Allied Health Activity: The Challenges of Legitimising and Prioritising Meaningful Work

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ABSTRACT

With growing service demand and constrained budgets, allied health services across New Zealand hospitals are focused on prioritising high-impact and high-value care. To inform understanding of what constitutes "high-value care", this study aimed to identify what allied health service activities are valued in a New Zealand District Health Board (DHB) setting. Semi-structured interviews were used to explore the perceptions of patients ($n = 2$), allied health staff ($n = 4$), and managers ($n = 3$) within one DHB as an exemplar. Following transcription, the data were analysed using conventional content analysis. There were differing perspectives between each participant group on high-value allied health care. Important allied health workplace activities were grouped into three categories: building relationships, providing meaningful allied health care, and backstage workplace activity. This research reveals the differences in perspective between what patients value and what organisations value. This tension may mean that allied health professionals struggle to prioritise and legitimise those aspects of care that matter most to patients.

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INTRODUCTION

Allied health encompasses a large, diverse range of autonomous professions who prevent, diagnose, and treat a range of conditions across a variety of health settings (Allied Health Aotearoa New Zealand, 2024; Ministry of Health, 2024). Allied health professionals undertake a range of activities including clinical, patient-related interventions and non-clinical activities such as research, management, and administration tasks (Jones & Jenkins, 2014; National Health Service Education for Scotland, 2021). Recent research focusing on allied health workplace activity profiles in hospital settings has identified that around a third of all allied health work is non-clinical in nature, with variations in role and experience evident (Brown et al., 2024; Hearn et al., 2017; McNicholl et al., 2024).

The New Zealand health system has experienced ongoing reforms since 2022 (Ministry of Health, 2025). At the time of this research, hospital services in New Zealand were managed by 20 District Health Boards (DHBs). During the analysis and write-up stages of this study, a major health reform was implemented following the Pae Ora Act (2022) (Ministry of Health, 2025). The DHBs were replaced with a new national entity, Te Whatu Ora–Health New Zealand (later rebranded as Health New Zealand), which is responsible for planning and commissioning of primary, community, and hospital health services (Ministry of Health, 2025). This paper will refer to the DHB setting, as that was the name at the time of research design and data collection; however, we note that the findings and implications are relevant to the new health system structure.

A key priority for Health New Zealand is improving financial performance; therefore, allied health services are expected to deliver sustainable and high-quality services in the context of dwindling health resources and increasing service demands (Health New Zealand, 2024b; Minister of Health, 2023). The national focus on financial imperatives has led to the prioritising of allied health service provision towards high-impact and "high-value" activities (Ministry of Health, 2021; Safe Staffing Healthy Workplaces, 2025). However, what constitutes "high-value" allied health activity is subjective, and must take into account the perspectives of the patients who access services, the allied health professionals who deliver the care, as well as the entities that fund these services (Comans et al., 2011).

Previous literature has outlined that patients value allied health services that are professional, accessible, convenient, affordable, co-ordinated, and provided by staff who are technically competent while maintaining continuity of care (Mutsekwa et al., 2022; Wong et al., 2022). Patients also place significant emphasis on allied health professionals' ability to develop positive relationships through communication, having time to develop a connection, and being consistent

(Bright et al., 2018; Sladdin et al., 2018; Wong et al., 2022). In comparison, research with allied health professionals highlights that they value workplace activities that improve clinical skills, knowledge, and competency (Comans et al., 2011; Wilson, 2015), and work that allows them to have meaning in their in day-to-day work (Scanlan & Hazelton, 2019). Professional development and supervision is a legal requirement for many health professionals, and available time at work for these activities has been shown to improve patient care, staff satisfaction, wellbeing, and retention (Cosgrave, 2020; Haywood et al., 2013; New Zealand Government, 2003; Wilson, 2015). Healthcare organisations, on the other hand, value direct patient activity and early, rapid assessments, which, in their view, influences system priorities such as waiting times, hospital length of stay, and costs (Adams et al., 2014; Comans et al., 2011; Harding et al., 2014). This reinforces that what constitutes "high-value" is influenced by who is being asked, suggesting there is scope for tension between what different parties value.

Based on these differing views and tensions, there is a need to understand these perspectives in the Health New Zealand setting given the potential influence on how allied health services are planned, delivered, and prioritised. It is unknown what allied health activities are most valued within Health New Zealand and, as such, this study aimed to determine what allied health workplace activities were most important to patients, allied health staff, and managers, using one district as an exemplar.

METHODS

This study was embedded within a larger sequential explanatory mixed-methods study focused on the value of allied health services in a New Zealand DHB (McNicholl et al., 2023). This was underpinned by a pragmatist paradigm, focused on participants' experience and actions to seek real-world solutions (Kaushik & Walsh, 2019; Morgan, 2014). The research team are experienced allied health clinicians and leaders, with the research supervisors (DR, FB) having significant experience in allied health research in New Zealand health settings. The aim of this qualitative component was to determine what allied health activities were most important to allied health staff, managers, and patients. Ethical approval was obtained from the Auckland University of Technology Ethics Committee (reference 20/288) and locality approval was obtained from the DHB.

Participants and recruitment

The research was based in a medium-sized DHB serving a population of over 300,000, of which almost 30% identified as Māori (Stats New Zealand, n.d.). The study included hospital inpatient, community, and outpatient allied health services and recruited patients, allied health staff, and manager participants to enable a range of stakeholder perspectives.

Potential patient participants who met the inclusion criteria were approached by senior allied health staff, who were not involved with the patient's treatment, to discuss the research. If interested, they were given a participant information sheet and the researcher's contact details. Allied health staff and manager participants were recruited via email, which outlined the study; this included the participant information sheet and researcher's contact details. The email was sent to all staff and managers in the DHB who met the below inclusion criteria, by a DHB administrator. Sampling sought diversity in participants, but recruitment, especially recruitment of Māori and patient participants was impacted by the COVID-19 pandemic and successive lockdowns.

Inclusion and exclusion criteria

Participants were eligible for inclusion if they were:

- patients receiving care from allied health services within the DHB
- staff members from one of six professional groups: allied health assistants, dietitians, occupational therapists, physiotherapists, speech and language therapists, and social workers
- managers who were an allied health service line manager of one or more of the included six allied health disciplines.

Participants were excluded if they were:

- patients from mental health services
- allied health staff who worked in mental health services
- allied health students
- allied health staff who reported to the lead researcher.

Data collection

Individual, face-to-face, semi-structured interviews were conducted at the DHB hospital site by the primary researcher (SM). The interviews were guided by a protocol designed to elicit people's experiences and perspectives on what allied health workplace activities were important (Rubin & Rubin, 2011). Sample questions are provided in Appendices A–C. Patient participants were asked questions about their health journey, what was important to them, which engagement they had with allied health staff, and asked about the type of work the allied health professional did to help them. Allied health staff participants were asked what a good patient encounter would look like from their perspective, what they felt were important work activities, and their views on workplace activity measurement. Allied health managers were asked about their views of high-value care, the measurement of workplace activity for allied health, and what allied health activity was important to management at the DHB. Interview questions were refined throughout the research in response to analysis. Interviews were audio-recorded and transcribed verbatim in English.

Data analysis

Conventional content analysis was used to analyse and interpret meaning from the data (Hsieh & Shannon, 2005). The researchers followed Hsieh and Shannon's (2005) approach, which included immersion with the text data, noting initial impressions, open coding, refining codes, and grouping codes into categories. Familiarisation came from re-reading the data with the research question and aims in focus (Erlingsson & Brysiewicz, 2017; Hsieh & Shannon, 2005). The primary researcher (SM) made notes of initial impressions

before open coding commenced (Hsieh & Shannon, 2005). This involved assigning brief labels to sections of text that provided insights into answering the research question. After coding multiple interviews, codes were compared and combined into broader categories. This process was recursive in that there was an ongoing process of analysis, writing, re-immersion with the text data, and refining analysis to organise and re-organise the categories. The final product was a conceptual map of findings on what activities were most important to all participant groups.

Trustworthiness

Credibility was enhanced by having prolonged engagement with participants during semi-structured interviews, actively exploring differing perspectives, and triangulating findings across participants (Lincoln & Guba, 1986). The risk of failing to identify areas of importance was mitigated by the research team (DR, FB) independently coding to ensure dependability of findings (Graneheim et al., 2017; Hsieh & Shannon, 2005; Lincoln & Guba, 1986). Reflexivity was enabled through a pre-understandings interview, exploration of experience biases and assumptions, ongoing reflection in supervision, and maintaining an audit trail of reflections and analytic decisions (Erlingsson & Brysiewicz, 2017; Graneheim et al., 2017).

RESULTS

Nine participants were recruited and included in the study. This included two patients, four allied health staff members, and three managers, the latter all with experience as registered allied health professionals. Participant details are below, with each person having a pseudonym to ensure anonymity (see Table 1).

Through analysis, important allied health workplace activities were grouped into three core categories. Table 2 outlines the categories and sub-categories of important allied health workplace activities: providing meaningful allied health care, building positive relationships, and "backstage" workplace activity.

Providing meaningful allied health care

This category reflects the importance of focusing on the individual patient and achieving positive patient outcomes by providing "meaningful" allied health care (Wai, allied health assistant).

Understanding what matters to patients

Obtaining an understanding of what matters to patients enabled allied health care to be planned and driven by individual patient needs: "Having conversations with patients about what matters. We should always start every

Table 1

Participant Demographics

Pseudonym	Participant role	Age (years)	Ethnicity	Clinical setting	Specialty
Kevin	Patient	20–30	European	Outpatient	Musculoskeletal
Manaia	Patient	70–80	European	Inpatient, community, outpatient	Rehabilitation
Wai	Allied health assistant	50–60	European	Inpatient, outpatient	Rehabilitation
Emma	Occupational therapist	40–50	Other	Community	Paediatric
Anne	Physiotherapist	40–50	Other	Inpatient	Acute
Emily	Physiotherapist	50–60	European	Outpatient	Women's and men's health
Susan	Allied health manager	50–60	European	Inpatient, community, outpatient	Manager
Rhonda	Allied health manager	20–30	European	Inpatient	Manager
Niamh	Allied health manager	40–50	European	Inpatient, community, outpatient	Manager

Table 2

Categories and Sub-categories of Important Allied Health Workplace Activities

Category	Providing meaningful allied health care	Building positive relationships	Backstage workplace activity
Sub-categories	Understanding what matters to patients An individualised approach to care Enabling and demonstrating positive patient outcomes	Effective communication Developing trust The "human aspects" of care	Indirect clinical activity Non-clinical activity

conversation with a patient asking, 'what matters to you?'. Then we can tailor our interventions around that" (Susan, manager).

The process of understanding what matters to patients was considered a key component and a starting point for allied health professionals delivering meaningful care. What matters to patients could get lost amid organisational imperatives. This contributed towards frustration from patients who did not always feel care was focused on what mattered to them:

> Try and work out what is important for them [the patients]. Then realign your goals to that person then you would get maximum results. If you come in and try to impose what you think needs to happen on the patient without involving them, then it is not going to work. (Manaia, patient)

An individualised approach to care

Participants articulated how allied health professionals need to support patients in decision-making about their preferred interventions. Activities that were individualised, meaningful, and flexible to changing needs were valued by all participant groups.

> Functional activities, activities that are appropriate for that person's life. If they play golf, for example, their exercises shouldn't be to practice skydiving. Even in a group class you need to tailor things to the patient even though we are in a hospital environment. (Wai, allied health assistant)

Individualised, meaningful interventions were considered to help patients to be more involved in their healthcare, as care was relatable to what matters to patients, and were seen as more effective than "off-the-shelf programmes, which mean nothing to patients" (Rhonda, manager).

Understanding the context of the individual person was important in developing treatment plans. Allied health professionals suggested they were able to provide more meaningful interventions when they had this wider understanding of the person, something supported by managers:

> We do not just give a patient a frame. We need to understand their [the patient] context, their home environment, social situation, and whānau support … it's not just that 30 minutes with the patient, it's the broader picture of looking after that person and thinking about their whole life journey and what they are going home to and understand that what we do today will influence how they recover and return back to their normal function. (Niamh, manager)

Enabling and demonstrating positive patient outcomes

Most participants agreed that the purpose of allied health activity was to support a meaningful improvement in quality of life, with an allied health assistant saying, "The whole point of rehab is to enable more quality of life at whatever stage they are at" (Wai, allied health assistant). Patients echoed these views, while also discussing the importance of a sense of progress, perceiving tangible and meaningful improvements from their allied health care:

> Seeing progress is really important … [and is] helpful also for my mental state of mind … I feel like I am progressing and this is reassuring and helps me focus on the longer term and letting me know that we will get there. (Kevin, patient)

Managers had different motivations for capturing and *showing* positive patient outcomes. Linking positive patient outcomes to allied health activities enabled managers to show value, improving visibility of allied health at an organisational level. It could also support organisational priorities such as best use of health resources, service improvement and effective service planning.

> How does our intervention marry-up with the improvement of a patient's outcome? We can show we have done X amount, but it didn't make a difference, or it did make a difference. We will be able to be much more discerning on where we do things and what we do. (Susan, manager)

Building positive relationships

This category reflects a common view that positive working relationships underpinned good patient care and experience. It was achieved through three relational workplace activities: communication, developing trust, and the human aspects of care.

Effective communication

Communication was multifaceted, including listening, ensuring enough time for communication, use of everyday language, and enabling safe transitions of patient care. Strong listening skills were seen as important in understanding patient needs and providing person-centred care:

> A good session is when we sit down at the start and I explain where I am at, what I think I am having difficulty with, and what I am progressing with … listening can let [the physiotherapist] know where I am at physically, mentally, and in life as a whole, which is important … we can then apply this into the gym. (Kevin, patient)

However, in the context of limited time with patients, allied health staff reported two co-existing priorities: getting information from patients while ensuring patients felt heard.

> It's how you ask the questions you can go through an assessment and it is very box ticky, but if you can say "tell me about". I know open ended questions can be a bit hard to direct but finding that balance to let the patient talk and getting the right information so that they feel heard. (Emily, physiotherapist)

Effective listening skills made allied health staff appear more approachable, enabling patients to express their needs and to participate in their treatment. In fact, this was often the first thing participants suggested when asked what matters most to patients: "That they are listened to, that they feel comfortable to bring up any issues. That they can participate in their treatment choices, and they get what they need, when they need it" (Anne, physiotherapist).

While people described communication as important, there was a tension between the importance of it and the

perceived legitimacy of communication as "real work" (Emma, occupational therapist). "Sometimes just sitting and having a cup of coffee and not even go near the kid. I would think I actually didn't do much worthwhile, I just listened" (Emma, occupational therapist).

Having time to communicate effectively and building a connection were important in sowing seeds of trust and opening the door for patients to engage, and could lay a foundation for an ongoing relationship and engagement in care.

Developing trust

Many participants identified that making a connection with patients and whānau was an essential part of allied health practice as it established trust: "Establishing a really special rapport is critical, absolutely critical. Like it is for a teacher and a student" (Manaia, patient).

Allied health staff used several strategies to build trust, including putting patients at ease, not rushing the process of connection, and finding a common ground before "getting into the rehab" (Wai, allied health assistant). A trusting, collaborative partnership was seen to improve engagement with care:

> I once had a family who said: "You keep coming back", and I thought well maybe they are starting to think they can trust me as I keep coming back and I am not judgemental. That's the only way and if we do not get buy-in we cannot do our therapy. (Emma, occupational therapist)

Trust was considered particularly relevant in the New Zealand context because of systemic marginalisation of Māori (Indigenous people in New Zealand who have experienced persistent barriers and negative health experiences and outcomes in the health system (Graham and Masters-Awatere, 2020)). When planning patient discharge, Anne (physiotherapist) highlighted the value of having a trusting relationship with whānau (family) as a "way in" to get the necessary information and form a robust, sustainable patient plan:

> The patients here [in our region] are more likely to engage with their whānau, I am more likely to find out things from the whānau, for example if they are in pain or if something might not work for the patient at home, they may not tell me, but the family will.

The "human aspects" of care

Human aspects of care included attributes such as compassion, empathy, and patients feeling respected as individuals. It also encapsulates concepts such as seeing the clinician as a person, not "just another white coat" (Emily, physiotherapist). By being "more human", allied health professionals were able to connect with patients more easily: "She was approachable and easy to talk to. A lot of my concerns and fears were allayed" (Manaia, patient).

Exploring what Emily (physiotherapist) described as the "softer aspects of care" helped in understanding the patient experience:

> I would ask [the patients] were they respected? Did they feel heard? You know more of the touchy-feely stuff rather than the outcome measure stuff … More of the feeling questions as opposed to – we improved you by this much.

A human approach to care was an important pre-requisite to patient care but was not perceived by staff as allied health "work". For staff, the human aspects of care were separate and needed to be balanced alongside providing the "actual rehab" (Wai, allied health assistant).

"Backstage" activity

"Backstage" workplace activities included indirect clinical activity and non-clinical tasks.

Indirect clinical activity

Indirect clinical activity was conducted away from the patient and included liaising with other healthcare professionals and external agencies, documentation, discharge planning, co-ordinating homecare supports, and planning for patient sessions. Indirect activity was not perceived as traditional allied health "work" but was required to support patient flow through the health system. "If I only did the physio things for this patient, I would already have them discharged, but they would sit in the hospital and never move" (Anne, physiotherapist).

The importance of indirect work was well-recognised by patients.

> This is when I had the most wonderful help from the occupational therapist, absolutely outstanding. He managed to requisition equipment at home for me because there was nowhere that the wheelchair could fit in my bathroom. Normally you cannot get this equipment, but he worked miracles and managed to get one. (Manaia, patient)

Indirect activity was not without tensions. First, many clinicians derived significant job satisfaction from their face-to-face work with patients. Indirect activity was acknowledged as important; however, it was not the source of value or joy. "A good day for me is when I work in the community with patients … you know that you are making a difference and that you are part of something" (Emma, occupational therapist).

Second, there were perceptions that indirect activity was not as important as the "actual work" (Anne, physiotherapist). In describing "actual work", Anne referred to working directly with patients doing activities such as assessments, therapy, and problem solving. Indirect activity was seen as something that needed to be done before "real work can begin" (Emma, occupational therapist).

Some indirect activity could be very time intensive, such as seeking funding and approvals for assistive equipment and housing modifications:

> Completing paperwork for, and co-ordinating housing modifications, is a roadblock created by an external agency, this is a colossal waste of resource. If we didn't have to do this, it would free up our resource and for us

that would mean no waiting list and a massively improved and more responsive service. (Niamh, manager)

While indirect activity was important for comprehensive and high-quality care, organisational key performance indicators focused on services delivering more direct patient encounters to reduce waiting times and optimise patient flow. Both managers and staff recognised the battle between providing enough direct patient contacts to manage demand, while providing quality care: "The constant challenge for us is how we balance quality and relationships versus quantity and the way the system needs us to work" (Rhonda, manager).

Non-clinical activity

Non-clinical activity reflects work done by allied health staff that did not relate to individual patients. This included operational, administration, and management tasks to support service delivery; training and supervising staff; and leading service improvement initiatives. This was seen as significant in terms of quality of patient care:

> We pushed in-service [training] and dedicated [more] time and this was reflected in our data. We could see there were less hospital readmission rates for patients we have been involved with, we [have] seen more home visits and access visits earlier in the patient journey as the team were skilled and could do that well. (Rhonda, manager)

While professional development was a highly valued activity, several staff participants viewed other aspects of non-clinical work as less fulfilling and menial. Wai (allied health assistant) commented, "You know some of the things I do behind the scenes are not that glamorous you know like cleaning, managing stock, and stuff like that … but at the end of the day it is just part of the role."

Staff had a perception of surveillance on the amount of non-clinical activity they do. Organisational priorities such as patient flow and reducing waiting times were addressed by clinical activities, which were more valued by managers. For example, Anne (physiotherapist) noted that: "My manager is very interested in my numbers, total patients waiting, patients seen, and patients discharged … we measure this [clinical activity] well but my non-clinical activity data is broad and lacks detail, suggesting that it is not as important."

DISCUSSION

This study on high-value allied health workplace activity has raised two phenomena worthy of discussion: the perceptions of which allied health activities are perceived as the "real work" and how allied health workplace activity is prioritised in the New Zealand health system. These have significant implications for patient outcomes, experience, and allied health staff wellbeing, and how these align with perceptions of high-value and low-value allied health workplace activity.

Participants provided differing perspectives on what allied health workplace activities were most important. Implicit through the interviews with allied health staff and managers was a belief that patient-facing activities such as clinical assessments, therapeutic interventions, and exercise groups were seen as the "real work". While patients valued the discipline-specific skills and expertise, they also highlighted the importance of hidden work such as active listening, relationship building, coordinating patient journeys, use of humour, and backstage activities as critical in enabling quality health outcomes, all of which have been shown to be critical in engagement in care and rehabilitation (Bright et al., 2018, Miciak et al., 2019). This finding echoes earlier research that demonstrated the differing views between patient and health organisations on the value-add of allied health (Comans et al., 2011; Mickan et al., 2019). The Health New Zealand focus on financial performance and meeting national health targets (Health New Zealand, 2024a; Health New Zealand, 2024b) may explain why the allied health staff and manager participants legitimised and valued direct patient care as the "real work".

There are several reasons why direct patient care was seen as most important by some participants. First, as highlighted by Bright et al. (2024), this research found that direct clinical interventions with patients such as early assessments were seen to support patient flow through the system and address organisational targets such as waiting times and hospital bed days (Health New Zealand, 2024b). Second, providing patient contact activities was a source of joy and meaning to allied health staff in this study. Scanlan and Hazelton (2019) found that mental health clinicians had better job satisfaction when they felt their work was meaningful, leading to recommendations to increase in-person interactions to improve workforce retention and wellbeing at work. Finally, patient-related activities are more visible to patients when receiving allied health care and to health services within Health New Zealand, and these are reflected in national allied health data standards (Health Information Standards Organisation, 2018; Safe Staffing Healthy Workplaces, 2024). Less visible activities such as service-related non-clinical work, professional development, and relationship building with patients may not be considered "real work" or an organisational priority.

Another key finding from this study was the differing views on high-value allied health activity and their potential impact on how allied health service activity is prioritised within Health New Zealand. In the context of high levels of service demand, allied health workforce shortages and well-publicised fiscal pressures, staff and manager participants described the challenge of meeting organisational and patient priorities in their day-to-day work (Health New Zealand, 2024a). National prioritisation guidelines are in place for hospital inpatient allied health services to enable services to identify and respond to patients with the highest clinical need (Safe Staffing Healthy Workplaces, 2025). However, prioritisation may lead to unintended consequences, including contributing to a quantity versus quality approach to allied health practice, where acute patient flow is prioritised over patient outcomes and experience. This may contribute to a rapid and transactional approach to allied health encounters where clinicians prioritise activities related to movement toward discharge and satisfying managers who are monitoring throughputs and volume of patients seen (Bright et al., 2024). This can impact on patient interactions,

leading to a therapist-centred approach to engagement, which can limit opportunities for person-centred care, with patient participants in our study voicing frustration with so called pre-set agendas (Hiller et al., 2015). Previous studies in Australia have outlined the negative impacts, such as patients not feeling heard or being involved with their health, when allied health services adopted a dictatorial approach to care (Sladdin et al., 2018; Slade et al., 2009). Further, it can contribute to moral distress and burnout for clinicians, as shown in a range of physiotherapy studies (Currie & Dafny, 2025; Inbar et al., 2024; Skamagki et al., 2025). This study echoes earlier research on the need for allied health services to be more person-centred and less "off-the-shelf" (Jesus et al., 2016; Sladdin et al., 2018; Slade et al., 2009), for the sake of both patient care and care for the healthcare professionals involved.

This study demonstrates the value of positive relationships between allied health professionals and patients. The importance of relational allied health practice is well recognised in physiotherapy and other allied health disciplines (e.g., Bright et al, 2012; Bright et al., 2018; Miciak et al., 2018; Sladdin et al., 2018). While investing time in developing therapeutic relationships is important to patients (Wong et al., 2022), our work supports previous research that highlights the challenges of developing these relationships in the context of high patient demand and organisational cultures of rapid assessment and discharge (Bright et al., 2012; Bright et al., 2024). This focus on organisational imperatives may also explain why allied health staff in this study did not see relational practices as legitimate "work". This has specific implications within the New Zealand context, where addressing health inequities has been identified as a priority (Ministry of Health, 2025). Positive relationships with healthcare staff have previously been identified as important to Māori in the New Zealand health system (Graham & Masters-Awatere, 2020; Levack et al., 2016). Provision of culturally safe care is critical for achieving equity in experience and outcome for Māori, and requires healthcare professionals to work to build trusting relationships (Dixon et al., 2021; Graham & Masters-Awatere, 2020; Sheehy et al., 2024). The lack of value placed upon relational aspects of practice has very real potential to reinforce health inequities for Māori patients receiving care from stretched allied health services within Health New Zealand.

The findings from this study on what allied health work is "real work" and the prioritisation of workplace activities can explain the differing views between patients, frontline allied health staff, and allied health managers. Patients expected and required helpful relationships with allied health professionals. The allied health workforce struggled to find time to develop a connection with patients, yet also consider it important. However, health organisations remain focused on the best use of health resources and productivity by measuring the volume of patients seen and by quantifying allied health staff time-use (Health Information Standards Organisation, 2018; Ministry of Health, 2021; Safe Staffing Healthy Workplaces, 2024). This is seemingly at odds with organisational values of being person-centred and talks to the complex environment within which clinicians are working (Health New Zealand, 2022).

This study has several strengths. Participants were recruited from a range of clinical settings (hospital inpatient, outpatient, and community). An iterative approach to data collection enabled emerging findings to be further explored in subsequent interviews. However, there were limitations of this study. The small sample size reflected recruitment challenges, exacerbated by the impact of the COVID-19 pandemic, especially for patient participants. Staff participants were not representative of the allied health workforce, although we sought to partially mitigate for this by including managers who had staff from these disciplines in their teams. Perspectives of other allied health professions may provide further insights into what matters for allied health practice. The small sample size, lack of Māori participants, and focus on one locality may limit the transferability of findings to all patient demographics, or to other districts in New Zealand, such as large, urban tertiary centres. Future research may focus on exploring high-value allied health activity in a specific setting, such as inpatient rehabilitation, across several districts and include other allied health professional groups.

CONCLUSION

Allied health professionals working in Health New Zealand struggle to balance organisational priorities, such as achieving national health targets and remaining within budget, while ensuring high-quality care is provided to optimise patient experience and outcomes. In the context of high demand and fiscal constraints, focusing on what matters to Health New Zealand may mean that allied health professionals struggle to prioritise what matters most to patients. Moving forward, health leaders should legitimise all aspects of allied health workplace activity that contribute to quality patient outcomes and experience.

KEY POINTS

1. Allied health services within Health New Zealand are prioritising perceived high-value activity in the context of financial constraints.
2. This research has highlighted differing perspectives on what constitutes high-value allied health workplace activity, which come with significant tensions.
3. Allied health services may prioritise financial and organisation imperatives, such as acute hospital flow and bed days, over what matters most to patients.

DISCLOSURES

This research did not receive any specific funding. No conflicts of interest exist that may be perceived to interfere with or bias this study.

PERMISSIONS

Ethical approval was obtained from Auckland University of Technology Ethics Committee (20/288). Locality approval was obtained from the District Health Board's Clinical School (2020-80).

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CONTRIBUTIONS OF AUTHORS

Design conceptualisation and methodology, SM, DR, and FB; formal analysis, SM, DR, and FB; writing: original draft preparation, SM; writing: reviewing and editing, SM, DR, and FB.

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APPENDIX A

PATIENT INTERVIEW PROTOCOL

1. Tell me about your most recent encounter with allied health.
   - Who was involved in your care?
   - What did they do?
   - Was the care timely?
   - What was most helpful to you?
   - What did you feel was unhelpful?
   - Do you feel that you had enough time with the therapist/clinicians/assistant?
   - How could the encounter be improved?

2. Tell me about your overall care.
   - What had largest impact on your treatment outcome?
   - What improved your overall experience?
   - How was the communication between you and the clinician?
   - Did you feel involved in your care?
   - Were your goals discussed?
   - How involved did you feel with problem solving and planning your care? If not, why not? If involved, why?

3. Reflect on your overall journey so far.
   - What made the biggest positive impact on you?
   - What would help improve your outcome/progress towards your goals?
   - What aspect of your care would you like to see improved? Why?
   - What would a good treatment session/encounter look like from your perspective?
   - When you see an allied health professional, what is the most important thing to you?
   - Overall, were your needs met? Who did you feel helped the most with your journey?

APPENDIX B

ALLIED HEALTH STAFF INTERVIEW PROTOCOL

Thank you for coming along and participating in this study. This study is aiming to understand the value of allied health.

1. What do allied health professionals/assistants do?
   - Reflect on a patient that you saw today/yesterday.
   - Tell me about all the things you did to provide care for that person.
   - How do you think these things impact on the patient's care?
   - What aspect of the care did you feel was most important?
   - Can you comment on the things that you did away from the patient?
   - Are these important? Why?

2. What workplace activities do allied health professionals/ allied health assistants think matter the most?
   - What do you believe are the core ingredients of quality patient care?
   - What is most important in terms of patient outcomes? Why?
   - What are the most important activities in terms of patient experience? Why?
   - What are the different factors that you consider when deciding how to spend your time?
   - What matters most to the District Health Board system? How do you know this?
   - What does a great day at work look like for you? Why?

3. Thoughts on recording/measuring what allied health professionals/allied health assistants do and what they think matters.
   - What are your opinions on your workplace activity being measured?
   - What value does this add to you?
   - What aspects of care do you feel are missing currently?
   - What would you like to be more visible?
   - What would make the data more meaningful to you?

Appendix C

ALLIED HEALTH MANAGER INTERVIEW PROTOCOL

1. What do allied health professionals/assistants do?
   - Tell me what your team do at work.
   - Tell me about all the things they need to do for patients.
   - Why are these activities important for patients?
   - Can you comment on the things that your team need to do when they are away from the patient?
   - How do you think this impacts on the patient's care?
   - Is there anything that you would like to see your team spend more time doing? Why?

2. What workplace activities do allied health professionals/allied health assistants think matter the most?
   - What do you believe are the core ingredients of quality patient care?
   - What is the most important in terms of patient outcomes? Why?
   - What are the most important activities in terms of patient experience? Why?
   - What are the different factors that your team consider when deciding how to spend their time?
   - Allied health professionals and allied health assistant participants feel the district health board cares most about number of patients seen, cost effectiveness, efficiency, but not the other aspects of care – have you any thoughts on this?
   - What would a great day at work look like for your team from your perspective?