforce demand overall, New Zealand's changing demographic profile and increasing demand for Māori health professionals, wide and enduring inequalities between the health status of Māori and non-Māori, evidence of treatment disparities, the positive health impact of ethnic concordance between practitioners and patients, and, the likely wider intergenerational and socio-economic benefits.

There is a clear Treaty of Waitangi based rationale for ensuring that there is a representative health workforce that has the maximum potential to contribute to ongoing improvements in Māori health. Article 2 guarantees tino rangatiratanga (self-determination) and the Treaty principles of partnership and participation provide for the leadership role of Māori in Māori health development. Further, the Treaty provides for the Māori right to good health through Article 2, the guarantee of protection of those things that Māori consider to be precious (including health), and Article 3 guarantees equity between Māori and non-Māori and the Treaty principle of active protection (M. Durie, 1998).

Increasing the capacity and capability of the MHDW is also important in the context of a projected excess in workforce demand. Maximising the potential of the MHDW may provide, at least in part, a solution to excess workforce demand for mainstream services.

New Zealand's changing demographic profile provides additional impetus for strengthening the MHDW. Statistics New Zealand population projections for the period 2006-2021 predict a 20% growth in the size of the Māori population, compared to a 10% increase in the same period for non-Māori

(<http://www.stats.govt.nz/additional-information/projections-overview>). Further, alongside a predicted excess in healthcare workforce demand by the year 2021 (NZ Institute of Economic Research, 2004) mainstream services are increasingly required to demonstrate Māori responsiveness, Māori providers have increased in number from around 20 in 1993, to 220 in 2000 (Mantell, 2005), and Māori consumers expect the health sector to recognise and value Māori service delivery preferences and processes (Health Workforce Advisory Committee, 2002a). It is clear that the demand for Māori health professionals who are able to facilitate Māori access to culturally appropriate mainstream health services and Māori-specific health services will increase substantially.

There is overwhelming evidence of the wide, and in some instances increasing, disparities between the health status of Māori and non-Māori (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; Ministry of Health, 2006e). For the period 1980-1999 there has been a progressive widening of the gap in life expectancy at birth between Māori and non-Māori non-Pacific ethnic groups (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). The over-representation of Māori in lower socio-economic strata accounts for at least half of the ethnic disparities in mortality for Māori of working-age (Goodman et al., 1998). Therefore, disparities in health status between Māori and non-Māori cannot be fully accounted for by socio-economic inequalities. The implication is that being Māori in itself leads to differential experiences and exposures that put health at risk. As an example, racism has been proposed as one mechanism which contributes to ethnic disparities in health (Harris et al., 2006; Jones, 2000).

There is substantial international and local evidence of differential access to health care by ethnicity (Cormack, Ratima, Robson, Brown, & Purdie, 2005; Kressin & Petersen, 2001). For both Māori and non-Māori the most common usual health practitioner was the general practitioner. According to data from the New Zealand Health Survey 2002/03, Māori adults were less likely than non-Māori adults to have seen a general practitioner in the previous 12 months (74% compared to 79% respectively) which is particularly concerning given disparities in health need. Māori adults were more likely than non-Māori adults to self-report an unmet need for a general practitioner visit in the previous 12 months (20% compared to 12% respectively) (Ministry of Health, 2006e). A study investigating Māori coronary artery health care demonstrated that despite Māori age-standardised mortality rates of at least twice that of non-Māori non-Pacific people, Māori men and women had the lowest rates of both coronary artery bypass grafts and percutaneous transluminal coronary angioplasty at the time of the study (Tukuitonga, 2002). The Cervical Cancer Audit (Sadler, McCowan, & Stone, 2002) identified that Māori women with a high-grade smear were more likely to experience delays in obtaining timely investigation and diagnosis. Māori women were more likely than non-Māori women with cervical cancer to wait for more than the recommended 12 weeks between first high-grade smear and colposcopy, for more than six months between first high-grade smear and diagnosis, and for more than two months between high-grade biopsy and diagnosis. These findings are consistent with strong international evidence of disparities in the receipt of investigations and treatment by ethnicity (Haynes & Smedley, 1999; Shavers & Brown, 2002).

There is international evidence that ethnic concordance between health care professionals and their patients leads to improved health outcomes for patients (Cooper & Powe, 2004; LaVeist, Nuru-Jeter, & Jones, 2003; Stevens, Mistry, Zuckerman, & Halfon, 2005). Further, practitioners from ethnic minority groups are five times more likely to provide health care to poor and underserved patients, and are more likely to practice in underserved areas (Finkbonner, Pageler, & Ybarra, 2001). These practitioners are therefore more likely to have a greater positive impact on the health status of minority populations. This evidence supports the value of strengthening the Māori health workforce as a legitimate strategy to improve health care for Māori, adherence to treatment, and Māori health outcomes (Jansen & Sorrensen, 2002). This approach is also consistent with the preferences expressed by Māori for Māori health professionals (Dyall et al., 1999).

It is also important to acknowledge that the benefits of MHDW development extend beyond the health sector. There are likely wider intergenerational and socio-economic benefits for Māori, and for New Zealand society.

The Māori health and disability policy context

Māori and the Government are in consensus that there is an urgent need to address Māori under-representation in the New Zealand health and disability workforce (Ministry of Health, 2002a). MHDW development has been identified in the two health sector overarching policy documents, the New Zealand Health Strategy (Ministry of Health, 2002c) and the New Zealand Disability Strategy (Minister for Disability Issues, 2001), as a priority area. He Korowai Oranga (Ministry of Health, 2002a) is the Government's overarching policy framework for Māori health development. One of the four Māori health pathways for action identified in He Korowai Oranga is to increase Māori participation in the health and disability sector, including the objective of increasing the number and improving the skills of the MHDW at all levels. Whakatātaka, the associated Māori Health Action Plan 2002-2005 (Ministry of Health, 2002d), provides additional detail as to how this objective may be achieved.

In April 2006 the Government published Raranga Tupuake: Māori Health Workforce Development Plan 2006 (Ministry of Health, 2006d). Raranga Tupuake is the strategic framework for Māori health and disability workforce development over the next 10 to 15 years. The Plan supports a range of initiatives to address MHDW capacity and capability issues. The three MHDW development goals identified in the Plan are to; (i) increase the number of Māori in the health and disability workforce, (ii) expand the skill base of the Māori health and disability workforce, and, (iii) enable equitable access for Māori to training opportunities. The concept of access, as it is used in this report, refers to obtaining entry into and through educational opportunities in health fields in a timely manner and takes into account the educational outcome.

Under each Raranga Tupuake goal, a number of actions are identified. Two of those actions are specific to the Hauora Māori Scholarship Programme and the objectives of this research project - to "Promote the uptake of the...Hauora Māori Scholarships" (p.3) and to "Evaluate the uptake of the Hauora Māori Scholarships" (p.3).

The priority accorded to MHDW development is also reflected in a range of other key health sector workforce development policy documents. These documents provide detail as to how health sector strategies for workforce development are to be achieved. The documents include Tauawhitia te Wero - the National Mental Health and Addiction Workforce Development Plan 2006-2009 (Ministry of Health, 2005b) and the New Zealand Health Workforce, Framing Future Directions (Health Workforce Advisory Committee, 2002a).

Stakeholders

The New Zealand Public Health and Disability Act 2000 (<http://www.legislation.govt.nz/>) defines the health sector structure, and provides the legislative framework for Māori health development within the sector. Section 1 Subsection B of the Act requires the sector "...to reduce health disparities by improving the health outcomes of Māori". The Act also requires the sector to "...enable Māori to contribute to the decision-making on and to participate in the delivery of, health and disability services".

There are a range of organisations involved in MHDW development, including Māori and mainstream health service providers, Māori purchasing organisations, Māori development organisations, Māori professional bodies and networks, and iwi and other Māori community organisations. The MoH, HWAC, and DHBs have a key role in developing and/or implementing Government MHDW development policy.

The MoH has responsibility for developing the overall strategy for the health sector. In terms of MHDW development, the major role of the MoH is to advise the Minister of Health as to policy that will meet the Government's objectives for MHDW as outlined in He Korowai Oranga (Ministry of Health, 2002a). The Ministry produced the Māori health workforce development plan Raranga Tupuake (Ministry of Health, 2006d). As well, generic health workforce development policy documents and plans developed by the Ministry identify specific objectives and/or strategies for MHDW development. The Ministry also has a leadership role in some specific areas of MHDW development, for example, in administering the Māori Provider Development Scheme.

HWAC, which was established in April 2001 under the provisions of the New Zealand Public Health and Disability Act 2000, is a health workforce advisory committee to the Minister of Health. The Committee's role is to provide independent advice with regard to health workforce capacity, national health workforce development goals and strategies, and future requirements to address policy goals. The Committee is also charged with facilitating co-operation between health workforce education bodies to support a strategic approach and to report on the effectiveness of health workforce development strategies. In 2004, the Committee established the Māori Health and Disability Sub-Committee to provide advice on Māori health and disability workforce issues (<http://www.hwac.govt.nz/mhd/>). Although there has been no formal announcement, it is expected that a re-organisation

later in the year will lead to the disestablishment of HWAC (including the Māori Sub-Committee) and that its function will be transferred to a new body.

The DHBs were established as part of the 2000 health reforms, which intended to move the sector towards a more planned and community-oriented health system (Ashton, 2005). The major responsibility of the 21 DHBs is to meet the health needs of those living within their region through purchasing health services on behalf of the Crown. The DHBs jointly established District Health Boards New Zealand (DHBNZ) as a body charged with providing national coordination of collective DHB strategic interests, including workforce development.

The 2003 DHB/DHBNZ Workforce Action Plan (District Health Boards New Zealand, 2003) was developed by DHBNZ to facilitate a co-ordinated approach to DHB workforce development across regions. The plan emphasises action in three areas – information, relationships, and strategic capacity. Consistent with the Action Plan, in 2004/05 the Future Workforce project was carried out and identified DHB priorities and action for health and disability workforce development for the period 2005-2010. The two main themes identified in the project are ‘nurturing and sustaining the workforce’ and ‘developing workforce/sector capability’. Each of these themes has a number of associated priorities. Māori health workforce development is one of the five priorities associated with ‘developing workforce/sector capability’. This priority area emphasises adequate resourcing for workforce planning and information, engagement with the Tertiary Education Commission (TEC) to support Māori participation in education, engagement with the school sector, facilitating workforce access to hauora Māori competency training opportunities, and investing in the development of Māori workforce capacity in primary care, rural health, public health and community health work. DHBs have set up the DHBNZ Workforce Development Group to oversee implementation of the Future Workforce Framework.

Alongside the health sector, the education sector has a critical role to play in increasing Māori participation and success in tertiary health-related fields of study, as a pre-requisite to entry into the MHDW and for ongoing workforce skill development. The Ministry of Education, TEC, and tertiary education providers are key education sector structures involved in MHDW development.

Each of the organisations identified above have specific objectives and strategies in place to strengthen the MHDW. The extent to which those strategies have been implemented varies, and there is clearly much to be done to address the current under-representation of Māori within the health and disability workforce.

Current activities

The recent report ‘Health Workforce Development – an Overview’ (Ministry of Health, 2006c) provides a summary of key current and proposed national health workforce development activities. It is apparent that a range of health and education sector stakeholders are investing substantial resources in workforce development, however, there is generally a lack of overall coordination of activities. In describing

the range of activities, the Report uses a framework of five areas for workforce development action based on the five strategic imperatives for mental health workforce development identified in the MoH document ‘Mental Health (Alcohol and Other Drug) Workforce Development Framework’ (Ministry of Health, 2002b). The five areas are: workforce development infrastructure; organisational development; recruitment and retention; training and development; and, information, research and evaluation. The Framework is used below in describing examples of a range of Māori health workforce development activities currently underway in the MHDW sector. While the Framework has been selected because it is comprehensive and is able to encompass a breadth of activities, it is worth noting that to some extent the divisions are artificial and there is overlap between categories.

Workforce development infrastructure

A comprehensive infrastructure that supports MHDW development provides the foundation for progressing stakeholder workforce development activities at all levels. Examples of initiatives that contribute to strengthening the MHDW development infrastructure are the HWAC Māori Health and Disability Sub-Committee, Te Rau Matatini, and Hauora.com.

The HWAC Māori Health and Disability Sub-Committee (<http://www.hwac.govt.nz/mhd/>) has been tasked with: providing independent advice to the Minister of Health on MHDW development issues in collaboration with HWAC; identifying initiatives to increase Māori participation in health training courses; facilitating collaboration between health providers and education providers with regard to the allocation of funding for MHDW development; monitoring other organisations (such as the TEC) on their delivery of health and disability workforce development; and, monitoring and evaluating the implementation of HWAC recommendations with regard to MHDW development.

Although the Māori Sub-Committee acts through HWAC, it has an important role in providing a national strategic focus for MHDW development that is independent of the MoH. It also strengthens the capacity of HWAC, as a major stakeholder in health and disability workforce development, to incorporate a Māori analysis within its recommendations. Sub-Committee membership comprises Māori HWAC members, and 3-5 members who have been co-opted by HWAC. HWAC, and therefore the Sub-Committee, are likely to be disestablished later in the year and its functions transferred to a new body.

The mental health field stands out as an area which has had the most consistent investment in workforce development in the past 15 years (Ministry of Health, 2006c). Te Rau Matatini (<http://www.matatini.co.nz>), which was launched in 2002, is a national Māori mental health workforce development organisation funded by the MoH and initially established in partnership with Massey University (Hirini & Maxwell-Crawford, 2002). Te Rau Matatini contributes to national and regional Māori mental health workforce policy development, increasing the capacity and capability of the Māori mental health workforce, and promoting career opportunities in mental health among Māori.

Te Rau Matatini contributes to national and regional Māori mental health workforce policy development, increasing the capacity and capability of the Māori mental health workforce, and promoting career opportunities in mental health among Māori. The organisation has a number of projects focussed on improving infrastructure and designed to enhance existing workforce development initiatives or create new initiatives. Te Rau Whakaemi is a project that focuses on enhancing the coordination of training for Māori mental health workers by supporting educational providers to align programmes with the needs of the Māori mental health workforce. Te Rau Arataki is a project under development that aims to increase recruitment and improve job satisfaction during the transition of Māori into the Māori mental health sector through an on-line orientation and preceptoring model.

Hauora.com Trust is the Māori-led National Māori Workforce Development Organisation formed in 2000 by Te Ohu Rata o Aotearoa (Te ORA - the Māori Medical Practitioners Association of Aotearoa/New Zealand) with the support of a number of Māori professional bodies. The mission of Hauora.com is to build a unified, effective and Māori-led MHDW. The organisation works across sectors and seeks to strengthen relationships within the health sector. Hauora.com is involved in a variety of Māori workforce development projects including training needs analyses, workforce planning, capacity building, cultural auditing of training, managing the Henry Rongomau Bennett Scholarship Programme (on behalf of Te ORA), and clarifying career pathways for Māori. Hauora.com's other major activity has been supporting the development of Māori professional organisations in a variety of professions including pharmacy, midwifery, and counselling.

Organisational development

Organisational development within mainstream and Māori-specific health services and educational institutions to facilitate positive cultures and responsive systems will be important in strengthening the capacity and capability of the MHDW. Organisations or initiatives in place to support health service organisational development include Māori Co-Purchasing Organisations, Māori Development Organisations and the MoH Māori Provider Development Scheme.

Māori Co-Purchasing Organisations (MAPO) were established in the mid 1990s by the Northern Regional Health Authority, and continue to operate in the northern region. MAPO are responsible for working with DHBs in the strategic planning, purchasing, and monitoring of health and disability services for iwi and Māori (Ministry of Health, 2003). Central to this role is facilitating health service cultures and systems that are responsive to both Māori health workers and Māori service users. The MAPO are important advocates in working with mainstream providers, including DHBs and PHOs, to enhance responsiveness to Māori. The role of MAPO includes the provision of advice to DHBs in relation to MHDW development, such as guidance with regard to Māori workforce development plans.

Māori Development Organisations (MDOs) were set up, largely in areas outside of the northern region, to contribute to strengthening the Māori health and disability sector. One of the ways these organisations achieve this is in assisting Māori provider development by providing direction and guidance with regard to strategic planning, quality and business management. Strengthening Māori health providers contributes

to Māori health workforce development by creating robust organisations that provide a healthy workplace that will attract and retain more Māori health professionals.

The Māori Provider Development Scheme (MPDS) was established in 1997 and is administered by the MoH. The objective of the scheme is to increase the capacity and capability of the MHDW and Māori provider development to contribute to improving Māori health outcomes. The annual funding allocation for the scheme since 1998/1999 is \$10 million per annum (State Services Commission, 2005a). Activities funded by the scheme include individual and collective workforce development and Māori provider infrastructure development, including the area of information technology development. The Hauora Māori Scholarship Programme is funded through the MPDS.

Recruitment and retention

A number of initiatives are in place within the health and education sectors to facilitate the recruitment and retention of Māori within the health and disability workforce. Interventions include the HRCs Māori Career Development Awards Programme, Te Rau Puawai, Vision 20:20, Manaaki Tauria, iwi scholarships, Hauora.com's career pathway project, and Auckland DHB's Therapy Workforce Development Framework. Generally, interventions mainly address recruitment, with a more limited focus on retention.

The HRC invests approximately one million dollars annually in Māori career development awards at the masters, PhD and post doctoral levels through an annual funding process (http://www.hrc.govt.nz/root/pages_research_funding/Māori_Health_Research_Awards.html). The purpose of the Māori Career Development Awards Programme is to foster the capability and capacity of the Māori health research workforce. Although the Programme has not been formally evaluated, its success is indicated in the growing numbers of PhD qualified Māori health researchers who are past recipients of the awards.

Te Rau Puawai Workforce 100 was established in 1999 (L.W Nikora, Levy, Henry, & Whangapirita, 2002), as a MoH and Massey University joint venture with the goal of accelerating the development of the Māori mental health workforce. At the end of 2003, Te Rau Puawai had achieved its initial goal of contributing 100 Māori graduates to the Māori mental health workforce. A further contract for three years was negotiated with the objective of contributing an additional 50 Māori graduates to the Māori mental health workforce. As of 2005, a further 46 Māori students have gained a mental health qualification. In total, Te Rau Puawai has contributed 146 graduates to the Māori mental health workforce (Koia, 2006). Te Rau Puawai has received \$675,000 in funding annually since 2004 (State Services Commission, 2005b). This is approximately 2.6% of the total MoH mental health and addiction-related training and workforce development budget for 2004/2005.

Te Rau Puawai is governed by a Board of Management which comprises representatives from Massey University and the MoH. The Programme is staffed by a full-time co-ordinator, part-time support tutor, and an administrator and is supported by peer and academic mentors. The Programme provides comprehensive support to Māori students seeking university qualifications in mental health-related fields (e.g.

psychology, nursing, rehabilitation, social work, social policy, Māori health). Support provided includes: financial assistance through scholarships; academic mentoring; individual learning and personal support; course planning assistance; advocacy; facilitation of access to Māori and student networks; and, curriculum vitae and interview preparation assistance. Programme evaluation indicated that key factors underpinning the success of the intervention are; that it is integrated within the university environment, that it is Māori focussed with strong leadership, the high standard of Programme coordination, the provision of financial assistance, access to mentoring and peer support, and, the comprehensive nature of the support provided (L. W Nikora, Rua, Duirs, Thompson, & Amuketi, 2005). This year, an accelerated leadership programme was launched that provides the opportunity for part-time, extramural recipients to accelerate academic progress and to return to employment with a completed qualification (M. Durie & Koia, 2005).

Vision 20:20 (Gluckman & Mantell, 1997) is the University of Auckland's Faculty of Medical and Health Sciences commitment to increasing the number of Māori training in health disciplines and moving into the health professions. Vision 20:20 has three components – the Māori and Pacific Admissions Scheme (MAPAS), the Whakapiki Ake Project, and Hikitia te Oranga o te Iwi - Certificate in Health Sciences.

MAPAS students receive a range of support including assistance with scholarship applications, facilitation of access to learning support, tutorials, academic and peer mentoring, student networking opportunities, hui, and access to Māori medical and research staff.

The Whakapiki Ake Project, initiated in July 2003, assists Year 13 Māori students from participating schools to enter the Certificate in Health Sciences course (University of Auckland, 2005). The Project provides assistance with course costs, facilitates entry into the course, and ensures access to support throughout the students' programmes of study (http://www.Māori_healthcareers.auckland.ac.nz). Whakapiki Ake is funded by the MoH through the MPDS. The Project has seen rapid growth in the number of Māori enrolling in the Certificate of Health Science, with 24 students enrolled in 2003, and projections for more than 70 enrolments in 2006 (University of Auckland, 2005).

Hikitia te Oranga o te Iwi - Certificate in Health Sciences is a one year foundation programme which prepares school leavers and young adults to enter health-related tertiary courses. MAPAS students are able to enrol in the Certificate programme.

Early in 2006, supported by one-off funding from the Disability Directorate of the Ministry of Health, the Auckland DHB established a pilot Therapy Workforce Development Framework (Auckland District Health Board, 2006). The Framework was a partnership agreement between the DHB and AUT University aimed at increasing the number of Māori and Pasifika occupational therapy and physiotherapy practitioners employed at the DHB. The Framework focussed on recruiting Māori staff through clinical placements, clinical assistant employment opportunities, and direct recruitment. It also supported Māori occupational therapy and physiotherapy practitioners to gain further qualifications through funded postgraduate study at AUT University. This pilot development ended in 2007.

The Manaaki Taura grant scheme is a national initiative for Māori studying at tertiary level in any discipline at an NZQA registered tertiary institution. The Scheme was established to ensure that Māori participation in tertiary education was not negatively affected when tertiary education fees increased in the early 1990s (Controller and Auditor General, 2004). The Scheme was taken over by the Ministry of Education in 1994, and has been administered by the Māori Education Trust since 2002. Students may apply for the lesser of \$1250 or 90% of their tuition fees. The annual budget for the scheme is capped at \$4.3 million (Controller and Auditor General, 2004). Criteria for eligibility include commitment to kaupapa Māori and financial need. The Ministry of Education determines the income level for eligibility. Approximately 10,000 students received grants for the year 2001-2002 (Ministry of Education, 2003b). In this year's budget, the Government revealed that the Manaaki Taura scheme will be disestablished (New Zealand Treasury, 2006, p. 400). There is a lack of clear or evidence-based rationale for the Programme's disestablishment.

A number of iwi offer support, mainly in the form of scholarships, to Māori students who whakapapa (have genealogical links) to the given iwi. For example, Te Tapuae o Rehua (<http://www.tetapuae.co.nz/>) is a registered company of Ngai Tahu which aims to increase Ngai Tahu peoples' participation in tertiary education (Te Tapuae o Rehua, 2005). Te Tapuae o Rehua has established relationships with six tertiary institutes in the lower South Island and provides financial assistance over one year to eligible students (criteria are Ngai Tahu descent, and demonstrated commitment to iwi development and advancement of the South Island Māori community).

A two year pilot project by Hauora.com named Te Papa Oranga, is exploring issues for Māori moving into the MHDW. The project will identify a transition pathway, from enrolment in tertiary education, through training, and into employment, to support Māori health professionals to achieve their career potential. This project is in its early stages, and undertakes to add vital information to the Māori health sector evidence base on career pathways.

Training and development

The tertiary education sector, working with medical colleges and registration authorities and professional associations, are responsible for health professional education. Under the provisions of the Health Practitioners Competence Assurance Act 2003 (<http://www.MoH.govt.nz/hpca>) registration authorities are required to develop standards for clinical competence, cultural competence, and ethical conduct which must be met by registered practitioners. Māori health professional bodies and networks have an important role in advocating for education and training that is consistent with MHDW development needs. The Clinical Training Agency (CTA), which administers funding for health and disability workforce post-entry clinical training, is also a major stakeholder.

Within the last three years, the Faculty of Health and Environmental Sciences at AUT University established Te Ara Hauora Māori and the Postgraduate Programme in Māori Health as initiatives to further support MHDW development. Te Ara Hauora Māori provides opportunities in Faculty undergraduate degrees for students to pursue a career path in Māori health across a range of disciplines (e.g. physiotherapy,

nursing, podiatry, oral health, occupational therapy). Aspects of the pathway include incorporation of Māori health papers into study programmes, access to Māori learning support, opportunities for placements or experience in Māori contexts, regular hui and peer support, and access to Māori mentors. The Postgraduate Programme in Māori Health enables students to complete a Postgraduate Certificate, Diploma or Master of Health Science in Māori Health, or a Master of Health Practice in Māori Health. The Programme is particularly tailored to those already working in the health sector, and most students are Māori health professionals in full-time employment in both Māori and mainstream settings who are seeking to strengthen their Māori health competencies.

Māori health professional associations have a primary focus on supporting and strengthening Māori participation within their respective professions. As an example, the Māori Medical Practitioners Association, Te ORA (<http://www.teora.Māori.nz>) have provided advice with regard to cultural competence standards to registration authorities and the recruitment and retention of Māori doctors for medical colleges. As well, Te ORA provides strong peer support for Māori doctors and leadership for Māori medical students.

The CTA is a division of the MoH responsible for the funding of Post Entry Clinical Training (PECT) programmes. The CTA administers a budget of \$100,730,000 (Ministry of Health, 2006a), and therefore has the potential to have a major impact on increasing MHDW capability and capacity. That potential has yet to be fully achieved. In an unpublished plan to the CTA (Lawson-Te Aho, 1997), a crisis of underdevelopment of the MHDW was noted and ten goals were recommended to improve PECT outcomes for Māori including; targeted funding for Māori PECT, better national coordination and oversight by Māori, improving access to CTA training opportunities particularly to nurses and community health workers, and improving the CTA and its providers' responsiveness to Māori needs, and Māori provider placements.

In a subsequent scoping report to the CTA (Hodges & MacDonald, 2000) key issues identified for Māori were the need to remove barriers to access CTA training given the demographics of the workforce, and to incorporate culturally effective support mechanisms within training programmes. Currently the CTA funds only a few Māori specific initiatives that support MHDW development. These include; the Certificate of Clinical Teaching - Māori, the Certificate of Hauora Māori, Child and Family, rongoa Māori training, and Māori support and access. All of these programmes amount to \$3 million of the CTA's budget (Ministry of Health, 2006a). The CTA states that a 10-year strategic plan for Māori health practitioner training will be developed to further advance MHDW development (Ministry of Health, 2004a).

Hauora.com undertook a cultural audit of CTA-contracted providers and worked with providers to improve compliance with contract clauses relating to Māori health and support for Māori trainees (Hauora.com, 2005). The Hauora.com report made a number of recommendations including that the CTA review clauses to ensure; relevance to health strategies and workforce development for Māori, alignment to professional requirements for the Māori workforce, improved Māori participation in the health workforce, and meeting Māori community expectations. A number of changes have also been recommended for CTA programmes as a result of the State

Services Commission review of ethnically targeted programmes and policies (State Services Commission, 2005c), including removing the criterion via provider contracts that trainees be Māori in order to be eligible for Māori specific training programmes.

Information, research and evaluation

An evidence-based approach to MHDW development planning is essential. This relies upon accurate data and systems to profile the MHDW and research to better understand MHDW development issues. For the health and disability workforce generally, and for the MHDW in particular, there is an inadequate evidence base and systems upon which to plan health sector workforce development (DHB/District Health Boards New Zealand, 2005). There is, however, recognition of the problem and some work is underway.

Health professional registration authorities and the New Zealand Health Information Service are the main sources of regularly collected information on registered health practitioners, though data quality, particularly ethnic data, is variable across professions (Health Workforce Information Programme Steering Group, 2005; Ministry of Health, 2006c). Some registration authorities do not collect ethnic data and the commitment to improving ethnic data collection is variable. DHBs recognise the need to improve health and disability workforce information systems and data, and the Health Workforce Information Programme is a DHB initiative (part funded by the CTA) underway to progress that aim. The Programme is intended to be comprehensive, and will be introduced in phases. It will include processes for improved workforce data collection, analysis, forecasting and modelling (Ministry of Health, 2006c). The Health Workforce Information Programme Steering Group have developed a business case (Health Workforce Information Programme Steering Group, 2005) which emphasises that there is minimal reliable data to draw on for managing and planning health workforce development. Surprisingly the business case does not identify a strategy specifically for Māori workforce information, but does aim to capture ethnicity data and iwi affiliations particularly through DHB data collection.

A number of research projects are currently underway exploring MHDW issues. The HRC and the MoH have jointly funded Taupua Waiora (the AUT University Māori health research centre) to carry out a research project investigating Māori participation and retention issues in the health and disability workforce. The report is due to be completed in 2006. As an example of a recently completed Māori health workforce project, in 2004 the Auckland Regional Public Health Service undertook to identify the requirements for Māori public health workforce development (Auckland Regional Public Health Service, 2004). The Report identified a number of barriers to Māori public health workforce participation including; a lack of career pathways and access to training opportunities, inadequate levels of support from management and organisations, culturally unsafe environments, and institutional racism. The report recommended; the development of a Māori public health workforce development strategy that encompasses Māori worldviews and includes meaningful Māori participation, the adoption of a framework similar to Te Rau Matatini and relevant to the public health sector, further investigation into the development of a public health industry training organisation, and improved access to public health careers and workforce development opportunities.

Initiatives in other sectors

There are a number of initiatives in other sectors that offer assistance to develop the Māori health workforce. However, there is a dearth of publicly available evaluation reports on those initiatives. Three programmes have been selected and are discussed below in terms of key success factors that may be transported to the HMSP and more generally to the health sector. The criteria for selection were that: information about the programme is accessible; the programme targets Māori or incorporates a Māori focus; the initiative provides financial assistance and is therefore relevant to the HMSP; and there are indications that the programme has been successful. As well, selected programmes are drawn from different sectors and have a varied scope in terms of, for example, recipient's age groups and anticipated educational outcomes. The selected programmes are TeachNZ Scholarships, Rangatahi Maia, and Te Ohu Kaimoana 'Fishfingers' Scholarships.

TeachNZ scholarships

In 1998 the Ministry of Education established TeachNZ Scholarships for Māori and Pasifika (<http://www.teachnz.govt.nz>) to contribute to addressing the under-representation of Māori and Pacific peoples as teachers. The Scholarships have been effective in the recruitment of Māori into teaching, with 128 Māori TeachNZ primary and secondary teaching scholarships taken up in 2001 (Ministry of Education, 2004b). However, following a review of the TeachNZ Scholarships, in 2004 the Minister of Education disestablished the TeachNZ scholarships for Māori and Pasifika, and introduced new categories of scholarships. In 2006, the TeachNZ Scholarships targeted Māori medium teachers, early childhood education, and secondary teachers of specific subjects.

TeachNZ Scholarships are intended to attract prospective students into teacher training, encourage qualified teachers to return to the workforce, and to encourage teaching in subject areas where positions are difficult to fill. For fulltime students, the scholarships pay core tuition fees plus an allowance of \$10,000 for the duration of the course of study. Recipients are bonded to teach in New Zealand for a period of time equal to the time during which they received the Scholarship. The TeachNZ Scholarship Programme is extensively advertised through television media, expo days, and career events.

The likely key success factors of the TeachNZ Scholarship Programme are the high profile of the Programme due to a well resourced marketing strategy and relatively generous level of scholarship funding which covers full tuition fees and contributes substantially to living expenses. The previous approach taken by the Programme, which specifically targeted Māori, provided a straightforward mechanism to address Māori under-representation as teachers in both mainstream and Māori medium settings. Removal of ethnic targeting and introduction of a category for Māori medium teachers, while continuing to address inadequate numbers of Māori medium teachers does not address Māori under-representation as teachers at all levels and across the range of subjects in mainstream.

Rangatahi Maia

Rangatahi Maia is a TEC funded Māori focused vocational training and education programme targeting young Māori (http://www.tec.govt.nz/education_and_training/rangatahi_maia/rangatahi_maia.htm). The scheme has assisted recipients to gain qualifications at Level 3 of the National Qualifications Framework and above. Recipients may complete a qualification and be supported to move into the workforce, or complete the first year of study in working towards a higher qualification.

Rangatahi Maia programmes are offered throughout New Zealand in a wide range of fields such as carpentry, aquaculture and business management, and through a variety of training institutions including polytechnics and whare wānanga. The courses are fully funded with no cost to the learner. The tertiary education organisation provides all course materials including tools and equipment, and covers travel costs. Participants may also receive assistance towards living and accommodation costs. Programmes are required to cater to the cultural needs of the learner and offer appropriate support to enable learners to maximise their success in the Programme, achieve the desired educational outcomes and successfully transition into employment.

In 2003, 79 percent of those on the Programme were Māori (Ministry of Education, 2004a). The Scheme has recently been restructured to target demand areas in the labour market following the review of ethnically targeted policies and programmes (Tertiary Education Commission, 2004). The restructuring has resulted in a greater focus on trade skill development.

Likely key success factors of the Rangatahi Maia scheme are that it specifically targets Māori, it is a national programme and therefore there are opportunities to participate throughout the country, that courses are fully funded with no costs for learners, and that young people are introduced to the tertiary education environment through culturally appropriate programmes.

Te Ohu Kaimoana

In 1995 Te Ohu Kaimoana established a Māori scholarship programme, 'Fish Fingers' (<http://www.fishfingers.Māori.nz/>), which aims to strengthen Māori participation in the seafood industry workforce (van Grondelle, 2003). Approximately \$1 million is invested annually in the Programme, and to date around 2,500 scholarships have been awarded (personal communication, Darrin Apanui, 28 April, 2006).

Scholarships are awarded in three categories; technical, management, and applied science and technology. Largely unskilled participants in the technical stream are recruited through agencies such as Work and Income New Zealand and Skillnz and are supported to complete the Commercial Fishing Processing Course at the Westport Deep Sea Fishing School or the Certificate in Seafood Vessel Operations at the Bay of Plenty Polytechnic. The scholarship covers course fees, travel costs, accommodation, and a small living allowance. Approximately 90% of programme participants in this stream complete courses and enter into the seafood industry workforce. The management stream operates in partnership with iwi. Students with financial support from iwi to complete programmes of study relevant to the seafood industry receive

scholarship funding that matches iwi investment dollar for dollar up to a maximum of \$5000. Key rationale behind this approach are; to build iwi capability to manage their own fisheries resources, and to enable iwi to take greater responsibility for growing their own workforce. Scholarships for tertiary level applied science and technology training range in value from \$6,000-\$20,000 depending on the course of study.

The Programme is run by a team of three staff, one of whom is responsible for pastoral care. There are also identified ‘champions’ in each tertiary institution who maintain contact with students and provide support. Recipients are assisted to attend the annual conference of Te Ohu Kaimoana (generally 250-300 students participate) and have the opportunity to learn about the industry and network. While participating students pay their own travel costs, all other costs are covered.

Identified strengths of the Programme are that it: specifically targets Māori; supports training at a variety of entry points (e.g. unskilled through to doctoral candidates); it is closely linked to industry (including iwi stakeholders) and workforce demand; the level of funding available to recipients is sufficient to minimise learner costs; and, alongside financial support the programme also offers pastoral care and opportunities to connect with industry.

Success factors

A number of transportable key success factors of assistance offered in other sectors to develop the Māori workforce have been identified. These factors are: (i) Programmes that specifically target Māori; (ii) well resourced marketing strategies that raise the profile of initiatives and are therefore likely to lead to high uptake rates; (iii) levels of scholarship funding that minimise costs to learners and therefore cover, for example, full tuition fees, other course costs, and living expenses; (iv) strong links between courses offered, industry needs and workforce demand; (v) opportunities to study in a variety of geographical locations; (vi) courses at varied skills levels are supported (e.g. for unskilled and skilled potential students; (vii) programme links to Māori stakeholders; (viii) assistance in the transition between study and work; (ix) and the provision of broad based support including pastoral care.

HAUORA MĀORI SCHOLARSHIP PROGRAMME

DEVELOPMENT AND ADMINISTRATION

Evolution of the programme

It is important to understand the history and evolution of the HMSP in order to inform and improve provision of the Programme in the future. The HMSP has a clear history and whakapapa stemming from the vision, passion, and commitment of health leaders of the time both at a governance and operational level.

The HMSP, formerly known as the Māori Health Scholarship Programme, began as an initiative emanating from the health reforms of the 1990s. Māori health and provider development were key priorities for Regional Health Authorities (RHAs), with scholarships identified as a way to increase Māori participation in the health and disability workforce.

In 1992, the North Health RHA established a joint venture relationship with the University of Auckland and committed \$50,000 to a pilot Māori scholarship programme for the northern region. North Health RHA board members Harold Titter (Chair) and Denese Henare and Midland RHA board members Sir Ross Jansen (Chair), Dr Pat Ngata and Georgina Te Heuheu were instrumental in the establishment of the Regional Health Authority Māori Health Scholarships in 1995 with a further \$50,000 committed by Midland RHA to the Programme. These leaders' championing of Māori health scholarships built momentum around MHDW development at all levels from governance to management. Informal discussions with those associated with the establishment of the Programme suggest that the symbolic passion and commitment from the highest levels is no longer as evident within the changing health sector environment

“The visionary leadership, passion and commitment of these early Board members at the highest levels marked a critical point to do something for Māori workforce development. They were remarkable” (personal communication, Gwen Te Pania Palmer, 11 May 2006).

From 1995, the HMSP was administered by North Health on behalf of both boards and covered the two regions. In subsequent years, the Central RHA and Southern RHA boards also committed \$50,000 each to comprise a total national fund of \$200,000 per annum. North Health RHA continued to administer the Programme on behalf of all the RHAs with its own sitting committees, application process and budget².

² Gwen Te Pania Palmer, confirmation to Ministry of Health, August 2007

In 1997, the Māori health scholarships programme was brought into the newly created Māori Health Provider Development Scheme (MPDS)³. HMSP became one of the four funding categories in MPDS. The HMSP was strategically aligned to the MPDS programme and managed through the Maori Provider Development Scheme core business activities.

In 1998, the RHAs were restructured through the Transitional Health Authority (THA) to form a single national funder, the Health Funding Authority (HFA). The MPDS and the HMSP within it was operated by the THA and then the HFA. The Māori Education Trust administered the scholarships for the THA and the HFA⁴. MPDS and the HMSP within it was monitored by the Ministry of Health. In 1998/99 funding increased to \$400,000⁵. Increases were commensurate with funding increases into the Māori health budget and the pooling of other Māori health scholarships that were started by the MoH and were held and administered by the Māori Education Trust. The total budget allocation for the HMSP by that time had increased to \$700,000 per annum. A further commitment was made by the board of the HFA which increased the total Programme budget to \$1 million per annum⁶.

The next administration change came with the disestablishment of the HFA in 1999 and the transferral of the HMSP fund as part of the Māori Provider Development into Te Kete Hauora, the Māori Health Directorate of the MoH in 2000. In 2007, the HMSP fund and administration transferred as part of the MPDS from Te Kete Hauora, the Māori Health Directorate to the Sector Innovation and Capability Directorate in the Ministry of Health⁷.

In 2001, Te Kete Hauora reviewed the Programme (International Research Institute for Māori and Indigenous Education, 2001; Toi, 2001a; Toi, 2001b) and identified a number of issues to be addressed with regard to assessment, uptake of scholarships and administration processes. Assessment of applications was largely carried out in-house and it had become apparent that a more transparent process that would be perceived as fairer was required. Another issue was that the number of scholarships available had grown with the increase in funds however, there had been no formal analysis of need and supply or review of existing allocation criteria. This led to difficulties in allocation of all scholarships against existing criteria and had an impact on potential uptake. With the increased number of scholarships, more efficiency was needed in administration and processing.

Consistent with findings of the Programme review, educational consultants were engaged to first assess the applications and draw analysis from the assessment process, and then to conduct a research project to inform the redesign of the Programme. The research was undertaken in four phases:

³ CAB(97) m23/15, Provider Development Fund: Specific Criteria for Maori Health and Health Information, Cabinet Office, Wellington, June 1997

⁴ Māori Provider Development Scheme 1998/99, Application Guidelines Health Funding Authority p9 and Media Release 'An Introduction to the Māori Provider Development Scheme', October 1997, Office of the Associate Minister of Health, Transitional Health Authority.

⁵ Maori Provider Development Scheme Business Plan, 1998/99, Health Funding Authority p9

⁶ Gwen Te Pania Palmer, confirmation to Ministry of Health, August 2007

⁷ Building a Healthy Future, Decision Document, June 2007, Ministry of Health

- Phase I: 2001 assessment of the HMSP applications (International Research Institute for Māori and Indigenous Education, 2001);
- Phase II: the assessment and redesign of the HMSP application form (S Toi, 2001a);
- Phase III: needs analysis of Māori students studying in health related fields (S Toi, 2001b);
- Phase IV: a final report summarising findings (Toi, 2004).

Recommendations from these reports were phased in over time and have resulted in; a better understanding of the number of Māori students studying in health-related fields (i.e. supply); the broadening of several eligibility criteria in line with changing trends of Māori in education and education delivery; the redesign of the application form; and overall improvement in the assessment and processing of scholarships (personal communication, Manu-Kiwa Keung, 8 May 2006).

While the majority of the scholarships available through the HMSP were aimed at supporting Māori students with fees and books during their studies, within the Programme three scholarships were set aside to signify Māori excellence and endeavour in health. The John McLeod Scholarships were established by North Health RHA in memory of the late Dr John McLeod, a Māori public health physician who worked as a senior administrator at North Health and who was tragically killed in a car accident in 1994. These scholarships were for Māori in nursing (given Dr McLeod's passion and history in nursing development) and in medicine inclusive of public health. According to the original designers of the programme, the scholarships were to be more distinguished; to be coveted and held in high regard. These scholarships were larger in amount (\$7000 per scholarship initially, however this has been reduced), as it was recognised that the recipients would likely be undertaking postgraduate study or research at a university overseas. There was also an expectation that these recipients would return and make a significant contribution to Māori health (personal communication, Gwen Te Pania Palmer, 11 May 2006). Each year an award ceremony is held to recognise these recipients. Key informants who had previously held Scholarships proudly referred to the experience of attending the award ceremony.

The prestige of the John McLeod Scholarship, appears to some, to have diminished over time and may be a consequence of the many changes of administration resulting in loss of history about the Programme and the subsuming of the John McLeod Scholarships into the broader milieu of the HMSP. Concern has been expressed by those originally involved in setting up the Programme that there appear to be lesser standards required in awarding these scholarships and that the John McLeod Scholarship has lost its focus. It was also intended that the McLeod whānau should form a vital part of the assessment and awards process, and it is interesting to note that Dr McLeod's son has recently graduated as a medical practitioner (personal communication, Gwen Te Pania Palmer, 11 May 2006). This process could be similar to the way the Bennett whānau are involved in the process of awarding the Henry Rongomau Bennett Memorial Scholarships in Māori mental health.

Intervention logic

There is currently a comprehensive national policy framework to support MHDW development and clear rationale for planning and action that will enable the development of a MHDW of optimum size, configuration, quality and retention that will in turn contribute to improved Māori health outcomes.

International evidence indicates that indigenous peoples and ethnic minorities face barriers to access to tertiary education (Reyes, 2001; Schuh, 1999/2000; Seidman, 2005). Financial barriers to tertiary education have been identified in the international literature, and the importance of financial aid through scholarships in the recruitment, retention and success of minority students has been emphasised (Reyes, 2001; Schuh, 1999/2000; Seidman, 2005; University of California, 2005). Scholarships have been identified as an important incentive to promote health-related study pathways and to recruit students into areas of high workforce demand (Mak & Plant, 2001; University of California, 2005). These findings are of high relevance to Māori given that affordability has been identified as one of the major barriers to Māori access to tertiary health-related education and that scholarships for Māori have been identified as a key mechanism to overcome that barrier (Taupua Waiora, 2006).

In New Zealand, government departments established equal employment opportunities (EEO) scholarships to attract and increase participation of members of EEO groups, including Māori, to work in the public service (State Services Commission NZ, 2001). A review of the impact of EEO scholarships was undertaken in 2001 by the State Services Commission (State Services Commission NZ, 2001). The review found that departments that had offered scholarships over a number of years, for example, the Ministry of Foreign Affairs and Trade and the Department of Corrections Psychological Service, considered that the scholarships had improved recruitment of Māori into their departments. Most departments found benefits in other ways, including increased awareness of the department through increased enquiries about employment opportunities from Māori and other EEO groups. Overall, all departments interviewed regarded their EEO scholarships as "...a useful and successful EEO strategy" (State Services Commission NZ, 2001, p. 55), and that more effective administration of the scholarship programme and mentoring support of the scholar is required for continued and increased success. Yet, despite these positive indications and clear need a number of these scholarships have been disestablished.

Key informants strongly supported the HMSP. "It's an important issue nationally...a national programme makes a statement, shows it's a priority" [Key informant 2]. A large number of key informants concurred that it was critical that the MoH actively showed that developing the MHDW was a Ministry priority, and that the HMSP was a practical demonstration of that commitment. "...its more than just dollars, it's a commitment and show of support" [Key informant 26].

Some key informants raised concerns that the Programme has a narrow scope. It was noted that while the provision of financial support is important it does not address Māori students' broader support needs. However, it was acknowledged that the intention of Programme was to complement other MHDW interventions "...it is

designed not to be the only means of support...” [Key informant 21], “...the pūtea [funding] may attract them, but it won’t keep them when the going gets tough.” [Key informant 26]. Responses indicated that the maximum benefit of the Programme would be achieved where it complemented broader support from other sources “...provided the university comes on board as well and not just leaving the Scholarship Programme to work independently.” [Key informant 29].

Key informant responses also reflected the view that the benefits of the HMSP extended beyond individual recipients and impacted positively on Māori whānau. “The Māori health scholarship and those who get them, helps them complete health qualifications which has a flow on effect on whānau, hapū and iwi. There is the awareness that to have someone who is a physiotherapist in their family, automatically this becomes an option for other whānau members, an aspiration for that whānau.” [Key informant 18].

According to key informants, the purpose of the HMSP was: to recognise high Māori academic achievement in health fields; to increase MHDW capacity and capability through the provision of financial support to Māori enrolled in tertiary health-related programmes; and to improve Māori health outcomes. Key informants noted that the Programme was intended to address affordability as a barrier to tertiary study. “...[the Programme] is based on the premise that cost is a barrier...” [Key informant 6].

The original intervention logic for the Programme was to contribute to ensuring equitable Māori participation within the health and disability workforce, and thereby facilitate improved health outcomes for Māori. The provision of financial assistance through scholarships to eligible Māori tertiary students was intended to address affordability as a barrier to Māori access to tertiary health-related education and support Māori student recruitment, retention and success within health-related programmes as a mechanism to strengthen the capability and capacity of the MHDW. This was in the context of introduction of tuition fees for tertiary students in the early 1990s.

Following the recent government review of targeted policies and programmes, a number of interventions aimed at strengthening the Māori workforce across sectors were disestablished or changed to eliminate ethnic targeting for Māori. In 2006, in line with the recommendations from the 2004 Ministerial Review Unit (Ethnically Targeted Programmes) recommendations, the HMSP changed its eligibility criteria enabling non-Māori who could demonstrate a commitment to and/or competence in Māori health and well-being studies and who had cultural links with te ao Māori or Māori communities to apply to the HMSP. Reflecting a widely held view, concern was raised in informal discussions and key informant interviews that the criteria had been changed in response to recent political pressure. Key informants strongly supported targeting the Programme to Māori. “...if the MoH have identified that increasing the Māori health workforce is a priority, then they should have a targeted intervention. The need has already been established and that’s why the intervention has been developed.” [Key informant 18]. “There is a need for more Māori health professionals...scholarships such as this are very much needs based.” [Key informant 2]. “For the betterment of Māori in terms of education to promote [the] Māori health workforce and to ensure Māori are represented in all levels of the professions. To

bring them up to par with predominantly tauwiwi parties and to honour the partnership or Treaty of Waitangi.” [Key informant 17]. “It’s supportive of Māori professional development. From a population perspective it’s putting in place positive role models and dispelling generalised myths that Māori can’t study.” [Key informant 20]

Further, some key informants indicated that the scholarships should support Māori students to gain qualifications and experience in Māori contexts. “Part of the programme should be aimed at getting people through in a Māori environment because not all are getting through...It should be Māori support, Māori ways of doing things, a face-to-face programme that’s also offering work. Work experience in different Māori providers.” [Participant 16].

The dilution of ethnic targeting appears to have been largely motivated by a changing political climate and in the absence of compelling evidence to support the decision. The core HMSP intervention logic, however, remains the same, in that the Programme is fundamentally concerned with ensuring equitable Māori participation within the health and disability workforce by contributing to addressing affordability as a barrier to Māori access to tertiary health-related education and thereby facilitating improved health outcomes for Māori.

Administration process

Te Kete Hauora is currently responsible for the overall administration of the HMSP. The entire delivery of the HMSP runs to a cycle which lasts just over a year. Table 2 below, which has been compiled from two sources (Toi, 2004; personal communication, Manu-Kiwa Keung, 8 May 2006) outlines a typical cycle for the delivery of the Programme.

Table 2. Typical HMSP process timeline

<i>Indicative dates</i>	<i>Task</i>
<i>July/ August previous year</i>	<i>Confirm budget allocation from total MPDS funding</i>
<i>September/ October</i>	<i>Develop categories and budget allocations as informed by analysis of supply, tuition fees, and previous years recommendations for improvement</i>
<i>November/ December</i>	<i>Printed information prepared, including application forms, posters</i>
<i>February</i>	<i>Scholarships advertised Distribute application forms and information to the sector</i>
<i>26 March</i>	<i>Application closing date Assessment framework confirmed</i>
<i>13 April</i>	<i>Acknowledgement of receipt letters to all students</i>
<i>17 May</i>	<i>Assessments completed by independent assessor Return to MoH</i>
<i>21 May</i>	<i>MoH peer review, compilation and photocopying Assessment material for panel meeting</i>
<i>26 May</i>	<i>Decision panel convened Assessments presented, decided on and approved Confirmed and approved through Senior Management Team</i>
<i>End of May</i>	<i>Notification letters to all students – successful and decline Successful letters requesting deposit slips Advise payment date</i>
<i>11 June</i>	<i>Deadline for receiving deposit slips from students</i>
<i>18 June</i>	<i>Complete batching of spreadsheets for HealthPac payment.</i>
<i>16 July</i>	<i>Expected payment date to all students</i>
<i>30 July</i>	<i>Final report done by scholarship assessor, including outcomes, issues and quality improvements</i>
<i>August/ September</i>	<i>MoH report on scholarships to the Minister of Health Invitations to John McLeod presentation awards</i>

Overall, the timing of the entire process is strictly managed by Te Kete Hauora. A project plan with a schedule of key dates and milestones is developed, agreed on each year, and implemented in a timely manner (Ministry of Health, 2004b). The timeframe aligns with the commencement and settling in period for the students' academic year. Key informants commented positively on systems in place, such as

the notification of applicants regarding receipt of application and subsequent payment to recipients. They did, however, indicate a number of areas for improvement with regard to the application process. It was suggested that an 0800 telephone number be put in place to enable student queries (other than by fax or email), that there is a named contact person for enquiries, and that students have the option to complete on-line applications.

Importantly, the Programme maintains a focus on continuous quality improvement. Issues that arise during the delivery of the Programme over the year are routinely analysed and reviewed at the end of each delivery cycle, with recommended improvements addressed the following year.

The Ministry of Health when it took over operation of MPDS and the HMSP did not receive additional funding to operate the scheme; this was to occur within existing departmental baselines. The Ministry estimates it spends \$60,000 on the administrative activities (see table 3) and 0.3 of an FTE.

Table 3. HMSP Administrative activities

<i>Activity</i>
<i>Marketing and application forms</i>
<i>Scholarship panel and associated costs</i>
<i>External assessments</i>
<i>John McLeod event/awards</i>

There was some discussion from key informants with regard to a centralised versus decentralised mode of Programme delivery. A few key informants commented that a locally delivered Programme would enable greater engagement with potential recipients. One key informant suggested that the Programme be administered by tertiary institutions in order to facilitate increased recognition and support by academic staff and peers, while another suggested that the Programme be administered at DHB level. Decentralising delivery would substantially increase the cost of administering the Programme. More generally, a number of key informants noted the potential benefits to the Programme of increased intersectoral communication and greater buy-in from a range of health and education sector stakeholders, including the Ministry of Education, TEC, tertiary institutions, and health sector employers “...everyone has a role to play...” [Key informant 19], “...we need to be working intersectorally...” [Key informant 29].

Needs analysis

Generally, key informants indicated the need for support across a range of professions, at all levels of tertiary study (from bridging course to doctoral students), and for the variety of students (e.g. school leavers, second-chance learners, and

members of the MHDW). However, there was a consistent view emerging from key informant comments that the Programme should be strategic in focus and consistent with a clear long term vision of the optimum MHDW. Further, comments indicated the importance of a sound evidence base on which to plan Programme development, including regular needs analysis.

The most important piece of work so far to inform the strategic management of the HMSP was the Needs Analysis project undertaken by Sharon Toi (2001b). The research was commissioned in response to initial assessment of the Programme which identified; fewer applicants were applying highlighting the need for a more targeted communications strategy, the standard of applications was relatively high, there were still a substantial number of applicants without the necessary academic background or field of study applying, and the number of Māori studying in medicine and health sciences overall remained largely unknown.

The three objectives of the research were:

1. to conduct a quantitative analysis of Māori studying in health related fields at tertiary institutions;
2. to analyse annual course costs for each type of health related course and determine how many years were required to achieve completion; and,
3. to conduct a quantitative analysis of Māori students studying in health related fields at high schools throughout the country.

The report identified; the types of health related courses offered by each tertiary institution in the country, the cost of each course, how many Māori were enrolled and studying in these courses, and the educational institution. It should be noted that the quality of ethnic data from institutions was likely to be variable. In summary, the report identified 1,775 Māori students studying in health related fields, with higher numbers of Māori students enrolled at polytechnics and institutes of technology as opposed to universities. Nearly three quarters (71%) of all Māori studying in a health related field at a polytechnic or institute of technology were completing nursing training. Polytechnics offered more degrees and postgraduate qualifications in health related fields, while health professional degrees remained the domain of the universities with the majority of undergraduate students studying health related degrees at university enrolled in medicine. The research also found that by charging a flat fee, AUT University had the most competitively priced programmes. Another important finding was that Māori students with proven academic ability to pursue medicine or other related degrees were easily identified as top achieving high school students that were likely go on to tertiary education directly from school. The research highlighted the need for Māori targeted bridging and foundation programmes for those capable students who might not otherwise have an opportunity to enter degree programmes for professions such as medicine, dentistry, physiotherapy or pharmacy.

The Needs Analysis provided the information required to better understand the potential numbers of Māori who may be encouraged to enrol in tertiary health-related courses and, how and where to target them for a scholarship. Other emerging trends could be identified such as a growing number of second chance learners enrolled in undergraduate study. The strengthened evidence-base enabled informed changes to eligibility criteria to accommodate this and other trends. Budgetary allocations could

also be better forecasted with the ability to extrapolate numbers. Overall, the Needs Analysis had a major impact on improving the management of the HMSP and is an important tool for managing the Programme in the future.

It would be sensible for the Needs Analysis to be refreshed regularly (perhaps every three years) and made available to the wider Māori health sector for workforce planning purposes and also to enhance Programme transparency.

Eligibility criteria

Changes in eligibility criteria serve to broaden or restrict access to the HMSP. It is evident that the HMSP eligibility criteria have been adjusted over time to address changing needs and trends of Māori in education, and also to encourage a greater commitment and contribution toward Māori health from scholarship recipients.

Initially, the HMSP operated on two main eligibility criteria; (i) whakapapa – any person of Māori descent who is enrolled as New Zealand Māori; and (ii) enrolled in a health related NZQA accredited course of at least 12 weeks duration. In 2004, the eligibility criteria were expanded to include any person; enrolled and attending a university, polytechnic or wānanga, that can demonstrate a commitment to and/or competence in, Māori health and well-being studies, and has whakapapa and/or cultural links with te ao Māori or Māori communities (Ministry of Health, 2005a).

Modifications to eligibility criteria reflected a number of identified issues such as incentivising secondary school students to take up health careers, recognising the broad range of health programmes that are on offer, ensuring recipients have a commitment to Māori health, and acknowledging a wider range of competencies (alongside academic grades such as work experience). The Ministry amended the whakapapa eligibility criteria to include and/or cultural links in line with recommendations from the Ministerial Review Unit (Ethnically Targeted Programmes). The Ministerial Review Unit recommended that the approach to the scholarships funded by the Scheme should be consistent with their review of public service scholarships, including complying with the Bill of Rights and the Human Rights Act [CAB Min (05) 9/11]. According to advice provided by the Crown Law Office as part of the review process, compliance with the Acts would require satisfying a number of criteria: the target group is underrepresented in the relevant area; that the under-representation can be attributed to disadvantage faced by that group; that the scholarship can be expected to provide a means to ameliorate that disadvantage; that the positive impacts of the policy are proportionate to the adverse impacts on ineligible individuals; and that in offering the scholarship monitoring is carried out to assess the effectiveness of the policy and that the under-representation that gave rise to these policies remains while the policies are in place (http://www.ssc.govt.nz/upload/downloadable_files/Cab-Paper-Public-Service-Scholarships-targeted-by-ethnicity.pdf).

A small number of lower value scholarships targeted at Year 12 and 13 secondary school students were in place in 2001 to provide some incentive for Māori secondary school students to pursue health-related studies and a career in health.

A new scholarship category for those taking undergraduate studies was introduced in 2001 in recognition of the large numbers of Māori (possibly second chance learners) taking courses outside of the traditional health professions. Toi (2004) suggested in her assessment that ‘undue relevance’ was placed on academic achievement and qualifications which tended to favour undergraduates pursuing conventional health professions. New assessment criteria were needed to allow for academic achievement, but also to provide for health workers who did not have professional qualifications (Ministry of Health, 2005a). As an example, the category enables Māori community health workers to apply for scholarships in order to gain tertiary level qualifications that will enable them to be more effective in their role at the interface between Māori communities and their health professional colleagues.

It was also apparent that Māori were attending a broader range of tertiary institutions (e.g. wānanga) and enrolling in a wider variety of courses than previously. In light of this finding from the Needs Analysis, Toi (2001b) recommended that the assessment framework be expanded to recognise that Māori are moving into new health fields, and therefore the definition of ‘health field’ needed to be broadened. The need to ensure that recipients demonstrate some connection with and commitment to te ao Māori and Māori health was also apparent.

Key informant comments emphasised the importance of both whakapapa (Māori descent) and a demonstrated commitment to things Māori, alongside academic criteria. “With the scholarship, it took into account whakapapa and commitment to Māori, not just academic...The scholarship application requirements were like a validation, what they brought with them, their contribution to Māori and whakapapa.” [Key informant 28]. “It’s also important to have the selection criteria balanced between academic ability and proven commitment to Māori health...It’s also about contributing to Māori health, to whānau, hapū and iwi to enable Māori access to good quality health services. Those with life experience or personal experiences working in or having received health care who have transferred that experience into a passion and an interest to study...Having selection criteria that prioritises and taps into that to meet the outcomes of the Scholarship Programme, to achieve its goal” [Key informant 26].

In terms of eligibility criteria, the dilution of ethnic targeting for Māori has been made in the absence of clear evidence based rationale, and is inconsistent with the original intent of the Programme. However, more generally, decision-making with regard to management of the eligibility criteria has been sound. In effect, new categories have been introduced to meet changing need, as well as at the same time sharpening the focus of recipients to ensuring a commitment to Māori health.

Assessment framework

As with the eligibility criteria, the Assessment Framework is the cornerstone of how the HMSP is strategically managed. The Assessment Framework is a combination of the number of scholarships specified for the year, the budget allocated, the amounts for each category, potential new categories and also any criteria and assessment

changes agreed on the previous year and built into the applications and assessment process.

The Assessment Framework is agreed each year at the beginning of each Programme cycle and reviewed again once the applications are received and assessed.

Table 4 outlines the Assessment Framework for the HMSP for 2004. The specified number of scholarships were forecasted and multiplied by the scholarship amount to calculate the overall total amount of budget commitment for the year.

Table 4. Assessment Framework for Hauora Māori Scholarship Programme 2004

<i>Category number</i>	<i>Category</i>	<i>Number of scholarships allocated</i>	<i>Scholarship value</i>	<i>Total amount budgeted</i>
1	<i>Year 12 & 13</i>	60	\$300	\$18,000
2	<i>Nursing</i>	180	\$1,500	\$270,000
3	<i>Midwifery</i>	25	\$1,500	\$37,500
4	<i>Pharmacy</i>	10	\$1,500	\$15,000
5	<i>Dental</i>	15	\$2,500	\$37,500
6	<i>Medicine</i>	90	\$2,500	\$225,000
7	<i>Physiotherapy</i>	30	\$1,500	\$45,000
8	<i>Health management</i>	10	\$2,000	\$20,000
9	<i>Undergraduate</i>	100	\$1,500	\$150,000
10	<i>Postgraduate</i>	30	\$2,500	\$75,000
11	<i>Excellence awards</i>	9	\$1,000	\$9,000
12	<i>John McLeod award</i>	5	\$5,000	\$25,000
Total		564	-	\$927,000

Once applications were received in March they were assessed against the Assessment Framework. In 2004, it was recommended that the assessment of applications take into account the following; academic record, motivation for entry into a course of study, life and work experience, initiative shown in preparation for study, evidence of financial need, and whakapapa with appropriate endorsement. These factors were weighted and informed the selection process. The allocation and adjustment of weightings is part of the Assessment Framework approval process.

Assessment and selection process

Since 2000, applications for the HMSP have been assessed externally by a consultancy firm. The reasons for this are that it provides some form of independence and greater transparency in the process. The assessment procedure is largely a mechanical data input and analysis process, and the systems required to do this are more effectively provided outside of the process (personal communication, Manu-Kiwa Keung, 8 May 2006).

The standard process is that applications are received and allocated a unique identifying number. Components of the application form are scored against the

Assessment Framework weightings. Data is then inputted into a master spreadsheet and applications are ranked from highest cumulative score downwards. Applications are then matched against the number of specified scholarships available in each category. For example, if 50 applications are received for a particular category of scholarship and only 30 scholarships are specified in the category, the top 30 highest scored applications are recommended to receive a scholarship. Each category of scholarship generally follows this process, with the exception of the John McLeod Scholarships where the applications are individually assessed in detail. One of the criticisms of this process is that while scoring gives a clear quantitative outcome, allocating scores is itself a subjective process (personal communication, Manu-Kiwa Keung, 8 May 2006). However, it is accepted that this is the fairest process possible within time and resource constraints.

Once the applications have been assessed and recommendations made by the consultants, a selection panel (with a moderating role) comprised of MoH officials and external representatives from Te Puni Kōkiri as well as a number of Māori organisations (such as Māori professional bodies) is convened to consider and approve recommendations. Each category of scholarship is summarised in terms of the numbers recommended for approval and those declined. Any under-spend in a category is noted.

Generally, key informant comments with regard to the selection panel noted positively the range of independent groups represented which incorporated a variety of perspectives. “Some representatives were community focused and not all about academic achievement, so it brings the two elements to the meeting, and there’s a good professional focus.” [Key informant 22]. However, one key informant indicated a need for greater consistency in selection panel membership, with a more explicit process for selection. The same informant was concerned that a representative from each professional group for which there is a scholarship category should be included in the panel [Key informant 27].

Categories and levels of funding

Twelve categories of scholarship were available in 2004 with allocated dollar values designated to each scholarship as outlined in Table 5.

Table 5. Value designated in each category for Hauora Māori Scholarship Programme in 2004

<i>Number</i>	<i>Category</i>	<i>Amount</i>
1	<i>Year 12 & 13</i>	<i>\$300</i>
2	<i>Nursing</i>	<i>\$1,500</i>
3	<i>Midwifery</i>	<i>\$1,500</i>
4	<i>Pharmacy</i>	<i>\$1,500</i>
5	<i>Dental</i>	<i>\$2,500</i>
6	<i>Medicine</i>	<i>\$2,500</i>
7	<i>Physiotherapy</i>	<i>\$1,500</i>
8	<i>Health management</i>	<i>\$2,000</i>
9	<i>Undergraduate</i>	<i>\$1,500</i>
10	<i>Postgraduate</i>	<i>\$2,500</i>
11	<i>Excellence awards</i>	<i>\$1,000</i>
12	<i>John McLeod award</i>	<i>\$5,000</i>

The categories cover the core health professions as well as health management, postgraduate, excellence and John McLeod awards. The scholarship categories, Undergraduate and Excellence, were added in 2001 and 2004 respectively.

The amount allocated to each category appears to be a mixture of historical amounts and alignment with the annual tuition fees for a course, as identified by Toi (2001b). For example, dentistry and medicine are at the higher end in terms of cost and length of study and attract a higher scholarship value than nursing and allied health professions as course costs are lower and the length of course is shorter. No scholarship exceeds \$5,000, with the majority of scholarships being \$1,500, \$2,000 or \$2,500. Most key informants considered that the dollar value of individual scholarships should be increased, particularly given increases in tuition fees and other related costs for students.

It was not possible for the Research Team to provide analysis of trends in uptake, as programme data from inception of the Programme was incomplete and could only be provided accurately for two years.

Marketing

Marketing and promotion of the HMSP is limited. The Needs Analysis (S Toi, 2001b) identified Māori in training and therefore allowed Te Kete Hauora to directly target students or their institutions with information and application forms. Having needs analysis information available to inform marketing strategies means that limited promotional resources can be applied in a targeted manner reducing expenditure. However, key informants raised concerns that marketing of the Programme is inadequate. “I’m in my last year of study and I only applied for the first time last year. The scholarship is not promoted enough.” [Key informant 1]. “The MoH scholarships are not advertised very well to students or organisations and as far as we are aware there is no marketing of the scholarships by the MoH.” [Key informant 12].

The key promotional methods used to advertise the Programme has been newspaper advertising, posting applications and guidelines on the MoH's website, posters, and application forms disseminated through Māori health sector networks. Another feature of the marketing is that scholarship recipients from previous years are automatically sent application packs in the post the following year. It has been suggested that additional promotion across Māori media, such as Māori television and iwi radio may be helpful in raising the profile of the Programme among diverse groups (personal communication, Manu-Kiwa Keung, 8 May 2006). Key informants recommended that there is: a link to a HMSP website available on educational institution websites (including on-line application forms); showcasing of successful Māori recipients in the media; targeted information to Year 13 secondary school students; information provision to secondary students outside of schools through Māori recruiters; and, that information about the Programme is presented to students face-to-face at educational institutions.

Output and outcome reporting

The safe and secure storage and maintenance of confidential Programme data relating to individual applicants and recipients by Te Kete Hauora is a key area that requires greater attention in order to facilitate future Programme evaluations and ongoing Programme improvement. Information and data collected for HMSP internal planning and accountability purposes has the potential to provide important information for the sector to inform broader MHDW planning. In essence, the HMSP provides an insight into the Māori health workforce supply, the numbers of Māori in training and those coming through the tertiary education system. This gives an indication of the impending distribution and future mix of the MHDW, and the impact this might have on future services. This is an important tool for strategic MHDW development and should be made available to the wider health sector such as DHB managers, Māori health providers, primary health organisations, and professional groups.

While information and outcome reporting should be available to the wider sector to assist workforce planning, an important issue is the safe and secure storage and maintenance of confidential Programme data relating to individual applicants and recipients by Te Kete Hauora. Greater attention is required in this area to facilitate future evaluations of the Programme.

SCHOLARSHIP RECIPIENT POSTAL SURVEY

Characteristics of respondents

The MoH's accessible data held on scholarship recipients provided a total of 1729 names of scholarship recipients from 1997 – 2005. A survey pack was sent to 1515 (88%) of these scholarship recipients. There were 197 scholarship recipients for whom the MoH had insufficient contact details (e.g. all recipients pre 2000 did not have contact details). As well, at least 17 recipients identified as receiving scholarships in multiple years. Therefore these recipients were not included in the mail out, unless they also received a scholarship in another year, and are therefore not included in any further statistical analysis.

Response rate

Table 6 presents the response rate by scholarship category. Of the 1515 scholarship recipients who were sent the survey pack, 593 (39%) responded, including a small number of people (n=23) that completed the survey questionnaire on-line (www.surveymonkey.com). There were 166 (11%) survey packs returned indicating incorrect mailing addresses. Although all efforts were made to update addresses, it is likely that some of the 756 non-respondents did not receive the survey pack due to the general mobility of the student population, therefore the response rate (39%) is likely to be an underestimate.

Table 6. Survey response rate by category

Category	Number of scholarship recipients sent a survey pack	Number of respondents	Response rate
Nursing	433	215	50%
Midwifery	105	27	26%
Medicine	197	88	45%
Physiotherapy	74	30	41%
Dental	39	17	44%
Pharmacy	50	8	16%
Health management	45	32	71%
Secondary school	103	28	27%
Other	469	148	32%
Total	1,515	593	39%

The highest response rates came from those who received scholarships in the health management, nursing, medicine, dental, and physiotherapy categories. The 148 respondents included in the 'other' grouping represent fields of study not specifically

listed as a category and capture recipients from the Undergraduate and Postgraduate categories. Examples of these fields of study include psychology (n=35, 24%), social work (n=18, 12%), public health (n=16, 11%), as well as a few from optometry, chiropractic, and occupational therapy.

Respondents were asked to choose a category which best described their course of study. However, the chosen course of study may not directly represent the scholarship category under which they were awarded the scholarship, as the respondent may have received scholarships in more than one category over different years. For example, one respondent received a scholarship in the secondary school category then went on to further tertiary study and received another scholarship in the undergraduate category, while another recipient received a scholarship in physiotherapy then went on to further study and received a scholarship in the postgraduate category. However, these numbers are small and may result in some categories being slightly under-represented or over-represented.

Demographics

Table 7 shows the distribution of current age by gender of respondents. The majority of respondents were female. The female recipients' age distribution was significantly different from their male counterparts ($\chi^2(6) = 20.01, p = 0.003$), with the females accounting for a higher proportion of the older age groups.

Note that as respondents were asked to provide their current age at the time of the survey, the age reported may not accurately represent the age at the time of being awarded a scholarship. However, considering that 52% of the respondents received a scholarship in 2005 with decreasing numbers in previous years, the age was outdated on average by only 1.9 years.

Table 7. Age and gender of respondents

Age group	Male	Female	Total
15-19 years	11 (30%)	26 (70%)	37
20-24 years	38 (26%)	106 (74%)	144
25-29 years	17 (20%)	69 (80%)	86
30-39 years	26 (17%)	130 (83%)	156
40-49 years	10 (9%)	107 (92%)	117
50-59 years	4 (10%)	38 (91%)	42
60+ years	2 (29%)	5 (71%)	7
Total	108 (18%)	481 (82%)	589

Female scholarship recipients were well represented in all the scholarship categories, and were particularly well represented in nursing, midwifery and health management (Table 8). The highest proportion of male scholarship recipients were in the medicine and dental categories.

Table 8. Gender by scholarship category

Category	Male	Female	Total
Nursing	8 (4%)	207 (96%)	215
Midwifery	1 (4%)	25 (96%)	26
Medicine	38 (43%)	50 (57%)	88
Physiotherapy	8 (27%)	22 (73%)	30
Dental	7 (41%)	10 (59%)	17
Pharmacy	1 (13%)	7 (88%)	8
Health management	2 (6%)	30 (94%)	32
Secondary school	7 (25%)	21 (75%)	28
Other	36 (25%)	109 (75%)	145
Total	108 (18%)	481 (82%)	589

Living arrangements

At the time the postal survey was conducted respondents were geographically spread across the country, located in; Northland (9%), Auckland (25%), Waikato (11%), Central North Island (21%), Lower North Island (14%), and South Island (15%).

Table 9 shows the marital status of scholarship respondents at the time they received a scholarship. The largest proportion of respondents (46%) reported that they were single at the time they were awarded a scholarship, and a further 42% were either single or defacto/married with dependents. However, it is interesting to note that there were significant differences between gender and marital status of the respondents ($\chi^2(3) = 21.95, p < 0.0001$), in particular just over one quarter of the female respondents (27%) were single mothers and, almost one fifth (18%) were women in a defacto relationship or married with dependent(s). Male scholarship recipients were more likely to be single (61%).

Table 9. Marital status of recipients at time awarded a scholarship

Marital status	Male	Female
Single	66 (61%)	204 (42%)
Single with dependent(s)	8 (7%)	132 (28%)
Defacto / Married	15 (14%)	57 (12%)
Defacto / Married with dependent(s)	19 (18%)	88 (18%)
Total	108 (100%)	481 (100%)

Table 10 presents the living arrangements of scholarship recipients at the time they received a scholarship. The largest proportion of male respondents were living in a

flating situation with friends/flatmates (36%), whereas the largest proportion of females were living with immediate family (45%). This is representative of the differences in age distributions and martial status between the genders.

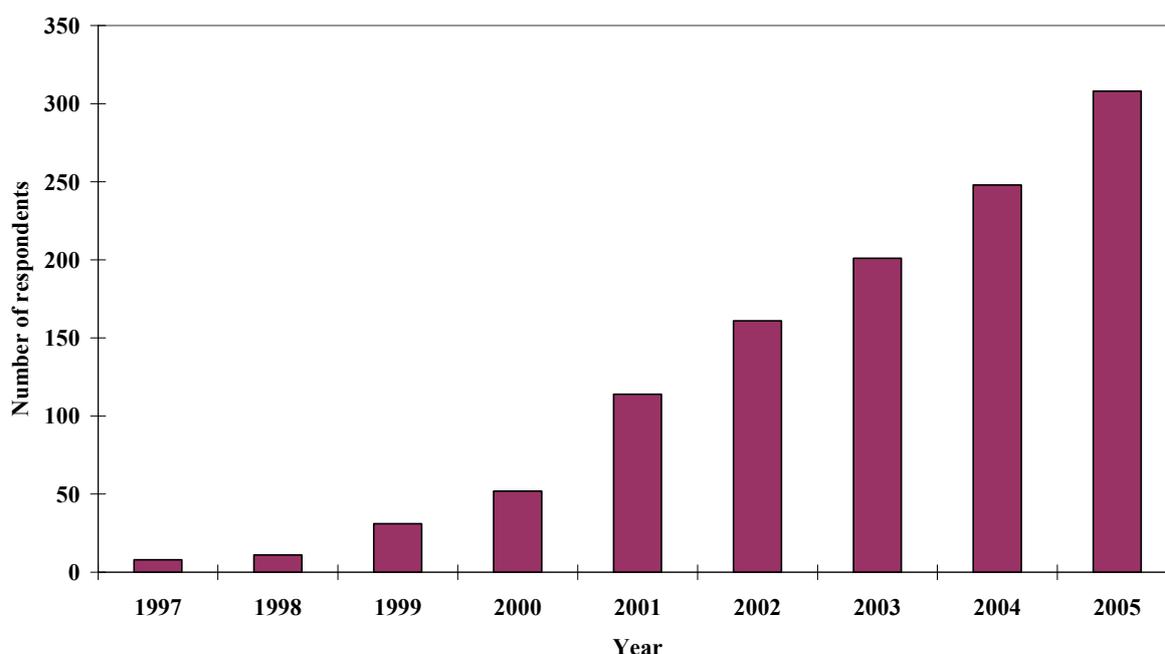
Table 10. Living arrangements of recipients at time awarded a scholarship

Living arrangements	Male		Female	
Living with immediate family	31	(29%)	216	(45%)
Living/ boarding with whānau/ extended family	3	(3%)	49	(10%)
Living with friends/ flatmates	38	(36%)	87	(18%)
Living with partner	17	(16%)	59	(12%)
Living alone	6	(6%)	40	(9%)
Boarding with others	8	(7%)	20	(4%)
Hostel	2	(2%)	4	(1%)
Other	1	(1%)	5	(1%)
Total	106	(100%)	480	(100%)

Year awarded scholarship

Just over half of the respondents (52%) received a scholarship in 2005 with decreasing responses from recipients awarded a scholarship in earlier years (Figure 1). This is in part due to the availability of most current postal addresses, but also adjustments to the number of scholarships awarded over time.

Figure 1. Number of respondents* by year scholarship awarded



* Those respondents who received scholarships in multiple years are represented multiple times in the chart.

As previously noted, scholarship recipients in years 1997 through 1999 were not directly surveyed and therefore respondents that indicated they received a scholarship in these years will have received a scholarship in multiple years.

Interestingly, 48% of respondents had been awarded a scholarship once, 29% of respondents had been awarded the scholarship twice, and 23% had been awarded a scholarship three or more times. Medicine and dental categories were more likely to be awarded a scholarship in multiple years.

The sample is reasonably representative of scholarship recipients by category and year awarded given the increase in the number of scholarships given out and the missing or outdated addresses of scholarship recipients since the inception of the Programme.

Student enrolment status

The majority of respondents were studying full-time (81%) at the time they received the scholarship, and nearly three quarters (74%) of this group were enrolled in undergraduate degree programmes. Fourteen percent of all respondents studied part-time and over half (57%) of these people were studying towards a postgraduate qualification.

Level of study

Table 11 presents respondents field of study by level of qualification sought. Approximately three quarters of all respondents (76%) were studying toward an undergraduate degree. These respondents tended to be in the 20-24 year (28%) and 30-39 year (27%) age brackets. Most of the remainder were studying at postgraduate level (16%). About half of the postgraduate respondents were studying full-time and the other half were studying part-time. Postgraduate respondents tended to be in the older age groups, 30-39 years (36%), and 40-49 years (32%). Over two thirds (67%) of postgraduate respondents were already working in the health and disability sector at the time they received the scholarship.

Table 11. Field of study by level of qualification sought

Field of study	Certificate or Diploma	Undergraduate Degree	Postgraduate	Total
Dental	1 (6%)	14 (82%)	2 (12%)	17
Health management	7 (22%)	13 (41%)	12 (38%)	32
Māori health	1	4 (50%)	3 (38%)	8
Medicine	1 (1%)	80 (93%)	5 (6%)	86
Mental health/ Counselling	6 (50%)	4 (33%)	2 (17%)	12
Midwifery	-	27 (100%)	-	27
Nursing	5 (2%)	180 (85%)	28 (13%)	213
Occupational therapy	1	4 (80%)	-	5
Pharmacy	1	7 (88%)	-	8
Physiotherapy	-	30 (100%)	-	30
Psychology	1 (3%)	22 (63%)	12 (34%)	35
Public health	1	5 (31%)	10 (63%)	16
Secondary school	1	2 (67%)	-	3
Social worker	11 (61%)	5 (28%)	2 (11%)	18
Sports/ PE/ Nutrition	-	12 (75%)	4 (25%)	16
Other	7 (23%)	17 (55%)	7 (23%)	31
Total	44 (8%)	426 (76%)	87 (16%)	557

Other grants and awards

Over half (54%) of respondents stated that they had received other scholarships or grants in the same year they were awarded the Hauora Māori Scholarship. Most of these people had been recipients of a Manaaki Tauria grant (34%) and/or hapū/iwi scholarships (30%).

Programme administration

Table 12 presents information on Programme administration. Respondents were asked to rate 14 questions relating to the Programme administration process on a scale from 1-5, 'outstanding' to 'poor'. Where relevant, some questions had an option of choosing 'not applicable' (N/A), this information is also included in the Table. As some respondents failed to answer every question, the 'valid response' varies according to the number of people who chose to answer each question. In the following section 'better than average' corresponds to combining 'outstanding' and 'above average' scores, and 'worse than average' corresponds to combining 'below average' and 'poor' scores.

Information availability

Forty eight percent (n=28) of those who received a scholarship in the secondary school category rated the information made available to them at school about the Programme as 'better than average', and 11% rated the information made available as 'worse than average'. Nearly two thirds of this group (64%) thought the assistance available to them to complete the form was 'better than average'.

Information availability at tertiary institutions was rated similarly to secondary school respondents with 43% rating the availability as 'better than average' and a slightly higher rate of 21% as 'worse than average'. However, tertiary respondents (n=562) rated the assistance to help fill out the forms much lower. Forty five percent rated the assistance as 'better than average' and 25% considered it 'worse than average'. It is also important to note that 18% of the respondents did not answer this question or stated that it was 'not applicable'; therefore it is likely that there is a large additional group that did not perceive that they had any access to assistance to fill out the forms.

Information availability in the workplace for respondents employed in the health and disability sector at the time of the survey (n=174) was rated as significantly ($\chi^2(4) = 35.95, p < 0.0001$) lower than tertiary settings, with only 27% rating it 'better than average' and 48% as 'worse than average'. However, assistance with filling out the forms rated similarly to the tertiary respondents with 41% rating assistance as 'better than average' and 33% rating it as 'worse than average'. It is also important to note that for this group there was a large proportion (25%) that did not answer the question, or stated that this question was 'not applicable'.

Table 12. Programme administration

<i>How would you rate the scholarship programme processes and administration in the following areas.....</i>	N/A (No.)	Valid response (No.)	Rating scale				
			Outstanding	Above average	Average	Below average	Poor
Q14. Scholarship information made available at my secondary school was... ¹	1	27	11%	37%	41%	4%	7%
Q15. Scholarship information made available at my tertiary institution was... ²	59	503	13%	30%	36%	11%	10%
Q16. Scholarship information made available at my workplace was... ³	69	105	9%	18%	26%	19%	29%
Q17. The availability of scholarship application forms was...	-	578	16%	36%	35%	9%	4%
Q18. The application guidelines and information on how to apply was....	-	577	19%	47%	29%	3%	1%
Q19. The ease of completing the scholarship application was...	-	577	15%	41%	37%	6%	1%
Q20. The assistance available from school / tertiary / workplace to help me fill out the scholarship application was... ¹	3	25	36%	28%	20%	12%	4%
Q20. The assistance available from school / tertiary / workplace to help me fill out the scholarship application was... ²	104	434	19%	26%	30%	15%	10%
Q20. The assistance available from school / tertiary / workplace to help me fill out the scholarship application was... ³	42	136	19%	22%	26%	18%	15%
Q21. The ease of contacting the right person(s) at the Ministry of Health was...	152	436	19%	29%	39%	9%	3%
Q22. Answers to my queries by the Ministry of Health staff were	215	373	22%	40%	32%	4%	3%
Q23. The willingness of the Ministry of Health to provide help was...	168	396	27%	41%	28%	3%	2%
Q24. The speed I was told that my application had been received was...	-	582	19%	36%	35%	8%	2%
Q25. The way I was told I had been successful in my application was...	-	585	32%	39%	25%	3%	1%
Q26. The time lag between being told and receiving the money was...	-	577	24%	39%	27%	7%	4%
Q27. Overall , the Scholarship Programmes processes and administration was...	-	577	28%	40%	29%	2%	1%

1 (secondary school category respondent answers only)

2 (all respondents excluding secondary school category respondents)

3 (all respondents who were working in health at the time excluding secondary school category)

When asked to identify all the sources through which recipients found out about the Programme, over half of all respondents stated that staff at tertiary institutions (55%) and friends and whānau (51%) were the main sources of information. Some respondents found out about the Programme through Māori health providers (16%), and only a small number of secondary school category applicants found out about the Programme from staff at secondary schools (5%). Few respondents reported mainstream media (2%) or Māori programming and print media (5%) as sources of information. It should be noted that all respondents were successful recipients and as such, their responses in terms of information availability would generally be rated more highly than other Māori tertiary health field students, some of whom are unaware of the HMSP as demonstrated in the MHDW project surveys.

Application process

Communication with MoH staff for assistance was generally rated favourably by the majority of respondents. Twenty six percent of the respondents are assumed to not have required contact with MoH staff as they either did not answer the question 'on ease of contact' or selected the 'not applicable' option. Of the remaining 436 respondents, 48% reported that the ease of contacting the right person(s) in the MoH was above average. Those who did make contact with MoH staff were generally satisfied with the response they received, and 68% of these respondents thought the staff were very willing to help, rating this 'better than average', and indicated that their queries were handled competently. Less than 4% of respondents considered MoH staff performed poorly. Respondents were generally pleased with the speed with which applications were processed and funds became available.

Overall administration

The majority of participants responded favourably in terms of how the Programme is administered with most (68%) rating the administration as better than average and only a few (3%) rating it as worse than average.

Student outcomes

According to respondents, the benefits of receiving a scholarship extend beyond purely financial gain. To capture this, respondents were asked to rate 19 questions on a scale of 1-5, on how significant receiving the MoH scholarship was in terms of supporting them (Table 13). The rating scale went from 'extremely' significant to 'not at all' significant. The 'valid response' column indicates the number people who answered each question.

Table 13. Broad areas of support

<i>Please rate how significant receiving the Ministry of Health scholarship was in terms of supporting you to.....</i>	Valid Response (No.)	Rating scale				
		Extremely	Very	Moderately	Somewhat	Not at all
Q29. Enrol in a health related course...	559	29%	21%	16%	9%	25%
Q30. Pass your course work each year...	580	32%	31%	23%	7%	8%
Q31. Achieve higher grades...	577	25%	32%	25%	8%	10%
Q32. Complete your qualification in the minimum amount of time...	570	27%	25%	25%	9%	14%
Q33. Commit to completing your qualification...	570	40%	29%	13%	7%	12%
Q34. Reconsider pulling out of the course...	541	13%	12%	11%	8%	55%
Q35. Graduate...	563	39%	26%	17%	8%	10%
Q36. Progress your career...	574	39%	28%	19%	6%	7%
Q37. Work in the health and disability sector...	564	35%	25%	22%	5%	12%
Q38. Choose to work in the Māori Health and disability sector...	567	36%	28%	18%	7%	11%
Q39. Continue to work in the health and disability sector...	553	32%	26%	19%	7%	15%
Q40. Link with other Māori health professionals...	574	37%	25%	15%	11%	11%
Q41. Reduce or avoid paid work while studying...	568	41%	19%	18%	9%	13%
Q42. Reduce stress while studying...	580	56%	22%	12%	6%	4%
Q43. Minimise your student debt...	572	48%	21%	14%	8%	10%
Q44. Reduce whānau concerns about your financial situation...	583	57%	21%	12%	5%	5%
Q45. Maintain whānau connections...	574	34%	22%	19%	11%	14%
Q46. Build a relationship with your hapū / iwi / the Māori community...	574	29%	24%	22%	11%	13%
Q47. Feel positive about being Māori...	585	61%	24%	8%	3%	5%

Recruitment into tertiary study

Results indicate that the HMSP is an extremely valuable tool in terms of attracting Māori into tertiary study in health fields.

Fifty percent of all respondents indicated that receiving a scholarship was ‘extremely’ or ‘very significant’ in terms of encouraging them to enrol in a health related course, even more respondents considered it impacted significantly in encouraging them to work in the health field (60%) and more specifically, the Māori health and disability sector (64%). Comments in this section from respondents included; “[the scholarship] helped me focus on how I see my place in Māori health.” (ID 297), a secondary school recipient stated that it “...has been helpful in convincing me to pursue a career in medicine.” (ID 325), another recipient already studying medicine stated that “...if I hadn’t gotten this scholarship, I would not have considered medicine as a viable career.” (ID 053). One respondent commented that, “...without it I would not have been able to afford to undertake the study.” (ID 434), and another stated that “...without it I would not be able to afford to do the papers required for masters level studies.” (ID 414).

A sizeable proportion of respondents (25%) reported that the scholarship had no bearing in their decision to enrol in a health related course. However, half of this group (50%) of respondents were already working in the health sector at the time they were awarded a scholarship. Although the scholarship did not play a vital role in recruiting these respondents into a health related course, this same group of people found the scholarship extremely significant in supporting them through their course as they did not need to undertake paid employment while studying (43%), minimising their student debt (40%), and reducing stress (47%). A comment made by one respondent highlights the wider impact the scholarship can have, as it “...raised the profile for me of Māori health initiatives and who to be in contact with regarding Māori health issues at my institution.” (ID 065). This group also reported that it was extremely significant in supporting them to reduce whānau concerns about their financial situation (53%) and feeling positive about being Māori (45%). One respondent stated that “The scholarship helped me hold on to my identity as Māori.” (ID 389), while another stated that, “...[the scholarship] helped me positively identify with my culture.” (ID 519). Another recipient said that, “...my whānau, hapū, and iwi depend on me to complete my course, so I can develop my skills to contribute to...health” (ID 255).

Retention in, and completion of, course of study

At the time of the survey, just over half (52%) of respondents were still completing the course of study for which they were awarded a scholarship. Over a third (36%, n=214) of respondents had completed their course of study at the time of the survey and a further 8% (n=47) had gone on to further study. One respondent stated that the scholarship, “...helped me to push harder...” (ID 148), another said that it “...inspired me to complete this degree and finish it” (ID 167).

One quarter of respondents (25%) considered that the scholarship had played a significant role in their decision to reconsider pulling out of the course and continue on in their course of study. Comments from respondents included: “Without the scholarship, I may have had to drop out of my course.” (ID 548), “I would probably not have carried on if I did not have this financial assistance.” (ID 522), and “...this scholarship anchored me. Kept me from pulling out of papers...kept me committed to working with Māori.” (ID 436). One secondary school recipient said that, “...[being awarded the scholarship] helped me find reasons to stick with school and attend university next year.” (ID 244).

A large proportion of respondents stated that receiving the scholarship had been ‘extremely’ or ‘very significant’ in supporting them to pass their course work each year (63%), to achieve higher grades (57%), and complete within the minimum timeframe (52%). A large proportion of scholarship recipients also felt that the scholarship was ‘extremely’ or ‘very significant’ in providing support to enable them to commit to completing their qualification (69%), to go on to graduate (65%), and progress their career (67%). Over half of respondents (58%) indicated that receiving a scholarship was ‘extremely’ or ‘very significant’ in their decision to continue to work in the health and disability sector.

Only a small proportion of respondents had discontinued their studies (4%, n=22) and did not plan to complete, or had withdrawn from their course. Respondents were asked to specify reason(s) for withdrawing from the course. The reasons given fell into the following categories; whānau commitments (n=3), failing a component of their course (n=3), pregnancy (n=2), difficulty balancing full time work and study (n=1), financial situation (n=1), illness (n=1), and 10 did not state a reason.

Of those who had completed their course of study, 11% completed a certificate or diploma, 73% completed an undergraduate degree, and 12% completed a postgraduate qualification. Over one third (n=9, 39%) of recipients from the secondary school category completed their qualification (generally NCEA level certificate). Recipients commented that, “...this has helped me immensely in being able to complete my course successfully with good results.” (ID 488), “The Scholarship Programme has been a great help for me to achieve my goals and to go on to the health sector [and] be able to help our people.” (ID 420), “I probably would not have graduated without the assistance provided.” (ID 297)”, and, “...[I] gained a qualification that I wouldn’t be able to get if I didn’t receive the scholarship.” (ID 550).

Financial pressure

The scholarship was extremely significant in supporting respondents to reduce or avoid paid work while studying (41%), minimise student debt (48%), and reduce stress while studying (56%). A typical recipient comment from respondents was that the scholarship, “...help[ed] to alleviate stress caused by huge financial commitment when undertaking tertiary study.” (ID 130). Over half of respondents (57%) stated that the scholarship was extremely significant in reducing whānau concerns about their financial situation. One respondent stated that “...the scholarship feels like a hand up, not a hand out.” (ID 590).

Cultural reinforcement

The scholarship was also considered to be extremely, or very significant in terms of enabling many recipients to maintain whānau connections (56%) and build a relationship with hapū, iwi and Māori communities (53%). The majority of respondents (85%) considered that the scholarship contributed strongly ('extremely', or 'very significant') to feeling positive about being Māori. One recipient expressed the opinion, "...anything that helps Māori get out into the world and make a positive contribution is not a privilege but common sense" (ID 066), and another said "I felt huge mana in being a recipient." (ID 130).

Networking

While there is the potential for the Programme to assist in linking recipients with Māori health professionals, the Programme appears to have had little impact in this area. Almost one quarter (22%) of respondents indicated that the scholarship was 'somewhat' or 'not at all' significant in supporting recipients to link with other Māori health professionals. One respondent commented that, "...it would be good to have more support in facilitating Māori connections and let the scholarship mean more than just money." (ID 342).

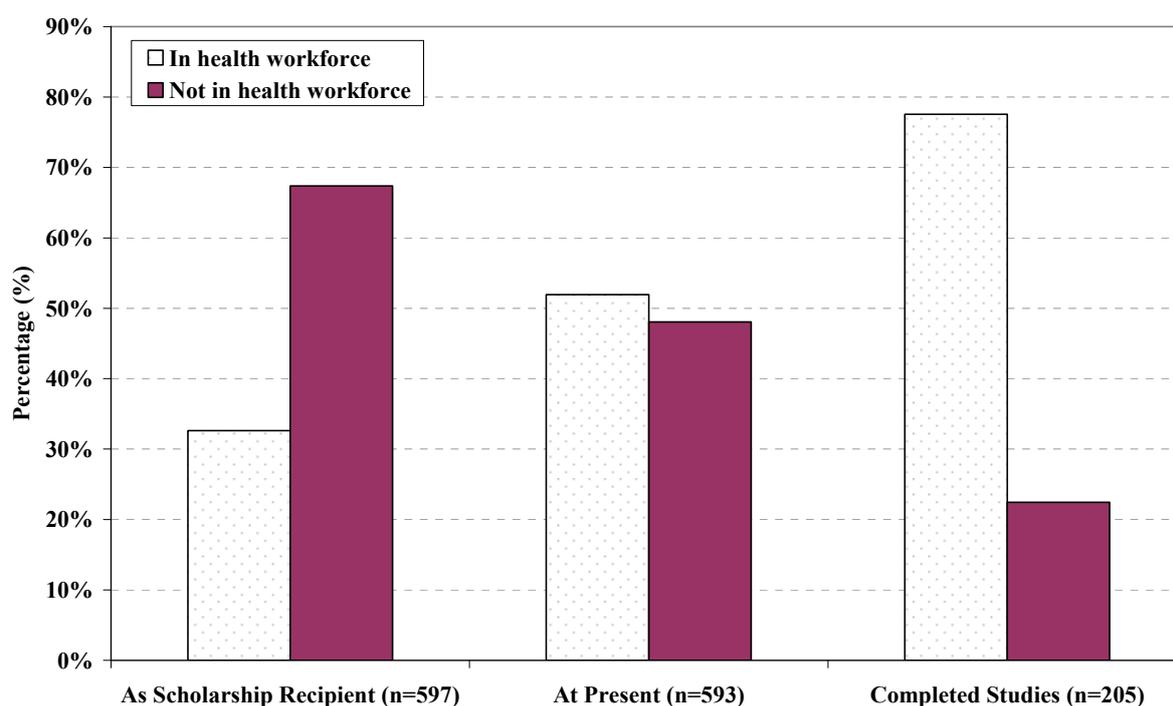
Māori health and disability workforce outcomes

MHDW capacity – recruitment and retention

Figure 2 presents the progress of surveyed scholarship recipients in terms of entry into the MHDW. One third (33%, n=189) of all surveyed scholarship recipients were already working in the health and disability sector at the time they were awarded a scholarship. When asked about their current employment status, just over half (52%) of the respondents indicated that they were actively working in the sector at the time of the survey. Of the 390 that were not employed in the sector at the time of receiving the scholarship, a further 135 respondents (22%) are now employed in the MHDW.

Examination of respondents who have now completed their course of study (n=205) shows that 78% are actively working in the MHDW; this is a possible predictor of future outcomes of the Programme. There are a further 284 surveyed recipients (48%) still completing qualifications, which is a substantial proportion yet to bolster Māori health professionals employed in the sector in the near future.

Figure 2. Recipient employment in the health and disability workforce



Of the scholarship recipients already working in the health sector at the time they were awarded a scholarship; over half (57%) were working part-time, and a third worked full-time while studying. The majority (87%) of those who were already working in the health sector have remained there. More than half (55%) of all respondents anticipate that they will work in the health and disability sector for more than 10 years.

Those who are not currently working in the sector are; still studying (83%), homemakers (4%), unemployed (4%), or working in another area (10%). Those who have moved into another sector tended to go into education (31%) or the leisure and hospitality industry (20%).

Occupation and employment settings.

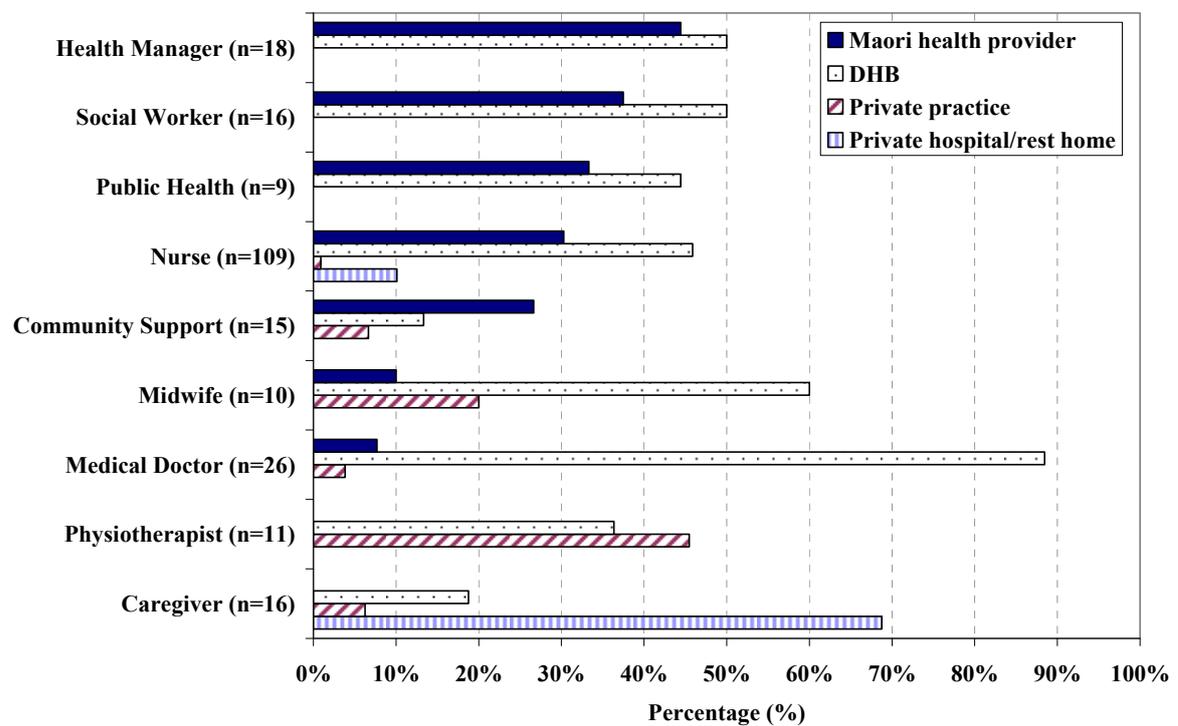
Figure 3 shows the main occupation groups and employment settings of scholarship recipients who have completed their study and gone on to work in the health and disability sector. Respondents are employed in a variety of settings including; DHBs (43%), Māori health providers (22%), private practice (8%), or private hospitals/rest homes (8%). The largest number of respondents employed in the health and disability sector are working as; nurses (37%), doctors (9%), and health managers (6%). There are also six respondents practicing as dentists, one pharmacist, two occupational therapists, and five naturopaths.

Of particular interest is respondent participation in Māori health provider settings. The respondents who are currently practicing as nurses are the largest numbers of scholarship recipients to have moved into Māori health provider settings (n=33),

equating to 30% of practicing nurse respondents. The greatest percentage of scholarship recipients by occupation now working in a Māori health provider setting are in the areas of health management (44%), social work (38%), public health (33%) and nursing (30%).

The DHB are one of the major employers of the health and disability workforce, as demonstrated in Figure 3 below. Scholarship recipient occupational groups more likely to work in private practice include physiotherapists, dentists and midwives. Note, these results relate to the number of respondents who reported as practicing in a health and disability occupational group and may not correspond to those that hold practicing certificates.

Figure 3. Scholarship recipients’ occupational groups and employment settings



MHDW capability

The capability of the MHDW is being strengthened through the assistance the HMSP provides, as the majority of people supported by the scholarship are studying at undergraduate degree or postgraduate level. Two hundred and fourteen (36%) respondents completed their course of study. Of these; seven percent completed an undergraduate certificate, seven percent completed an undergraduate diploma, most (88%) completed an undergraduate degree, and 15% completed a postgraduate level qualification. Overall the scholarship has provided assistance to the extent that 189 (33%) respondents have increased their capability through upskilling, and increased capacity by a further 135 (22%) respondents that have gained skills to allow them to move into employment in the health workforce.

Programme improvements

A range of suggestions were made when recipients were asked what improvements should be made to the Programme, with the majority of recipients indicating that changes could be made to improve the Programme. There was a strong feeling from respondents that continuation of the Programme is essential, one respondent commented that “It’s essential that these scholarships continue and if possible increase if we are to change the Māori health workforce, statistics and ultimately Māori health” (ID 071).

Just over a quarter (26%) of respondents indicated that the MoH should be doing more to promote the Programme. Some possible suggestions were; that representatives from the MoH visit secondary schools and tertiary institutions to promote the Programme, that information should be available at university orientations, and that all Māori students who enrol in health-related courses should automatically be sent application forms by their tertiary provider. Some considered the application form needed reviewing (17%), while others felt communication between the MoH and scholarship recipients could be improved by setting up an ‘0800’ phone number for those wanting to contact the MoH with enquiries. It was suggested that the Programme could keep recipients informed of developments in the Māori health field, for example; upcoming conferences, job opportunities, and profiles of previous recipients, through an electronic newsletter. One respondent, who had received a scholarship in 2001 and again in 2005, remarked that there had been significant positive changes which had improved the application process (ID 393).

Summary

The analysis presented in this section of the report indicates that, from the perspective of recipients, the HMSF is well administered. The data also demonstrates that the Programme has had a substantial impact on respondents’ recruitment, retention, and qualification completion in tertiary health-related study. The majority of surveyed scholarship recipients indicated that the scholarship influenced their decision to enrol in a health-related course, to continue their studies, and to successfully complete their qualification. It appears that there is a low attrition rate, with almost all respondents either completing or having completed their course of study at the time of the survey. In addition, the data shows that the positive impacts of the Programme have extended to the MHDW. Survey results demonstrate that the capability and capacity of the MHDW has been increased. The majority of respondents supported by a scholarship were studying at undergraduate degree or postgraduate degree level, producing more Māori who are able to move into health professional roles. One hundred and eighty nine (33%) respondents have increased their capability through upskilling and a further 135 (22%) respondents have gained the skills and qualifications to allow them to move into employment in the health and disability sector. Of those recipients that have completed their qualification, 78% are working in the health and disability sector.

MATCHING DATABASES

Professional councils and registration boards were contacted to verify the total number of scholarship recipients that are registered with their regulating body. This data provides an indication of recipients who have completed their qualifications. Only recipients that received scholarships under specific professional categories and whose names were obtained from the MoH scholarship recipient databases from 1997-2005 were searched. These are the results and information gathered from the on-line databases available to the public as of January 2006, and from lists provided by some of the boards.

At least 459 people have been awarded scholarships under the nursing category. Two hundred and twenty seven (49%) scholarship recipients names were found on the Nursing Council of New Zealand's on-line registration check at www.nursingcouncil.org.nz, 232 (51%) were not. Two hundred and two (44%) were on the register with an annual practicing certificate (APC).

The website database for the Medical Council of New Zealand is a list of medical practitioners, including interns. However, it does not include those who are still training; students and trainees, or those who do not hold current practicing certificates. There have been a total of at least 206 scholarship recipients in the medicine category. Eighty five (41%) of this group were found through the on-line registration check at www.mcnz.org.nz and therefore hold an APC, 121 (59%) were not found.

There is no on-line registration check for physiotherapy so a list of 76 names was provided to the Physiotherapy Board of New Zealand to check registration status. The results detailed that 38 scholarship recipients (49%) were registered (current APC (n=29, 37%), no APC (n=10, 13%), and 38 scholarship recipients (49%) were not registered.

The Dental Council of New Zealand's website is reported to be a full and comprehensive list of all registered dental practitioners, including those who hold non-practicing certificates. The register does not include trainees. There have been at least 36 scholarship recipients in the dental category; 20 scholarship recipients (56%) were found on the on-line registration check at www.dentalcouncil.org.nz, 16 scholarship recipients (44%) were not. Of the group registered (n=20), 11 (55%) general dental practitioners held an APC, four (20%) dental therapists held an APC, and five (25%) of those registered did not hold an APC.

The on-line registration check for the Pharmacy Council of New Zealand is updated regularly, but does not cover the full legal register. It does not include pharmacy interns and students. There have been 25 scholarship recipients in the pharmacy category, nine people (36%) were found on the on-line registration check at www.pharmacycouncil.org.nz, 16 (64%) were not. A total of six (25%) recipients currently hold APCs.

The Midwifery Council of New Zealand has an on-line registration database which includes all midwives that are legally registered, and is updated weekly. There have been at least 106 scholarship recipients in the midwifery category. A search of the Midwifery Council Register (www.midwiferycouncil.org.nz) identified 46 midwives (43%) that were registered, 60 (57%) were not. Twenty three (22%) midwives supported by the Programme hold a current APC.

The total percentage of scholarship recipients (for the period 1997-2005) identified as registered in each of the professional categories searched was; 56% dental category, 52% physiotherapy category, 49% nursing category, 43% midwifery category, 41% medicine category, and 36% pharmacy category. The following percentages of scholarship recipients in each professional group were identified as holding a current APC; 44% of nurses, 41% of doctors, 37% of physiotherapists, 41% of the dental category, 25% of pharmacists, and 22% of midwives.

The registration and APC figures provide an indication that scholarship recipients are completing health qualifications and are actively part of the MHDW. However, it should be borne in mind that substantial numbers of scholarship recipients are still completing their qualifications (e.g. 284 [48%] of participants in the Scholarship Recipients Survey are still completing qualifications). Further, councils and registration boards offered a number of reasons why some scholarship recipients' names were not found on the register including that they may; be trainees, have changed their name, not have registered following graduation (but still participating in the health workforce in non-clinical roles), or have moved country of residence.

MĀORI HEALTH AND DISABILITY WORKFORCE

PROJECT SURVEYS

Tertiary health field student survey findings

Māori tertiary students enrolled in a wide range of health fields were recruited to take part in a national survey in early in 2006. Criteria for inclusion were that respondents were Māori and currently enrolled in health field courses at Level 5 and above. A total of 1100 survey packs were sent out nationwide. Of the 1100 total survey packs sent out, 326 survey questionnaires were completed. One hundred and forty six (45%) survey questionnaires were received by post, and 180 (55%) were completed on-line (<http://www.surveymonkey.com>). This equates to a response rate likely to be greater than 30%, allowing for survey packs not reaching potential respondents. Of the total 326 returned or entered on-line, 41 were eliminated due to the following reasons; respondents did not identify as New Zealand Māori, the survey questionnaire was incomplete, or, duplicate surveys were completed. A total of 285 (87%) survey questionnaires were eligible and analysed in this report.

The most significant barrier by far for Māori taking up tertiary study within health-related programmes was 'Financial cost', identified by 66% of respondents, followed by other factors including inadequate 'Career guidance' (36%), 'Lack of Māori role models' (31%), and 'Distant location of institution' (25%). The most important support mechanism identified by the respondents as either giving 'a lot' or 'quite a lot' of encouragement for Māori to enrol, be successful in, and complete tertiary study within the health sciences was the availability of 'Māori scholarships and grants' (60%).

Sixty one percent of respondents identified that they were aware of the HMSP, of which (55%) of these had applied. The reasons stated for not applying were variable including; unnecessary as courses were free or fees were paid from other sources including employers (36%), information/administration and application process (20%), and criteria/ineligibility (16%).

Survey findings indicate that affordability is a major barrier to Māori participation in tertiary study within health-related programmes, and that scholarships are considered an important mechanism through which that barrier may be addressed. Findings also indicate a need for increased Programme marketing to raise awareness of the HMSP among potential and current Māori health field tertiary students and to ensure student access to accurate information regarding eligibility criteria, the application process and Programme administration.

MHDW survey findings

Māori health and disability workers from a range of health professions were recruited to participate in a national survey in early 2006. Criteria for inclusion were that participants were members of the MHDW at the time of the survey. One thousand five hundred (n=1500) survey packs were sent out nationwide. A total of 551 survey questionnaires were completed, 114 (21%) were received by post, and 437 (79%) were completed on-line. Of the total 551 questionnaires returned or entered on-line, 102 were eliminated due to the following reasons; 55 participants did not identify as NZ Māori, 22 submitted incomplete survey questionnaires, 20 were received by mail after the closing date, three were duplicate surveys and two participants did not complete consents. For duplicate surveys, the second entry was eliminated. Therefore, a total of 449 survey questionnaires were eligible and analysed in the report. While the overall response rate is calculated at 64%, this is likely to be an overestimate as eligible potential participants who did not receive a survey pack were able to complete the survey on-line.

Almost half the respondents said 'financial cost of tertiary study in health' was at least a moderate barrier (44%) to initially choosing a career in health. The majority of all respondents reported four main factors that encouraged them to remain working in the health sector. All four factors relate to contributing to the wider Māori community. They include; 'Making a difference for Māori health' (77%), 'Strengthening the Māori presence in health' (70%), 'Being able to work with Māori' (69%), and 'Making a difference for my hapū/iwi' (67%). Nearly two thirds (66%) of respondents indicated that the availability of scholarships and grants had at least some influence on their decision to remain working in the health and disability sector. Additional support factors that would encourage respondents to further up-skill through tertiary study or other mechanisms rated most highly by more than three quarters of all respondents were 'Māori scholarships/grants' (78%).

While just over half (57%) the respondents were aware of the HMSPP, a substantial 43% were not. Of those who knew about the Programme, 29% had applied for scholarships. The main reasons stated for not applying were that: they were not studying (24%); their course fees were covered from other sources such as employers (32%); criteria/ineligibility (16%), and inadequacies in Programme administration or poor availability of Programme information (9%).

MHDW survey findings indicate that affordability of tertiary study in health-related fields is a barrier to recruitment of Māori into the health and disability workforce. The results also indicate that scholarships influence Māori to remain in the MHDW, and therefore contribute to MHDW retention. Findings also suggest a need for increased Programme marketing to raise awareness of the HMSPP among the MHDW and to improve access to accurate information regarding eligibility criteria, the application process and Programme administration.

DISCUSSION

Intervention logic

There are clear rationale for initiatives to strengthen the participation of Māori at all levels and in a range of roles within the health and disability workforce. Those rationale relate to: the Treaty of Waitangi; projected excess health and disability workforce demand overall; New Zealand's changing demographic profile and increasing demand for Māori health professionals; wide and enduring inequalities between the health status of Māori and non-Māori; the longstanding under-representation of Māori within the health and disability sector workforce; evidence of differential treatment pathways; the positive health impact of ethnic concordance between practitioners and patients; and, the likely wider intergenerational and socio-economic benefits. Further, those rationale are consistent with the Government's vision and direction for the coming decade of economic transformation; making life better for families, young and old; and building our national identity.

A representative and culturally competent national health and disability workforce is best placed to enable optimal health outcomes for all New Zealanders, as the basis for a healthy workforce overall to drive the transformation of our economy. Reducing inequalities in health between Māori and non-Māori will be critical to the achievement of a better life for whānau, and this will rely in part on the development of MHDW capacity and capability in order that the health sector is best equipped to facilitate health gain for Māori. The Māori identity is fundamental to New Zealand's national identity and, like other elements of our national identity, should be nurtured and reflected in all domains including health settings. A strengthened MHDW, will facilitate the provision of culturally sound health services that support Māori to be healthy as Māori and contribute fully to the New Zealand national identity.

The core intervention logic for the HMSP is to contribute to ensuring equitable Māori participation within the health and disability workforce through strengthening the capacity and capability of the MHDW, and thereby facilitating improved health outcomes for Māori. The provision of financial assistance through scholarships to eligible Māori secondary school students with an interest in pursuing a career in health and Māori health field tertiary students is intended to address affordability as a major barrier to Māori access to tertiary health-related education. The concept of access encompasses entry into, success in, and completion of programmes of study. In the context of evidence of affordability as a major barrier to Māori participation in tertiary health field education, ongoing marked under-representation of Māori within the health and disability workforce, increased demand for Māori health professionals, and the Government's direction for the coming decade, that logic remains sound.

Programme complementarity

Current health and disability workforce shortages and projections of substantial excess future demand have led to a proliferation of workforce development planning and interventions. Activities in the area of MHDW development have increased in recent years, however, like health and disability workforce development generally, these activities are not yet co-ordinated, comprehensive or driven by a clear vision of what the optimum future MHDW should look like. A comprehensive MHDW development framework, Raranga Tupuake the Māori Health Workforce Development Plan 2006, was released in April 2006 to support a more co-ordinated and consistent national approach.

Initiatives currently in place to support MHDW development can be grouped into the following categories: workforce development infrastructure; organisational development; recruitment and retention; training and development; and, information, research and evaluation. The HMSP fits within the recruitment and retention category.

MHDW recruitment and retention initiatives to support capacity and capability building are varied and include health field specific interventions (e.g. Te Rau Puawai), multidisciplinary approaches (e.g. Hauora.com), pre-entry support (e.g. Whakapiki Ake Project), and post-entry clinical training (e.g. CTA funded initiatives). The HMSP is the only national scholarship initiative to specifically target the critical need for MHDW development across professions and at a range of levels. While just over half of the recipient survey respondents stated that they had received other scholarships or grants in the same year they were awarded a Hauora Māori Scholarship, generally the other award was a Manaaki Tauira or hapū/iwi grant. While respondent comments indicate that those grants would have been an important source of financial support, they are generally not substantial in terms of the level of funding provided.

The HMSP has much potential to support MHDW participation in emerging areas, for example in relation to new health technologies, and will be important in fostering the growth of Māori health role models across professions. Key informant and recipient survey results indicated that the Programme was of value and useful to stakeholders including students, whānau/hapū/iwi, DHBs and Māori and mainstream health service providers. This was reflected both explicitly in comments, and in the numbers of recipients who had successfully completed their studies and were employed in DHB, and Māori and mainstream provider settings.

Generally, the HMSP is unique in its focus as the only national multidisciplinary Māori health scholarship programme and as such complements other MHDW development initiatives. However, there are two potential areas of overlap. The mental health field is an area where relatively high and consistent levels of funding are being invested with good workforce outcomes through Te Rau Matatini and Te Rau Puawai. Te Rau Puawai offers comprehensive support, including scholarships, to Māori students seeking university qualifications in mental health-related fields, though the focus is on one university. The second area is with regard to post-entry training. Approximately one third of surveyed recipients were already working in the

sector at the time they were awarded the scholarship. The CTA administers substantial post entry clinical training funding. Though the potential contribution of CTA to MHDW development has yet to be fully achieved, work has been done previously to recommend areas for improvement. Other options for funding post-entry health field study include employer support, MPDS funding, tertiary education provider support, and HRC Māori career development awards.

Success factors in other sectors

A range of assistance is offered in other sectors to develop the Māori workforce, however, generally there is a lack of publicly available evaluation reports that enable a thorough identification of the key success factors of these programmes which may be transported to the health sector. This reinforces the importance of making HMSP evaluation reports readily available to other Māori workforce development stakeholders to support cross-sectoral efforts to strengthen the Māori professional workforce. However, from what information is available it is possible to identify features of interventions that are likely to underpin intervention success and which may be transportable to the health sector.

Despite a current political environment which favours the removal of ethnic targeting to reduce longstanding disparities, the specific targeting of Māori remains the logical mechanism for addressing the enduring under-representation of Māori in the workforce and is an approach taken in a range of interventions across sectors. It appears that multifaceted approaches are important that support: the recruitment of Māori secondary school students, second-chance learners (including a large pool of Māori youth) and from the unqualified workforce; the retention and development of current workers; and, the attraction of ex-workers back into the sector. Therefore, participation in courses at a variety of levels and in a range of geographical and institutional locations was supported. In addition, in all interventions reviewed there was a strong link between courses supported and workforce supply and demand. Further, for some interventions, formalised relationships between the intervention and the tertiary education provider were in place which included requirements on the provider such as the integration of Māori-specific material within the course curriculum and the availability of on-site mentors or champions specific to the intervention. Programme links were also developed with Māori stakeholders.

For some interventions a strong emphasis has been placed on well resourced marketing to raise the profile of schemes, leading to high uptake rates. Another strategy used included addressing the barrier of affordability of study through interventions that meet most or all learner costs. Further, one intervention used phased payment to incentivise movement through courses of study and into the relevant workforce.

All of the interventions reviewed moved beyond the sole provision of financial assistance, to providing more comprehensive support. That support included, for example, pastoral care, maintaining contact with students and keeping students informed of developments in the sector as a means to strengthen their connection with the sector and thereby likelihood of moving into the workforce on qualification

completion, as well as more general support in the transition from study into the workforce.

Nine best practice characteristics of interventions in other sectors that may be transported to the health sector are:

1. specific targeting of Māori;
2. well resourced marketing strategies that raise the profile of initiatives;
3. levels of scholarship funding that minimise costs to learners and therefore cover, for example, full tuition fees, other course costs and living expenses;
4. strong links between courses offered and workforce supply and demand;
5. opportunities to study in a variety of geographical and institutional locations;
6. courses at varied skill levels are supported;
7. programme links to Māori stakeholders developed;
8. assistance to transition from study to work; and,
9. the provision of broad based support including pastoral care.

Student outcomes

Findings from the research indicate that the Programme has been successful in terms of supporting student outcomes. Positive recipient outcomes are reported with regard to entry into and retention in tertiary health-related programmes of study, and qualification completion rates.

Surveyed recipients were carrying out study across a wide range of health-related disciplines in areas in which Māori are under-represented in the workforce. Recipients included a mix of full-time (81%) and part-time students (14%) studying at the undergraduate (84% - mainly enrolled in undergraduate degrees) and postgraduate (16%) levels.

The majority of surveyed recipients indicated that the scholarship influenced their decision to enrol in a health-related course. One in four survey respondents stated that receiving a scholarship had played a significant role in their decision to reconsider pulling out of their course and continuing their studies. A large proportion of respondents indicated that the scholarship provided significant support to enable them to commit to completing their qualification (69%) and to go on to graduate (65%). While just over half of respondents were still completing the course of study for which they were awarded a scholarship, almost all of the remaining recipients had successfully completed their course, and 8% had also gone on to do further study. This demonstrates a very high completion rate among surveyed recipients. Most of the recipients surveyed had completed an undergraduate degree (73%) or a postgraduate qualification (12%). According to respondents, receiving a scholarship had been very or extremely significant in supporting them to pass their course work each year (63%), to achieve higher grades (57%), and to complete their course of study within the minimum timeframe (52%).

Impact on the MHDW

The data presented in this report clearly indicates that the Programme has made a substantial contribution to the MHDW in terms of both capacity and capability. Reported outcomes are consistent with the HMSP intervention logic.

Survey respondents indicated that receiving a scholarship impacted significantly in encouraging them to work in the health field (60%), and more specifically in the Māori health and disability sector (64%). Of the 390 survey respondents that were not employed in the health sector at the time of receiving the scholarship, 135 (33%) are now employed in health. The percentage of respondents now working in the health and disability sector has increased from one third to just over half. Of those respondents who had completed their qualification, more than three quarters are now working in the health sector. Data on recipient registration and annual practicing certificate status from professional council and registration boards supports findings that there are substantial numbers of scholarship recipients who are active within the MHDW. Further, at the time of the survey there were an additional 284 (48%) respondents still completing qualifications, which within a relatively short timeframe will strengthen the MHDW.

Approximately one third of surveyed recipients were already working in the sector in a range of professions and employment settings at the time they were awarded a scholarship. The majority of these respondents were enrolled at the undergraduate degree or postgraduate level. The Programme has provided assistance to the existing MHDW to the extent that 189 (33%) respondents have increased their capability through upskilling as just over half of this group (n=96, 51%) had completed the qualification that they were enrolled in at the time of completing the survey questionnaire.

Of those who were already in the MHDW at the time they received the scholarship, the majority have remained in the health sector (87%). A high proportion of respondents (85%) indicated that receiving a scholarship had at least some significance in their decision to continue to work in the health and disability sector, and for almost one third (32%) of surveyed recipients it was 'extremely' significant. More than half (55%) of all respondents anticipate that they will work in the health sector for more than 10 years. The implication is that the Programme positively influences MHDW retention.

There is evidence that the Programme has been successful in contributing to strengthening the Māori health provider workforce. Thirty percent of the practicing nurse respondents who received a scholarship are working in a Māori health provider setting, and this equates to the largest number (n=33) from any of the professional categories to work in this setting. The greatest percentage of scholarship recipients by occupation now working in a Māori health provider setting include health managers (44%), social workers (38%), public health workers (33%) and nurses (30%).

Findings from this research indicate that increases in both the capacity and capability of the MHDW can in part be attributed to the HMSP.

Strengths of the Programme

Eight best practice characteristics of the Programme in achieving the outcome of greater participation of Māori in the health and disability workforce were identified in this research as:

1. a history of governance-level champions;
2. a clear Programme intervention logic;
3. targeting of Māori and an evidence-based Programme rationale;
4. consistency with Government policy;
5. an interdisciplinary and multi-level focus;
6. the complementary nature of the Programme;
7. provision of financial support to address the barrier of affordability of tertiary education; and,
8. the way in which the Programme has been administered.

The origins of the HMSP can be traced back to the early 1990s. The early evolution of the Programme relied on strong Māori and non-Māori governance level support from RHA and university board members. Champions of the Programme included Sir Ross Jansen, Dr Pat Ngata, Georgina Te Heuheu, Harold Titter and Denise Henare. The support provided by these leaders imbued the Programme with a level of mana that has somewhat dissipated as Programme administration has become more routine and mechanistic and with the absence of formal patrons or political sponsors. It would be timely to identify Programme patrons who could provide leadership for ongoing Programme development and through their involvement continue to enhance the mana and status of the Programme and support its political durability.

The clear Programme intervention logic, that emphasises equitable Māori participation in the health and disability workforce and improved Māori health outcomes, is important in driving Programme development. A strong theme to emerge from this research, is the value of the Programme overall and the importance of targeting Māori. There are evidence-based rationale that support MHDW development specifically, and targeting of Māori is a logical mechanism to address Māori under-representation within the health and disability workforce. This approach is consistent with Government policy frameworks which give priority to the urgent need to address disparities between Māori and non-Māori in health and disability workforce participation. Overall, the Programme is a logical intervention that contributes to addressing an area of high need and wide disparity.

Given the under-representation of Māori in almost all health and disability sector professions, a strength of the Programme is that it works across professions and at multiple levels. The Programme supports pre and post-entry education, and therefore targets school leavers, second chance learners, and those already in the workforce. In addition, the broad focus enables the Programme to support MHDW development in emerging areas, such as health information technology. Data from this research demonstrates the contribution of the Programme to increasing both the capacity and capability of the MHDW across professions and at a variety of educational levels.

The HMSP does not attempt to address the range of MHDW development needs, and nor should it. In order to fully address Māori under-representation within the workforce, a broad range of interventions and comprehensive support will be required. The Programme should be considered as one element of a comprehensive strategy to support MHDW development. Within its scope, it is a useful and effective strategy largely complementing other initiatives in the sector. Given evidence that affordability is the major barrier to Māori participation in tertiary education in health-related fields, the Programme's strategy of providing financial assistance is appropriate. In the context of limited resources, some further consideration may be given to prioritisation in order to ensure best return on investment and avoid duplication or provision of funds where other options are available such as in mental health and post-entry training.

Overall, within the scope of this research (this project did not include a financial audit of the Programme), data indicated that the Programme is well administered. That is, there is a clear structure and assessment process well aligned with the academic year, applications are processed and payments made in a timely manner, there is a process in place for ongoing Programme improvement, and recipients expressed high levels of satisfaction.

The administration process is reasonably robust, with an inbuilt system for continuous quality improvement. The majority of surveyed recipients responded favourably in terms of how the Programme was administered with very few rating the administration as 'worse than average'. Over half of the respondents rated the availability of information, the ease of completing applications, and access to assistance to complete forms as 'better than average'. There were, however, differences between groups, with those already in the workforce indicating significantly more limited availability of information in the workplace compared to tertiary institutions. Communication with Ministry staff for assistance was generally rated favourable, and staff were found to be willing to help by most respondents. Respondents were generally pleased with the speed with which applications were processed and the funds became available. Some areas for improvements were suggested, and related mostly to access to information and marketing.

Programme improvements

Some areas for Programme improvement were identified that may further strengthen the Programme. These areas relate to eligibility criteria, resource levels, marketing, the application process, information issues, and the John McLeod Scholarships.

There are strong evidence-based rationale for targeting the Programme to Māori. Findings of this research reinforce those rationale, and highlight the major contribution of the Programme to MHDW capacity and capability building. There are indications in this research that the Programme could also be further improved through increasing the level of scholarship funding available to individual recipients to better reflect growing costs of tuition fees and other study-related expenses. Interventions reviewed in other sectors tended to fund a higher proportion of student costs than the HMSP. However, specific recommendations with regard to changes to

the level of funding will require a cost analysis that takes into account the variable costs of study programmes and differences in the extent of increases over time across programmes.

Marketing of the Programme has been minimal, and has tended to focus on directly targeting students with information and application forms through their institutions. Surveys of Māori health field tertiary students and the MHDW indicate that there are substantial numbers of eligible individuals who are either not aware of or have inadequate knowledge of the Programme. Both key informants and scholarship recipient survey respondents recommended greater attention to promotion of the Programme at secondary schools, tertiary institutions, and workplaces. It was suggested that information should be made available at university orientations, and that all Māori students who enrol in health-related courses should automatically be sent application forms by their tertiary provider.

There were limited suggestions as to how the Programme's application process could be improved, and generally comments related to increased assistance in completing application forms. Practical suggestions were that there is an opportunity to complete applications online, that an 0800 telephone number is set up to facilitate student enquiries, and that there is a named individual as the contact point for enquiries. With regard to information issues, to facilitate future Programme reviews, greater attention is required to Programme record keeping. This includes electronic databases of recipient details, and details of those whose applications were declined.

Since the Programme's establishment, the most important piece of work to inform Programme improvement was the Needs Analysis completed in 2001. The analysis identified what types of health related courses were offered by each tertiary institution, the cost of courses, and the number and institutional spread of Māori enrolments. The Needs Analysis was important in informing the forecasting of scholarship demand, management of uptake rates, changes to eligibility and assessment criteria, and improving Programme administration and management generally. However, within the health sector generally, insufficient work has been carried out to profile the health and disability workforce and clarify future supply and demand issues in order to facilitate fully informed planning. This information should inform all health and disability workforce development initiatives, including the HMSP and will strengthen the link between Programme planning and MHDW supply and demand, particularly in relation to scholarship categories and the numbers of scholarships provided in various categories. Also, in considering allocation issues, the different health professional roles are likely to vary in the extent of their impact on Māori health and this should be considered. For example, general practitioners are in front line clinical roles with both high exposure to Māori people and a gatekeeping function. Increasing the recruitment of Māori into medicine (and subsequently general practice) may have a greater impact on Māori health relative to some other health sector roles. These comments should, however, be balanced against the fact that Māori are under-represented in almost every health professional group and therefore the need for MHDW development is so widespread among professions that support within any professional group will have benefits.

A further area for improvement relates to the John McLeod Scholarships. The original intent behind the establishment of the John McLeod Scholarships had been to

provide an excellence award for the highest achieving Māori scholars in medicine and nursing as recognition of academic excellence, to encourage postgraduate research, and as an incentive for Māori academic success. While the broadened scope, to include the range of health disciplines, is sensible in terms of seeking to recognise the highest performing scholars it appears that the prestige of the John McLeod scholarships has become somewhat diluted. It would be timely to reassess the criteria for the John McLeod awards in consultation with the McLeod whānau in order to better meet the original intent of the award in terms of recognising Māori academic excellence. The awarding of a coveted scholarship that is held in the highest regard has the potential to support Māori health leadership development, promote the value placed on Māori academic excellence in health, and provide an incentive for the highest Māori health academic achievers.

RECOMMENDATIONS

Overall, within the scope of this project the data indicates that the HMSP is well administered by Te Kete Hauora and has been effective in contributing to improved outcomes for Māori health field tertiary students, and increasing the capacity and capability of the MHDW. The following recommendations are intended to strengthen what is already a successful MHDW development initiative.

The recommendations are based on literature review, a review of Programme documentation and discussions with current and former Regional Health Authority and Ministry of Health personnel, key informant interviews with Programme stakeholders, a survey of scholarship recipients, review of recipients registration and practicing status, a survey of Māori tertiary health field students, and a survey of the Māori health and disability workforce.

Programme patrons

Much of the momentum and status of the Programme was originally derived from Māori and non-Māori leaders driving its development. This has to some extent been eroded, possibly as a result of the transfer of the Programme between health funders and the implementation of an effective, but largely mechanical, administration process. Continued evolution of the Programme and its political durability, would be enhanced by the involvement of eminent leaders as Programme patrons.

It is recommended that:

Programme patrons be appointed to enhance the mana and status of the Programme, and support its ongoing development and positive contribution to MHDW development. The role of Programme patrons would include the provision of input into high level decision-making, support in raising the profile of the Programme, and endorsement and representation of the Programme at public events.

Eligibility criteria

There are evidence-based rationale for targeting the Programme to Māori through whakapapa-based eligibility criteria, as a mechanism to enhance equitable representation of Māori within the workforce. Findings of this research reinforce those rationale, and highlight the major contribution of the Programme to MHDW capacity and capability building.

It is recommended that:

The Programme continue to build on its strengths, and reinstate whakapapa-based eligibility criteria for all recipients alongside a demonstrated commitment to Māori health.

Resource issues

There are indications that the Programme could be further improved through increasing the level of scholarship funding available to individual recipients to better reflect growing costs of tuition fees and other study-related expenses. Interventions reviewed in other sectors tended to fund a higher proportion of student costs than the HMSP. However, specific recommendations with regard to changes to the level of funding will require a cost analysis that takes into account the variable costs of study programmes and differences in the extent of increases over time and across programmes.

Although largely outside the scope of this study, there is also a need to consider prioritisation of scholarship funding in order to ensure the best return on investment and to manage expectations if available funding does not meet demand for scholarships or adequately cover increasing costs of health field tertiary study. Identified possible areas of funding overlap may be further explored (such as the mental health field and post-entry training), alongside consideration of whether a stronger emphasis on undergraduate level study may result in greater returns in terms of supporting increased Māori entry into the workforce. Further consideration of the health professional roles that are most likely to impact directly on Māori health outcomes should also inform prioritisation.

It is recommended that:

Cost analysis be undertaken to determine the extent to which increases in the level of scholarship funding to individual recipients is justified due to increasing tuition fees and other study-related costs, and the formula by which funding levels may be increased if advisable.

Additional analysis be undertaken in order to ensure prioritisation of scholarship funding that facilitates the best return on investment and greatest impacts on Māori health outcomes.

Marketing

Marketing of the Programme has been minimal, and has tended to focus on directly targeting students with information and application forms through their institutions.

Data indicates that there are substantial numbers of eligible individuals who are either not aware of or have inadequate knowledge of the Programme.

It is recommended that:

A more comprehensive HMSP marketing strategy be developed that utilises both mainstream and Māori media. Additional resources should be provided to meet the costs of marketing the Programme. The level of resources should be benchmarked against successful education-related marketing campaigns such as those for TeachNZ Scholarships and Te Mana.

As part of the marketing strategy, Te Kete Hauora facilitates increased communication between the health, education, and employment sectors with regards to the Programme in order to raise Programme awareness among stakeholders across sectors.

All eligible applicants in a given year are automatically sent application forms in the following year (both successful recipients and those who were declined), and the Programme work with tertiary providers to encourage a process by which all new Māori students who enrol in health-related courses are sent Programme application forms.

That particular attention is paid to increasing Programme awareness among Māori Year 12 and 13 secondary school students and second chance learners considering entry into foundation courses and programmes for health field auxiliary staff.

Application process

There were limited suggestions as to how the Programme's application process could be improved, and generally comments related to increased support for completing application forms.

It is recommended that:

An on-line application process be developed.

Consideration be given to additional measures to facilitate applicants access to information to assist in completing application forms, including for example the establishment of an 0800 telephone number for enquiries, and that there is a named individual as the contact point for enquiries.

Information issues

Within the sector generally, insufficient work has been carried out to profile the health and disability workforce and clarify future supply and demand issues in order to facilitate fully informed planning. This information should be available to inform all health and disability workforce development initiatives, including the HMSP to strengthen the link between Programme planning and MHDW supply and demand, particularly in relation to scholarship categories and the numbers of scholarships provided in various categories. There are also opportunities for the Programme to enhance its contribution to MHDW development through increased sharing of information and data gathered for HMSP internal planning and accountability purposes. This may include Programme specific data as well as wider analysis.

Since the Programme's establishment, the most important piece of work to inform Programme planning was the needs analysis completed in 2001. While regular needs analysis would be useful, this should be balanced against the fact that Māori are under-represented in almost every health professional group and therefore the need for MHDW development is so widespread across professions that support within any professional group will be beneficial. Also with regard to information issues, to facilitate future Programme planning, greater attention is required to maintaining Programme databases. This includes electronic databases of scholarship recipients and unsuccessful candidates.

It is recommended that:

Information collected that relates to MHDW supply including programme needs analysis and evaluation reports, be made available to Māori workforce development stakeholders to support Māori workforce development in the health and other sectors and to improve accountability and transparency.

Greater attention be paid to ensuring the accuracy and completeness of Programme databases, including electronic databases of scholarship recipients and unsuccessful candidates to facilitate Programme planning.

That Programme development be further informed by data on MHDW supply and demand which draws on, for example, secondary school NCEA data, Ministry of Education undergraduate and postgraduate uptake trend information, and NZHIS workforce data.

John McLeod Scholarships

A further area for improvement relates to the John McLeod Scholarships. The original intent behind the establishment of the John McLeod Scholarships had been to provide an excellence award for the highest achieving Māori scholars in medicine and nursing as recognition of academic excellence, to encourage postgraduate research,

and as an incentive for Māori academic success. While the broadened scope, to include the range of health disciplines, is sensible in terms of seeking to recognise the highest performing scholars it appears that the prestige of the John McLeod scholarships has become somewhat diluted. It would be timely to reassess the criteria for the John McLeod Scholarships in consultation with the McLeod whānau in order to better meet the original intent of the award in terms of recognising Māori academic excellence. The awarding of a coveted scholarship that is held in the highest regard has the potential to support Māori health leadership development, promote the value placed on Māori academic excellence in health, and provide an incentive for the highest Māori health academic achievers.

It is recommended that:

The criteria for the John McLeod Scholarships is reviewed in consultation with the McLeod whānau in order to better meet the original intent of the award in terms of recognising Māori academic excellence.

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Appendix 1

Key informant interview schedule

**Ministry of Health Māori Health Scholarship Programme
Evaluation
Key informant interview schedule**

HMSP/participant code

1. What, if anything, is your experience or involvement with Māori health and disability workforce development?
2. Are you aware of the Ministry of Health's Māori Health Scholarship Programme?
If NO, go to question 5.
If YES, go to question 3
3. Have you been involved in the Programme's inception or administration?
If NO, go to question 4.
If YES: a) What is your understanding of the intervention logic or rationale for the Programme?
4. Are there any issues with the administration or Programme processes that you are aware of?
5. What are the strengths of the Programme / a scholarship programme (that provides financial assistance only) in terms of contributing to Māori health and disability workforce development?
6. What are the weaknesses of the Programme / scholarship programmes?
7. What impact has the Programme / have scholarship programmes had on Māori health science student recruitment, retention and achievement?
8. What impact has the Programme / have scholarship programmes had on the Māori health and disability workforce?
Prompts: recruitment, retention, skill level
9. How useful has the Programme / have scholarship programmes been to key stakeholders, including Māori students, whānau, hapū, iwi, DHBs and providers?
10. How does the Programme / do scholarship programmes complement other Māori health workforce development initiatives?
11. Are you aware of initiatives in other sectors to develop the Māori workforce?
If NO: go to question 12.
If YES: a) Are there key elements of those initiatives that could be usefully applied to Māori health and disability workforce development?
12. How could the Programme be improved to make a stronger contribution to Māori health and disability workforce development?
13. If you were to devise a scholarship programme designed to contribute to expanding the capacity and skill level of the Māori health and disability workforce, what would the programme look like?
14. Are there any other issues you would like to raise, or comments you would like to add?

Appendix 2

Key informant participant information sheet

Participant Information Sheet

Exploring the Māori Health and Disability Workforce Māori Health Scholarship Programme evaluation

Date Information Sheet Produced: 21 April 2005

Invitation

You are invited to contribute to the evaluation of the Ministry of Health's Māori Health Scholarship Programme (MHSP). We would like your thoughts and ideas about the Programme to assist us in carrying out the evaluation.

What is the purpose of the study?

The purpose of this research project is to evaluate the MHSP, including an assessment of the strengths and weaknesses of the Programme and its overall impact on the Māori health and disability workforce (MHDW). We will also explore the extent to which the Programme complements other Māori health workforce development initiatives.

Who are the researchers?

The Māori Health Research Centre, Auckland University of Technology.

Researcher Contact Details:

Cathrine Waetford
Research Officer
Māori Health Research Centre, AUT
Tel (09) 917 9999 ext 7245
Email: cathrine.waetford@aut.ac.nz

Project Supervisor:

Associate Professor Mihi Ratima
Māori Health Research Centre, AUT
Tel (09) 917 9999 ext 7234
Email: mihi.ratima@aut.ac.nz

What happens in the study?

The project will be carried out by a multidisciplinary research team which has Māori health, public health, research, and policy expertise, as well as current experience in the provider and funder environments. The research will include literature, document and data review, interviews with key informants, a survey of scholarship recipients, and a survey of the Māori health workforce.

How are people chosen to be asked to be part of the study?

You are being asked to participate as we consider you to be an important source of information in regards to the MHSP and/or MHDW development.

What will I be asked to do?

We will be asking you to take part in an interview that will take up to 40 minutes to get your views on issues related to MHSP and its impact on the MHDW.

What are the benefits?

Information gathered in this research will strengthen the evidence base to develop a Māori health and disability workforce of optimum size and configuration, which will in turn contribute to improved Māori health outcomes.

How will my privacy be protected?

Only the researchers will have access to identifying data. Identifying data will not be included in reports and you will not be named.

Participant Concerns

Any concerns regarding the nature of this project should be notified in the first instance to the Lead Investigator, Associate Professor Mihi Ratima.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz , 917 9999 ext 8044.

Approved by the Auckland University of Technology Ethics Committee on 9 May 2005 AUTECH Reference number 05/102

Appendix 3

Key informant participant consent form

Participant consent form

Consent to participate in key informant interviews

Title of Project: Exploring the Māori Health and Disability Workforce.
Māori Health Scholarship Programme Evaluation.

Researchers: Associate Professor Mihi Ratima, Cathrine Waetford

- I have read and understood the information provided about this research project regarding the evaluation of the Māori Health Scholarship Programme (Information Sheet dated 21 April 2005.)
- I have had the opportunity to discuss this research study and I am satisfied with the answers I have been given.
- I understand that taking part in this interview is voluntary (my choice) and that I may withdraw at any time.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to, and up to 2 weeks following the completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant transcripts, or parts thereof, will be destroyed.
- I understand that my participation is confidential and that no material that could identify me will be used in any reports regarding this research.
- I know whom to contact if I have questions about the research.
- I agree to take part in this interview.
- I wish to receive a copy of the report from the research:
tick one: Yes No

Signature:

Name:

Participant Role, Organisation and Contact Details (if appropriate):
.....
.....
.....
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee
on 9 May 2005 AUTEK Reference number 05/102**

Note: The Participant should retain a copy of this form.

Appendix 4

Letter of invitation to scholarship recipient survey participants

Tēnā koe e

Tēnā ra koe me ō karangatanga katoa. Tēnei te mihi ake ki a koe i noho hei puna kōrero mō tēnei kaupapa. Ko te tūmanako ka whai hua tēnei kaupapa hei oranga mō te iwi.

Re: Māori Health Scholarship Programme Evaluation

The AUT Māori Health Research Centre is carrying out an evaluation of the Ministry of Health's Māori Health Scholarship Programme on behalf of the Ministry. Your name has been given to us by the Ministry as a past recipient of a scholarship. I am approaching you to invite you to take part in a postal survey of scholarship recipients. You will find enclosed an information sheet explaining the background to the project, a consent form, and a questionnaire that will take no longer than **10 minutes** to complete.

If you agree to take part, **please complete the consent form and questionnaire and return** them to us in the pre-paid reply envelope enclosed by **Friday 25 November**. All those who return questionnaires will go into a draw to win an **Apple iPod** or a **\$50 music gift voucher**.

I hope that the scholarship has supported you in your studies, and that you will see the value of supporting us in completing the evaluation. It is intended that the results of the evaluation will be used to guide improvements in the Ministry's Scholarship Programme, so that it makes the strongest contribution possible to supporting Māori students and strengthening the Māori health workforce for the benefit of te iwi Māori. Your support is critical to the success of this kaupapa and we appreciate your time and effort.

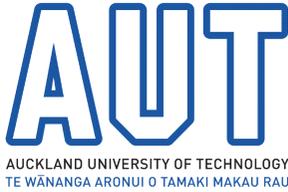
Noho ora mai i roto i ngā mihi

Associate Professor Mihi Ratima
Māori Health Research Centre
Division of Public Health & Psychosocial Studies

Participant Code: «Parcode»

Appendix 5

Participant information sheet – scholarship recipient survey



**Māori Health Research Centre,
Auckland University of Technology**

**POSTAL SURVEY
QUESTIONNAIRE
Participant information sheet**

**Exploring the Māori
Health and Disability
Workforce**

**Māori Health Scholarship
Programme Evaluation**

**WIN AN APPLE
IPOD!!**



Participant concerns

Any concerns regarding the nature this project should be notified in the first instance to the Project Supervisor,
Associate Professor Mihi Ratima
Email: mihi.ratima@aut.ac.nz
PH (09) 921 9999 ext 7234

Concerns regarding the conduct of the research should be notified to the Executive Secretary,
AUTEK, Madeline Banda
Email: madeline.banda@aut.ac.nz
PH (09) 921 9999 ext 8044

Privacy protection

Only the researchers will have access to identifying data. Identifying data will not be included in reports and you will not be named.
All returned survey questionnaires will be coded to ensure anonymity and stored in a locked filing cabinet in the Māori Health Research Centre at AUT.

**Date Information Sheet Produced:
24 August 2005**

Approved by the Auckland University of Technology Ethics Committee on
18 October 2005, AUTEK Reference number 05/102

Researchers

Māori Health Research Centre, AUT

Researcher contact details:

Cathrine Waetford

Research Officer

Māori Health Research Centre, AUT

Ph: (09) 921 9999 ext 7245

Email: cathrine.waetford@aut.ac.nz

Project Supervisor contact details:

Associate Professor Mihi Ratima

Māori Health Research Centre, AUT

Ph: (09) 921 9999 ext 7234

Email: mihi.ratima@aut.ac.nz



As an incentive for your valued contribution, you will also put you into the draw to win an Apple iPod when the completed postal survey is returned. The winning scholarship recipient will be notified by mail.

What is the purpose of this survey?

To evaluate the Ministry of Health Māori Health Scholarship programme (MHSP). As a part of the overall research project, we are seeking your contribution towards this research project by completing this postal survey. We would like your thoughts and ideas about the programme, to assist with evaluating the scholarship programme.

What happens in this study?

This component of the study requires a postal survey questionnaire to be completed by the Ministry of Health (MOH) Māori health scholarship recipients. We will be asking you to complete the survey questionnaire to get your views on a wide range of issues related to scholarship programmes, in particular, the Māori health scholarship programme and its contribution in developing the Māori health and disability workforce.

How are people chosen to be asked to be part of this research?

Your name has been selected from the Ministry of Health's database of scholarship recipients. You are being asked to participate, as we consider you to be an important source of information in regards to this research project.

What are the benefits?

Your feedback from the postal survey will contribute to a thorough appraisal of the scholarship programme and assist in its evaluation for the Ministry of Health. Recommendations can be made to the MOH for planning and action to improve the MHSP's effectiveness to contribute to the Māori health as disability workforce, which will in turn, lead to improved Māori health outcomes.

Appendix 6

Participant consent form - scholarship recipient survey

Participant consent form

Consent to participate in postal survey.

Title of Project: Exploring the Māori Health and Disability Workforce.
Hauora Māori Scholarship Programme Evaluation.

Project Supervisor: Associate Professor Mihi Ratima

Researchers: Cathrine Waetford, Kris MacDonald

-
- I have read and understood the information provided about this research project regarding the evaluation of Hauora Māori Scholarship Programme (Information Sheet dated 24 August 2005).
 - I have had the opportunity to make contact and discuss this research and I am satisfied with the answers I have been given.
 - I understand that my participation is confidential and that no material that could identify me will be used in any reports regarding this research.
 - I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
 - If I withdraw, I understand that all relevant information, or parts thereof, will be destroyed.
 - I know who to contact if I have questions about the research.
 - I agree to take part in this survey.
 - Please enter my name into the prize draw for an Apple iPod or \$50 music voucher. tick one: Yes No
 - I wish to receive a copy of the report from the research: tick one: Yes No

Signature:.....

Name: Date:.....

Participant Contact Details to send out copy of the report:

.....
.....
.....

Approved by the Auckland University of Technology Ethics Committee on 18 October 2005. AUTEK Reference number 05/102.

Note: The Participant should retain a copy of this form.

Appendix 7

HMSP survey questionnaire

Exploring the Māori Health and Disability Workforce HMSP evaluation
--

Part A: Personal details

Participant Code:

1. I am ... (please circle) Male Female
2. I am...(please tick one box)

<input type="radio"/> 15 – 19 years old	<input type="radio"/> 20 – 24 years old
<input type="radio"/> 25 – 29 years old	<input type="radio"/> 30 – 39 years old
<input type="radio"/> 40 – 49 years old	<input type="radio"/> 50 – 59 years old
<input type="radio"/> 60 years or more	
3. What region do you currently live in?

<input type="radio"/> Northland	<input type="radio"/> Wellington
<input type="radio"/> Auckland	<input type="radio"/> West Coast
<input type="radio"/> Waikato	<input type="radio"/> Nelson / Marlborough
<input type="radio"/> Bay of Plenty / Gisborne / Hawkes Bay	<input type="radio"/> Canterbury
<input type="radio"/> Taranaki / Manawatu / Wanganui	<input type="radio"/> Southland
<input type="radio"/> Other _____	

.....

Part B: When you received the Māori health scholarship

4. Which of the following best described your personal circumstances at the time?
(tick as many as apply)

<input type="radio"/> Single	<input type="radio"/> Defacto / Married
<input type="radio"/> Single with dependent(s)	<input type="radio"/> Defacto / Married with dependent(s)
5. Who did you live with at the time?

<input type="radio"/> Living with your immediate family	<input type="radio"/> Living with friends / flatmates (not family)
<input type="radio"/> Living / boarding with whānau / extended family	<input type="radio"/> Living with your partner
<input type="radio"/> Boarding with others	<input type="radio"/> Living alone
<input type="radio"/> Other _____	
6. What region did you live in at the time?

<input type="radio"/> Northland	<input type="radio"/> Wellington
<input type="radio"/> Auckland	<input type="radio"/> West Coast
<input type="radio"/> Waikato	<input type="radio"/> Nelson / Marlborough
<input type="radio"/> Bay of Plenty / Gisborne / Hawkes Bay	<input type="radio"/> Canterbury
<input type="radio"/> Taranaki / Manawatū / Wanganui	<input type="radio"/> Southland
<input type="radio"/> Other _____	
7. Which year, or years did you receive a Ministry of Health Māori health scholarship?
(tick as many years that apply)

<input type="radio"/> 1997	<input type="radio"/> 1999	<input type="radio"/> 2001	<input type="radio"/> 2003	<input type="radio"/> 2005
<input type="radio"/> 1998	<input type="radio"/> 2000	<input type="radio"/> 2002	<input type="radio"/> 2004	
8. At the time you received the Ministry of Health Māori health scholarship, were you a:

<input type="radio"/> Full-time tertiary student	<input type="radio"/> Secondary school student
<input type="radio"/> Part-time tertiary student	<input type="radio"/> Other (please specify) _____

9. Were you employed in health sector at the time? Yes No
- 9a. If yes, (please specify)
- Full-time paid work Part-time paid work Voluntary work
- Other _____

10. Which of the following best describes your course of study while you were a scholarship recipient?

- | | |
|---|--|
| <input type="radio"/> Dental | <input type="radio"/> Psychology |
| <input type="radio"/> Nursing | <input type="radio"/> Occupational Therapy |
| <input type="radio"/> Physiotherapy | <input type="radio"/> Social Worker |
| <input type="radio"/> Medicine | <input type="radio"/> Public Health |
| <input type="radio"/> Midwifery | <input type="radio"/> Secondary School |
| <input type="radio"/> Health Management | <input type="radio"/> Pharmacy |
| <input type="radio"/> Other _____ | |

11. What qualification would you obtain at the end of the course?
- Certificate (e.g. Certificate in Emergency Management)
- Diploma (e.g. Diploma in Community Work)
- Degree (e.g. Bachelor of Health Science)
- Postgraduate level (eg Masters, Doctorate, Postgraduate Diploma / Certificate)
- Other (please specify) _____

12. Have you completed this course of study?
- Yes, I have completed the course.
- Yes, I have completed and gone on to do further tertiary study.
- Did not complete, changed to other health related course.
- No, I am still completing the course.
- No, I withdrew from the course and did not complete (Why did you withdraw from the course?.....)
-
-

13. At the same time as you received the Ministry of Health Māori health scholarship, did you receive other scholarships or grants?
- Yes (please specify) _____
- No

.....

.....

.....

Part C : Scholarship Administration

Rating scale
(please circle)

How would you rate the scholarship programme <u>processes and administration</u> in the following areas:		Rating scale (please circle)					Not applicable
		Outstanding	Above average	Average	Below average	Poor	
14.	Scholarship information made available at my secondary school was.....	1	2	3	4	5	N/A
15.	Scholarship information made available at my tertiary institution was.....	1	2	3	4	5	N/A
16.	Scholarship information made available at my workplace was.....	1	2	3	4	5	N/A
17.	The availability of scholarship application forms was.....	1	2	3	4	5	
18.	The application guidelines and information on how to apply was.....	1	2	3	4	5	
19.	The ease of completing the scholarship application was.....	1	2	3	4	5	
20.	The assistance available from school/tertiary/workplace to help me fill out the scholarship application form was.....	1	2	3	4	5	N/A
21.	The ease of contacting the right person(s) at the Ministry of Health was.....	1	2	3	4	5	N/A
22.	Answers to my queries by the Ministry of Health staff were.....	1	2	3	4	5	N/A
23.	The willingness of the Ministry of Health to provide help was.....	1	2	3	4	5	N/A
24.	The speed I was told that my application had been received was.....	1	2	3	4	5	
25.	The way I was told I had been successful in my application was.....	1	2	3	4	5	
26.	The time between being told and receiving the money was.....	1	2	3	4	5	
27.	Overall , the Scholarship Programmes processes and administration was.....	1	2	3	4	5	

28. What changes do you think could improve the Ministry of Health's programme processes and / or administration of the HMSP?

.....

.....

Part D : Scholarship recipient student outcomes

Rating scale
(please circle)

Please rate <u>how significant</u> receiving the Ministry of Health’s Māori health scholarship was in terms of supporting you to:		Extremely	Very	Moderately	Somewhat	Not at all
29.	Enrol in a health related course.....	1	2	3	4	5
30.	Pass your course work each year.....	1	2	3	4	5
31.	Achieve higher grades.....	1	2	3	4	5
32.	Complete your qualification in the minimum amount of time.....	1	2	3	4	5
33.	Commit to completing your qualification.....	1	2	3	4	5
34.	Reconsider pulling out of the course.....	1	2	3	4	5
35.	Graduate.....	1	2	3	4	5
36.	Progress your career.....	1	2	3	4	5
37.	Work in the health and disability sector.....	1	2	3	4	5
38.	Choose to work in the Māori health and disability sector.....	1	2	3	4	5
39.	Continue to work in the health and disability sector.....	1	2	3	4	5
40.	Link with other Māori health professionals.....	1	2	3	4	5
41.	Reduce or avoid paid work while studying.....	1	2	3	4	5
42.	Reduce stress while studying.....	1	2	3	4	5
43.	Minimise your student debt.....	1	2	3	4	5
44.	Reduce whānau concerns about your financial situation.....	1	2	3	4	5
45.	Maintain whānau connections.....	1	2	3	4	5
46.	Build a relationship with your hapū / iwi / the Māori community.....	1	2	3	4	5
47.	Feel positive about being Māori.....	1	2	3	4	5

48. Are there other ways being a scholarship recipient has helped you?

.....

Part E: Scholarship marketing

49. Where did you find out about the scholarship?

Please identify the source(s) through which you heard about the Ministry of Health’s Scholarship Programme (you may tick as many as you like).

- | | |
|--|--|
| <input type="radio"/> Internet | <input type="radio"/> Māori health provider organisation |
| <input type="radio"/> Friends / Whānau | <input type="radio"/> Employer |
| <input type="radio"/> Staff at tertiary institution | <input type="radio"/> Radio / Television |
| <input type="radio"/> Staff at Secondary school | <input type="radio"/> Newspaper / Magazines |
| <input type="radio"/> Iwi / hapū organisation | <input type="radio"/> Māori programming (Māori television) |
| <input type="radio"/> Government agency (e.g. Ministry of Health, Ministry of Education) | <input type="radio"/> Māori print media (e.g. Mana magazine) |
| <input type="radio"/> Other _____ | |

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Part F: Current employment

50. Are you currently employed in the health and disability sector?
 Yes No → go to Q52

50a. If yes, What is your main employment setting?

- | | |
|---|--|
| <input type="radio"/> District Health Board (public hospital) | <input type="radio"/> Schools (Education Service) |
| <input type="radio"/> Māori health provider | <input type="radio"/> Government department |
| <input type="radio"/> Private practice | <input type="radio"/> Commercial industrial organisation |
| <input type="radio"/> Private hospital / rest home | <input type="radio"/> Voluntary agency |
| <input type="radio"/> University / Polytechnic | <input type="radio"/> Other (please specify) _____ |

50b. If yes, are you currently practicing as a;

- | | |
|---------------------------------------|--|
| <input type="radio"/> Dentist | <input type="radio"/> Health Manager |
| <input type="radio"/> Nurse | <input type="radio"/> Pharmacist |
| <input type="radio"/> Physiotherapist | <input type="radio"/> Psychologist |
| <input type="radio"/> Medical doctor | <input type="radio"/> Occupational Therapist |
| <input type="radio"/> Midwife | <input type="radio"/> Public Health person |
| <input type="radio"/> Social Worker | <input type="radio"/> Other (please specify) _____ |

51. Do you see yourself working in the health sector in the next:

- Year?
- 2 - 5 years?
- 6 - 10 years?
- More than 10 years?
- Other (please specify) _____

52. If no, are you:

- | | |
|---|--|
| <input type="radio"/> A student | <input type="radio"/> Homemaker |
| <input type="radio"/> Unemployed at present | <input type="radio"/> Working in another area (please specify below) |

52a. What area are you working in now?

- | | |
|---|---|
| <input type="radio"/> Agriculture / Forestry / Fishing | <input type="radio"/> Leisure and Hospitality industry |
| <input type="radio"/> Construction / Manufacturing | <input type="radio"/> Retail Trade |
| <input type="radio"/> Education | <input type="radio"/> Cultural and Recreational Services |
| <input type="radio"/> Property and Business | <input type="radio"/> Finance and Insurance |
| <input type="radio"/> Transport, storage and communication services | <input type="radio"/> Government Administration and Defence |
| <input type="radio"/> Other (please specify) _____ | |

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Part G : General comments

Do you have any other comments on the scholarship programme?

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Thank you very much for taking the time to complete this survey.
Your assistance is appreciated.

Please remember to return your survey and consent form by
Fri 25th November
to be in the draw for an Apple iPod or a \$50 music voucher.

