APEX
ALLIED SCIENTIFIC AND TECHNICAL

A workforce in survival mode: Findings from the APEX Health Charter survey

November 2024

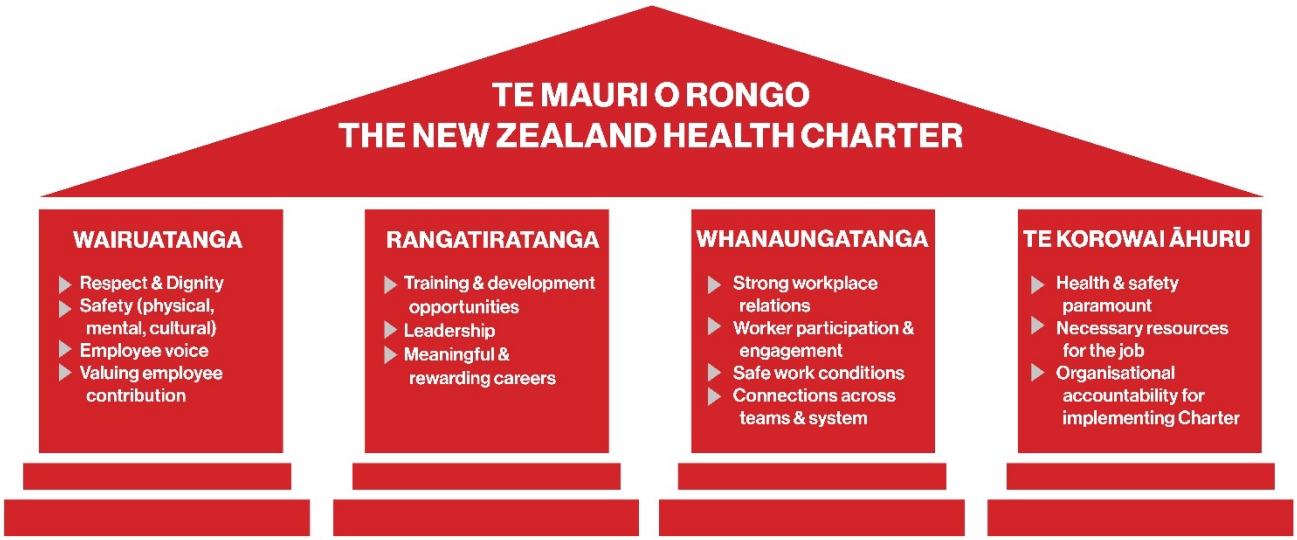
Navigating this document

1. Introduction

1.1 Background to the Charter

Te Mauri o Rongo – the New Zealand Health Charter was endorsed in August 2023 as part of the health sector reforms, under the Pae Ora (Healthy Futures) Act 2022.[1] It was intended to transform the way the sector worked; aiming to support and retain the health workforce by promoting a safe working culture for all. The Charter applies to all health entities, but our focus in this report is on Health New Zealand | Te Whatu Ora as the largest employer within the sector and in Aotearoa.

The Charter comprises four pou (pillars). Each pou sets out values, principles, and expected behaviours at the collective, organisational, and individual levels (see figure below for a summary).[2]



It's fair to say from the outset the Charter has been fraught with challenges – including scepticism about the transformation promised. Prior to the Charter's endorsement, an APEX survey revealed that while our members agreed with its aims in principle, they remained unconvinced it would achieve its purpose due to a lack of resourcing and trust in Health NZ.[3]

A particular issue is the noticeable absence of employer accountability mechanisms. Pae Ora (s58) only requires Health NZ report on the Charter "at least once every 5 years".[1] This is concerning as the Health Charter purportedly underpins most Health NZ staff policies. While there are myriad policies holding employees to account (ranging from Code of Conduct to Disciplinary and Investigation policies) there is little to ensure the employer is accountable for implementing the Charter, nor complying with its legal obligations to provide safe and mentally healthy work and other employee entitlements.[4,5]

This report set out to capture perspectives of our Allied Scientific and Technical (AST) workforce employed by Health NZ to understand exactly what, if any, impact the Health Charter has had on their health, safety, wellbeing, and working conditions over the last year.

1.2 Purpose of the survey

Our survey, launched at the one-year mark of Te Mauri o Rongo being endorsed, was aimed at:

1. Establishing a baseline measure for monitoring the effectiveness of Te Mauri o Rongo on workplace culture and conditions for the AST workforce.
2. Assessing the impact of Te Mauri o Rongo by profession, and not simply grouping together the entire 'AST' workforce as Health NZ's Ngātahitanga Pulse surveys do.[6,7]
3. Identifying what further action is required and where.

It is also one of the first comprehensive reports into the working conditions and wellbeing of the AST workforce in Aotearoa – as a collective and broken down by profession.

1.3 Methodology

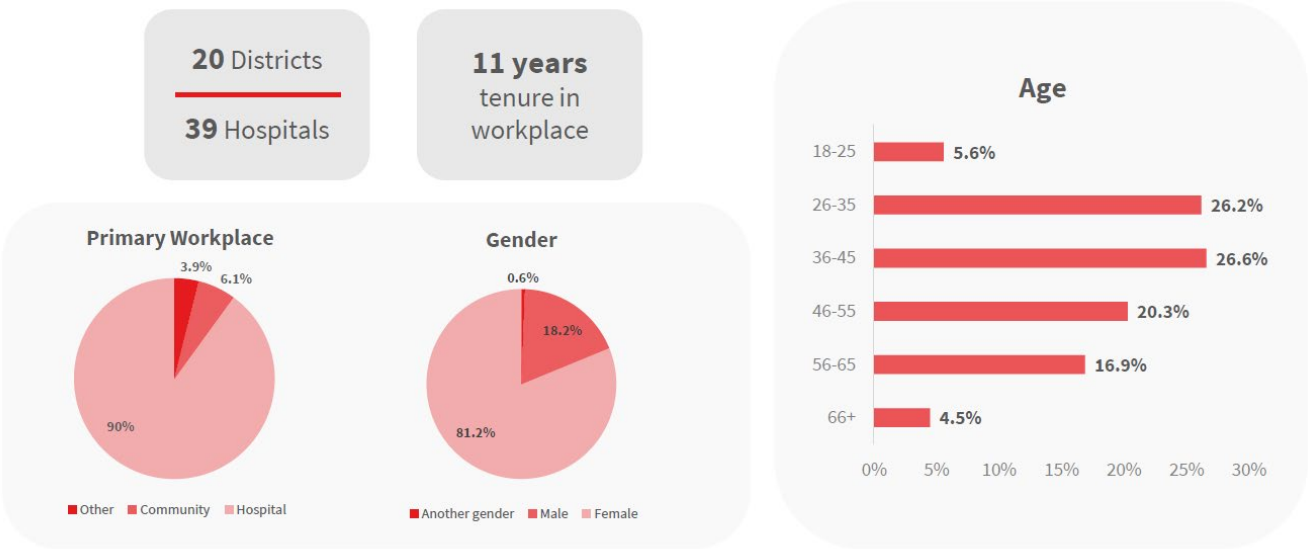
An online survey was sent out to all APEX members employed by Health NZ and was open for 11 days in August 2024. Survey items were designed to capture an overall assessment for each of the four pou, with a free-text option for select questions. Full detail on our methodology is provided in the Appendix.

2. Findings across the AST workforce

2.1 Demographics

A dashboard summarising the demographic profile of our respondents is provided below.

Most respondents worked in a hospital (90%), representing 39 sites across the country. The remainder worked in a community setting (6.1%) or other workplace (3.9%) such as a clinic, laboratory, or home office.



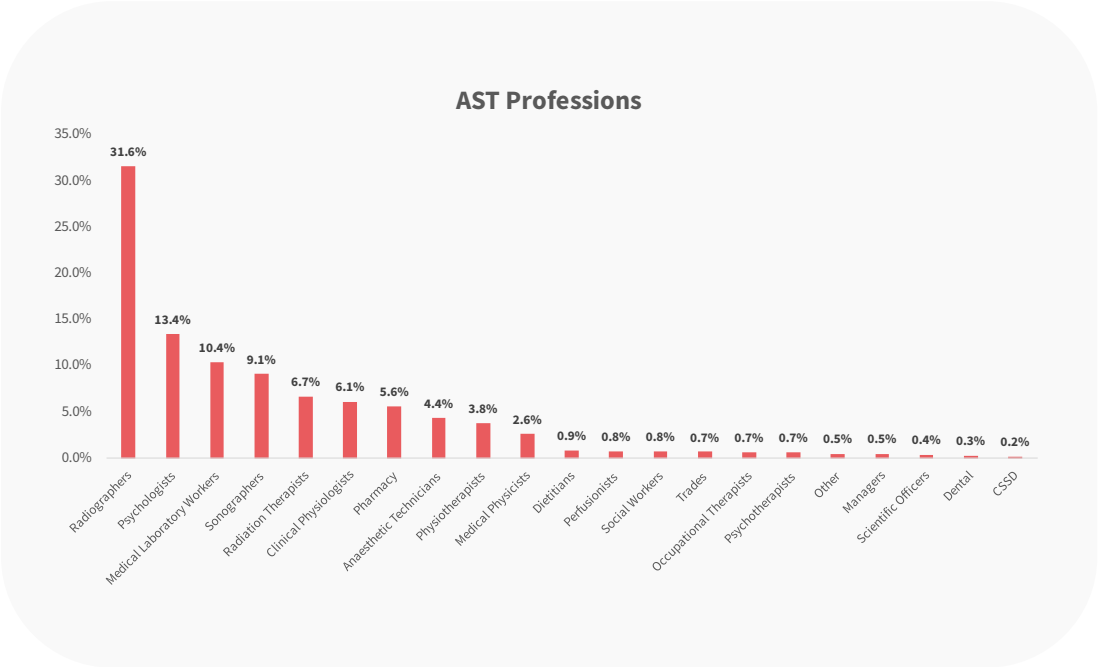
Their tenure in their workplace ranged from a month to a maximum of 53 years, with an average of just over 11 years. Only 3.5% of respondents had been at their current workplace for under a year.

A majority identified as female (81.2%), with less than a fifth identifying as male (18.2%) and 0.6% identifying as another gender.

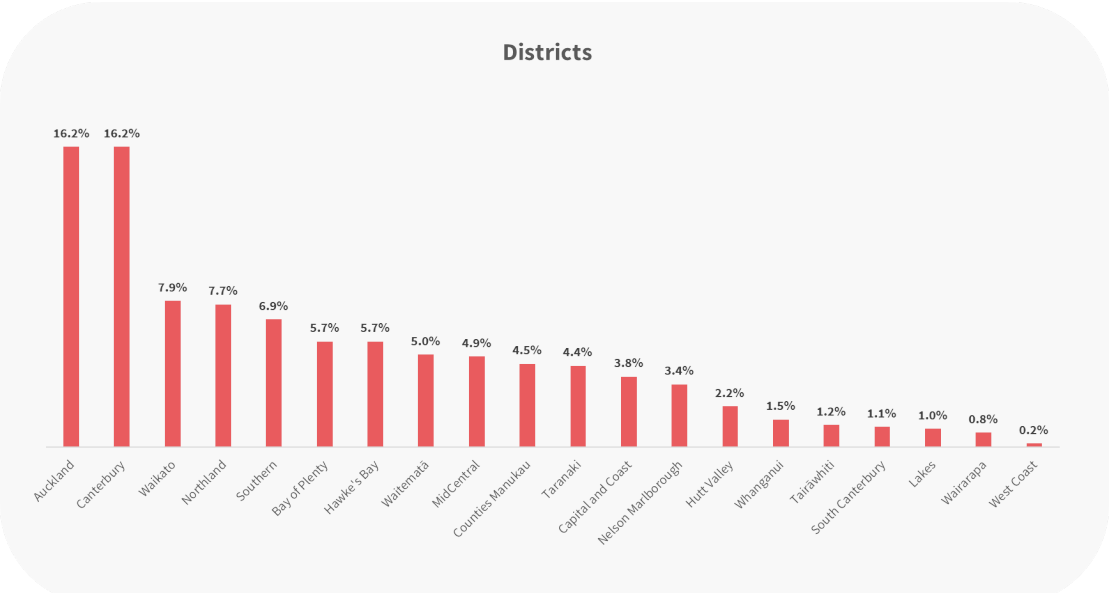
Over two-thirds (67.2%) identified as New Zealand European, followed by an 'other' ethnicity. We have not broken this down further to preserve respondent anonymity.

A little over half of all respondents were aged between 26 to 45 years, with around 4.5% of respondents aged 66 or older. The graph on p3 also indicates that around a fifth of our AST workforce is aged 55 and over, and therefore likely to retire within the next 5-10 years. This underscores the need for strategic planning and investment in our AST workforce pipelines.

Our respondents were represented across the following APEX professions:



They were represented across all Districts, as shown below.



2.2 Overview of four pou

Below is a high-level overview of indicators across each of the four pou. This is a similar approach to the Pulse surveys, with a traffic light system indicating how strongly respondents agreed (green) or disagreed (red) with each item.

It is immediately clear that the employer's performance in terms of providing a safe working environment and workplace culture is less than satisfactory. Most indicators score within the 50-60% range, or what would only just qualify as a 'passing' grade.

A note on survey representativeness

It is worth acknowledging that these indicators reflect the AST workforce 'average' and therefore the collective experience of a diverse range of professions and regions. They are not, and cannot ever be, entirely representative of every Health NZ workplace, department, or team. In fact, a few respondents told us of positive experiences within their own service or team:

> *"When considering the daily environment and team I work in [things are] great compared to the overall workplace (really not great)."*

> *"The reason my responses have been generally positive is my team leader is absolutely wonderful. In other teams I see toxic cultures that are a symptom of chronic understaffing and to be fair, difficulty recruiting, because teams get a reputation for being a very stressful place to work."*

However, where things were going well this was very much still occurring in "pockets" and driven by particular staff or teams, rather than happening across the entire system:

> *"I think positive change had occurred in our service, but not confident this has flowed out from the Charter and is instead enacted by front line staff."*

> *"The only wellness initiatives implemented in my job have come from staff created wellness efforts and team."*

Whilst it is reassuring to hear examples of positive initiatives and good team cultures, the issue is that individuals (staff and leaders) come and go in an organisation – but this should not be what props up safe working conditions or a positive workplace culture. If these values, behaviours, and practices were truly embedded across the entire health system, this would be more evident in our survey results.

The consistency and frequency of issues raised across respondent comments suggest these are systemic issues that require coordinated effort and resourcing, with the Health Charter as a mechanism for catalysing this change. And the very first step in addressing these issues is to acknowledge they exist.

In the sections that follow, we explore these and other indicators across each of the four pou, drawing attention to particular issues and need for change.

2.2.1 Wairuatanga

Wairuatanga was assessed through seven indicators, four of which were rated on a six-point 'Agree-Disagree' scale. As shown below, all items in this pou score in the 'orange' zone – indicating underlying concerns and a need for action.

We also included three additional indicators within this pou: two relating to workplace bullying, harassment, and discrimination, and one reflecting turnover intent. Here, respondents were also able to elaborate on their experiences through free-text comments.

Together, the findings in this pou show that while respondents feel somewhat valued by their workplace (57.2%) and recognised for their good work (54.7%), just over two-fifths of respondents do not feel their workplace supports their overall wellbeing. Only 57.9% of respondents would recommend their workplace as a good place to work, with 24.8% indicating they were likely (very likely 6.6%; likely 5.1%; or somewhat likely 13.1%) to leave their workplace within the next six months.

These findings are unsurprising when we look at specific indicators related to workplace hazards of bullying, sexual harassment, and discrimination. Given the high rates of these behaviours experienced by our AST workforce and their harmful impacts on employee wellbeing, we take a deep dive into respondent experiences overleaf.

AST experiences of workplace bullying, harassment, and discrimination

Experiences of workplace bullying, harassment, and discrimination (collectively referred to as 'workplace abuse') are common experience for many AST workers.[8,9] In our survey just over one in five respondents (21.3%) directly experienced these behaviours in the last 12 months, and a further 1 in 3 (33.8%) had witnessed these behaviours over the same period.

Perpetrators of these behaviours

Perpetrators included SMOs, Consultants, Nurses, and other AST colleagues, and often a power imbalance was at play (explored later in this section). However, patients were the main perpetrators of racism and sexual harassment, and in one case, sexual assault of a respondent.

Frequently, the perpetrator was a 'known bully' in the organisation – yet in many cases this behaviour was seemingly tolerated due to their status or seniority. Respondents elaborated:

> *"A manger in particular is well known for her aggressive and reductive approach... at least 10 people have left because of her bullying and nothing is done about it"*

> *"The Group Manager had a history of [bullying] in other workplaces. Te Whatu Ora committed to not hiring bullies some time ago so I'm not sure why he keeps getting sent around different hospitals destroying departments."*

What do the behaviours look like?

Behaviours could be generally categorised as personal attacks or task-related bullying behaviours.

Personal attacks ranged from low-level incivility (e.g., unwelcome comments about appearance, sarcasm, being ignored) and microaggressions to more severe forms of abuse including harmful false accusations, verbal attacks, and aggression. More covert personal attacks involved hostile body language and tone, spreading gossip behind people's backs, and social exclusion. Respondents noted that subtle behaviours were often difficult to pinpoint or call out; "hence why this sort of behaviour often gets to carry on as it seems pretty innocuous in the cold light of day." Within the high-pressure environment of healthcare, respondents explained it was common for staff to become "passive aggressive" or "short and unkind to one another, especially when stressed". However, when left unchecked or poorly managed, this escalated into a pattern of bullying.

Several respondents experienced discrimination based on their race, gender, cultural background, sexuality, and neurodivergence. Gender-based discrimination related to pregnancy, return to work, and childcare was also a common theme:

> *"I was informed that I did not get the management position that I applied for because I only had a few months left at work, since I was due to go on parental leave. The position was then given to someone, although slightly more qualified than me, was also pregnant."*

> *"I asked to reduce my hours for childcare reasons, and was given no real options, and so felt like I had to resign. It felt like my choice was my kid or my job – we live in 2024."*

> *"Have been told I wasn't considered for a role because I was likely to have another child..."*

> *"When I addressed my annual leave entitlement since returning from maternity leave after 14 weeks, I was told that 'because I gave birth, I was not allowed to work for 6 months full stop' and that it needed to be escalated because I shouldn't have been working."*

A range of **task related bullying** behaviours were also experienced by respondents, ranging from being excluded from important communications (emails, conversations, and meetings) and plans; being micromanaged; being undermined in their role; having essential resources and information withheld; and having concerns dismissed. In some cases, institutional policies were misused against them; for instance, collecting data on their errors or mistakes (not as part of a PIP) or having trivial (later unsubstantiated) complaints about them being raised through formal channels, including through professional bodies. Concerningly, a couple of our APEX Delegates mentioned being targeted or mistreated because of their union role.

Finally, we briefly touch on a much more insidious but less-discussed form of bullying known as **institutional bullying**. This refers to the systematic mistreatment of workers by an organisation, through poor management of workload, rostering, and resourcing; organisational inaction in relation to complaints being raised; and individuals being scapegoated for systemic failures.[10] One respondent elaborated:

> *"[I was] being blamed for mistakes or errors that weren't mine or are systemic in nature – constantly fighting against being talked to like I'm error prone/careless when I'm actually really careful but short staffed and under pressure to get results out."*

Underlying dynamics of workplace abuse

While the dynamics of workplace abuse are numerous and complex, we have identified three consistent themes across respondent experiences.

Driven by power differentials

Workplace abuse was commonly driven by one or more types of power imbalances.

First, the deeply entrenched medical hierarchy meant respondents frequently experienced or witnessed bullying and harassment from SMOs and Consultants – not just toward AST workers, but also toward RMOs, Nurses, and other staff. This reflects a power differential between professions.

Second, hierarchies within each profession also meant some of this bullying and harassment was based on job title and role, directed mainly toward assistants or students.

Third, organisational hierarchies also came into play with many respondents experiencing bullying and harassment from those in supervisory, managerial, or leadership positions. This type of 'top-down' bullying represents a power imbalance formalised within the organisational structure itself.

The fourth type of power imbalance played out via an individual's proximity to power. Here, the perpetrator was often close with someone in a position of power (medical, professional, or organisational) and this served as a 'shield' to protect them from being held accountable for their behaviour. Respondents frequently noted experiencing or witnessing bullying from a

"friend of my manager" or a "leadership favourite", but despite raising complaints no action was taken.

While these dynamics illustrate the workplace politics in healthcare that can give rise to workplace abuse, on their own they are insufficient to explain why these behaviours are tolerated to the point of becoming ingrained into the organisational culture.

Permitted due to poor management practices

It is poor management that enables such behaviours to continue and escalate over time. This can look like a 'hands-off' laissez faire approach to dealing with issues; management incompetencies due to a lack of training; or even leaders who intentionally use bullying tactics as part of their approach. One respondent explained:

> *"Management bodies do not seem to know how to keep employees towing the line evenly to prevent toxic environments. New Zealand culture is very passive aggressive, ineffective managing. I have worked in numerous DHB departments in NZ. This is one of the toxic ones because of toxic management."*

Resultantly, respondents who raised complaints about workplace abuse to their supervisor or manager were frequently dismissed, and often the abuse became worse:

> *"Management go on to say that my issues are not serious and that I shouldn't take things so seriously. I was told to harden up and try to become thick skinned because this is what it takes to be a Sonographer."*

> *"We have been told to basically shut our mouths as top management don't want to hear. So many staff now keep quiet as they have been told not to rock the boat."*

> *"I have raised issues with my immediate charge and was dismissed and told to manage my own stress levels better."*

Others pointed to wider issues with HR processes and systems:

> *"HR systems seem much more geared to protect the instigator of bullying rather than the victim. They place a lot of onus on the victim to advocate and make changes to ensure their own wellbeing, rather than anything that would require changing for the person performing the bullying behaviour."*

> *"HR seems to favour processes that keep [the perpetrator] employed by allowing them to work for a period of time under certain conditions but as soon as it's done the slate is wiped clean and those employees go back to their old ways."*

> *"HR continue to put up "anti-bullying posters", but it's a token gesture. Everyone is well aware who the bullies are, but nothing is done."*

Ultimately, due to an inability or unwillingness to intervene, management are complicit in tolerating and perpetuating these harmful workplace behaviours.

Perpetuated by toxic workplace cultures

Over time tolerating bad behaviours and 'known bullies' creates an unhealthy workplace culture, with the status quo going unchallenged. In these cases, even minor dissent or attempts at using worker voice can be viewed as "major insubordination". As a result, this reluctance to

intervene can create "an atmosphere of fear and apathy". Respondents described such workplace cultures:

> *"There is a real unique culture about this lab, and frequent sayings of 'this is how it has always been', which isn't too healthy"*

> *"It is just par for the course and a normal part of the culture. Bullying stems from the very top of the organisation."*

Impacts of these behaviours

Directly experiencing and witnessing workplace abuse can take a significant toll on employee's physical and mental health, with effects long enduring. Respondents in our survey who experienced this abuse felt "incredibly devalued", "demoralised", and experienced a "loss of mana". For some, this negatively impacted their "professional development and patient care". Others experienced physical and moral injury as a result:

> *"You just have to go to work and survive everyday just to get your pay check to put food on the table. You become mentally and physically drained, tired and unhealthy. There is no hope. You become a zombie at work."*

Ultimately, the impacts and costs of bullying are largely borne by employees themselves. Some were forced to take sick leave as a coping and recovery mechanism. One respondent explained their experience of workplace bullying "cost me a lot of money seeking medical care outside of Te Whatu Ora due to the long wait lists." This perfectly illustrates the double whammy of our current health crisis that is degrading employee wellbeing whilst simultaneously restricting their access to help.

Several respondents noted that workplace bullying and harassment was directly impacting on their desire to remain in the profession, while others who witnessed this feared a "mass exodus" of staff. A few respondents also spoke of others who were so badly impacted by workplace abuse, they "can now no longer work in the field due to anxiety issues" or "got bullied to the extent that they felt so traumatised that they now refuse to work for Te Whatu Ora."

Together, these findings highlight a significant risk to AST workers' health, safety, and wellbeing at work, and a failure by Health NZ as the employer in managing these workplace hazards under the Health and Safety at Work Act.[4] Given none of the indicators in this pou exceed the 60% mark, it is safe to assume Wairuatanga of our AST workforce remains compromised.

2.2.2 Rangatiratanga

Rangatiratanga was assessed through three indicators rated on a six-point 'Agree-Disagree' scale. As shown below, all three items in this pou score in the 'orange' zone – where there are concerns and need for action – however one item tends to be slightly more favourable.

Whereas respondents are more likely to be able to access the right learning and development opportunities when they need to (62.1%), this is less so for leadership opportunities (52.2%), suggesting fewer clinicians are empowered or given the chance to step into leadership roles. The lack of leadership pathways and representation for ASTs is a significant missed opportunity as there are demonstrated upshots to having services led by allied health clinicians, in terms of better patient outcomes, reduced wait times, and provision of high-quality care.[11]

Respondents are also less likely to see opportunities for career progression within their workplace (52.4%), reflecting the numerous delays and implementation challenges with designated positions and career progression frameworks. Together these findings suggest that the collective clinical expertise, specialist knowledge, and leadership potential of our AST workforce is still largely being undervalued and unrecognised. These are crucial elements of a meaningful and rewarding career.

2.2.3 Whanaungatanga

Whanaungatanga was assessed through eight indicators, six of which were rated on a six-point 'Agree-Disagree' scale. As shown below, one of the items in this pou is in the 'red' zone, with four in the 'orange' zone – suggesting urgent and much needed room for improvement. Only one item scored within the 'green' zone.

The lowest scoring items within this pou pertain to employee consultation on work-related changes (49%), particularly those that have a direct impact on employees themselves (52.9%) – despite worker participation and consultation being key requirements under the Health and Safety at Work Act and the Employment Relations Act.[4,5] These findings are not entirely unexpected, given the recent restructuring announcements alongside an onslaught of funding cuts and hiring freezes.

Communication also fares very low (50%), although relations between management and employees are marginally better (57.3%). All in all, these findings suggest significant room for improvement in how workers are communicated with, consulted, and treated at work.

It is noteworthy that relations between coworkers (74.6%) is the only item within the 'green' zone. As the highest rated item across the *entire survey*, it is also the only factor not directly in the employer's control.

11.6% **RARELY or NEVER able to take minimum rest breaks**

10.5% **HAD DIFFICULTIES accessing sick/ discretionary leave**

Other indicators of whanaungatanga were around accessing the minimum mandated rest breaks and leave entitlements as per the collective agreement. 11.6% of respondents are rarely or never able to take their minimum rest breaks, and a similar percentage (10.5%) have experienced challenges with accessing sick or discretionary leave entitlements. These are relatively lower percentages, suggesting most employees are able to access the minimum requirements in their collective agreements – however, there is still room for improvement.

2.2.4 Te Korowai Āhuru

Te Korowai Āhuru was assessed through 11 indicators, six of which were rated on a six-point 'Agree-Disagree' scale. As shown below, most items in this pou score within the 'orange' zone, with one indicator firmly in the 'red' zone. The lowest scoring item in the entire survey is also contained within this pou, which is concerning since Te Korowai Āhuru is about safety at work.

There are two aspects to worker safety and wellbeing. The first requires a work environment and conditions that support worker health and wellbeing. The second involves a workplace culture that is conducive to employees raising concerns and having management systems and processes to address these concerns in a timely manner. In short, health and safety at work is about more than just harm minimisation – it is about actively fostering and prioritising employee wellbeing on par with other organisational goals.

Unfortunately, as the indicators show, neither holds up in the case of the AST workforce across Health NZ workplaces. Only 62.2% of employees feel they have a safe work environment, which is unsurprising given health and safety appears to be only marginally prioritised over other competing goals such as cost-savings and productivity (57.2%).

While employees feel somewhat safe to speak up about anything that concerns them at work (60%), they are generally not confident their concerns will be actioned (50.3%). This is indicative of a poor reporting culture, which can deter respondents from raising concerns around risks, errors, and accidents, and ultimately perpetuate unsafe practices. In this way, a poor reporting culture also has implications for patient safety and care.

Perhaps most confronting is the finding pointing to severe staff shortage issues across the sector, with only a minority of respondents feeling they have adequate staffing (38.4%). On the other hand, more respondents felt they had the tools and resources needed to do the job well (58.1%). Adequate staffing levels are critical in ensuring AST employees are able to do their jobs effectively, without compromising quality of care or patient safety– especially since individual AST practitioners can be, and are, held accountable for failing to provide adequate care under the Health and Disability Commissioner Act.[12] It is unfair that this leaves individual practitioners in the position of being scapegoated for system failures. Yet, this is the lowest rated item in our

survey, sparking major alarms for the safe provision of health services. This is, in fact, not just a wellbeing issue for AST workers but a major public health concern.

Under this pou we also consider other indicators of a 'safety cloak' around working hours and sickness presenteeism. Nearly a third of employees (27.7%) are more often than not working overtime or outside of their rostered hours, and three in five workers feel pressured to work despite feeling unwell (60.8%). This is also symptomatic of staffing issues and suggests our AST workers are consistently extending themselves – over and above contractual obligations – for their work, with little by way of employer care for their health, safety, and wellbeing.

27.7% **ALWAYS or USUALLY** work overtime or beyond rostered hours

60.8% **SICKNESS PRESENTEEISM** in the last 3 months

Te Mauri o Rongo – the Health Charter

We also asked members questions pertaining directly to Te Mauri o Rongo, including an option for free-text comments. We have included this under Te Korowai Āhuru as this pou references organisational accountability for implementing the Health Charter.

79.1% **DID NOT UNDERSTAND** what the Charter was trying to achieve

93.9% **HAVEN'T SEEN** the Charter implemented in their workplace

97.1% **HAVEN'T SEEN** any positive change as a result of the Charter

Most respondents (79.1%) did not understand what the Charter was setting out to achieve, and even more have not seen any practical implementation of the Charter in their workplace (93.9%), nor any positive change as a result (97.1%).

Indeed, respondent comments consistently indicated they had never heard of the Charter outside of APEX communications or until this survey. Those who were somewhat familiar with the Charter saw it as a "high-level", "very idealistic" and "virtue-signalling" document that did not meaningfully affect their day-to-day work:

> *"It's hard to see how this translates into anything tangible at work. Given our current government's determination to spend less and less and trying to roll back the changes made by the previous government, on the shop floor all these documents and wordy policies mean very little. The health workforce is in survival mode. Just getting up and coming to work is enough for a lot of staff."*

> *"There is no evidence of practical change on the coal face."*

Instead, these respondents wanted the Charter to be more relatable and visible to staff, with leaders driving change:

> *"More proactivity and engagement from my Team Leader in promoting these values. Especially modelling them themselves."*

"It needs to be demonstrated by senior management, who we nothing to do with except emails telling what an amazing job we do but giving us nothing new or more to help us do this."

They also wanted greater employer accountability for implementing the Charter, suggesting a yearly review as one mechanism for doing so.

Overall, then, it appears that the effects of Te Mauri o Rongo are not being widely seen nor felt by our AST workforce – despite most being open to this change.

2.3 Priority changes for the AST workforce and recommendations for Health NZ

Lastly, we asked our AST workforce what they would like to see change, or happen, at their workplace in the next 12 months. Respondent comments for proposed changes were grouped into six key themes, which informed our recommendations for Health NZ as the employer.

Staffing

Overwhelmingly respondents wanted to see improvements to the staffing crisis, noting that adequate staffing was integral to a healthy work environment, enabling safe clinical practice, and supporting retention. Respondents collectively called for an end to hiring freezes and rejected the rhetoric that cuts to 'back office' staff were not impacting frontline care as a "blatant lie".

Responses indicated the dire state of staffing was "soul destroying" and driving further challenges around safe rostering, leave access, health and safety, and patient safety. As a result, staff were increasingly experiencing burnout and moral injury:

> *"The [staffing shortages] means we often have to provide sub-standard levels of care as a result – the only alternative to this is burnout."*

> *"We care that we're not doing right by our patients (as a result of insufficient staffing/vacancies) but the organisation does not seem to acknowledge our concerns, and ultimately makes us feel like they're ok with providing substandard care. That hurts morale more than the stress of working in a crisis."*

Some felt unsupported by management in accessing sick, discretionary, or annual leave entitlements, and others noted "the rostering system works against maintaining a healthy lifestyle". These fundamental worker rights are a basic hygiene factor in good workplace relations; yet continue to remain a challenge for our AST workforce.

As a result of persistent short staffing, respondents felt their wellbeing was not a priority for the employer or the government:

> *"The government and the employer only care about saving money rather than staff wellbeing."*

> *"There is no focus on employee wellness and treating employees like people rather than numbers. Unfortunately, this carries over to patients who are seen as numbers in context of intense pressure."*

> *"This government treats staff and patients as a financial burden."*

Our recommendations for Health NZ:

- Promptly advertise and fill existing vacancies across AST and other workforces;
- Recruit more staff into permanent positions, not just temporary or locum roles;
- Increase worker pay – through collective bargaining processes – to stop the haemorrhaging of staff into the private sector and overseas; and
- In the interim, better manage workload and management expectations around what staff can realistically achieve when under resourced.

Training

Staff shortages were also impacting employee access to training and CPD opportunities. Respondents raised concerns that newer staff were often being forced to work beyond their level of clinical competence or agree to duties beyond what their training permitted, to cover roster gaps:

> *"The increase in workload and the hiring freeze across the health system means more workload on existing staff. This greatly delays the training of staff who are not fully trained to meet their job description requirements and some of them have been working for years due to rostering and staff levels. This goes directly against the Te Mauri o Rongo*

which stated that the health system workers are supposed to be supported and well-trained. How can they be well trained if they are prematurely pushed onto shift work while other senior staff have reservations about this kind of decisions."

"As a profession, we are being forced to agree to duties outside of our scope of practice, which we refuse to do."

Such practices carry increased clinical risk, while simultaneously leaving untrained staff to bear the brunt of team members' frustrations. Respondents spoke of senior staff in their department "belittling newer staff members and complaining the job isn't for them, they are too slow at the job, keep making mistakes" where ultimately this came down to insufficient training.

Challenges with accessing training weren't isolated to newer entrants. Many respondents had been unable to access their CPD requirements, without which they stand to lose their scopes of practice and be unable to work. Some felt pressured to choose between training and service:

"I nearly had training declined because after approval, was told - 'it will take clinician time off the floor' (for 5 days). Should I be pressured into cancelling my training? I would like more opportunity to attend time away from endless clinic pressure."

Others were "verbally promised extra study time closer to assignment submission dates or exams, which has never happened and now is being totally denied due to staffing issues" or had approval for career-advancing study declined for "questionable reasons". Addressing these barriers to training is essential in retaining our skilled AST workforce.

Our recommendations for Health NZ:

- Allow sufficient training time for newer entrants to become fully trained and practice safely, without rostering practices compromising this;
- Allocate the necessary time and resourcing to enable staff to undertake training opportunities, CPD, and career-advancing study;
- More effectively balance training against service delivery to ensure staff can keep up with their CPD requirements; and
- Enable easier (and more transparent) access to existing CME funds.

Career development

Related to training, respondents also sought greater clarity and transparency around career progression pathways. Many were currently taking on added responsibilities without recognition or recompense. Others pointed out that existing mechanisms, such as merit progression, raised their own challenges:

"I struggle to use merit progression. If I do, who sees my clients while I'm off doing other things to increase my salary and status (meeting criteria for progression)? I feel I'm given the choice to progress my career/salary at the expense of seeing clients. The wait lists are long. I am the only practitioner in my field in this area. Nobody picks up the clients while I advance my career. It's an invidious choice."

Importantly, favouritism was frequently raised as an issue impacting on career progression. In some workplaces career development was "definitely about who you are 'buddies' with", with "opportunities offered to individuals not to the whole group". One respondent elaborated:

> *"I witness people getting asked if they want a secondment (which was a promotion) but it is the friend of the team leader or the nurse co-ordinator, so other staff are not considered – they can't put their hand up, no general expressions-of-interest process is put out to team. This happens often, at least 3 times this year so far. Deals are made with no due process and transparency."*

The flip side of favouritism was that respondents rightly perceived this as unfair, biased, and discriminatory:

> *"I do feel that because of my ethnicity and gender, other colleagues have received positions despite me doing exact or more duties outside of my scope."*
>
> *"I've seen staff advanced to senior positions, while other staff with more knowledge and years of experience are overlooked."*

Our recommendations for Health NZ:

- Develop transparent, fair, and consistent career progression pathways, especially for those professions with no clear opportunities to progress further or into leadership positions;
- Ensure designated positions are informed by realistic job sizing, with specialised skillsets and scopes recognised and appropriately remunerated; and
- Ensure staff are appropriately recognised and remunerated for additional responsibilities and advanced duties (e.g., training other staff) they are undertaking.

Leadership and management

Another consistent theme was our AST workforce wanting major improvements in the leadership and management of Health NZ workplaces. The constant changes and restructuring have created an environment of uncertainty, and done little to maintain trust and confidence in Health NZ's leadership, with respondents frequently mentioning a leadership disconnect:

> *"I have a good relationship with my immediate manager who is supportive but don't feel valued or appreciated by senior management. The breakdown is at that senior management level and how they make decisions."*

Respondents desired "a settled and visible senior management" and "stability in tier 1 and 2 with an understanding and definitive future direction" of where the organisation was headed. They also wanted to see a demonstrated commitment by leadership that worker health, safety and wellbeing was paramount. Under the Health and Safety at Work Act, employers have a primary duty of care to prevent and manage these workplace hazards (such as workplace bullying and harassment), reduce stress, and create mentally healthy work environments.[4]

However, the high prevalence of many of these workplace hazards shown in our findings are indicative of serious breaches of employer obligations under the Act.

At an operational level, respondents wanted to have greater confidence in the competencies and integrity of those in supervisory, charge, or managerial roles. Many were currently unhappy with individual managers and team leaders who had done little to address concerns raised or, in a few instances, had actively denigrated our AST workers:

> *"[Managers] do not listen or care for us. One told my colleagues that we are 'bottom of the food chain'."*

> *"One manager continually denigrates the [District] Physics team at every opportunity."*

Our recommendations for Health NZ:

- Senior leadership to better demonstrate their prioritisation of worker health, safety and wellbeing in high-level decision making as well as day-to-day practice;
- Leaders "leading from the top" and role modelling Health NZ's espoused values and priorities;
- Ensuring those promoted into managerial (e.g., team leader, supervisor, clinical lead) roles are equipped with the necessary skills, training, and emotional intelligence to carry out their duties, respond to concerns appropriately, and support their staff;
- Consistently apply rules and policies, and ensure fair treatment of staff; and
- Build into leadership and management roles better accountability mechanisms for delivering on change and for failing to manage key risks to employee health, safety, and wellbeing.

Communication and worker participation

Across the board respondents wanted improved communication and genuine worker participation on issues that affected their work and wellbeing. Currently, communication was largely a 'top-down' information overload, with staff feeling unheard. Respondents wanted senior management to:

> *"Stop bombarding us with 'communication' (that we don't have time to read/ listen to) and listen to the exhausted coal face workers."*

Where communication had to necessarily be 'top down', our AST workforce wanted greater transparency and line of sight on upcoming changes and – importantly – how this would impact on their day-to-day work.

Equally, they wanted to have a greater say in changes that impacted their work. Our AST workforce has a huge amount of clinical expertise, but most felt they were excluded from decision-making on key changes that impacted their work. Our findings indicate that staff who are best positioned to inform clinical decision making are often excluded from these processes.

Improving two-way communication and worker voice mechanisms requires a climate of psychological safety, where staff feel comfortable raising their concerns and confident they will be heard. However, many respondents currently felt unsafe to speak up, fearing retaliation or being blamed themselves:

> *"I don't feel safe giving feedback to management or discussing my concerns as I don't think it would be taken into account and I may be seen as a 'difficult' person."*

Our recommendations for Health NZ:

- Improve the process and mechanisms for two-way communication;
- Engage in genuine employer-led consultation on big picture changes and those that directly impact employees' day to day work, allowing sufficient time and resourcing for workers and their representatives (unions) to have their say;
- Acknowledge and better value the clinical expertise of our AST staff by enabling input into decision-making, especially leadership decisions; and
- Foster a climate of psychological safety that ensures staff concerns are listened to and acted upon.

Resourcing

Lastly, respondents wanted better access to the resources needed to do their job. Many described not having essential practice requirements such as a consultation room to see patients, enough beds for admission, and scanners to cut through waitlists and meet the pressures of growing public demand. Others described the "outdated" nature of equipment and digital infrastructure that was a further barrier to being able to do their job well:

> *"Quite regularly the lack of resources makes us feel unsafe at work. The inability to get a bed or a needed intervention when patients really need it makes professionals feel useless.... It makes the health (and mental health) professionals carry a risk that is actually systemic. That doesn't feel safe."*

Some even noted their workplace conditions were a major risk to safety, deterring from them accessing the service as a user themselves:

> *"Our hospital leaks when it rains, there are pins in the ceiling to tell the cleaners where to leave the 100's of buckets. Our carpark looks like multiple bombs have been let off, some of the potholes are so big. A patient fell into one and broke her leg, and still they remain."*

> *"I pray my family don't need public healthcare anytime soon...because we are providing such a poor standard."*

> *"I would not be a patient at our broken, dirty, unsafe hospital."*

Overall, urgent infrastructure improvements were needed to bring the level of service up to a decent standard.

Our recommendations for Health NZ:

- Urgently invest in key facilities (e.g., consult rooms, beds, building heating and cooling, safe parking) and equipment (e.g., scanners) needed to provide clinical services and bring the level of service up to a decent standard; and
- Continue investing in upgrading and maintaining capable and fully-functioning IT systems that streamline administrative duties of our clinical workforce.

Other changes

In addition to the above, respondents also suggested improvements around making the workplace a more family friendly environment; reducing administrative work; more support for Māori staff and patients; and other improvements to services and models of clinical practice (that were out of scope for this report).

2.4 Contextualising our findings

Before delving into the profession-based reports, we briefly compare our findings to the employer-run Ngātahitanga Pulse surveys, conducted in December 2022 and April 2024.[6,7] These Pulse surveys consolidated the AST workforce into a single occupational grouping, which unfortunately revealed nothing about the specific priorities and challenges across professions. We are also yet to receive a breakdown of findings for the 2024 survey by occupational grouping – so even at a high level we cannot identify changes for the AST workforce collectively.

Nonetheless, the Pulse survey findings indicate that the AST workforce had an average score of 59% across sixteen items, comparable to midwifery and nursing. This is similar to our own findings – with most indicators falling in the 'orange' zone (ranging between 50-70%).

The Pulse survey also outlines high-level changes employees wanted to see across Te Whatu Ora in the next three to twelve months. Amongst the major themes were:

- More resources – more staffing, better pay, reduced workload, and more facilities and equipment.
- Leadership and transition – better communication, transparency, and visibility of managers at the 'coalface'.
- People experience – feeling respected and supported at work, as well as training and development.

Again, this is largely aligned with our own findings and paints a picture of a workforce that is severely under resourced and undervalued, struggling with workload pressures exacerbated by training and career development challenges, and dissatisfied with leadership. These factors are also consistently identified in the research as precursors for turnover amongst this workforce.[13] These issues further compound challenges with safe working conditions, retention and recruitment, collective wellbeing, and in the long term threaten AST workforce sustainability.

The Hauora Haumi Allied Health report similarly identifies common barriers across AST professions, including retention challenges, loss of skilled and experienced workers, and insufficient training and supervision models that are creating significant workforce pipeline challenges.[14] However, whereas that report is the first to collate information on the AST workforce and their impact on population health, our own report is the first to do the same for the health, wellbeing, and workplace conditions *of* this workforce.

Across the health system, the value of our allied health sector as 'pivotal change agents' continues to be espoused, including the need to better retain and grow critical and hard-to-fill specialist roles such as RTs, ATs, Radiographers, Sonographers, Physiologists, and Pharmacists.[15,16] And as the second biggest clinical workforce in the country, AST remains a linchpin in achieving better public health outcomes for Aotearoa.[13,17] Yet, as our findings show, the current system is not enabling this.

4. Profession reports

Within this section we provide a series of mini reports for those AST professions with sufficient numbers to allow a separate analysis while preserving respondent identities.

We first provide a high-level overview of the demographic profile of these professions, then compare findings against the AST workforce average where there are notable variations (i.e., five or more percentage points) from the workforce average. These variations are highlighted in green (where these are favourable) or red (where these are worse). Relevant profession-specific challenges and concerns are also briefly summarised.

A full 'heatmap' comparing indicators across all 10 of these professions is shown overleaf.

Once again, scores that vary notably (i.e., more than five percentage points) from the AST workforce average are highlighted in green (where favourable) or red (where less favourable). The highest and lowest scoring professions for each item are indicated in darker shading, or with an outline where there is a less than five percent variation from the AST average.

'Heatmap' comparing indicators across AST professions and the workforce average

Pou	Indicator	APEX	AT	Physiol	Lab	Physicist	Radiogr	Pharm	Physios	Psych	RT	Sonogr
	My workplace supports my overall wellbeing	**58.7**	57.3	61.3	55.3	58.3	60.5	66.1	53.2	56.9	57.5	56.5
	I feel valued by my workplace	**57.2**	59.1	62	52.8	62.6	56.1	64.9	51.6	62.6	55.1	53.4
	In my workplace I get recognition for good work	**54.7**	57.3	53	49.3	61.7	53.1	60.7	48.4	61	56	56
Wairuatanga	I would recommend my workplace as a good place to work	**57.9**	64.5	64.7	53	58.3	59.7	64.1	55.8	55	55.9	55.8
	Directly experienced bullying in last 12 months	**21.3**	27.5	29.3	21.1	18.2	18.7	16.7	13.9	16.8	30	23.6
	Witnessed bullying in last 12 months	**33.8**	50	34.5	32.6	27.3	34	29.6	27.8	28.8	45	25.8
	Likely to leave workplace in next 6 months	**24.8**	17.5	25.8	19.6	9.1	27.5	20.4	27.8	22.8	26.7	29.2
	I am able to access the right learning & dev opportunities when I need to	**62.1**	59.5	55	54	67.3	64.5	60.4	53.2	72.5	61.2	63.7
Rangatiratanga	I get the leadership development opportunities that I want	**52.2**	59.5	50	48.2	57.1	52.9	54.4	45.3	55	55.4	52.4
	There are opportunities for me to develop my career in my workplace	**52.4**	52.6	51	46	59.1	54.1	55.8	45.8	56	53.5	55.6
	Relations between management and employees in my workplace are good	**57.3**	54.1	60	57	55.7	58.3	59.6	55.3	57.8	56.6	55.6
	Relations between coworkers in my workplace are good	**74.6**	74.1	78	67.2	80.9	75.5	78.5	74.2	78.1	73.4	74.2
	Communication between senior leadership and employees is good	**50.0**	48.8	52.8	48.8	50.4	53.6	49.1	45.3	42.3	53.1	54.2
Whanaungatanga	For the most part, my workplace treats its employees fairly	**57.6**	54.1	60.3	53.2	57.4	59	59.6	57.4	57.9	58.8	58.7
	My opinions are sought on the issues that affect me and my job	**52.9**	55.1	51.9	53	59.1	53.6	53.7	45.3	51.2	53.7	54.4
	I am consulted about proposed changes at work	**49.0**	51.2	49.2	47.4	48.2	50.7	49.4	49.5	44.5	50.6	51.8
	Rarely or never able to take minimum rest breaks	**11.6**	17.1	17	5.1	4.3	11.7	15.1	8.4	14.1	0	17.8
	Had difficulties accessing sick or discretionary leave	**10.5**	2.4	15.3	8.2	8.7	13.4	11.1	2.8	6	16.1	11.1
	I have the tools and resources I need to do my job well	**58.1**	63.6	58.3	58.3	59.1	60.6	59.3	47.4	51.2	57.8	62.6
	There are enough staff at my workplace for me to do my job properly	**38.4**	34.1	41	43.3	54.8	38.3	37.9	33	34.4	37.5	41.8
	In my workplace health & safety is considered just as important as other goals	**57.2**	56.1	62.7	60	60	56.7	61.9	54.6	51.6	57.1	55.8
	My workplace has a safe working environment	**62.2**	58	67.8	62.6	71.3	62.3	69.1	58.9	56.7	62.3	62.4
	I feel safe to speak up about anything that concerns me in my workplace	**60.0**	62.9	60	57	63.5	62.5	63	53.5	59.5	57.1	59.3
Te Korowai Āhuru	If I spoke up about a concern, I am confident my workplace would address it	**50.3**	50.7	53.6	49.1	56.5	53.1	54.3	44.9	43.6	52.3	49.8
	Always or usually work overtime or outside their rostered hours	**27.7**	46.3	23.7	22.4	30.4	29.6	22	25	28.4	11.3	25.5
	Sickness presenteeism	**60.8**	63.4	61	59.2	39.1	64.3	59.3	55.6	63.2	54.8	64.4
	Did NOT understand what the Health Charter was trying to achieve	**79.1**	80	67.2	91.5	40	77.4	86.7	94.5	73.5	83.6	77.3
	Have NOT seen practical implementation of the Charter in their workplace	**93.9**	87.5	86.2	97.9	90	95.2	98.1	97.2	96.2	85.2	93.2
	Have NOT seen any positive changes as a result of the Charter in their workplace	**97.1**	100	93.2	96.8	90	97.6	100	97.2	97.7	91.8	96.6

3.1 Anaesthetic Technicians

Demographic profile

Anaesthetic Technicians (AT) respondents were represented across nine Districts and 11 hospitals sites, with an average tenure in their workplace of 12 years and 7 months. Nearly two-thirds identified as female (64.4%) with the rest as male (35.6%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the AT profession, where there are notable variations.

Pou	Indicator	APEX	ATs
Wairuatanga	I would recommend my workplace as a good place to work	57.9	64.5
	Directly experienced bullying in last 12 months	21.3	27.5
	Witnessed bullying in last 12 months	33.8	50
	Likely to leave workplace in next 6 months	24.8	17.5
Rangatiratanga	I get the leadership development opportunities that I want	52.2	59.5
Whanaungatanga	Rarely or never able to take minimum rest breaks	11.6	17.1
	Had difficulties accessing sick or discretionary leave	10.5	2.4
Te Korowai Āhuru	I have the tools and resources I need to do my job well	58.1	63.6
	Always or usually work overtime or outside their rostered hours	27.7	46.3
	Have NOT seen practical implementation of the Charter in their workplace	93.9	87.5

*Note: numbers reflect percentages

Key points

- Amongst all professions, ATs reported the highest rates of experiencing and witnessing workplace bullying, sexual harassment, and discrimination in their workplace. Rates of witnessing these behaviours are considerably higher (50%) than directly experienced (29.3%), suggesting a lot of this behaviour may be directed toward other staff members within the same service. This is consistent with international findings identifying surgery as a 'hotspot' for bullying.[18]
- ATs had greater difficulties with accessing their minimum rest breaks and usually or always worked outside their rostered hours.
- They are also more likely to have access to the tools and resources needed to do their job well – likely reflecting the nature of surgical services being unable to proceed otherwise.
- However, compared to other professions ATs are most likely to get the leadership development opportunities they want, and they also experience fewer challenges with accessing leave entitlements compared to the AST workforce average.

3.2 Clinical Physiologists

Demographic profile

Physiologists were represented across 13 Districts and 14 hospital sites, as well as a few in other work sites. They had an average tenure in their workplace of 10 years and 4 months. Nearly three-quarters identified as female (73.4%), with the remainder identifying as male (26.6%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Clinical Physiology profession, where there are notable variations.

Pou	Indicator	APEX	Physiologists
Wairuatanga	I would recommend my workplace as a good place to work	57.9	64.7
	Directly experienced bullying in last 12 months	21.3	29.3
Rangatiratanga	I am able to access the right learning & dev opportunities when I need to	62.1	55
Whanaungatanga	Rarely or never able to take minimum rest breaks	11.6	17
Te Korowai Āhuru	In my workplace health & safety is considered just as important as other goals	57.2	62.7
	My workplace has a safe working environment	62.2	67.8
	Did NOT understand what the Health Charter was trying to achieve	79.1	67.2
	Have NOT seen practical implementation of the Charter in their workplace	93.9	86.2

*Note: numbers reflect percentages

Key points

- Physiologists were least likely to be able to access the right learning and development opportunities when they need to, reflecting wider workforce issues around having clear and transparent career progression pathways.
- They experience greater challenges with being able to access minimum rest breaks, as well as sick or discretionary leave than the rest of the AST workforce in our survey, and report higher rates of directly experiencing workplace bullying, sexual harassment, and discrimination.
- Despite the above, this profession scores highest for perceptions of health and safety being prioritised within their workplace, and a safe working environment. This might indicate a focus on different aspects of safety – i.e., safety around clinical practice vs psychological safety for workers.
- Interestingly, physiologists also seem to have a higher awareness of the Health Charter, compared to many other professions.

3.3 Medical Laboratory Workers

Demographic profile

Medical Laboratory Workers were represented across eight Districts including nine hospital sites and a smaller percentage in other settings. They had one of the longest average tenures in their workplace of 17 years and 8 months. The majority of respondents identified as female (80.4%) with the remainder as male or gender diverse.

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Medical Laboratory profession, where there are notable variations.

Pou	Indicator	APEX	Lab Workers
Wairuatanga	In my workplace I get recognition for good work	54.7	49.3
	Likely to leave workplace in next 6 months	24.8	19.6
Rangatiratanga	I am able to access the right learning & dev opportunities when I need to	62.1	54
	There are opportunities for me to develop my career in my workplace	52.4	46
Whanaungatanga	Relations between coworkers in my workplace are good	74.6	67.2
	Rarely or never able to take minimum rest breaks	11.6	5.1
Te Korowai Āhuru	Always or usually work overtime or outside their rostered hours	27.7	22.4
	Did NOT understand what the Health Charter was trying to achieve	79.1	91.5

*Note: numbers reflect percentages

Key points

- Medical Laboratory Workers are less likely to get recognition for their work, reflecting the historical undervaluing of this often 'invisible' workforce and the significant clinical value they contribute toward medical decision-making.
- This group also had the lowest scores for coworker relations, reflecting the sometimes isolated and siloed nature of their work often with minimal staff interaction.
- Laboratory Workers also tend to have lower scores for accessing training and career development opportunities. Options for career progression are limited, compared to other AST professions, with fewer Medical Laboratory Workers represented in leadership roles.
- Yet, this profession has one of the lowest turnover intentions, which may be explained by the recent pay equity settlement for public sector Lab Workers, resulting in a huge pay disparity with private providers. Thus, retention of this workforce may be temporarily bolstered, despite other workplace challenges such as increasing workload and burnout from unsustainable rostering practices. However, this finding around turnover intent may also be disguising the loss of this skilled workforce overseas, which over the long term will compromise our training pipeline and ability to upskill new graduates.

3.4 Medical Physicists

Demographic profile

Physicists were represented across six Districts and the same number of hospital sites, with an average tenure in their workplace of approximately 12 years. Just over half of the workforce identified as male (55.6%), with the remainder as female or gender-non-binary.

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Medical Physics profession, where there are notable variations.

Pou	Indicator	APEX	Physicists
Wairuatanga	I feel valued by my workplace	57.2	62.6
	In my workplace I get recognition for good work	54.7	61.7
	Witnessed bullying in last 12 months	33.8	27.3
	Likely to leave workplace in next 6 months	24.8	9.1
Rangatiratanga	I am able to access the right learning & dev opportunities when I need to	62.1	67.3
	There are opportunities for me to develop my career in my workplace	52.4	59.1
Whanaungatanga	Relations between coworkers in my workplace are good	74.6	80.9
	My opinions are sought on the issues that affect me and my job	52.9	59.1
	Rarely or never able to take minimum rest breaks	11.6	4.3
Te Korowai Āhuru	There are enough staff at my workplace for me to do my job properly	38.4	54.8
	My workplace has a safe working environment	62.2	71.3
	If I spoke up about a concern, I am confident my workplace would address it	50.3	56.5
	Sickness presenteeism	60.8	39.1
	Did NOT understand what the Health Charter was trying to achieve	79.1	40
	Have NOT seen any positive changes as a result of the Charter in their workplace	97.1	90

*Note: numbers reflect percentages

Key points

- Physicists were the highest scoring profession across most indicators in this survey. However, it's important to bear in mind that the majority of indicators still sit in the 'orange' zone.
- They were also the profession most familiar with what the Health Charter was trying to achieve, however comments largely reflect the lack of its implementation by management. As a workforce which largely understands the Charter, the discrepancy between what is espoused and enacted may be especially pronounced in their responses.
- Comments also reflected the desire for greater psychological safety in raising issues, as well as better resourcing of services.

3.5 Radiographers (MIT, MRI, Nuc Med)

Demographic profile

Medical Imaging Technicians (MIT, MRI, and Nuc Med) were represented across 20 Districts and 25 hospital sites, with a smaller number of respondents across other sites. They had an average tenure in their workplace of 10 years and 4 months. Most of this workforce identified as female (84%), with the remainder as male or gender-non-binary.

Comparative findings

Scores for Radiographers were largely reflective of the AST average with any deviations being between one two three percentage points; hence there are no variations to highlight here.

Key points

- While Radiographers' scores are largely comparable with the AST workforce average, they do have a higher turnover intent compared to many other professions reflecting the high attrition of this workforce into private practice or overseas due to remuneration and workload issues.
- Opportunities for career progression, whilst not the lowest, remain a challenge for this workforce. These issues are two-fold. First, there are fewer opportunities for career advancement of general MITs, whereas on the other hand specialist scopes (e.g., NucMed) have less capacity to train new entrants and are therefore experiencing challenges with the training pipeline.
- Sickness presenteeism also tends to be higher, once again reflecting staffing shortages in the public sector combined with growing need for this public service as part of timely diagnosis and treatment. However, this is ultimately burning out our existing workforce.

3.6 Pharmacy Workers

Demographic profile

Pharmacists and Pharmacy Technicians and Facilitators (Pharmacy Workers) were represented across nine Districts and 11 hospital sites, with fewer working in other sites. They had an average tenure in their workplace of 8 years and 1 month. The vast majority identified as female (85.5%), with the remainder as male (15.5%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Pharmacy profession, where there are notable variations.

Pou	Indicator	APEX	Pharmacy Workers
Wairuatanga	My workplace supports my overall wellbeing	58.7	66.1
	I feel valued by my workplace	57.2	64.9
	In my workplace I get recognition for good work	54.7	60.7
	I would recommend my workplace as a good place to work	57.9	64.1
Te Korowai Āhuru	My workplace has a safe working environment	62.2	69.1
	Always or usually work overtime or outside their rostered hours	27.7	22
	Did NOT understand what the Health Charter was trying to achieve	79.1	86.7

*Note: numbers reflect percentages

Key points

- Pharmacy was another profession that tended to score higher than the AST workforce average, just after Physicists. However, as noted earlier, these indicators continue to remain within the 'orange' zone.
- As with many other AST professions, Hospital Pharmacy Workers struggle with attrition overseas and into the community sector, leaving fewer experienced staff to support and train new entrants to the workforce. As a result of these pressures on top of high workloads, Pharmacy Workers are also more likely to experience challenges with taking minimum rest breaks.
- Workforce shortages may also reflect the somewhat lower scores for career progression within the workplace. For many Hospital Pharmacy Workers, staffing issues prevent them from working at the full extent of their scope of practice, with missed opportunities for crucial pharmacist intervention in the patient journey. For more experienced Hospital Pharmacists, training other staff may also be an expected rather than recognised part of their role – which impacts on recognition, remuneration, and career advancement.

3.7 Physiotherapists

Demographic profile

Physiotherapists were represented across three Districts and four hospital sites, with fewer in other settings. They had an average tenure in their workplace of nine and a half years. A vast majority of respondents identified as female (84.6%), with the remainder as male or gender-non-binary (15.4%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Physiotherapy profession, where there are notable variations.

Pou	Indicator	APEX	Physios
Wairuatanga	My workplace supports my overall wellbeing	58.7	53.2
	I feel valued by my workplace	57.2	51.6
	In my workplace I get recognition for good work	54.7	48.4
	Directly experienced bullying in last 12 months	21.3	13.9
	Witnessed bullying in last 12 months	33.8	27.8
Rangatiratanga	I am able to access the right learning & dev opportunities when I need to	62.1	53.2
	I get the leadership development opportunities that I want	52.2	45.3
	There are opportunities for me to develop my career in my workplace	52.4	45.8
Whanaungatanga	My opinions are sought on the issues that affect me and my job	52.9	45.3
	Had difficulties accessing sick or discretionary leave	10.5	2.8
Te Korowai Āhuru	I have the tools and resources I need to do my job well	58.1	47.4
	There are enough staff at my workplace for me to do my job properly	38.4	33
	I feel safe to speak up about anything that concerns me in my workplace	60.0	53.5
	If I spoke up about a concern, I am confident my workplace would address it	50.3	44.9
	Sickness presenteeism	60.8	55.6
	Did NOT understand what the Health Charter was trying to achieve	79.1	94.5

*Note: numbers reflect percentages

Key points

- Physiotherapists were the lowest scoring profession across most indicators in this survey. However, rather than an exhaustive list of where conditions might be worse for this profession, we point out a few pertinent challenges.
- Training and career-development related opportunities were amongst the lowest for this profession, reflecting the limited opportunities for advancement into designated roles – particularly for specialist physiotherapists. This profession also struggles with limited recognition and opportunities for non-clinical or leadership roles.

- Psychological safety – the ability to speak up about concerns in the workplace – is the lowest across all AST professions, as is confidence that issues raised would be addressed.
- However, it is interesting that this workforce reports one of the lowest rates of workplace bullying, harassment, and discrimination across professions. A lower reported rate does not always translate to a lower prevalence of workplace abuse – as many of these behaviours may go unreported or underreported. It is possible this finding reflects the relatively isolated nature of physiotherapists' work, with fewer interactions with other health professionals.

3.8 Psychologists

Demographic profile

Psychologists (including Clinical Psychologists) were represented across 19 Districts and 21 hospital sites. A sizeable number also worked in other work sites. They had an average tenure in their workplace of 7 years and 11 months. The vast majority identified as female (86.9%) with the remainder as male (13.1%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Psychology profession, where there are notable variations.

Pou	Indicator	APEX	Psych
Wairuatanga	I feel valued by my workplace	57.2	62.6
	In my workplace I get recognition for good work	54.7	61
Rangatiratanga	I am able to access the right learning & dev opportunities when I need to	62.1	72.5
Whanaungatanga	Communication between senior leadership and employees is good	50.0	42.3
Te Korowai Āhuru	I have the tools and resources I need to do my job well	58.1	51.2
	In my workplace health & safety is considered just as important as other goals	57.2	51.6
	My workplace has a safe working environment	62.2	56.7
	If I spoke up about a concern, I am confident my workplace would address it	50.3	43.6
	Did NOT understand what the Health Charter was trying to achieve	79.1	73.5

*Note: numbers reflect percentages

Key points

- Psychologists tended to feel more valued and recognised for good work at their workplace, compared to other AST professions.
- Whilst they were more likely to be able to access training and development opportunities when they needed to, for some psychologists – especially those providing specialist services – high caseloads and supervision responsibilities are still a constraint on accessing CPD. Many continue to have to choose between training and service delivery, with career pathways and remuneration still being limited in the public sector.
- Many raised concerns that inadequate staffing and resourcing further compounded their workloads, constraining them from being able to do their job well.
- Psychologists also tended to consistently score indicators of workplace safety and communication lower compared to other AST professions. This may be because the profession is more attuned to aspects of psychological and psychosocial safety, due to the nature of their role, and therefore experience any incongruity more strongly.

3.9 Radiation Therapists

Demographic profile

Radiation Therapists (RTs) were represented across six Districts and the same number of hospital sites, with an average tenure in their workplace of 12 years and 5 months. The vast majority identified as female (86.6%), with the remainder as male (13.4%).

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Radiation Therapy profession, where there are notable variations.

Pou	Indicator	APEX	RTs
Wairuatanga	Directly experienced bullying in last 12 months	21.3	30
	Witnessed bullying in last 12 months	33.8	45
Whanaungatanga	Rarely or never able to take minimum rest breaks	11.6	0**
	Had difficulties accessing sick or discretionary leave	10.5	16.1
Te Korowai Āhuru	Always or usually work overtime or outside their rostered hours	27.7	11.3
	Sickness presenteeism	60.8	54.8
	Have NOT seen practical implementation of the Charter in their workplace	93.9	85.2
	Have NOT seen any positive changes as a result of the Charter in their workplace	97.1	91.8

*Note: numbers reflect percentages

**No respondents selected 'rarely' or 'never' for this item.

Key points

- As with ATs, RTs also tended to report higher rates of experiencing and witnessing workplace bullying, sexual harassment, and discrimination in their workplaces.
- They also consistently experienced greater challenges with accessing sick or discretionary leave entitlements compared to the AST workforce average, reflecting workforce shortages and the steady loss of graduates overseas.
- However, fewer RTs indicated they were working overtime or outside their rostered hours, with none indicating challenges with taking rest breaks.
- While not immediately apparent in the quantitative findings, comments consistently pointed to an urgent need to address short staffing issues to relieve pressure on the existing workforce.

3.10 Sonographers

Demographic profile

Sonographers were represented across 17 Districts and 19 hospital sites, with an average tenure in their workplace of 12.5 years. The vast majority identified as female (84%), with the remainder as male or gender-non-binary.

Comparative findings

The table below provides a comparison between the AST workforce average ('APEX') and scores for the Sonography profession, where there are notable variations.

Pou	Indicator	APEX	Sonographers
Wairuatanga	Witnessed bullying in last 12 months	33.8	25.8
Whanaungatanga	Rarely or never able to take minimum rest breaks	11.6	17.8

*Note: numbers reflect percentages

Key points

- Sonographers were the least likely to access their minimum rest breaks and had a greater incidence of sickness presenteeism than the AST workforce average. This likely reflects high workloads due to workforce shortages.
- Challenges with staffing, unclear career progression pathways, and limited progression opportunities may also be driving burnout and morale issues with this workforce, who tend to have one of the highest rates of turnover intent in this survey across the AST professions, with the private sector being an attractive alternative.

4. Conclusion

4.1 A summary of our findings

Our AST workers are loud and clear in their messaging: this is a workforce in survival mode. Urgent employer action is needed to transform work conditions and lift employees' collective wellbeing.

The New Zealand Health Charter has been specifically developed to drive this culture shift, with the goal of supporting and retaining our valued health workforces.[14] It is high time Health NZ gives effect to the Charter, so that it can function as intended.

Health NZ has signalled an e-learning module is planned to 'go live' in Q1 2024/25 as a means of supporting staff to embed the values and principles of the Charter into their daily work.[19] This is a much needed and commendable first step, as most respondents in our survey have never even heard of the Charter. However, it needs to be accompanied by employer accountability mechanisms to ensure effective implementation. In this regard, we recognise a Te Mauri o Rongo Steering Group is currently in the process of defining flagship Charter initiatives and developing resulting internal reporting metrics.

We understand as part of this programme of work, the Steering Group is engaging with union partners. As the specialist union for over 5,000 AST workers employed in Aotearoa New Zealand – and equipped with our survey evidence – APEX will be welcoming engagement with the Steering Group and with Health NZ on work around the Charter.

4.2 Where to from here?

Our findings highlight six priority areas for change, as identified by our AST workforce, and this has informed our recommendations for the employer. These six areas are inherently related. Improvements in one will have natural flow-on impacts on others, with staffing being central amongst these.

Importantly, these recommendations are neither new nor radical. Many of the proposed changes we have set out have been identified by the government and employer themselves. The Government Policy Statement on Health, for instance, sets out the dual priorities of workforce and infrastructure as 'essential enablers' for improving health services.[20] Likewise, findings from the Pulse surveys come to similar conclusions as we have.

In parallel to Health NZ rolling out work on the Charter, our findings from this survey will no doubt inform and drive profession-specific initiatives. However, APEX is of the view that workers should be empowered to use the Health Charter to drive meaningful change within their own teams and departments.

Giving life to the Charter is a shared responsibility. But the first step to change is awareness. This is where we are starting. We will be socialising the Health Charter with our members, through Delegates, and supporting the initiatives that arise from these discussions. We will not solve the health crisis with a report alone. So, this is our call to action: if you haven't already, have a look at the Health Charter. And then, simply begin a conversation about it in your workplace. This is how we make sure the Charter becomes a living, breathing document across the sector.

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6. Appendix: Methodology

Survey design

We developed indicators for each of the four pou, focusing primarily on indicators at the organisational level, and to a lesser extent the collective level. This is because the organisational level is where accountability should start.

Indicators were selected based on a review of the relevant literature on constructs related to organisational culture and workplace conditions and drawing on select indicators of workplace culture from the NHS in the UK.

Since each pou vary in the breadth of principles, values, and behaviours, we were selective in our use of indicators; noting that some pou such as Rangatiratanga had a smaller and more defined scope. Where indicators overlapped across multiple pou, we have made a judgement call about where any one indicator best fit and ascribed it to that pou. However, there is considerable overlap of concepts across the pou – so the analysis should be interpreted as a whole, rather than as a reflection of performance across any one pou.

Data analysis

Our analysis aimed at capturing an overall snapshot of indicators for each pou. Most items were rated on a six-point Likert scale from Strongly Agree to Strongly Disagree, and for these items we have coded this similar to the Pulse surveys; converting them as a percentage on a 'traffic light' continuum to show how well Health NZ is faring.

Demographic data such as gender and ethnicity have been coded in line with Stats NZ standards. To ensure participant anonymity is preserved, we have not provided a demographic breakdown for categories and groups with significantly fewer participants – however their responses are included in the overall results.

Free-text qualitative responses were analysed using thematic analysis to extract high-level themes across the data.

Profession reports

In addition to analysing the collective responses across the AST workforce, we have also analysed responses across those professions where there were sufficient numbers of respondents to preserve individual respondent anonymity. These mini reports serve to highlight variation from the AST workforce average, as well as briefly capture specific professional challenges and areas of concern. However, varying sample sizes across professions mean there was insufficient statistical power for some professions. Therefore, any variations between sample scores don't necessarily represent a statistically significant difference.


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