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Original Research

The Australian Allied Health Rural Generalist Pathway: contextual factors for success

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Abstract

Introduction: Allied health workforce challenges in Australian rural areas have negative implications for employers, due to high staff turnovers, and consumers, who receive suboptimal care. Rural health services cannot provide the range of specialised allied health providers available in urban areas, resulting in disparity in access and outcomes for rural people. Rural allied health professionals are required to work across the full scope of professional skills to meet the needs of their local communities, which is particularly challenging for early-career professionals. The allied health rural generalist pathway was introduced as a workforce strategy in South Australia's regional areas to develop and recognise the specific skills and knowledge required for rural practice. This research retrospectively explored the contextual factors impacting on the success of the pathway, including personal and organisational factors, to support generalisability.
Methods: A pragmatic qualitative study was undertaken over four

research phases. In-depth interviews were conducted with trainees, supervisors, line managers, profession leads and the project team throughout the pathway. Qualitative and quantitative results were analysed separately and reported together to comprehensively explore research findings.

Results: Community integration, personal attributes, availability of support, timing of commencement and a generalist caseload were found to be important factors for success. Trainees who elected to participate in the generalist pathway were also more likely to complete. Location and profession were not found to predict success in the pathway.

Conclusion: A range of contextual factors was analysed to explore who, where and what circumstances were better suited to the allied health rural generalist pathway as it was introduced in South Australia. It is recommended that organisations consider the selection process, support available, caseload breadth and opportunities for participation in service development projects to promote successful completion of the pathway.

Keywords

allied health, Australia, context, generalist practice, organisational factors, personal factors, training, workforce.

Introduction

Retaining an allied health workforce is one of the many challenges faced by rural and remote health services, negatively impacting health outcomes for communities and adding cost burdens to health services[1]. High health professional turnover results in service gaps for rural communities and varying quality and consistency of services provided[2].

Supporting early-career rural allied health professionals through targeted professional development positively impacts satisfaction and retention[3,4]. This includes training, education and learning activities to improve professionals' knowledge, skills, competence and service delivery[5]. Organisations invest in professional development in order to develop and retain staff to meet the needs of their businesses[6]. Professional development activities are often expensive and resources available to fund them are limited. It is therefore important that organisations invest in activities that are targeted and effective in enabling health professionals to deliver sustainable, accessible, quality health services[5]. Access to allied health professional development activities in rural and remote areas is variable, with challenges relating to travel, heavy workloads, lack of backfill and limited funding availability[7].

Research investigating the selection of participants for rural workforce training and education predominantly focuses on undergraduate medical student selection, and recommendations include choosing students who have a rural background or an intention to work in a rural area[8-10]. There is a gap in current allied health research exploring the impact of contextual factors on professional development and training outcomes. One study considered allied health professionals and nurses' motivation to undertake a specialist training program and found that people were motivated by the quality of the trainers, by the desire to improve service provision and to advance their career or gain recognition of skills[11], but how they were selected or the outcomes of the training were not described. Another study investigating training effectiveness found that supervisor support and teams with a continuous learning culture were significant factors in participants maintaining motivation for training[12].

The Allied Health Rural Generalist Pathway (AHRGP) was originally developed by the Allied Health Professions Office of Queensland in 2013 as a workforce strategy to develop and recognise the specialist skills and knowledge required for rural and remote allied health practice[13]. Since 2013, the pathway has evolved to include a two-level postgraduate rural generalist program (RGP) provided by James Cook University and has been implemented across Australia. The level 1 program, designed for allied health professionals with up to 3 years of experience, includes 12 online modules that each require around 22 hours to complete. Level 2 is a graduate diploma qualification designed for allied health professionals with more than 2 years of clinical experience, with eight online modules requiring approximately 130 hours of work each[14]. Employing organisations provide allied health rural generalist trainees with dedicated study time and supervision at work and opportunities to participate in service development or quality improvement projects relevant to their study. The pathway is available to 10 allied health professions: dietetics, exercise physiology, medical radiation, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, social work and speech pathology[14]. The RGP was designed to be relevant for practice in rural and remote Australian contexts.

Early research investigating the impact of the AHRGP has been positive. The AHRGP has been found to be excellent value for money in a cost–consequence analysis[3], and an effective strategy to retain early-career allied health professionals[15] and build and support an allied health workforce[16,17]. A study examining the RGP across state jurisdictions found the RGP to be an effective strategy for building rural generalist capabilities with benefits outlined for the participants, employers and consumers[18]. There is a gap in the research investigating the selection of rural generalist trainees and associated outcomes. Previous research has identified the professions and jurisdictions of trainees, but other factors that may influence individuals' experience or likelihood of completing the AHRGP have not been explored. This information is important to realise the benefits of the program for individual clinicians, and ultimately the rural communities, by increasing their access to services routinely provided in metropolitan areas. Furthermore, an understanding of the contextual factors will support the generalisability of the program in other contexts.

In an early evaluation of the AHRGP, personal attributes for success were described based on the qualitative findings from a wide range of stakeholders. These included being flexible and organised, managing time effectively, being self-motivated, self-aware, independent and confident, and having an understanding of rural and remote contexts for working[19]. While these findings are interesting, it is not clear from where they were drawn. Although there is a gap in the literature concerning the selection of allied health professionals for training programs, the factors that impact on allied health professionals' retention in rural and remote areas are known. Organisational factors include quality of supervision, level of competence to do the job, recognition for doing their job, career advancement opportunities, autonomy, feelings of accomplishment and communication and support from a manager[20]. Personal factors include personal attributes, having a rural background, integration into a local community, location of family or a partner and lifestyle factors[21]. It is not known whether these wide-ranging personal and organisational factors could predict successful completion of appropriately targeted professional development activities.

The AHRGP, or the pathway, was introduced in regional local health networks (LHNs) across South Australia in 2019, through Rural Health Workforce Strategy funding, provided by the government of South Australia. As a targeted professional development activity, this study aimed to identify the personal and organisational contextual factors that were associated with completion of the pathway by allied health professionals. Drawing on previous research, the factors that have the potential to impact an individual's experience and success with the AHRGP described in this study are rural background, community integration, intention to stay and personal attributes. As there is limited research examining enablers and barriers, the research team was also interested in exploring whether particular professions, locations, selection processes and timing of enrolment were related to successful completion of the pathway. The phenomenon of interest in this study is the completion of the AHRGP. The study aims to identify the contextual factors that influenced allied health professionals' likelihood of completing the pathway.

Methods

This qualitative study was implemented over four phases from 2019 to 2023. This study is one part of a larger study investigating the experience and outcomes of the AHRGP for individuals, organisations and consumers in rural and remote South Australia.

Data collection and sampling

Purposeful sampling was used to select research participants. SA Health provided the contact details of the allied health professionals who were participating in the AHRGP (herein referred to as 'trainees') and their associated line managers, clinical supervisors, profession leads and the AHRGP program managers coordinating the pathway across South Australia (herein collectively referred to as 'service leaders'). The research team emailed participant information sheets and consent forms to all potential participants. Informed consent was gained prior to data collection.

The four data collection phases were (1) pre-pathway, (2) mid-pathway, (3) end of pathway and (4) 6 months post-completion follow-up. Data were collected through semistructured interviews and surveys. Interviews were conducted face to face or by teleconference, and surveys were conducted online using Qualtrics software. The RGP level was also tracked for patterns as there were significant differences between the level 1 and level 2 programs in terms of volume of work, focus of topics and qualification on completion.

This study collected data exploring the individual and organisational contextual factors that impacted on the experiences and outcomes of the AHRGP in South Australia pertaining to the first cohort of trainees in 2019. Phase 1 survey collected trainee rural or metropolitan background, location, intention to stay in a rural area, years of experience, selection process, profession and details of community integration. Phase 2 and 3 trainee and service leader interviews collected data relating to timing for enrolment, profession and location factors. Phase 2 and 3 service leader interviews collected data in relation to personal attributes relevant for the AHRGP. In the follow-up survey in phase 4, the intention to stay and work location were revisited with trainees (see Table 1).

Table 1: Research phases and corresponding methods

Research phase	Data collection methods for participant groups	Contextual data collected
Phase 1 – Pre-pathway 2019	Trainee survey and interview Clinical supervisor, line manager, profession lead and program manager (service leaders) interviews	Metropolitan or rural background Work location Intention to stay in a rural area Years of experience Selection process utilised Profession Details of community integration
Phase 2 – Mid-pathway 2020	Trainee survey and interview Service leader interviews	Timing for enrolment Profession and location factors Personal attributes
Phase 3 – End pathway 2020–22	Trainee survey and interview Service leader interviews	Timing for enrolment Profession and location factors Personal attributes
Phase 4 – 6-month post-pathway completion 2021–23	Trainee follow-up survey	Work location Intention to stay in a rural area

Data analysis

Qualitative content analysis methods were utilised throughout this study. Content analysis is used to interpret and generate meaning from research data by isolating small pieces of data or codes that help to explain or explore a phenomenon[22]. Survey data and workforce data were downloaded into Excel. Through the content analysis process, data relating to predetermined contextual factors were counted and described to determine the extent to which each factor was associated with successful completion of the

pathway. For example, the number of trainees who completed or discontinued the pathway was described according to how many years of experience they had before commencing the pathway or whether they had a rural or metropolitan upbringing to identify patterns, similarities and differences among groups.

Interviews were transcribed by a professional transcribing service and checked for accuracy by the research team. Data relating to contextual factors from interviews were coded deductively using NVivo v13 (Lumivero; https://lumivero.com). Predetermined codes were based on individual and organisational contextual factors drawn from previous studies and new categories emerging from immersion in the data. Codes were grouped together by meaning into categories by the researchers.

Analysed findings from the surveys, workforce data and interviews were analysed descriptively across research phases and participant groups to explore contextual factors that were described as influencing trainees' likelihood of succeeding in the pathway. For example, survey data relating to the extent to which trainees were integrated into the community in the phase 1 survey were analysed with interview data describing how trainees spent their time outside of work. Using multiple sources of data to explore and describe a phenomenon strengthened the reliability and trustworthiness of findings[23].

Ethics approval

Ethics approval was gained by the Southern Adelaide Clinical Human Research Ethics Committee, 21 August 2019, HREC/19/SAC/170. The research was undertaken with informed consent of participants.

Results

This research was conducted between September 2019 and June 2023. A total of 15 trainees commenced the AHRGP, 10 in level 1 and five in the level 2 pathway. Of the 10 level 1 trainees who participated, three completed the AHRGP. Of the five level 2 trainees, four completed and one was continuing at the time of the study cut-off date (June 2023). As they did not withdraw and planned to complete the pathway, this remaining trainee is reported in the completed group for analysis (June 2023). All but two of the trainees were female, and both males completed the pathway. While only 13% of participants were male, this was consistent with the gender balance within the regional LHNs in South Australia. Table 2 outlines the trainee levels, rural backgrounds, community integration and selection process of trainees who completed or discontinued the AHRGP.

Table 2: Trainee demographics

Characteristic	Trainees who commenced AHRGP (*n*=15)	Trainees who discontinued AHRGP (*n*=7)	Trainees who completed AHRGP (*n*=8)
Level 1	10	7	3
Level 2	5	0	5
Female	13	7	6
Male	2	0	2
Metropolitan raised	7	3	4
Rural raised	8	4	4
Limited integration in local community	4	2	2
Integrated in local community	11	5	6
Expressed interest in AHRGP	5	2	3
Nominated by employer	9	6	3
Occupational therapists	4	1	3
Physiotherapists	3	1	2
Podiatrists	4	2	2
Speech pathologists	3	2	1
Social workers	1	1	0

AHRGP, Allied Health Rural Generalist Pathway.

Rural background of trainees

In total, eight of the 15 trainees grew up in a rural area and seven grew up in a metropolitan area. Four of the five level 2 trainees were raised in rural areas. Of the 10 level 1 trainees who started the pathway, all three who completed were raised in metropolitan areas. Four rurally raised and three metropolitan-raised level 1 trainees withdrew from the pathway. Two of the completing trainees commuted from Adelaide each day to a regional centre for work and found this to be a favourable option for their personal circumstances and work opportunities.

Community integration

Other than the two trainees who commuted each day to the regional centre, all the completing trainees reported that they had integrated into the rural community in which they worked. They played sport locally, had family who lived nearby or described enjoying the rural lifestyle. Most of the trainees that left the pathway before completion also reported staying in the rural area on weekends, with only two of them reporting that they returned to metropolitan areas most weekends. These trainees did not report a close connection to their local community in their discussions. They cited a lack of incentives to stay, changes in personal circumstances or job opportunities elsewhere as reasons for leaving the town.

> *Yeah, or a lot of people I've met have relationships in Adelaide and have come here because it's easy enough to come back and forth, which is hard for me because then you have great friends at work, but they always go to Adelaide on the weekends. (Trainee 8)*

Selection of trainees

Trainees had the opportunity to express their interest in participating in the AHRGP, or employing organisations could nominate allied health professionals to participate. In this cohort, three of the five trainees who expressed an interest and three of the nine trainees who were nominated by their employer completed the pathway.

Intention to stay

On commencement of the pathway, completing trainees planned to continue working in a rural area for on average 6.8 years, while those who did not complete had planned to stay for 2.6 years. Service leaders reflected in phase 3 that intention to stay was an important factor to consider in appointing suitable trainees in order for the organisation to benefit from the investment in staff.

> *There's no point having a whole lot of people who end up just going back to metro after the investment in this program. (Service leader 20)*

Locations suited to AHRGP

The AHRGP was offered in all six regional LHNs across South Australia. The trainees who completed the pathway worked in three regional LHNs. Geographically, rural regions in South Australia are made up of multiple small towns that connect as a region, with their own independent health services and hospitals. The towns in which trainees were working were either coastal or on the River Murray.

Service leaders reported that any rural or remote region would suit hosting an AHRGP trainee if the location was able to provide the necessary support and opportunities. Locations that can offer trainees a generalist case load, consumers with wide-ranging conditions relevant to the pathway activities and a level of complexity that suits the advancement of generalist skills and knowledge were reported to be imperative for trainees having a meaningful experience in the AHRGP. It was also important that locations had sufficient resources to enable the trainees to undertake study leave and the availability of clinical and managerial support for trainees.

> *They have to be able to manage whatever comes through the door. It's very different from metro … the case load is often very broad and very diverse. So, anything that we can do to help skill them and prepare them for that, I think, is really helpful, especially when they're going off to do that outreach. (Service leader 28)*

Professions suited to the AHRGP

Trainees in this study were recruited from occupational therapy, physiotherapy, podiatry, speech pathology and social work. Completing trainees included three occupational therapists, two physiotherapists, two podiatrists and one speech pathologist. When considering the professions that were best suited to the AHRGP, service leaders reported that the pathway was well suited to professions that offered a broad range of clinical services.

> *Because our practice is so broad as rural generalist physio clinicians, there's been something there that they could all apply, and they all had access to consumers that would fit the topics for their case studies and those sorts of things. (Service leader 22)*

Service leaders also reported that the AHRGP offered the development of strategic, evidence-based, broad and flexible thinking, which suited a range of allied health professions. Service leaders described the importance of trainees understanding the purpose of the pathway before participating, including the focus on developing broad knowledge and skills related to rural and remote practice.

> *Because I think there is a very different, and I think it's, again, it's a very podiatry thing, because we're a very technical profession, it's about wanting to be able to do things better. So, you know, having them have a clear understanding of actually you're not going to get high-level debridement skills out of this, that's not what it's about. (Service leader 17)*

Service leaders recognised that all allied health professionals in rural areas are required to work in broad scope of practice roles in rural areas due to the vast geographical distances and various clinical presentations they were working across.

> *All of them. I'm an AHP [allied health professional] and I think this is relevant for all my allied health particularly because of the environment that they're working in is broad, it is complex, we don't have the luxury to say actually I only want to see this tiny little bit. (Service leader 19)*

Targeting professions that have difficulty retaining staff was also discussed as a priority, but across the six regional LHNs, managers reported it was difficult to recruit all allied health professions.

Timing of enrolment into the program

Trainees' years of experience working in a rural or remote area before commencing the AHRGP ranged from 3 months to 6 years. Level 2 trainees had more experience than level 1 trainees (at least 3 years). Level 1 trainees who discontinued the pathway had on average 7 months of experience before commencing the AHRGP. Trainees who completed had on average 15 months of experience before starting.

Service leaders were asked to recommend how much experience an allied health professional should have before commencing the AHRGP. The managers' responses were heterogeneous, with recommendations ranging from 3 months to two or three years. Supervisors and clinical leads supervising level 1 trainees reported that allied health professionals should have at least 12–18 months' experience working in a rural area before commencing the pathway. They identified the first year of working as a challenging time of transition, and that the pathway would add extra pressure that would not be helpful. Service leaders described choosing potential trainees who intended to stay in a rural area long term as important. Considering the discontinuation of early-career allied health professionals in this cohort, it may be worth considering delaying trainees' commencement until they have worked for at least 12 months and are intending to stay for an extended period of time.

> *I think it would be a great opportunity to offer a clinician once they've completed that new graduate sort of phase and that transitional year from student to functioning clinician. (Service leader 16)*

Several clinical supervisors recommended that allied health professionals should have at least 3 years' experience or be working towards a promotional role before considering the level 2 AHRGP. Some supervisors and level 2 trainees also recommended that allied health professionals who were already working in a senior role may be less suited to the AHRGP, as they would be managing high-level responsibilities that were less likely to be flexible when juggling study requirements.

> *Level 2s, I would probably say someone who is working towards an AHP2 reclass or applying for a level 2 job. So was that, about 4 years out or something (Service leader 34)*

Personal attributes suited to the AHRGP

In phase 3, service leaders reflected on the personal attributes that they would recommend for future trainees based on what had enabled success with the trainees in this study. These are outlined

in Table 3 and included a desire to grow professionally and develop rural generalist skills, self-management skills and an understanding of self, and be in it for the right reasons. Service leaders felt these attributes could be considered in the selection process for future AHRGP trainees. For example, trainees could describe the strengths they bring to the pathway, how they plan to use the pathway to benefit their organisation and community, challenges they may face and strategies for overcoming these.

Table 3: Desired personal attributes of trainees as perceived by service leaders, and illustrative quotes

Personal attributes	Illustrative participant quotes
A desire/commitment to grow professionally and develop rural generalist skills	From the couple, I've learnt, certainly, I think, someone that has a desire to grow professionally (Service leader 51)
	I think people need to have a love of learning because there is a lot of new learnings and also to want to apply that to the work setting. (Service leader 34)
Self-management skills • motivation • time management • accountability • balancing responsibilities • managing stress levels • balancing responsibilities	They also have to be really organised because obviously it puts extra pressure on their workload to be able to manage their clinical and their study time (Service leader 28)
	They should also have the drive in terms of, first for improving their skills and knowledge. (Service leader 21)
	They would have to have probably good time management skills in order to fit it all in and good boundaries as well and not I suppose burning themselves out by doing too much at home and actually trying to get it done within the allocated time at work. (Service leader 34)
	Someone that's starting, that's not going to get too overwhelmed by just starting a new position and having a caseload, being away from family, and adding something else on top of an already busy caseload (Service leader 49)
	They need to be mindful of their own levels of stress and how much they can take on at certain times. (Service leader 24)
Understanding self • reflective • flexible thinking • confident • advocating for self	And the ability to really be able to be constructively critical of yourself and look at your leadership styles and your strengths (Service leader 43)
	They've got to be self-directed with their learning I guess because as much as we're all here to support, really, it's on them to be doing the study that they're supposed to be doing (Service leader 50)
	Open to that reflective practice so that they're going to think about what difference is this making... (Service leader 28)
	So, you have to be able to be flexible rather than saying, okay, yes, take a day off their studies but your work wants you more, so you need a trade-off and negotiate better (Service leader 21)
	Confident enough to speak up and let their line manager and clinical senior know when they might need a bit of extra support with some of those topics (Service leader 22)
In it for the right reasons • open to sharing skills • consumer focused • being goal focused • passion for rural • commitment to improve services/practice • team player	I don't think it should be somebody going into this saying oh it's just something as an add-on to my CV, they need to really want to do it because then you're getting the most out of it. (Service leader 19)
	I think also the skills to be able to present your teachings or your learnings back to your team (Service leader 16)
	Interested in improving their skills to support the community. (Service leader 29)
	With a view of knowing basically which direction they want to take, more clinical or having, you know, preparing themselves for leadership type roles and therefore can be able to sort of focus and embrace the whole program itself. (Service leader 21)
	Need to be brave in that space, to be really contemporary, and to be able to look at efficiencies, and from that regional perspective, so you really have to have that strategic view on what you do operationally to make those changes. (Service leader 43)

Discussion

The study aimed to identify the contextual factors that influenced allied health professionals' likelihood of completing the AHRGP. Research investigating allied health workforce and training in rural and remote areas has predominantly focused on Australian contexts[7,24]. While the AHRGP is contextualised to Australia, with a lack of similar pathways internationally, potentially other countries facing similar workforce shortages could learn from our research findings. This novel study explored personal and organisational contextual factors that influenced the successful completion of the pathway in a cohort of public service allied health professionals in rural South Australia. This study included a small cohort of trainees and so the results may not be generalisable; however, pragmatic research methods have been utilised to describe what was found and potential factors for consideration for future research.

This research explored the characteristics of rural regions and professions that were aligned with successful completion of the pathway. These included regions and professions that had opportunities for rural generalist scope of practice to implement learnings, provision of study time during work hours, appropriate clinical supervision, and availability of support by managers. While a range of rural contexts have been included in postgraduate training research[13,16,19], location and profession factors associated with health professionals completing training have not previously been explored.

The trainees who applied to participate in the pathway in this research were more likely to complete it than those who were nominated by their organisation. Evidence from a recent systematic review found that when allied health professionals self-elect to participate in training, they are more likely to implement learning into practice[25]. When the pathway was introduced in Queensland, all of the trainees self-elected to participate and, in most cases, new positions were created[13]; in the present study, the trainees were existing employees. Considering that more trainees who elected to participate completed the pathway, and the trainees who completed the pathway in Queensland also nominated themselves, it may be more suitable for allied health professionals to apply to participate than for organisations to identify who they think should participate in the pathway.

In this study, the timing of enrolment was explored. James Cook University recommends level 1 AHRGP trainees have up to 3 years' experience working in a rural or remote area, and for the level 2 program, at least 2 years' experience[14]. Variability exists nationally with two state (New South Wales and Queensland) governments recruiting new staff to undertake the pathway. In an early evaluation of training positions in Queensland, trainees were mostly new graduates and all of the trainees completed the pathway[13]. In New South Wales, the trainees had on average 1.75 years of experience, and while four trainees stayed longer than 12 months, just one had completed the level 1 program within the 4-year follow-up period and no one participated in level 2[16]. This study is the first to analyse years of experience and

completion rates as well as qualitative data exploring recommended levels of experience for participation. Consistent with previous workforce research, the highest levels of turnover were evident for trainees who started the pathway very early in their careers[26]. The findings showed that trainee years of experience appeared to be related to program completion, and this has not been explored in previous studies. In comparison, specialist training for doctors is introduced after the first 2 years of practice, allowing graduates to explore potential areas of interest before embarking on specialisation, and for some, the decision to choose a postgraduate training pathway this early feels rushed[27]. Based on trainee completions and interview data from service leaders, the optimum time to provide the training pathway opportunity appeared to be after the new graduate has settled into their rural position and is committed to rural and remote work, but before they have taken on added responsibilities due to having more experience. Thus, organisations considering hosting trainees and allied health professionals considering AHRGP participation should consider their readiness to commit to the program.

Personal factors contributing to trainees either completing the AHRPG or discontinuing partway through, included rural background, community integration, intention to stay and personal attributes. These factors are multifaceted, and no one factor predicted an individual's likelihood of succeeding or leaving. Trainees had a mixture of rural and metropolitan upbringings; although previous research has linked a rural background to improved retention[7,21,28], this was not a predictor of completion of the pathway in this research. On average, trainees who completed the pathway intended to stay in a rural area longer than those who did not complete. Previous research has found that opportunities for professional development and career development impact on allied health professionals' intention to stay[7]. This study has demonstrated that intention to stay may also be an important factor to consider when selecting staff to undertake professional development opportunities. Asking applicants about their intention to remain working in a rural area would be helpful in ascertaining how many years an organisation is likely to benefit from having an AHRGP trainee and whether the investment is likely to be beneficial.

Community integration in a rural area was described as a positive retention factor in this research, which is consistent with previous studies[7]. Trainees who completed the pathway and lived in a rural or remote area described participating in community-based activities on the weekends rather than travelling away regularly. Previous research found that being connected to the community was a significant retention factor, but governments and employers often overlook the positive impact a sense of belonging can have on workforce outcomes[29]. This research found that although most of the trainees who discontinued the pathway stayed in the rural areas on the weekend, they did not necessarily report being integrated into the community. Some of these trainees may have stayed longer if they were more connected to their local community and employers should consider strategies to assist their trainees to integrate into the community.

While more research would be helpful in ascertaining the impact of personal attributes on success in the pathway, the findings of Nancarrow et al[19] overlap with the identified personal attributes described by service leaders in this research as desirable. Many of the attributes described by the service leaders would also be applicable to new professionals embarking on postgraduate training in urban settings. However, the traits that stand out as specific to rural and remote contexts are centred on commitment to rural and remote and a willingness to manage the independence and self-direction often required.

Conclusion

This study described contextual factors that contributed to the experience of trainees undertaking the AHRGP across regional LHNs in South Australia. Organisational factors, including the availability of supervision and management support and the opportunity for trainees to participate in a broad, complex scope of practice, were found to be more important than location or profession in the success of the pathway. Trainees who nominated themselves to participate in the pathway were more likely to complete the pathway than those who were nominated by their employer; this is a useful finding for planning future selection processes. Considering the alignment of personal attributes with postgraduate training and rural and remote work could also be a valuable exercise for individuals to consider when undertaking the AHRGP. In terms of supporting allied health professionals more broadly, it may be useful for managers and supervisors to consider how they can account for the personal attributes of early-career allied health professionals in their teams to best adapt the supports provided. The contextual factors identified in this study can be considered in the context of other allied health rural initiatives, to maximise the benefits to allied health clinicians, and the access to and outcomes for services for rural people.

Data availability

The data that support this study were obtained from SA Health by permission, and cannot be publicly shared due to ethical and privacy reasons. Data may be shared on reasonable request to the corresponding author if appropriate with permission from SA Health. The full reports on each phase of the study are available on the SA Health website: https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+healt

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Conflicts of interest

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