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Hidden in plain sight: A critique

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ABSTRACT

INTRODUCTON: In 2020, the Health and Disability Sector Review (H&DSR) for Aotearoa New Zealand was published (Simpson, 2020). It called for widespread structural change and reform within the health and disability sector. As a response to this report, Allied Health Aotearoa New Zealand (AHANZ) sought advice from the New Zealand Institute of Economic Research (NZIER) as to how their membership could contribute to addressing the issues raised in the H&DSR (Simpson, 2020). The resultant report, *Hidden in plain sight (HiPS)* is the focus of this critique (Hogan, 2021).

APPROACH: An overview of *HiPS* (Hogan, 2021) is presented along with an analysis using a strengths, weaknesses, opportunities and threats (SWOT) framework. Some of the critique offered is from social work literature based on research conducted in Aotearoa New Zealand.

CONCLUSIONS: What becomes evident is: 1) that the proposed change is general practice-centric; and 2) *HiPS* has not considered the wealth of experience of interprofessional collaboration that is already occurring within the sector. What at face value appears a positive response to the proposal of the H&DSR lacks substance when subjected to robust analysis.

Keywords: Allied health, healthcare, interprofessional collaboration, model of practice, social work

Overview of *Hidden in plain sight*

To achieve more equitable health outcomes for all New Zealanders, the Health and Disability Sector Review (H&DSR) was commissioned in 2018 (Simpson, 2020). The review paid specific attention to the needs of Māori, Pacifica, those who have disabilities, and those who live rurally. It highlighted a shift in focus from treatment of illness to health and wellbeing. Following the release of the H&DSR (Simpson, 2020), Allied Health New Zealand (AHANZ) approached the New Zealand Institute of Economic Research (NZIER) seeking advice for members of the allied health professions to contribute to addressing the issues raised. *Hidden in plain sight* (*HiPS*) is the report produced in response to that request (Hogan, 2021).

This critique provides a brief overview of *HiPS* (Hogan, 2021) followed by a critique using a *strengths*, *weaknesses*, *opportunities* and *threats* (SWOT) framework. Hogan (2021) sought to explore how members of the allied health workforce can respond to the way healthcare is delivered in Aotearoa New Zealand. "Equity, effectiveness, efficiency and sustainability" are all key objectives to achieve in the delivery of care (Hogan, 2021, p. 1). Barriers in current models of care are identified, along with the risks that accompany making changes to the models of care. The proposed benefits of what might be possible should changes to the models of care be embraced are articulated. However, the only detail provided regarding current models of care is that of general practitioners (GPs) offering 15-minute consultations who

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are unable to provide "person-centred care needed for people with multiple long-term conditions, or even single conditions with complex biopsychosocial contributing factors" (Hogan, 2021, p. 6).

HiPS emphasised the role of GPs as the most prominent primary care providers, highlighting that the shifts occurring within the healthcare system are placing GPs under increasing workload pressure (Hogan, 2021). This pressure comes from a range of systemic sources which include: the devolution of some hospital services back to GPs; a move to more GPs working part time; 15-minute consultations that inhibit GPs' ability to provide holistic care; a lack of ability to refer patients to allied health practitioners where fees for services apply; a lack of ability to pay for GP services; and a lack of opportunity to see a GP which contributes to a lack of continuity of care. A consequence of this pressure is that there are people in the community whose healthcare needs are not being met (Hogan, 2021). Although *HiPS* maintains the central role of GPs as *care coordinators* due to their medical knowledge, it does recommend direct access to allied health professionals thereby reducing "GP control over access to allied health" (Hogan, 2021, p. 7).

After doctors and nurses, the allied health workforce across District Health Boards (now Te Whatu Ora) in Aotearoa New Zealand is described as the country's "second largest clinical workforce" comprising over 30,000 people (Hogan, 2021, p. 3). More than half of these professionals belong to professional bodies that are regulated by the Health Practitioners Competence Assurance Act (2003). The remainder belong to professional bodies that regulate the knowledge and skills of their membership. This regulation is designed to provide a level of protection and assurance for the public that the allied health professionals they work with are competent, fit and proper to provide an expected standard of knowledge and skills pertinent to their professional discipline. In the 2022 workforce survey, 1800 registered social workers identified as working for a government health organisation (Social Workers Registration Board, 2023, p. 16). This number does not include registered social workers working in the not-for-profit sector.

Throughout *HiPS*, an emphasis is given to a move to an interprofessional practice model of care delivery (Hogan, 2021). Interprofessional practice is defined as:

> … a professional behaviour that identifies and engages optimal use of each practitioner's skillset for each patient to provide comprehensive, coordinated, person and whānau-centred care. Interprofessional practice is flexible, adjusting the level of collaboration and the number of practitioners according to the complexity of needs and circumstances of the person receiving care. It requires a clear understanding of roles and team dynamics, and effective leadership and conflict resolution skills. Interprofessional practice works best when practitioners learn from each other and improve their own practice with this acquired knowledge base, creating overlaps in skillsets that reduce fragmentation in professional services. (Hogan, 2021, p. 2)

According to *HiPS* (Hogan, 2021), healthcare services are generally divided into two tiers as determined by the H&DSR (Simpson, 2020). Tier 1 services encompass a broad range of services delivered in the home and community, including marae and schools to meet the needs of most people (Hogan, 2021). Tier 2 services are defined as "health and disability services provided in a hospital setting or by specialists (including outpatient, inpatient, non-community mental health, and hospital based diagnostics)" (Hogan, 2021, p. 2). It is recommended that healthcare provision be integrated and coordinated either vertically

or horizontally across providers depending on the needs of each person. The purpose of integrated healthcare services is to ensure people have access to a continuum of healthcare and services across their lifespan (Hogan, 2021).

Together with a growing expectation for targeted, person-centred care specific to each recipient, a move to elevate members of the diverse allied health workforce to work to the full extent of their professional scope of practice is proposed. The purpose of this is to enable health professionals to take a more proactive role in providing healthcare to meet the growing consumer need. To facilitate this, Hogan (2021) recommended assessment and therapeutic intervention by an allied health professional prior to seeing a GP. Benefits include reduced time spent accessing a GP, direct access to an appropriate allied health practitioner, and a reduction in referrals sent to medical specialists.

> According to Hogan:
>
> Current use of allied health is sub-optimal. The solution requires a fundamental shift in the way Tier 1 services are organised and in the behaviours of the Tier 1 workforce. In designing Tier 1 services to support interprofessional practice with increased allied health input, critical design elements include:
>
> - The patient-centred medical home (PCMH)
> - Practice ownership and governance models that support greater community participation and breakdown professional hierarchies
> - Payment models that align with service models
> - Referral processes for direct access to a range of health professionals
> - Cost containment measures
> - Culture shift
> - Empowering with information. (Hogan, 2021, pp. 29–30)

GPs are regarded as key to implementing change in the health and disability sector (Hogan, 2021). They are identified as *gatekeepers* to health services. As many GPs work in private practice with associated business models; their referrals to allied health professionals are dependent on their knowledge and trust in the services provided (Hogan, 2021).

Strengths

The allied health workforce

A strength of *HiPS* is the attention given to identifying the depth and breadth of professions that make up the allied health workforce (Hogan, 2021). This consists of over 30,000 people across 29 professional disciplines who belong to regulatory bodies and/or professional associations. Members of the allied health workforce who belong to a regulatory body and/or a professional association hold a relevant tertiary qualification, have a process for assessing competence to practise, abide by both professional standards of practice and codes of ethics, and have a robust complaints system (Hogan, 2021).

Whilst it is a convenient term to use, a concern when using *allied health* as a generic name for this workforce, is the danger of diluting the specific skills and knowledge these practitioners hold into a bland amorphous group who are unseen and unacknowledged in their practice. Thus, the generic term allied health is also a weakness as it perpetuates medically dominant terminology *othering* highly skilled practitioners of different disciplines. When members of the allied health professions are referred to in a discipline-specific manner, this enhances their visibility, as well as the uniqueness of their skills that are more widely known within the community. It is considered that using the professional title given to the various practitioners provides a context to understand their purpose in being included as a member of the team for the services they deliver to a particular person or population group.

Model of practice

HiPS proposes delivery of care based on the biopsychosocial model of care (Hogan, 2021). A biopsychosocial model of care focuses on empowering people in the community to maintain as much independence as possible, focusing on quality of life, within the constraints of their personal circumstances. A biopsychosocial model of health is proactive and preventative. It enables the members of the allied health workforce to provide healthcare that is specific to the needs of each person. The preference for the model proposed is to "provide better alignment between the health and disability system and the Treasury's Living Standards Framework (Treasury New Zealand, 2019)" (Hogan, 2021, p. 24).

HiPS recommends shifting some work currently undertaken by GPs to their allied health colleagues (Hogan, 2021). In following this practice, GPs are better placed to respond to services that have devolved to their practices from hospital specialists. This move would increase efficiencies in the health sector and give recognition to the role allied health practitioners have in providing preventative health care and education. A challenge to making these types of transitions in healthcare provision is the willingness of GPs to hand over roles they are used to providing (Hogan, 2021). It appears that lower cost of providing allied health services is a key factor driving this recommendation. If cost is the only motivation to transform the delivery of health care services, this reinforces the ongoing status and power disparities between medical and allied health practitioners and is both disingenuous and demeaning. Hence, what at first glance looks like a strength, under further examination becomes a weakness (Hogan, 2021).

While the recommendation for a biopsychosocial model is a strength, it poses risks in implementation as no detail is provided in *HiPS* regarding how this might look for social work (Hogan, 2021). Social workers bring strengths in making holistic assessments of the needs of patients and family/whānau. They have expertise in community networking and linking people with resources in the community that are relevant to their needs. The roots of health social work are described as a *guest* operating "under the benign control of the medical and nursing professions" (Beddoe, 2011, p. 26). Inherent within this positioning is the implication that in holding a guest status, social work is either included or excluded dependent on the understanding of what medical and nursing colleagues understand social work offers. Thus, the ability to be effective as social workers is more dependent on the meaningful relationships they hold that determine the scope of their work, rather than a prescribed or mandated definition.

Within *HiPS*, the allied health workforce is considered to be a critical component when moving to offer the patient-centred medical home (PCMH) model of primary health care delivery (Hogan, 2021). The PCMH model was originally introduced as an American interprofessional model of care for children who had complex healthcare needs. It has since evolved as "an ideal for areas of high deprivation, where multi-morbidity and high prevalence of risk factors are observed" (Hogan, 2021, p. 30). It is argued that allied health practitioners are well placed to be influential in the care coordination and case management of people from these communities. If a PCMH model is implemented, questions remain about the efficacy of allied health practitioners if they are subject to the authority of their GP and nursing colleagues. *HiPS* advocates that GPs hold the role of care coordinator, yet also indicates they do not always know what services allied health practitioners provide (Hogan, 2021, p. 7). Given this statement, the number of allied health practitioners presented in the following table (Table 1) may not reflect a workforce that is sustainable in an area of high deprivation with a population who have co-morbidities and a high need for health care.

Table 1. Staffing Requirements for an Aotearoa New Zealand PCMH Model

	FTE per 10,000 high needs patients	FTE per 10,000 non-high needs patients
General Practitioner	7.9	6.0
Nurse Practitioner	4.0	2.0
Nurse	6.0	4.5
Reception / Administration	6.7	5.0
Behaviourist / Counsellor	3.5	2.5
Social Worker / Kaiāwhina / Navigator	2.5	1.0
Health care assistant	4.0	3.0
Clinical pharmacist	1.0	1.0
Physiotherapist	1.0	1.0
Trainee doctor	1.0	1.0
Trainee nurse	1.0	1.0
Trainee allied health	1.0	1.0
Student clinicians	2.0	2.0
Manager	1.0	1.0
Total team FTE	42.6	32.0

Source: GPNZ, 2020 (cited in Hogan, 2021, p. 31).

The PCMH model outlines the following staffing resource (Hogan, 2021, p. 31):

From Table 1, it is unclear whether a social worker, a kaiāwhina, and a navigator are all employed by the PCMH or any of these could be employed interchangeably. Patient navigators are described as "trained, culturally sensitive health or social care workers who provide support and help families navigate through the various components of the health and social services systems. … it is often a role played by nurses, social workers, or other allied health professionals" (Hogan, 2021, p. 25). There is risk in assuming a social worker has the same knowledge and skills as a kaiāwhina or navigator.

"A social worker is a qualified and registered professional. Social work is a practice-based profession … that promotes social change and development, social cohesion, and the empowerment and liberation of people" (International Federation of Social Workers, 2014, p. 1). "Kaiāwhina represent people within the health and disability sectors who support tāngata (people) to live well, embrace and exercise tino-rangatiratanga (self-determination) in navigating their own journey to pae ora, a healthy future" (Ministry of Health, 2021, p. 9). Kaiāwhina bring cultural expertise to their role and may also have a formal qualification. This raises questions as to the information regarding professional qualifications and regulation the author had access to when preparing *HiPS* (Hogan, 2021).

The development of allied health *ambassadors* to overcome barriers between integrating primary care and allied health professionals is promoted (Hogan, 2021). The strength of the ambassador role is to act as a mediator or broker between both medical and allied health professionals. This proposal is one of intentional recruitment to ensure professional networks and pathways exist to facilitate referrals between all parties. A secondary purpose is for members of different allied health professions to be appointed to the ambassador role within

the same geographic area to ensure cross-pollination of networking relationships and access to allied health professionals. This is an extension to the scope of practice for a senior practitioner (Hogan, 2021).

Weaknesses

Workforce model of care

Notwithstanding the qualifications, knowledge and skills members of the allied health workforce hold, the report lacks clear and comprehensive detail of how this might occur. Attention is given to general practice and the need to transform the systems which historically maintain and finance general practice as a cornerstone of health within Aotearoa New Zealand. Many general practices are considered unsuitable to provide person-centred care for people with long-term or complex conditions due to being "profit-maximising" and "unidisciplinary" (Hogan, 2021, p. 6). This creates an opportunity and a necessity to consider an alternate GP model of care that is for community based, not-for-profit and focused on providing interprofessional healthcare (Hogan, 2021). These are based in communities where people experience complex care needs, high levels of deprivation and minority populations (Hogan, 2021). Funding for community based PCMH models would include a mix of fee for service payments, financial incentives to meet performance targets, a population-based capitation payment, fees to cover overheads, and a prospective care management and coordination fee to cover labour costs. Further work needs to be undertaken to develop the financial arrangements that fund this model (Hogan, 2021).

Given the overreliance on GP-centric literature throughout *HiPS*, it raises questions about why other literature was not included (Hogan, 2021). It also raises questions as to the degree of consultation that was undertaken with the regulatory boards and professional associations that monitor and guide the practice of members of the professional allied health workforce. None of this is evident within the report. Nor does the report offer the experience of interprofessional care from the perspective of the various professional disciplines that make up the allied health workforce in Aotearoa New Zealand. Within *HiPS*, the examples given of interprofessional collaboration maintain GPs holding a pivotal role in the healthcare equation (Hogan, 2021). When one professional discipline is privileged over others, it is difficult to determine how a change in the provision of healthcare will occur. By exploring the experience of various members of the healthcare workforce in the provision of interprofessional collaboration, it is considered that a more robust model of interprofessional collaboration might be arrived at.

For example, within the proposed model, palliative care services are described as both Tier 1 and Tier 2 services. Within Aotearoa New Zealand, there are two categories of palliative care: generalist and specialist. Those who require generalist palliative care are primarily looked after within the community by their primary health care provider, usually a GP, with support and advice from community and specialist services as needed. For those recipients of specialist palliative care services, they are under the oversight of an interprofessional team who have specific training in palliative care, who aim to provide holistic care in conjunction with their GPs and community health services (Ministry of Health, 2009).

Health social workers who work in palliative care may be employed in the community, in hospitals and in hospices. They are familiar with working collaboratively in interprofessional teams. Palliative care social workers are concerned with resolving problems, or where matters arise relating to social or psychological factors (Payne, 2004). This might include access to suitable

housing, immigration matters, and other family/whānau stressors. Referral to social work may occur where there is concern about the needs of the carer and family/whānau including future bereavement concerns. Palliative care social workers hold specialist knowledge on current models of grief and loss.

Within *HiPS*, Māori, Pasifika, the disabled and the rural community are only mentioned in the context of being drivers for change in the way health services are delivered (Hogan, 2021, pp. 7–8,15,20). *HiPS* does not provide any examples of how interprofessional collaboration currently occurs within these communities, what services already exist, and/or the benefit to their specific communities (Hogan, 2021). *HiPS* fails to acknowledge that within the community of allied health professions, they have members who belong each of these demographics (Hogan, 2021). These voices are missing from the report.

Interprofessional collaboration

HiPS refer to two international initiatives (Centre for the Advancement of Interprofessional Education [CAIPE], 2022; Nolte, 2005) advocating at a policy level to promote systemic change to reshape the workforce so that interprofessional collaboration is embedded into the healthcare system (Hogan, 2021). Whilst this is useful, it fails to acknowledge and explore evidence of interprofessional collaboration already occurring within Aotearoa New Zealand. This is considered a weakness in the report.

The National Centre for Interprofessional Education and Collaborative Practice (NCIPECP) is based at the Auckland University of Technology (AUT). At its opening, Minister Ryall spoke of the Government's belief that interprofessional collaboration was "crucial for improving the significant health workforce crisis we have inherited" (Ryall, 2009, p. 1). NCIPECP's purpose is to provide leadership, facilitation and the promotion of person-centred collaborative practice, education and research which benefits the health and social outcomes for all in Aotearoa New Zealand (AUT, n.d.). Since that time, NCIPECP has published research across a range of professional disciplines nationally and internationally. That the work of NCIPECP is not present in *HiPS* (Hogan, 2021) is disappointing as their research is intentional in its culturally responsive approach to person and whānau-centred care (Auckland University of Technology [AUT], n.d.).

Within Aotearoa New Zealand, social workers are familiar with working as part of an interprofessional team. This is especially the case when working in health settings. Giles' (2016) research explored the social workers' perception of interprofessional teamwork in a major regional hospital. Eleven out of 16 health social workers within the hospital were interviewed. The findings of the research highlighted the benefits of holistic care when interprofessional meetings were well facilitated. These included clear communication and effective coordination of care between members of the interprofessional team and the person and family/whānau they were attending to. In contrast, when interprofessional meetings were poorly facilitated, it was found that the person who was the focus of care was often treated as if they were a "site of disease"; discussions tended to be more perfunctory, and, at times, had an overemphasis on avoidance of risk (Giles, 2016, p. 30). When this occurred, there was a greater likelihood that social work and patient concerns were devalued. This resulted in a higher incidence of patient and family/whānau distress and poorly coordinated discharge planning. The effective inclusion of social workers into the interprofessional team has significant benefits for the team, the patients and family/whānau with whom they work (Giles, 2016). Although this example occurs within a hospital environment, it highlights tensions which can occur within the interprofessional team. Whilst these findings cannot be generalised to other settings, they

may be transferable to other settings where interprofessional collaboration occurs.

Opportunities

Structural workforce issues

At first reading, a huge opportunity exists within *HiPS* to reshape healthcare delivery in Aotearoa New Zealand (Hogan, 2021). If the 30,000 members of the allied health workforce were enabled to practise at the top of the scope of their practice, opportunities for innovation and creativity to shape the design of healthcare services in a way that is specific to the needs of the communities would occur. *HiPS* proposes a workforce planning approach that focuses on skill flexibility, skill development, and the development of new roles to meet the needs of the population in which they are situated (Hogan, 2021). In focusing on the needs of the community, this has the potential to drive the training so that it is community specific. This ignores the knowledge and skills held by members of the allied health workforce who hold a broad base of skills that adapt to a range of environments. An associated threat to the engagement of allied practitioners is their relatively low numbers across 29 professional groups. This may require active recruitment and training into these professions to boost the workforce requirements.

In response to the New Zealand Ministry of Health's Primary Health Care Strategy and the ongoing call for comprehensive integrated healthcare to address issues of inequity, one of the strategies implemented was to establish social workers in primary health care (PHC) organisations (Ministry of Health, 2001). Research exploring the perceptions of, and experiences gained through including, social workers in PHC teams in Aotearoa New Zealand has occurred (Döbl et al., 2017). Benefits included enhanced communication between all services, as well as ease of access to people of low socio-economic status and those from ethnic minorities. For those people who had complex psychosocial needs, including trauma, being able to access a social worker located within their primary care provider enabled easier acceptance of social work intervention. Following the Christchurch earthquakes in 2011, the importance of social workers in the PHC team environment was especially valuable (Döbl et al., 2017).

The lack of ongoing government funding to support social workers being employed within the PHC model was challenging. This was evidenced by social workers being required to "provide evidence of its usefulness with respect to financial gains rather than to improved healthcare provision" (Döbl et al., 2017, p. 126). Issues of equality and power were noted across various levels: between people who accessed health services and health professionals, between professions, and within the healthcare system itself (Döbl et al., 2017).

The knowledge, skills, values and practice approach social workers brought to the PHC team was considered to complement and address a gap in the knowledge and skills of their medical and nursing colleagues. Many of the issues social workers attended to were endemic within the community and impacted all aspects of each person's health (physical, emotional, psychological, spiritual and family/whānau). These included poor access to housing, food insecurity, workplace conflict, unemployment, poverty, obesity, terminal illness, disability, depression, loss and grief, caregiver distress, social isolation, emotional volatility, family/whānau dynamics, immigration issues, domestic violence and abuse (Döbl et al., 2017).

Social workers who were situated in a community PHC identified as having high needs and wishing to support holistic health reported being well supported in the workplace and satisfied with their conditions of employment (Döbl et al., 2017). For employers, it was critically important that they and their colleagues understood what the social work role entailed to build effective working relationships both

with the people and families/whānau of the community with whom they worked. Information sharing by social workers between service receivers, health professionals, and external agencies was vital in maintaining communication between all parties. Professional supervision for social workers ensured they continued as a 'safe' practitioner for all whom they worked alongside. A recommendation was made that to enable social workers to continue to be located within PHC teams, an ongoing commitment to funding is needed (Döbl et al., 2017).

Funding models

People who are unable to privately access allied health professionals due to cost generally turn to their GP to access those services (Hogan, 2021). If, in turn, they cannot afford to visit their GP, they are excluded from accessing the healthcare they require.

> The right care at the right time, delivered in the right way for the right person is impossible to achieve if the public health system does not employ the right mix of professionals. Allied health professionals are highly trained, highly specialised practitioners who can offer safe and effective, evidence-based interventions for a wide range of conditions.
> (Hogan, 2021, p. 22)

The funding model proposed in *HiPS* recommends financial incentives are provided for teams who meet quality and efficiency targets, extending this to including meeting equity targets (Hogan, 2021). Interprofessional teamwork is more apparent in not-for-profit community organisations who exhibit the following qualities: salaried team members, interdependent incomes, whole of team funding, and service contracts hold explicit expectations for interprofessional collaboration (Hogan, 2021). Given one of the stated aims within *HiPS* is for "cost containment" a model of risk stratification is offered which categorises patients according to diagnosis, and the needs assessed to meet the unwell person's health care needs, adjusted for demographic and other factors which can include both objective and subjective information (Hogan, 2021, p. 41).

With a move to align payment to service models that are financially motivated, and the expectation that Tier 1 teams demonstrate capacity and evidence of interprofessional collaboration, this is both an opportunity and a threat to the successful implementation of the recommendations of *HiPS* (Hogan, 2021). The greatest opportunity is enabling members of the allied health workforce to participate in interprofessional collaboration. The greatest threat is that financial incentives and penalties will inhibit the ability of interprofessional teams to collaborate in a way that is most meaningful to the community they serve. While accepting there is a need for contracted organisations to meet a minimum set of standards, concern is raised that when teams are required to meet a set of specifications, this may become a maximum in service delivery thus inhibiting innovation. The following example provides evidence of this risk when the accountability requirements of government contracted services operate at cross-purposes to holistic care provided by community organisations (Dormer, 2014).

Dormer (2014) undertook research with government officials and non-government organisations to explore matters of collaboration and accountability. The research highlighted tensions that occur when an alternate model of practice (Whānau Ora) is developed that devolves decision making for a particular population back to the community. Whānau Ora was developed "to foster a greater sense of local community and individual responsibility" (Dormer, 2014, p. 835). Finding a model that meets the needs for community organisations to attend to the needs of their clientele as well as the accountability needs

of government organisations who provide funding is both challenging and a source of tension. It is considered both parties need to develop an understanding of the aspirations and limitations of the other (Dormer, 2014). If funding organisations have one set of criteria for delivery of services that are neither compatible nor congruent with the core mission of a community organisation, this can constrain and limit the effectiveness of any services that are delivered.

The experience of Whānau Ora exposed the difficulty in measuring outcomes where service delivery is values-based and focuses on enhancing the mana (strength) and wairua (spirit) of Māori. Dormer (2014) described efforts that build mana and wairua as "aspirational". Interviews with officials engaged in funding Whānau Ora initiatives, revealed a reluctance to allow tino rangatiratanga (self-determination) due to contractual requirements that included standards of professionalism, how whānau are to be treated and expected outcomes for services delivered. It was concluded that, depending on which side of the negotiating table one sat, these tensions contributed an ongoing experience of coercion versus empowerment (Dormer, 2014). Rather than focusing on accountability that was finance- or outcome-focused; in 2012, Minister Turia advocated for outcomes to be focused on the stories and feedback given by the people Whānau Ora worked alongside (Dormer, 2014). This was more meaningful and relevant. The stories of change to the welfare of Māori whānau wrought over time are the strongest indicator of effective collaboration and provision of care. A change to a more collaborative style of accountability is necessary when implementing meaningful change to "seemingly intractable social problems that are not unique to New Zealand" (Dormer, 2014, p. 844).

The funding models that accompany the changes to the health and disability sector are both an opportunity and a threat to successful implementation. Unless they take account of issues that have already been raised in a meaningful way, any initiatives run the risk of being undermined and unable to fulfil their mandate. A further threat is that funding providers may not fully appreciate the value of the cost of employing allied health professionals at the top of their scope of practice thus constraining the ability of the workforce to meet the requirements of contractual agreements. Allied health professionals working in the community are not second-class professionals when compared to their colleagues employed in statutory organisations, therefore the terms and conditions of employment, including salaries, need to reflect this.

Associated with this, and implied within HiPS, is the lack of knowledge of the skills and knowledge allied health professionals bring to interprofessional collaboration (Hogan, 2021). National and international research has found health care administrators and managers lacked an understanding of what social workers could contribute to the organisation (Hobbs & Evans, 2017; Lévesque et al., 2019). This resulted in a reductive and simplistic view of social work within the organisation, including exclusion from consultation and discussion about decisions that directly impacted their practice. The systemic power imbalance was a source of frustration by health social workers and considered to be discriminatory and stigmatising (Hobbs & Evans, 2017; Lévesque et al., 2019). In situations where innovative services are created as occurred with social workers employed in PHC teams, yet ongoing funding is challenging, this can have a negative effect on the morale and productivity of affected team members (Döbl et al., 2017).

Threats

Systemic issues to model of care

Implementing an alternate model of healthcare requires careful planning (Hogan,

2021). To remove ownership of GP practices and transition this to non-profit community health practice risks losing an element of flexibility within the workforce (Hogan, 2021). GPs in private practice are more responsive to cater to additional demand for their services. Conversely, community-owned non-profit and government-owned practices are considered to better able to meet the demand for healthcare that is appropriate to meet the diverse needs of the community in which they are situated (Hogan, 2021). Within Aotearoa New Zealand, government public health organisations (PHOs) have been funded to provide healthcare that is complementary to, and independent from, private GP practices.

Unless systemic change is supported during the transition and implementation process of integrating allied health professionals into healthcare practice, this will detrimentally affect the experience of both healthcare providers and healthcare recipients (Hogan, 2021). Some may regard *HiPS* as visionary and embracing of the inclusiveness of the allied health workforce (Hogan, 2021). Yet no information is provided regarding the process of developing interprofessional teams and what helps/hinders their effectiveness. This is the biggest threat to making change.

Interprofessional collaboration

Interprofessional collaboration does not just happen. It is a process that evolves under skilled leadership within a facilitated structure. A high trust environment and a culture of sharing power are critical factors in facilitating the successful functioning of the interprofessional team. It is when interprofessional practice is enabled to take place in an environment where all team members operate from their strengths that the potential of interprofessional teams can begin to be realised (Best & Williams, 2019).

A growing body of literature is available to support those wishing to develop, grow and support teams to function in a truly interdisciplinary manner. Research identifying the factors that contribute to the development of a quality interdisciplinary team is available, as are tools to assess the effectiveness of the interdisciplinary team (Nancarrow et al., 2013; Nancarrow et al., 2015). McNeil et al. (2013) identified triggers that hinder the effective cohesiveness of the interprofessional team. Best and Williams (2019) provided strategies to support the interprofessional team during times of organisational change and uncertainty.

Conclusion

It is considered *HiPS* falls short as it fails to go far enough (Hogan, 2021). It is GP-centric in its design. If the purpose of the report was to move from a “biomedical model of healthcare” as offered by GPs, to a more fit-for-purpose model that delivers healthcare services for people who have “complex health, disability and psychosocial issues”, it is considered that HIPS misfires (Hogan, 2021, p. 1). The act of writing a report that is based on literature about GPs by its very nature has excluded relevant literature written by members of the professional allied health workforce. Out of a workforce of over 30,000 allied health professionals, it is unfortunate that other frameworks for healthcare delivery were not considered. Given the acknowledged role of GPs as gatekeepers for patients accessing allied health professionals, to draw on the models and frameworks developed for GPs explicitly maintains the process of privileging their knowledge over that of their allied health colleagues (Hogan, 2021, p. 6). It further reinforces the lack of equity among the healthcare workforce whereby medical knowledge and models are given precedence over those developed and/or utilised by members of the allied health workforce.

When I first heard of HiPS being released, I felt excited, thinking this report would give recognition to the knowledge and skills members of the allied health workforce bring to healthcare (Hogan, 2021). How wrong I was! Taken in its entirety, I find

HiPS disappointing (Hogan, 2021). Whilst it advocates support for enabling allied health practitioners to practise at the top of their scope of practice, it fails to articulate the breadth of knowledge and skills allied health practitioners have, it fails to challenge the historical structural inequities allied health practitioners face every day. By not doing this, the report colludes with the practice of maintaining the status quo of privileging the knowledge of GPs over other professional disciplines. This renders the recommendations of the report to the level of soundbites and lacking in substance.

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