Strategies to strengthen rural allied health workforce recruitment and retention in Aotearoa New Zealand: evidence-based recommendations from qualitative research

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ABSTRACT

INTRODUCTION AND AIM: Rural and remote communities in Aotearoa New Zealand face persistent challenges recruiting and retaining allied health professionals (AHPs). Despite investment enhancing medical and nursing rural workforces, the more than 40 professional groups comprising allied health, scientific and technical collectives have received little attention. We aimed to undertake a secondary analysis to systematically develop evidence-based, actionable and context-specific recommendations to improve rural AHP recruitment and retention in Aotearoa.

METHODS: We used a five-step process to translate evidence into context-specific guidance for five stakeholder groups (line managers, health organisations, recruiters, professional bodies/regulatory authorities, education providers) drawing on: a) empirical data and findings from qualitative research involving 18 AHPs with rural experience across Aotearoa; and b) targeted literature scans to identify intervention and implementation research and policy-relevant evidence from comparable rural and remote health system contexts.

RESULTS: Twenty recommendations were developed and then grouped into four focus areas: 1) build workforce integration and belonging, 2) establish sustainable practice environments, 3) design career-worthy rural roles, and 4) match people, place and practice. Implementation actions for key stakeholder groups were developed within each focus area. These recommendations collectively address the three key themes identified in our original research.

CONCLUSION: Successful recruitment and retention of rural AHPs requires a multifaceted, collaborative approach. Implementing these targeted recommendations can create environments where AHPs feel valued, supported and connected, ultimately improving allied health service access for rural communities.

Rural and remote communities in Aotearoa New Zealand continue to face persistent challenges in accessing comprehensive health services, with allied health professionals (AHPs) being particularly difficult to recruit and retain.[1] While these communities have always struggled with health workforce stability, the COVID-19 pandemic created volatile conditions, compounded by the effects of ongoing health system reforms that have intensified these challenges to critical levels.[2,3]

Rural communities experience poorer health outcomes compared with their urban counterparts.[4] Limited access to a full and well-distributed health workforce—including allied health—is identified as a key contributor to poorer health outcomes in rural and remote communities.[5]

AHPs, encompassing more than 40 professions including physiotherapy, occupational therapy, social work, pharmacy, paramedicine and dietetics, provide essential services across prevention, treatment and rehabilitation. In rural contexts, these professionals assume even greater significance, often practicing at extended scopes to address service gaps, while managing complex presentations with limited specialist support.[6] Yet, despite their critical contributions to comprehensive health delivery, rural allied health workforce development has received minimal policy attention or targeted investment compared to medicine and nursing initiatives.[7] This neglect represents a systemic inequity and a missed opportunity. A well-supported rural allied health workforce could transform health service delivery in these communities, offering sustainable models that optimise professional capabilities within resource-constrained environments.

To address this gap, we undertook research[7,8]

exploring the factors that influence AHPs' decisions to work and remain in rural settings (see overview of the original research below). In this paper we present the outcome of a secondary analysis of the original research aiming to systematically develop evidence-based, actionable and context-specific recommendations to improve rural AHP recruitment and retention in Aotearoa. This represents a critical bridge between research and action, translating findings from our comprehensive study of rural AHP experiences[7,8] into practical recommendations for key stakeholder groups.

The original research: understanding rural AHP experiences

The original research[8,9] drew on interpretive descriptive methodology[10] to address two key research questions: 1) what do AHPs identify as the attractive aspects of living and working rurally, and 2) how could this inform how we recruit and retain AHPs in rural and remote health settings? The research drew on an appreciative lens, shifting from deficit orientation to a strength-based focus.

Eighteen AHPs representing diverse professions (social work, physiotherapy, occupational therapy, music therapy, dietetics, psychology and pharmacy) contributed their perspectives through semi-structured interviews conducted via videoconferencing between July 2019 and December 2021. Data were analysed using reflexive thematic analysis.[11]

Three interconnected themes were constructed: **sense of connection and belonging** (feeling valued professionally and personally within rural communities), **safe and supported practice** (environmental and organisational conditions necessary for quality service delivery) and **creating roles people want to come for** (job characteristics attracting and retaining rural AHPs). Woven throughout was the concept of **fit**: a felt sense of alignment between personal values, professional aspirations and the rural context. When fit was present, other challenges felt manageable. When absent, even positive aspects of rural practice were insufficient to compensate.

Methods: developing evidence-based recommendations

We developed a systematic five-step process to translate findings into context-specific guidance for five stakeholder groups (line managers, health organisations, recruiters, professional bodies/regulatory authorities, education providers) drawing on: a) empirical data and findings from the original research; and b) targeted literature scans to identify intervention and implementation research and policy-relevant evidence from comparable rural and remote health system contexts. The five-step process is described further below.

The development of stakeholder-specific recommendations was led by JEG, with NK and PJL contributing through iterative and recursive discussion throughout the analysis. Recommendations were discussed, challenged, debated and refined by the research team. Researcher positionality was considered throughout. JEG is a social worker with clinical, leadership and policy experience in rural allied health settings. NK has a background in health psychology and extensive experience in allied health education and research. PJL is a physiotherapist with experience in allied health education, leadership, governance and professional regulation. Collectively, the authors brought multiple professional and system-level perspectives to the analysis, having held clinical, educational, management, leadership, policy, advisory and governance roles relevant to the stakeholder groups represented in this study. This provided insight into the contexts, priorities, opportunities and constraints facing different groups, supporting the development of recommendations that were both evidence informed and contextually grounded. At the same time, the team recognised their perspectives to be inherently partial; therefore, recommendations were subject to critical discussion and challenge within the research team to reduce reliance on any single perspective.

1. Identifying target audiences

Our findings highlight that the responsibility for recruitment and retention of rural AHPs must be distributed. No single entity can solve rural workforce challenges alone. Generating change in this space must be a collective endeavour, involving a range of key influencing groups. To identify key influencers, we undertook a secondary analysis of transcripts from the original research,[7,8] coding all references to individuals or groups that influenced participants' employment decisions. We then categorised these references according to sphere of influence (direct/indirect) and level

of impact (individual/systemic). This revealed five key stakeholder groups whose co-ordinated actions are essential to creating sustainable change: line managers, health organisations, recruiters, professional bodies/regulatory authorities and education providers.

2. Mapping findings to stakeholder groups

We then mapped each theme and sub-theme to the five stakeholder groups, identifying where stakeholders had meaningful capacity to influence outcomes. Some themes and sub-themes were mapped to more than one stakeholder group, highlighting the importance of distributive and collaborative leadership. We extracted data relevant to each stakeholder group.

3. Generating preliminary recommendations

Drawing on extracted data, the research team brainstormed key actions and activities for each stakeholder group, drawing on our collective leadership, clinical and research experience to consider what each group could feasibly action. These were iteratively developed and refined through independent work by the lead author and collaborative work, where emergent ideas were presented for discussion and challenge by the research team. Through this process, a set of preliminary recommendations were developed.

4. Contextualising recommendations

Given the changing context in which this research was undertaken, our next step was to consider the preliminary recommendations in relation to the context in which they would be implemented. Three context features were identified as being particularly relevant: 1) alignment with the Pae Ora (Healthy Futures) legislation,[12] 2) feasibility in the context of workforce impacted by COVID-19, and 3) barriers to implementation in the context of health system changes. Recommendations were reviewed and contextualised to ensure they remained relevant, salient and actionable in this changing context.

5. Grounding in existing evidence

We conducted a targeted literature scan for each preliminary recommendation, focussing on intervention and implementation research from comparable rural contexts in Australia, Canada and rural European settings.[13–15] This literature scan was purposive rather than systematic, reflecting the applied nature of the analysis. As recommendations were developed, the research team engaged iteratively with relevant theory, empirical evidence and sector literature to refine recommendations and identify actionable strategies. Sources included literature already known to the research team, supplemented by targeted searches of academic databases available through the Auckland University of Technology library and relevant sector grey literature. This approach is appropriate for evidence-informed recommendation development, where the aim is not to comprehensively synthesise all available evidence but rather to identify and apply relevant evidence to contextualise and refine recommendations. Each recommendation was evaluated against the evidence of effectiveness in similar contexts, its implementation feasibility given Aotearoa's health system structure and reforms[16] and alignment with Te Pae Tata strategic priorities.[17]

Ethics approval

This research received ethics approval from the Auckland University of Technology Ethics Committee (AUTEC 18/424) and adheres to established guidelines for qualitative research reporting. The study methodology and reporting follow recognised standards for interpretive descriptive research and qualitative inquiry in health services. Participants consented to the anonymised sharing of quotes within published literature such as this.

Results: recommendations to strengthen rural allied health workforce recruitment and retention in Aotearoa

The research findings were originally translated into 20 distinct recommendations distributed across five key stakeholder groups: line managers (n=6), health organisations (n=7), recruiters (n=4), professional bodies/regulatory authorities (n=2) and education providers (n=2). These recommendations were systematically derived from research findings through the five-step process described in the methods section. The recommendations were then grouped into four focus areas. Table 1 presents each focus area alongside its evidence basis, demonstrating the direct link between participant experiences and practice recommendations. Each recommendation is further grounded in existing evidence from comparable rural contexts, as described in step 5.

Table 1: Key focus areas and related implementation actions by stakeholder group.

Stakeholder group	Implementation actions	Evidence base
Focus area 1: build workforce integration and belonging		
Line managers	**Become a local resource:** develop knowledge of local networks, recreational opportunities and community organisations to facilitate connection for new staff.	Participants emphasised the importance of managers helping them navigate community integration, particularly in the early stages of rural practice when establishing personal and professional connections was challenging.
	Spend time in remote locations: regular visits to remote work locations to understand team realities.	This practice was highly valued by participants, as exemplified by one who described her manager's reaction after experiencing the workload: *"She was just like, 'So what do you guys normally do when you have got this?'"* Direct experience builds empathy and informs contextually aware decision making.
Health organisations, professional bodies/ regulatory authorities	**Champion rural allied health professionals' (AHPs) expertise:** positively represent rural colleagues and their skills within the broader organisation and profession; challenge narratives that diminish rural expertise.	Addresses the impact of "geographical narcissism" identified in the research, where participants described feeling their rural knowledge and skills were undervalued compared to urban specialist roles. This undermined their sense of professional identity and belonging.
Health organisations	**Demonstrate respect for AHPs:** build organisational cultures where AHPs feel valued and respected as essential contributors; challenge professional hierarchies that privilege medicine and nursing.	Participants described experiences of being overlooked in service planning: "*The nurses take that, become geriatrician nurse specialists, pulmonary nurse specialists, rehab nurse specialists ...* [We] *aren't sought for those roles at all*." Lack of recognition reduced their sense of belonging and contribution.
Recruiters	**Prioritise rural recruitment:** recognise different dynamics of rural recruitment where candidates are scarce; provide timely communication, personalised approaches.	Participants contrasted experiences of responsive rural recruitment with impersonal urban processes, emphasising how recruitment interactions shaped their perceptions of organisational culture and their potential fit.
	Create connection opportunities: co-ordinate start dates to build social connections among new staff when possible.	"*We ended up all getting together coz we were all new to town ... it was really neat to have this group of people*." Facilitating peer connections helps new staff build support networks in unfamiliar communities, reducing isolation.

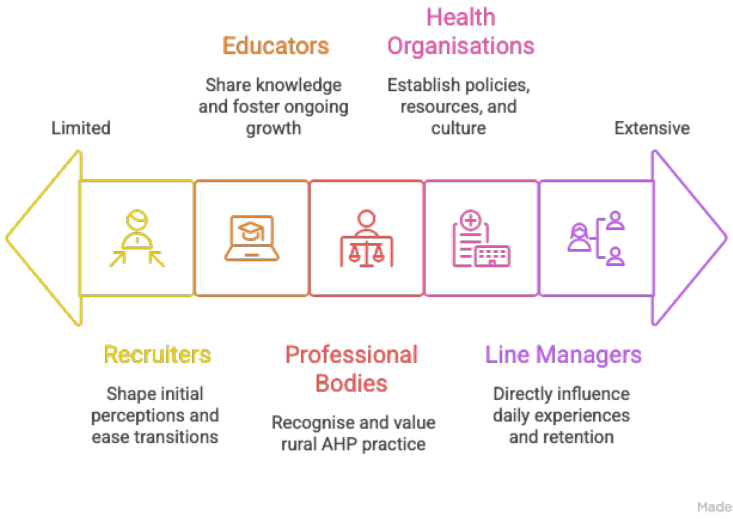
Table 1 (continued): Key focus areas and related implementation actions by stakeholder group.

Stakeholder group	Implementation actions	Evidence base
Focus area 2: establish sustainable practice environments		
Line managers	**Invest in leadership development:** actively seek opportunities to develop capabilities in remote team leadership.	Rural AHP management requires unique skills. Participants identified responsive, contextually aware leadership as critical to their sense of being supported in rural practice. Lack of manager understanding created unsafe practice environments.
	Assume good intent: Approach rural staff with trust and respect for their capabilities; combat "urban narcissism".[18]	Leadership that assumes competence fosters supportive environments: "*I feel like I've got that freedom. She definitely trusts me that I'll do the work.*" Conversely, lack of trust created defensive, unsustainable practice conditions.
Line managers, health organisations	**Apply the reasonableness test:** at management level, critically examine expectations of rural staff for reasonableness given travel time, safety, resources. At policy level, examine urban-derived policies for rural applicability.	Participants described policies requiring multi-hour trips to access shared equipment, reducing clinical time and creating safety concerns. One reflected that local tool availability even twice weekly would be more practical than requiring staff to spend hours travelling for single-use access.
Health organisations	**Value AHPs' learning needs:** develop professional development addressing AHP-specific needs rather than adapting nursing-focussed education.	Participants described frustration with professional development designed for nursing that didn't address their specific clinical or professional needs, leaving them without appropriate skill development opportunities.
	Apportion resources equitably: provide equitable access to professional development, equipment and technology across all professional groups.	Participants particularly noted disparities compared to medical and nursing colleagues, describing situations where they lacked basic equipment while other professions had ready access, creating unsafe and unsustainable practice conditions.
Education providers	**Develop remote learning opportunities:** create accessible pathways for rural learners to access knowledge, skills and qualifications without requiring relocation.	Successful models exist (e.g., Massey University's distance speech and language therapy programme). Participants emphasised that accessible professional development was essential for maintaining competence and career progression in rural settings.

Table 1 (continued): Key focus areas and related implementation actions by stakeholder group.

Stakeholder group	Implementation actions	Evidence base
Focus area 3: design career-worthy rural roles		
Health organisations	**Include AHPs in decision making:** ensure AHPs are included in service planning and development from the outset.	Participants described being overlooked in service development, with opportunities defaulting to nursing roles. Exclusion from decision making reduced job satisfaction and signalled that AHP contributions were not valued.
Professional bodies/ regulatory authorities	**Recognise rural scope of practice:** establish mechanisms to recognise rural practice as advanced practice and develop pathways to specialise in rural generalism.	Rural generalist practice requires expertise in managing complex health needs across the lifespan, deep understanding of community contexts and advanced clinical reasoning with limited resources. This distinct skillset warrants formal recognition, creating legitimate career pathways.
Education providers	**Develop rural generalist pathways:** establish education programmes that specifically prepare AHPs for the breadth of rural practice.	"*I like the variety, so that keeps my head engaged. It means I know a little about a lot, instead of a lot about a little.*" Formal pathways provide structure for developing the diverse capabilities required, creating recognised career progression.
Focus area 4: match people, place and practice		
Line managers	**Support boundary navigation:** prepare staff for unique boundary challenges where professional and personal relationships overlap; provide practical support and guidance.	Participants described challenges managing community expectations while maintaining boundaries, particularly for new graduates. Practical support (e.g., flexibility with pool vehicles for personal errands during work trips) demonstrates understanding of rural realities and builds trust.
Health organisations	**Create fit-for-purpose policies:** ensure policies acknowledge rural realities and allow appropriate flexibility.	Participants described how urban-derived policies imposed inappropriate or unsafe expectations in rural settings. Policies that recognised rural context enabled sustainable practice; those that didn't created constant tension.
Recruiters	**Know your audience:** understand specific needs and motivations of different AHP professions rather than treating them as homogenous.	Different professions are motivated by different factors. Tailoring recruitment approaches demonstrates respect for professional diversity and increases likelihood of successful matches between people and place.
	Understand recruitment patterns: use data to identify trends in recruitment cycles and tenure to anticipate needs and plan accordingly.	Understanding the natural "lifespan" of rural roles for different demographic groups enables proactive planning rather than constant crisis recruitment, supporting better matches between individuals and contexts.

Figure 1: Continuum of influence.



The implementation actions for **line managers** focus on building trust-based relationships with rural teams and developing contextual understanding of rural practice. For **health organisations**, they address systemic issues including resource allocation, policy development and organisational culture. **Recruiters'** implementation actions emphasise the unique dynamics of rural recruitment and the importance of facilitating connections for new staff. For **professional bodies and regulatory authorities**, establishing recognition for rural practice as a legitimate specialty is paramount, while **education providers** are encouraged to develop accessible learning pathways and rural-specific curricula.

We acknowledge that each stakeholder group exerts varying degrees of influence over the experiences of rural AHP. This ranges from recruiters, whose impact may be more limited, to line managers, who have significant day-to-day influence on AHP wellbeing and practice. These dynamics are illustrated in Figure 1.

These recommendations collectively address the three key themes identified in our original research, with many recommendations supporting multiple themes as indicated in Table 1. **Sense of connection and belonging** is primarily addressed through line managers becoming local resources and spending time in remote locations, health organisations acting as allies for rural AHPs and recruiters creating connection opportunities for new staff. **Safe and supported practice** emerges through leadership development initiatives, the application of reasonableness tests at management and policy levels, equitable resource allocation and the development of remote learning opportunities. **Creating roles people want to come for** is supported through the inclusion of AHPs in decision making, understanding recruitment patterns and, critically, the recognition and development of rural scopes of practice as legitimate specialities. The overarching theme of **fit** permeates all recommendations, particularly those requiring reasonable expectations and fit-for-purpose policies that acknowledge rural realities.

Implementing the recommendations

These recommendations are not intended to be implemented in isolation. Rather, they form an interconnected framework in which actions by one stakeholder group can enable or amplify the efforts of others. Stakeholders should adopt a strategic approach that acknowledges resource constraints, organisational contexts and the interdependencies between recommendations.

A phased approach

Implementation can be conceptualised across three phases. **Phase 1 (0–6 months)** includes addressing recommendations that require minimal resources and lay the foundations for further

change. Line managers can begin by applying the "reasonableness test" to expectations of rural staff and consciously assuming good intent. Organisations can examine policies for urban bias, recruiters can prioritise rural recruitment processes and professional bodies can initiate discussions about rural practice recognition.

Phase 2 (6–18 months) builds on phase 1 actions by establishing systems and processes that institutionalise support for rural AHPs. This includes managers developing their role as local resources, organisations creating fit-for-purpose policies and equitable resource allocation systems and recruiters implementing connection strategies for new staff. Professional bodies can progress development of rural scopes of practice while educators can design more accessible learning pathways.

Phase 3 (18+ months) focusses on recommendations requiring structural change, or substantial resource investment. These include developing comprehensive rural generalist pathways, establishing formal recognition systems for rural practice specialisation and implementing integrated rural workforce strategies.

Critical interdependencies

Implementation should acknowledge the interdependencies between recommendations. The "reasonableness test" functions as a foundational concept enabling many other recommendations by challenging urban-centric assumptions. Similarly, managers spending time in remote locations develops contextual understanding that informs policy development and resource allocation. Professional bodies' recognition of rural practice as a legitimate specialty creates necessary conditions for education providers to develop rural generalist pathways.

While recommendations are organised by stakeholder group, effective implementation requires collaboration. No single stakeholder possesses sufficient influence to resolve recruitment and retention challenges independently. Rural AHPs themselves should be meaningfully involved in implementation planning and evaluation, ensuring strategies remain responsive to workforce needs. This collaborative approach recognises that sustainable rural workforce development requires simultaneous action at individual, organisational and system levels.

By adopting this structured yet flexible approach, stakeholders can maximise impact while acknowledging resource constraints and organisational realities. The framework allows organisations to adapt recommendations to their specific contexts while maintaining focus on creating conditions where rural AHPs experience professional fulfilment, personal connection and organisational support.

Other implementation considerations

While these recommendations offer evidence-based strategies for improving rural AHP recruitment and retention, their implementation requires careful consideration of several factors. Organisations must balance investment against other priorities within constrained budgets. Some recommendations, such as the "reasonableness test" or assuming good intent, require minimal resource investment but may yield significant returns, while others represent longer-term investments requiring substantial resource commitment. The current health system reforms in Aotearoa present opportunities and challenges. The shift toward locally led, integrated models aligns well with enhancing rural allied health services,[17] though the transition period may create temporary implementation barriers.

Organisations should establish evaluation frameworks to measure impact and to assess whether interventions achieve intended outcomes. Key metrics might include recruitment timeframes, retention rates, staff satisfaction and service delivery indicators. Additionally, while these recommendations focus specifically on AHPs, many offer potential benefits for other rural health workforces. Organisations may consider broader application across professional groups where appropriate, while remaining mindful of profession-specific needs and contexts.

Discussion

The recommendations address multiple dimensions of rural AHP experience, reflecting the complexity of recruitment and retention challenges of this workforce. These findings emphasise the need for a systemic approach to rural AHP workforce development, with several key themes warranting further discussion.

Challenging urban-centric assumptions

A significant finding was the impact of what Fors[18] terms "geographical narcissism": the unconscious devaluing of rural knowledge and expertise. This manifests in various ways, from resource allocation decisions to professional

development opportunities, and can significantly impact rural AHPs' sense of value and professional identity.

Recommendations such as the reasonableness test, assuming good intent and recognising rural scopes of practice seek to directly challenge urban-centric perspectives. By legitimising rural practice and rural knowledge, these strategies aim to disrupt hierarchies that privilege urban settings and approaches.[19] This is particularly important in the Aotearoa context, where centralisation of specialist services has historically reinforced perceptions of rural practice as less sophisticated or valuable. Changing these perceptions requires deliberate effort across all stakeholder groups.

Maximising AHP contributions

The research findings revealed that many AHPs feel their skills are under-utilised in rural settings, often due to professional hierarchies that privilege medicine and nursing. This aligns with research by Rees,[20] who identified how these hierarchies influence health workforce policy and practice.

Recommendations for organisations to include AHPs in decision making and for professional bodies to recognise rural scopes of practice aim to address this issue. By creating opportunities for AHPs to work to the full extent of their scope and be recognised for their unique contributions, these strategies can enhance job satisfaction and service delivery.[6] This approach aligns with the health system reforms in Aotearoa, which emphasise integrated models and efficient use of workforce capabilities.[17]

Building connection and community

The importance of connection and belonging emerged strongly in the research, consistent with findings by Cosgrave[21] and Kumar et al.[22] What distinguishes these recommendations from generic workforce strategies is their specific attention to the rural context, where personal and professional boundaries are more permeable and community integration is more challenging and more essential.[6,23]

Building sustainable rural careers

The research highlights the importance of creating sustainable career pathways for rural AHPs. Access to professional development has been identified as a key factor in rural retention internationally.[24] The recommendations extend this by addressing access issues and recognition of rural expertise through proposals for equitable resource allocation, remote learning opportunities and formal recognition of rural generalism.

This approach responds to the dual challenges of geographical isolation and professional isolation often experienced by rural AHPs.[6] Establishing rural generalism as a legitimate specialty pathway offers a mechanism to validate and reward the breadth of knowledge required in rural contexts, potentially transforming how rural practice is perceived by practitioners and the wider health system.

Implementing a multi-stakeholder approach

A key strength of these recommendations is their recognition that no single stakeholder can resolve rural recruitment and retention challenges. The targeted approach acknowledges the interconnected nature of influences on rural workforce experiences while distributing responsibility appropriately. The practical, actionable nature of the recommendations reflects the pragmatic orientation of the interpretive descriptive methodology[10] underpinning the original research. By focussing on changes implementable within existing structures while still challenging problematic assumptions, these recommendations provide opportunities for stakeholders to adopt what they can, when they can rather than waiting for wholesale system transformation.

Future directions

Further research is essential to enhance rural AHP recruitment and retention efforts. Immediate priorities include evaluating the implementation and impact of these recommendations on recruitment and retention outcomes, alongside the development of standardised metrics to assess intervention effectiveness across diverse rural contexts. Research examining rural generalist pathways could illuminate how formal recognition and specialised education programmes influence workforce stability and career trajectories.

Additionally, investigating interprofessional approaches to workforce development may reveal how collaborative models between AHP, nursing, and medical professions could strengthen rural health services more comprehensively than discipline-specific initiatives. Importantly, incorporating health service user perspectives from rural communities would provide crucial insights into how workforce stability translates to service

quality and access, ensuring that workforce initiatives ultimately benefit the communities they aim to serve.

Strengths and limitations

This paper has several strengths and limitations. The recommendations are grounded in the first qualitative study of its kind in Aotearoa exploring rural AHP workforce experiences, with diversity across professions, geographical locations and cultural backgrounds. Limitations of the original research are relevant here, including that all participants identified as female, social workers were over-represented relative to workforce composition and some disciplines such as pharmacy were under-represented.

Specific to this paper, the five-step translation process was undertaken by the research team without external stakeholder engagement to test the recommendations. While the research team's familiarity with the stakeholder groups provided contextual insight, it also carries the risk of assumptions and blind spots associated with insider perspectives. Although reflexive discussion and critical challenge within the research team were used to address this, interpretations remain shaped by the professional backgrounds and experiences of the researchers. Moreover, the authors acknowledge that there may be contextual, organisational, political or resource constraints affecting stakeholder groups that were not fully visible to the research team, and which may influence the feasibility or implementation of these recommendations in their current form. Future work should engage directly with stakeholder groups to further refine, adapt and prioritise the recommendations, and to support their translation into practice. Nevertheless, we hope these recommendations serve as provocations for critical reflection and dialogue, encouraging each stakeholder group to consider the role they can play in strengthening the recruitment and retention of rural allied health clinicians.

The Ministry of Health – Manatū Hauora *Rural Health Strategy*[5] was published in July 2023, after the recommendations in this paper were developed and submitted as part of the doctoral thesis from which this paper is derived. While it was not available to inform the recommendation development process, there is strong alignment between these two bodies of work, particularly in priority 5, which directs the expansion of rural scopes of practice and use of the breadth of health workforce roles. This alignment provides external validation of the direction taken in these recommendations.

Conclusion

The recommendations presented offer evidence-based strategies to strengthen the recruitment and retention of AHPs in rural and remote settings across Aotearoa. Derived from qualitative research with rural AHPs, these recommendations provide practical guidance for five key stakeholder groups: line managers, organisations, recruiters, professional bodies and educators.

At the heart of this approach is the understanding that strengthening rural AHP recruitment and retention transcends monetary enticements or lifestyle marketing; it fundamentally depends on creating environments where professionals experience a sense of fit—feeling valued professionally, connected personally and able to contribute meaningfully to their communities. This holistic approach to workforce wellbeing is essential for sustainable rural health services.

As Aotearoa continues through health system reforms aimed at improving equity and access, strengthening the rural allied health workforce must be a priority. The recommendations presented here offer practical pathways towards achieving this goal, ultimately enhancing health service delivery for rural communities throughout the country.

COMPETING INTERESTS
This research was undertaken as part of the DHSc programme at the Auckland University of Technology. NK undertook this work as part of usual paid duties as professor of rehabilitation.
JEG is: co-chair of the Scientific, Technical and Allied Health Chapter of the Hauora Taiwhenua Rural Health Network; on the board of Allied Health Aotearoa New Zealand; and earns money speaking at conferences and from paid consultancy work as a self-employed thought leader.
NK is: chair of the RAIL research centre executive committee, Monash University (unpaid); and member of the National Trauma Network rehabilitation rōpū (unpaid).
PJL holds a leadership or fiduciary role in Hospice New Zealand.

ACKNOWLEDGEMENTS
Figure 1: Continuum of influence was designed by the primary author using prompts in Napkin.ai.

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URL
https://nzmj.org.nz/journal/vol-139-no-1644/strategies-to-strengthen-rural-allied-health-workforce-recruitment-and-retention-in-aotearoa-new-zealand-evidence-based-recommen

CITATION
George JE, Kayes N, Larmer PJ. Strategies to strengthen rural allied health workforce recruitment and retention in Aotearoa New Zealand: evidence-based recommendations from qualitative research. N Z Med J. 2026 Oct 23;139(1644):14-25. doi: 10.26635/6965.7333.

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