Policy Paper 1: Joined-up, community-based care utilising a strong allied health workforce

Our position
Every New Zealander should be able to access the right health care and treatment, from the right professional, at the right time, in their own community.

To facilitate this, allied health must be embedded as a core part of tier 1 community and primary services, not treated as an optional add-on, as it is now. Allied health professionals are trained, available qualified to relieve pressure on an ageing and overstretched GP workforce, while improving patient outcomes and experience.

The problem
New Zealand's health system still revolves around hospitals and GP-led general practice, even though most care needs could be safely and effectively met in the community by broader, appropriately-qualified and integrated, multi-disciplinary teams.

This over-reliance on GPs creates bottlenecks, long waits, and rising unmet need because tier 1 capacity hasn't grown to match demand from a growing and ageing population.

Meanwhile, thousands of allied health professionals remain largely outside publicly funded primary care. Despite being trained to manage high-volume community health needs, they are constrained by private-pay models, patchy local commissioning, and limited referral pathways. This leaves a significant pool of clinical expertise underutilised while pressure on GPs intensifies.

The background
The *Hidden in Plain Sight* report argues that shifting more care into Tier 1 is essential to reducing pressure on hospitals, but this requires a broader team delivering first-contact, rehabilitation, prevention, and chronic condition management.

International models (e.g., Canada, Australia, the PCMH model in the US) consistently demonstrate that interprofessional primary care reduces acute demand, improves continuity, and lifts patient satisfaction. These models rely heavily on allied health roles such as physiotherapy, occupational therapy, podiatry, speech-language therapy, dietetics, audiology and social work as core Tier 1 professions.

New Zealand currently lacks a unifying framework for integrating these professions into community-based services. Funding mechanisms reinforce professional silos, IT systems do not support shared care, and workforce planning is largely GP-centric. This means significant opportunities for early intervention, safe triage, and community rehabilitation are being missed — increasing cost and demand downstream.

The solution
Adopt community-based interprofessional models as the norm.
Move toward PCMH-style services and allied-health-inclusive tier 1 networks so people can receive integrated care close to home.

Fund teams, not silos.
Introduce funding that pays for collaborative care capability in primary care (including allied health roles), rather than rewarding short GP visits.

Enable allied health to work at top of scope.
Expand and formalise extended scopes and "first-contact practitioner" roles in conditions where allied health is safe, effective, and faster for patients.

Improve referral and triage pathways.
Build direct access and supported triage into tier 1 care so patients flow to the most appropriate practitioner first time.

Done well, this creates a joined-up system where allied health relieves GP pressure, people get earlier help, and care is delivered where it works best — in the community.

Policy Paper 2: Prevention, not just treatment

Our position
Prevention is better than cure. As New Zealand's population grows and ages, health services must shift from a system that waits for people to become unwell and then provides treatment, to one that actively keeps people well.

Allied health should be recognised and funded as a frontline prevention workforce, leading health promotion, risk reduction, early intervention, and rehabilitation in communities.

The problem
New Zealand's health system is dominated by treatment rather than prevention, even though the leading causes of health loss - cardiovascular disease, diabetes, MSK conditions, obesity-related illness, cancer, hearing loss - are largely preventable or manageable with early intervention.

Long-term and more complex conditions now drive the bulk of health demand, and they increasingly show up earlier in life, especially in high-need and vulnerable communities. That creates avoidable pressure on GPs, hospitals, and household budgets.

This imbalance means that demand continues to flow into the most expensive parts of the system - GPs, EDs, urgent care and hospitals - despite allied health having clear, evidence-based roles in prevention, functional improvement, and long-term condition management.

The background
The *Hidden in Plain Sight* report describes a mismatch between population health needs and service investment. While modifiable risk factors account for the majority of poor health outcomes, preventive programmes receive a small fraction of health funding.

Allied health professions provide core prevention capabilities:

- mobility and falls risk management
- chronic pain intervention
- MSK assessment
- hearing and balance screening
- nutrition and physical activity support
- swallowing and speech interventions
- early identification of developmental delays
- home and environmental assessments that prevent injury and decline

However, the system relies heavily on private payment for many of these services, and communities with the highest lifetime need face the greatest barriers to preventive allied health care. Without early functional support, people decline faster and require higher levels of medical intervention later, increasing both direct cost and lost productivity.

The solution
Make prevention a funded core function of tier 1 care.
Allocate sustained funding for allied-health-led prevention programmes (e.g., MSK health, falls prevention, nutrition and activity, mental wellbeing, chronic pain management).

Embed self-management support into primary care teams.
Ensure allied health roles are permanently integrated in community services to help people manage conditions before they escalate.

Target prevention where risk is highest.
Prioritise outreach and culturally-grounded prevention services for Māori, Pacific peoples, disabled people, and high-deprivation communities, where risk factors and unmet need are greatest.

Measure value over the long term.
Adopt investment settings that recognise prevention returns take time, but deliver major savings by reducing avoidable hospitalisation and complications.

A prevention-first system saves money, reduces suffering, and keeps people thriving. Allied health is essential to leading that shift.

Policy Paper 3: Better information and visibility

Our position
You can't fix what you can't see.

New Zealand needs a health information system that makes allied health visible in workforce planning, service design, and outcome reporting, so decisions reflect the real shape of the tier 1 workforce.

The problem
New Zealand lacks complete and reliable data on the allied health workforce and its role in Tier 1 services. This invisibility affects every level of the system.

Because allied health activity is poorly captured in national datasets, including workforce numbers, service utilisation, wait times, and unmet need, the professions are frequently excluded from planning, modelling, and investment decisions. Health reforms assume GP-centric service delivery because allied health contributions cannot be easily quantified or compared.

The lack of interoperable digital systems prevents shared care planning, limits communication between practitioners, and forces patients to repeat their stories and assessments. This leads to duplication, inefficiency, and frustration, and contributes to safety risks when different parts of the system operate with incomplete information.

Without consistent data on allied health roles, services, and outcomes, policy makers can't design integrated care or monitor whether reforms are working.

The background
The *Hidden in Plain Sight* identifies the absence of a "whole-system view" as a major barrier to integrated care. Key gaps include:

- No standardised national reporting of allied health services
- Limited insight into service gaps, unmet need and geographic variation
- Outdated or incomplete workforce datasets
- Fragmented funding systems that obscure how and where services are delivered
- Lack of shared clinical information across providers

It also notes that New Zealand stopped detailed OECD health accounts reporting years ago, weakening our ability to track spending and outputs across provider types, including allied health.

HiPS argues that unless the system can see where allied health is, who it serves, and what outcomes it delivers, it cannot design an efficient Tier 1 system — nor measure the success of reform initiatives.

The solution
Reinstate and modernise national reporting.
Return to detailed OECD-aligned health accounts and workforce datasets that include allied health, enabling transparent tracking over time.

Create allied-health-specific workforce and service indicators.
Measure supply, vacancies, utilisation, waiting times, and geographic gaps for allied health in tier 1 and tier 2.

Build shared digital records across tier 1 teams.
Support interoperable IT that allows allied health, GPs, and hospitals to share notes, reduce duplication, and coordinate plans.

Track outcomes that matter to people.
Report allied health-relevant outcomes (functioning, recovery time, wellbeing, pain reduction, participation), not just biomedical measures.

Making allied health count in data and visibility is a precondition for a smarter, more accountable health system.

Policy Paper 4: Reaching everyone, everywhere

Our position
Access to the right care should not be a post-code lottery. It should not depend on where you live, how much you earn, or what community you belong to.

New Zealand's 30,000+ allied health workforce can help address that issue – but the workforce must be resourced to deliver equitable, locally grounded services that reach people who are currently left behind.

The problem

New Zealand has persistent and well-documented inequities in access to primary and community care. Distance, transport constraints, out-of-pocket costs, and gaps in local service availability mean that many people cannot obtain timely, appropriate allied health support.

The *Hidden in Plain Sight* report highlights that allied health services are among the most inequitable in the country, because they are often privately funded, unevenly distributed, and unavailable in rural or high-deprivation communities.

Access barriers lead to delayed care, deterioration in health, avoidable hospital admissions, and escalating long-term needs. When people cannot access allied health services publicly, they rely on GPs or EDs for conditions outside the GP's optimal scope, or go without care entirely.

The background
Equity must underpin all Tier 1 reforms, especially in light of significant disparities affecting Māori, Pacific peoples, disabled people, older adults, and those living in remote regions. The HiPS report highlights that outreach, community-governed models, mobile teams and culturally-grounded services are both cost-effective and essential to delivering care where it is needed. Mobile allied health services in particular show strong impact on:

- Early identification of chronic conditions
- Fall and frailty prevention
- Developmental support for children
- Disability and sensory impairment support
- Hearing and vision screening
- Home-based rehabilitation

New Zealand's geography and population distribution mean traditional clinic-based service models cannot reach everyone. Without intentional investment in outreach and locally led commissioning, existing inequities will widen and pressure on hospital and urgent care services will continue to grow.

The solution
Fund mobile and outreach allied health teams.
Scale culturally-anchored, locally-led outreach services (including rural and disability-focused teams) to reduce distance and cost barriers.

Place equity requirements on tier 1 funding.
Tie collaborative care and prevention funding to demonstrated equity outcomes and access improvements for high-need groups.

Support community-governed service models.
Encourage iwi, Pacific, disability, and rural community governance in tier 1 services, with salaried teams designed around local priorities.

Enable allied health to deliver first-contact care in underserved areas.
Use extended scopes and direct access pathways so people can see allied health earlier, without unnecessary GP gatekeeping.

If we want a health system that truly reaches everyone, everywhere, allied health must be a funded, visible, community-based equity engine — not a private luxury.