THE STATE OF

Burnout in Allied Health

How everyday pressures are influencing burnout in allied health



zanda

RESEARCH REPORT | 2026

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Executive summary

Nearly half of the allied health practitioners (47.1%) surveyed by Zanda in 2026 rate their burnout risk as moderate or worse, and one in six (16.1%) rate it as high or severe. Burnout builds as everyday pressures stack up, and the practitioners carrying the most are also the most likely to say they'll leave the profession. Five findings stand out.

1 Burnout risk climbs as everyday pressures stack up

We identified seven everyday pressures linked to burnout risk: feeling professionally isolated, feeling underpaid, heavy admin hours, heavy documentation hours, technology that feels overwhelming, concern that AI will replace part of the role, and revenue and profit margin falling. Among practitioners carrying none of them, 4.3% rate their burnout risk as high or severe. Among those carrying four or more, 62.8% do. Nearly a quarter of practitioners (23.7%) already carry three or more.

2 Half of the most burned-out practitioners say they're likely to leave within three years

Among practitioners at severe burnout risk, 51.9% say they're likely or very likely to leave the profession within three years, compared with 6.0% of those at no risk, and the share rises at every level of burnout risk in between. Counting those who are unsure, nearly three in ten practitioners (29.4%) aren't confident they'll stay.

3 Isolation is the strongest burnout risk factor

Practitioners who feel professionally isolated very often are five times as likely to rate their burnout risk as high or severe as those who never do (51.6% vs 9.9%). Isolation runs through the rest of the data too. The biggest jumps in burnout risk come when it is paired with another pressure, it shows up at every practice size, and more than a third (35.5%) of the most isolated say they are likely to leave the profession. Yet no practitioner used the word "isolated" or "lonely" in their written answers. Instead, they described it, wishing for a colleague to bounce ideas off, supervisors to talk to, or someone to look after their clients when they take time off.

4 Feeling underpaid is linked to burnout, even when revenue is holding up

Practitioners who strongly disagree that they're paid adequately are nearly five times as likely to rate their burnout risk as high or severe as those who strongly agree (35.3% vs 7.7%). Most of them (64.2%) report stable or growing practice revenue, so the problem isn't simply a struggling business.

5 Heavy documentation load is linked to nearly four times the burnout risk

Practitioners spending 21 or more hours a week on documentation are nearly four times as likely to rate their burnout risk as high or severe as those spending two hours or less (50% vs 12.9%). Unlike scheduling or invoicing, documentation can't be handed to someone else. Among practitioners spending nine or more hours a week on documentation, those who have cut that time with AI are half as likely to be at high or severe risk as those whose time hasn't changed (18.4% vs 36.8%).

Methodology

The Zanda 2026 State of Allied Health survey was distributed to allied health practitioners and completed by 682 practitioners between March and May 2026. It included more than 30 questions covering documentation and admin hours, technology and AI use, finances, client load, and how sustainable the work feels.

Because sample sizes vary by country and subgroup, country-level findings should be read as directional rather than precise, particularly for markets with smaller samples. The same applies to findings for smaller subgroups. Some figures reflect the 583 practitioners who answered all seven risk-factor questions, not the full 682 survey respondents. We checked whether the 99 who didn't answer every question skewed the result, and they didn't. Their overall burnout rate came back statistically the same as the group that did (17.4% vs 16.0%), so the finding holds even on this smaller base.

The relationships in this data are correlational. A seven-factor risk stack that lines up with burnout, or a documentation-hours number that climbs alongside it, shows two things moving together. Where this report says a factor is linked to burnout, tracks with it, or shows up alongside it, that's the full strength of the claim being made. Nothing in this dataset isolates a single cause on its own.

Definition of “burnout risk”

Burnout risk in this report is self-rated, not diagnosed. Practitioners placed their own current burnout risk somewhere on a five-point scale, no risk through severe, and every "burnout risk" figure in this report refers specifically to the share who rated themselves high or severe on that scale.

Definition of “allied health”

This report uses "allied health" broadly, covering the range of specialties represented in our respondent base. Alongside psychology, counseling, physiotherapy/physical therapy, occupational therapy, speech pathology, and massage therapy, respondents also included podiatrists, dietitians, exercise physiologists, chiropractors, and practitioners across a range of complementary and allied disciplines. In some markets, including the UK, "allied health professions" refers to a narrower, formally regulated list of professions. Readers in those markets should note the broader scope used here.

Introduction

How everyday pressures are influencing burnout in allied health

The survey behind this report set out to capture the day-to-day realities of running an allied health practice. We expected burnout to be one finding among many. Instead, it was linked to nearly everything else we asked about, from admin hours and pay to isolation and technology. The findings on what predicts it, how the pressures stack, and what practitioners say would fix it were strong enough to warrant a report of their own.

Zanda co-founder Damien Adler, a registered psychologist who ran his own private practice for about fifteen years, saw the warning signs early enough to change course. “I wouldn’t say I got to the stage of burnout,” he says, “but I definitely changed, and course corrected to prevent that.”

Burnout appeared in the 10th revision of the International Classification of Diseases, but in 2019 the World Health Organization gave it a formal definition in the 11th revision, describing it as an “occupational phenomenon,” not a medical condition, that results from chronic workplace stress that has not been successfully managed. The WHO defines it by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one’s job or feelings of cynicism toward it, and reduced professional efficacy.[1] Importantly, burnout isn't a personal failing to be treated in an individual. Instead, it should be viewed as a signal that something in the workplace or industry isn’t working.

Most of the research built on that definition since has focused on physicians and nurses, both well-studied, well-funded professions. Allied health has had comparatively little of that same attention, despite carrying many of the same pressures. This report spotlights how burnout is specifically impacting allied health professions globally.

Burnout isn't confined to one kind of practice. Larger practices are more likely to rate their burnout risk as high or severe (21.4% at practices of 6 to 15, against 13.5% for solo practitioners). But because solo practitioners make up about two-thirds of respondents, they still account for 58% of everyone at high or severe risk.

A survey spanning many countries and professions inevitably carries obvious differences underneath it. Reimbursement pressure from insurers in the US and administrative demands from Australia’s National Disability Insurance Scheme (NDIS) are different problems, and a psychologist's week may look nothing like a massage therapist's.

But certain patterns held up again and again regardless of specialty or geography: the shape of who burns out, what predicts it, and what practitioners reach for when asked what would fix it. Where this report draws conclusions across the whole dataset, it's because the pattern earned it. Where it doesn't, the differences are called out directly.

About this report

This report draws on the Zanda 2026 State of Allied Health survey, completed by 682 practitioners between March and May 2026. Respondents are based in Australia (68.8%), the UK (13.7%) and the US (9.5%), with others in New Zealand, Canada, Ireland, South Africa and elsewhere. More than half (56.0%) work in psychology or mental health practices, alongside physical therapists / physiotherapists, occupational therapists, speech pathologists, massage therapists and other allied health practitioners, and two-thirds (67.5%) are solo practitioners.

SECTION 1

A quarter of allied health practitioners are one bad year away from burnout

Burnout in allied health rarely comes down to one thing. In the Zanda 2026 State of Allied Health survey of 682 practitioners, seven everyday pressures stood out, and they stack. Among practitioners carrying none of them, 4.3% rate their burnout risk as high or severe, compared with 62.8% of those carrying four or more.

The seven pressures that wear a practitioner down are:

1. **Feeling professionally isolated** (often or very often)
2. **Disagreeing they're paid fairly** (disagree or strongly disagree)
3. **Heavy admin hours** (26+ a week per practice)
4. **Heavy practice documentation hours** (9+ a week per practitioner)
5. **A technology environment that feels overwhelming instead of helpful** (slightly or significantly more overwhelmed)
6. **Concern that AI will replace part of their role** (very or extremely concerned)
7. **A practice where revenue and profit margin are both sliding at the same time** (declining slightly or significantly on both)

Damien Adler designed his own practice to stop that load building up in the first place: "We limited how many patients someone could see in a day. We wouldn't even hire full-time practitioners easily. Someone had to convince us it was sustainable before we'd agree to it."

Most practitioners are already carrying some risk, and it may not take much more to tip them into the danger zone. The data backs that up directly: the average practitioner already carries 1.5 of the seven risk factors, and more than 40% carry two or more.

23.7%

of practitioners carry 3+ burnout pressures

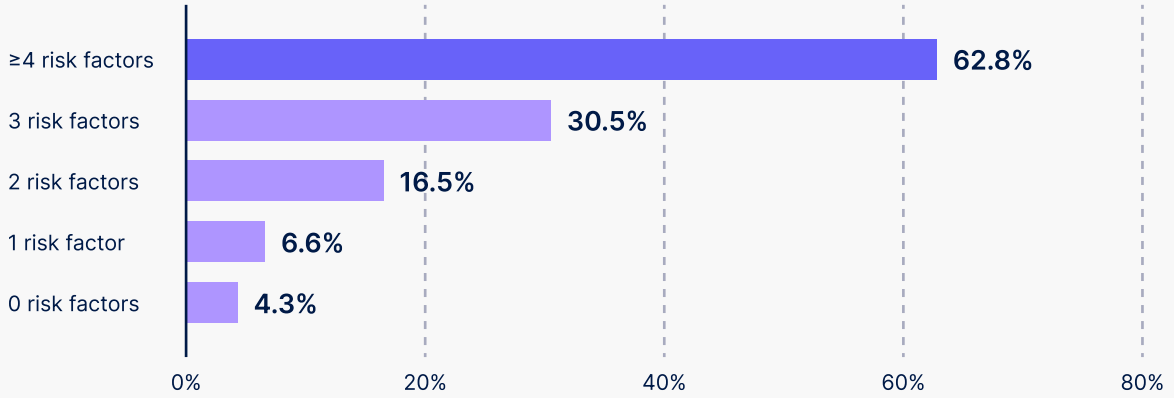
Burnout risk is

40.6%

for practitioners with 3+ pressures

Burnout risk climbs with every pressure a practitioner carries

% rating their burnout risk high or severe, by number of the 7 risk factors carried



Note: *The admin-hours factor in this index is measured at the practice level rather than per individual practitioner, so it may run somewhat higher for practitioners at larger practices independent of their own personal admin load. We tested the index with this factor removed entirely, and the same compounding pattern held: burnout risk still climbed from a low single-digit floor into majority-risk territory as the remaining six factors stacked, so this finding doesn't depend on any single input.*

The most prevalent risk factors

Two of these seven pressures show up more than any other. Pay dissatisfaction (34.3%) and isolation (32.8%) are each carried by roughly a third of respondents on their own, before any stacking happens at all.

38.0%

of practitioners whose client base has shrunk over the past year carry 3 or more risk factors

A shrinking caseload is a warning sign

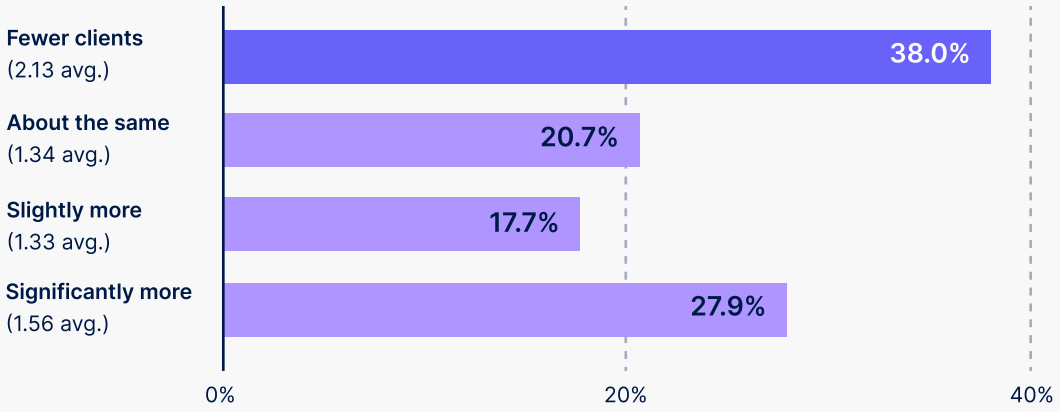
Practitioners whose client base has shrunk over the past year carry the highest average risk-factor count of any group measured, over two factors on average. Among them, 38.0% already carry three or more, well above the 23.7% population average. This is what "a bad year" concretely looks like when you can see inside it: lose clients for twelve months, and the share carrying three or more of the seven pressures rises from about one in five (20.7%) to nearly four in ten (38.0%).

> *"As a therapist I feel that people will always need individual validation and support. However there is a growing number of people who cannot afford to pay for ongoing therapy and many funding schemes are under-paying and have significantly increased administrative load which further decreases your hourly take home rate. Private practice for solo-preneurs feels increasingly unviable."*
>
> — Australian psychologist

Financial and risk-factor stress cluster tightly together for practitioners whose business is shrinking. Some of that's almost mechanical. "Revenue and margin declining" is literally one of the seven factors, so a shrinking client base is going to impact that directly. But the finding is about the average across all seven, which means this group is elevated on the other factors too.

Practitioners losing clients are most likely to carry 3+ risk factors

% carrying 3 or more of the 7 risk factors, by client load vs. last year

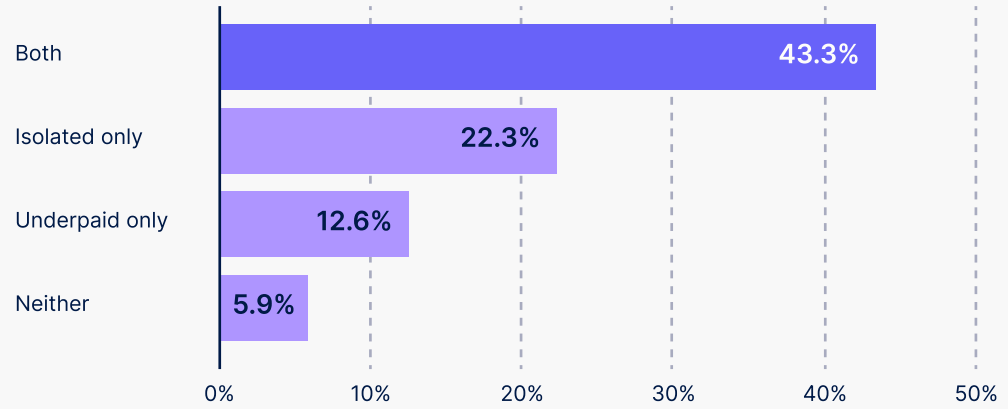


Pay dissatisfaction and isolation compound each other

A practitioner who experiences both pay dissatisfaction and isolation has a burnout risk of 43.3%, against 5.9% for practitioners who experience neither.

Feeling underpaid and isolated together pushes burnout risk to 43%

% rating their burnout risk high or severe, by whether they feel underpaid, isolated, both, or neither



These pressures land on practitioners who are also delivering care to clients every day, and the burden isn't getting lighter: 93.1% of practitioners say documentation requirements are the same or higher than three years ago.

One Australian psychologist described this compounding of burnout risk factors directly, clinical demands and business ownership landing at once: "The field is experiencing severe burnout juggling [a private practice model that isn't sustainable] as well as all the work of being a business owner or self-employed."

93.1%

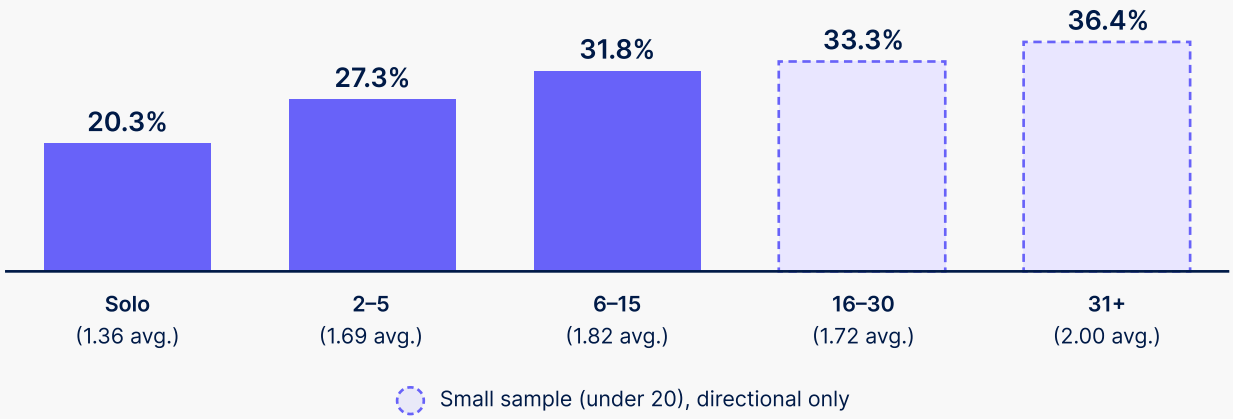
of practitioners say documentation requirements are the same or higher than three years ago

Risk factors climb with practice size

The US, UK, and Australia carry roughly the same average number of stacked factors, and it isn't a training gap since practitioners with formal business education carry about the same number of risk factors as those with none. It is, however, concentrated by practice size. Solo practitioners carry the lowest average risk-factor count of any practice size, with an average of just 1.36 risk factors. That number generally climbs as practice size grows, reaching 2.00 at practices of 31 or more, nearly 50% more. The share carrying three or more risk factors follows the same shape, 20.3% for solo practitioners, 36.4% at the largest practices (a directional sample).

Larger practices carry more burnout risk

% carrying 3 or more of the 7 risk factors, by practice size



Burnout risk rises with practice size. Solo practitioners carry an average of 1.36 of the seven risk factors, compared with 2.00 at practices of 31 or more, and 13.5% of solo practitioners rate their burnout risk as high or severe, compared with 42.9% at those largest practices. Pay dissatisfaction follows a similar pattern. Isolation is the exception: between 24% and 36% of practitioners feel isolated often or very often at every practice size.

Daily AI users carry the fewest burnout risk factors

AI adoption shows daily users carry noticeably fewer stacked risk factors than everyone else, but occasional users actually carry more than practitioners who don't use AI at all.

Consistent AI use may reduce admin and documentation hours, two of the seven factors directly, and lower tech-overwhelm and isolation indirectly. Low-confidence users report feeling overwhelmed by technology at a rate of 60%, versus 7.5% for the most confident.

Occasional use is probably where confidence is lowest, learning a new workflow without ever getting fluent enough for it to pay off, which would explain why it adds burden rather than reducing it.

16.6%

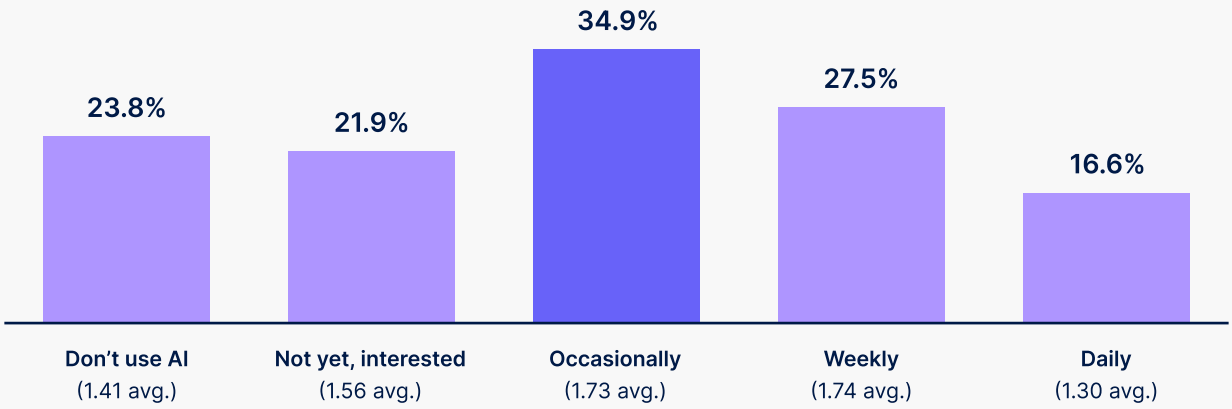
of daily AI users carry 3+ burnout risk factors, the lowest of any group

34.9%

of occasional AI users carry 3+ burnout risk factors

Share of practitioners carrying 3+ risk factors, by AI usage

% of practitioners carrying 3+ of the 7 risk factors, by AI usage



Three patterns hold across everything in this section. Burnout risk climbs with each added pressure (4.3% at none, 62.8% at four or more), pay dissatisfaction and isolation compound each other (43.3% when both are present, 5.9% when neither is), and the pressures cluster in practices that are shrinking (38.0% carry three or more) or large (36.4% at practices of 31 or more).

SECTION 2

Half of the most burned-out practitioners are planning to quit within three years

Nearly half of allied health practitioners are already at moderate burnout or worse, one bad year away from crossing into the highest-risk tier. But it's also alarming to see what happens once someone crosses that line: leave intent holds at 11.2% or lower through moderate risk, then more than doubles at high risk and nearly doubles again at severe.

One in six practitioners, 16.1%, already sit at high or severe burnout risk. Of those at severe risk, 51.9% say they're likely or very likely to leave the profession within three years. Among practitioners with no burnout risk at all, that number is 6.0%. Burnout risk is one of the clearest signals of who intends to leave: the share likely to leave rises at every level, from 6.0% at no risk and 7.5% at mild to 11.2% at moderate, 28.7% at high and 51.9% at severe. This is the same shape found in burnout itself. Risk holds flat for a while, then compounds sharply once a threshold is crossed. Here, that same cliff determines whether someone says they'll walk away.

If you count "unsure" alongside "likely" and "very likely" to leave, that's 29.4%, nearly three in ten practitioners not confidently staying.

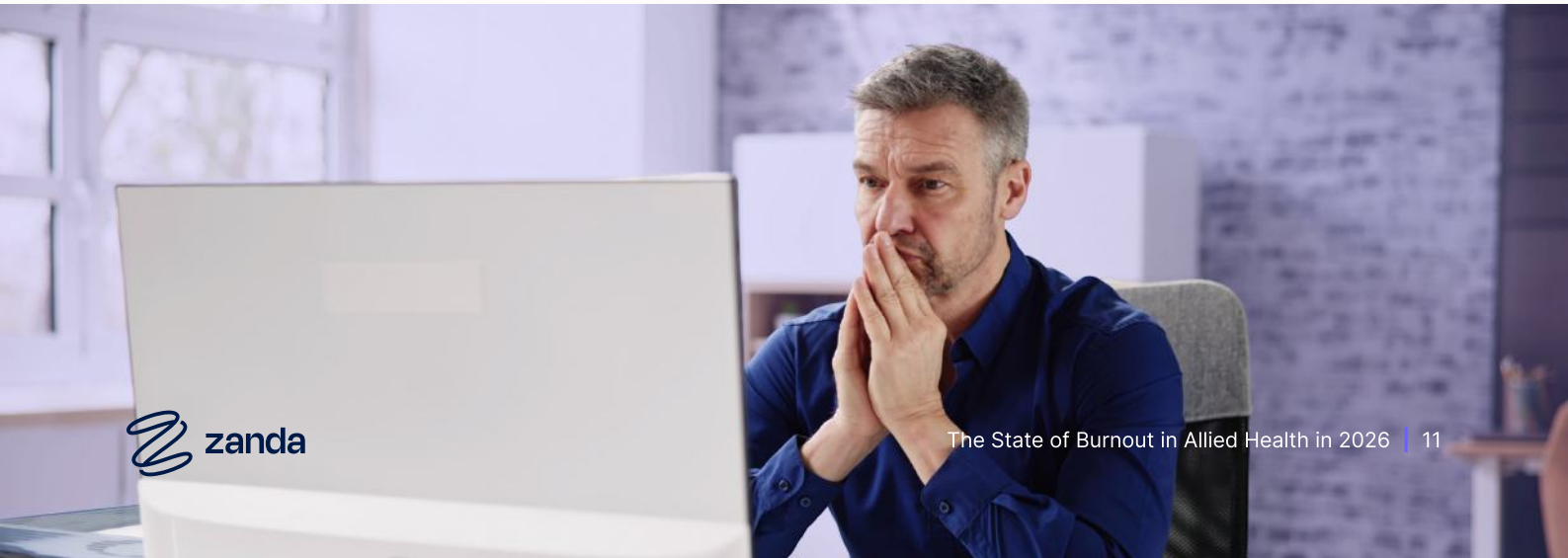
Note: *"within the next three years" is the literal survey question wording, not a projection or a model. This is stated intent, not confirmed attrition.*

16.1%

of practitioners are already sitting at high or severe burnout risk

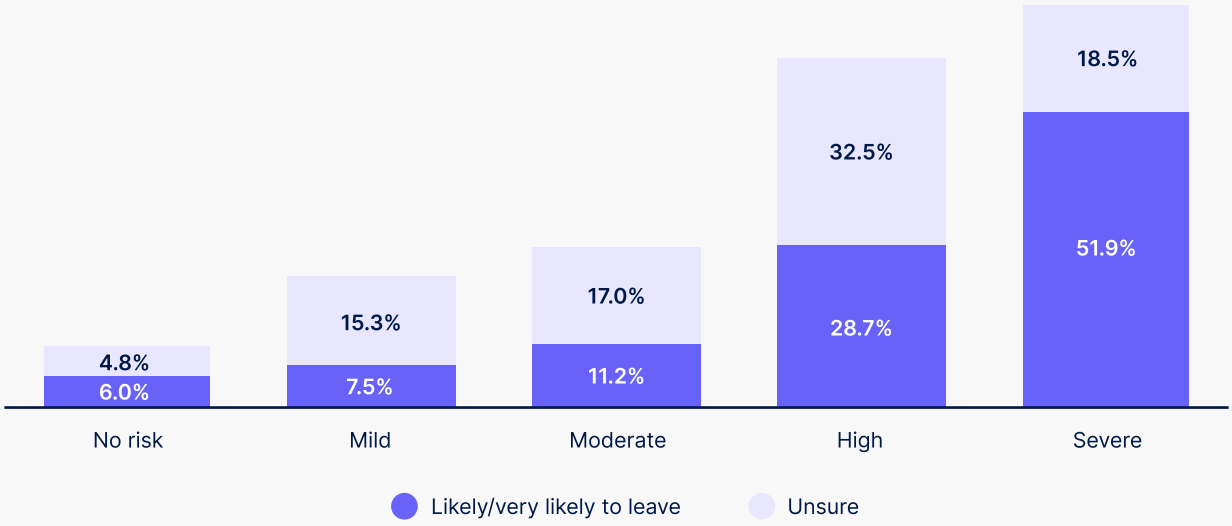
51.9%

of that severe-risk group say they're likely or very likely to leave the profession within three years



Leave intent jumps once burnout risk reaches ‘high’

Likelihood of leaving the profession within 3 years, by self-rated burnout risk



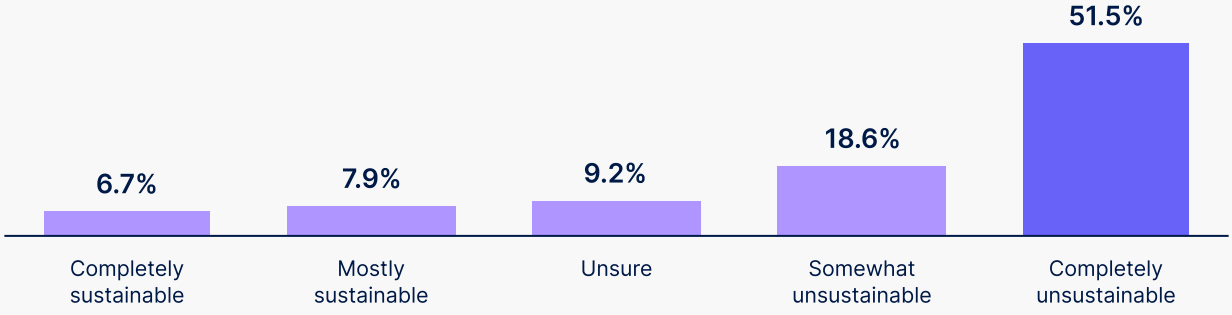
Counting those who are unsure, 61.2% of practitioners at high risk and 70.4% at severe risk aren’t confident they’ll stay.

> *"There is plenty of work, however I feel that burnout and low pay will see more [practitioners] pull out of the industry leaving an even greater shortage."*
>
> — Australian psychologist

Workload sustainability tells the same story even more sharply. Among practitioners who say their workload feels completely unsustainable, 51.5% are likely or very likely to leave. Among those who call it completely sustainable, that's 6.7%.

Half of practitioners with an unsustainable workload say they’re likely to leave

% likely or very likely to leave in the next 3 years, by workload sustainability



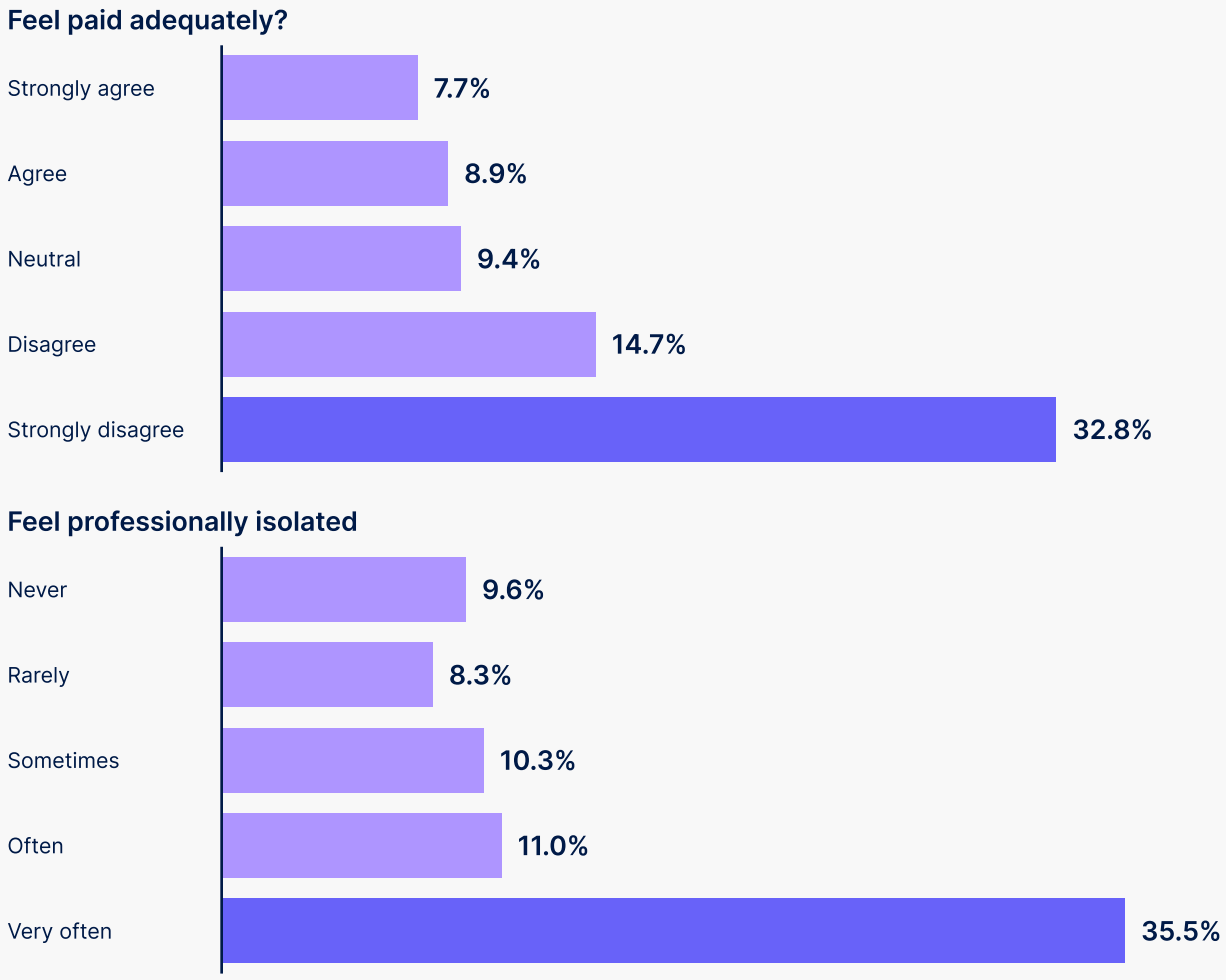
Pay and isolation are linked to leaving

Pay and isolation are both linked to plans to leave the profession, as well as to burnout. Practitioners who strongly disagree that they are paid adequately are nearly four times as likely as those who feel paid fairly to say they are likely or very likely to leave within three years (32.8% vs 8.7%). Intent to leave stays near 10% at every level of isolation until practitioners feel isolated very often, where it reaches 35.5%, more than triple the rate for those who never feel isolated (9.6%). Rates also differ by specialty: multidisciplinary clinics and speech pathology show the highest rates in this sample, though each group is small.

One Australian practitioner, running a multidisciplinary clinic, put the exhaustion plainly: "I've been burnt out for years if I'm honest. Definitely time for a change after 25 years!"

Leave intent spikes for the most underpaid and most isolated

Likelihood of leaving, by pay adequacy and isolation frequency



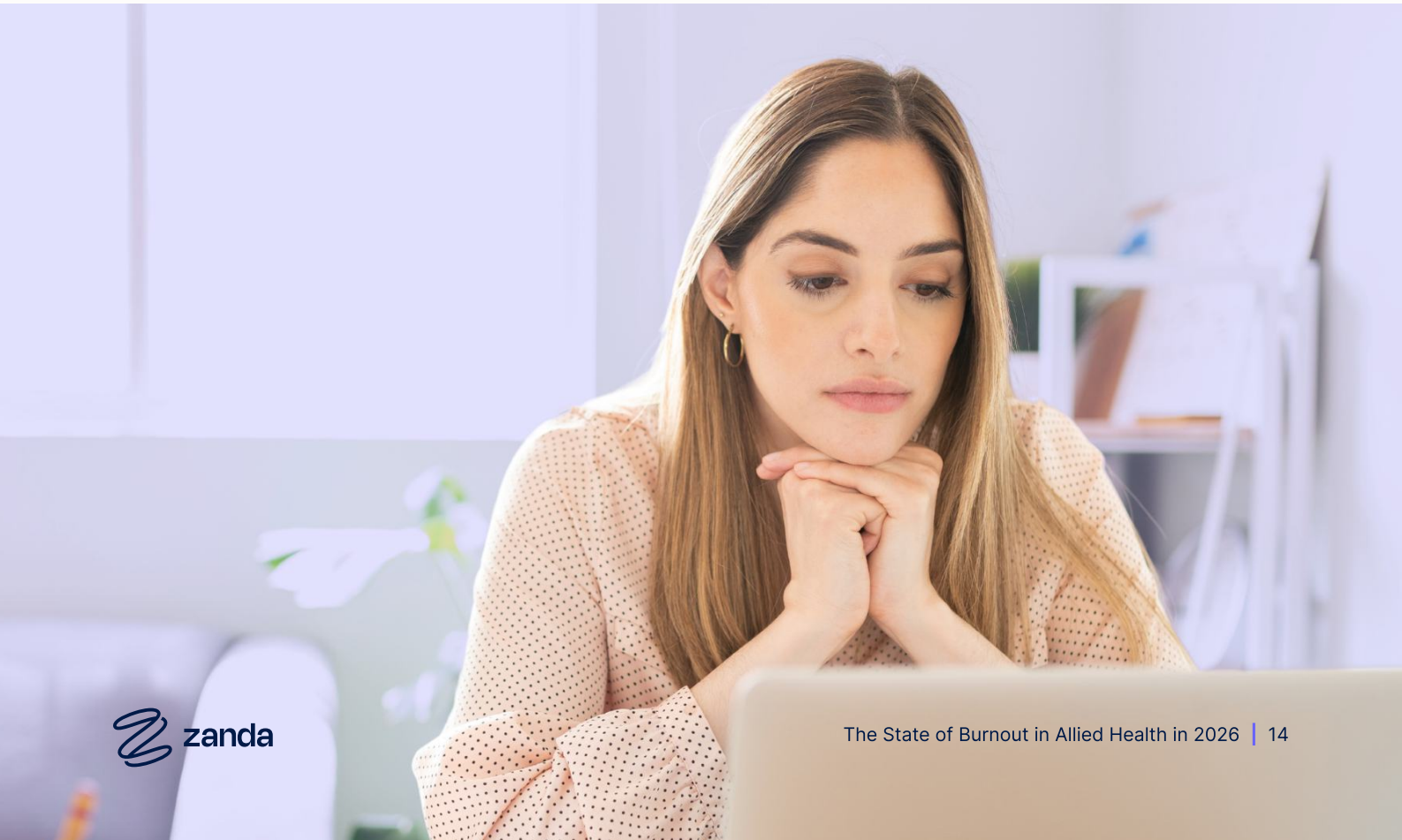
The same seven pressures predict leaving

The same seven pressures (isolation, pay dissatisfaction, heavy admin hours, heavy documentation hours, tech overwhelm, AI-replacement concern, and revenue and margin both declining) predict leaving on their own: practitioners with none of them report 6.8% leave intent, practitioners with four or more report roughly 49%.

Business decline turns out to be a stronger predictor of leaving than overwork itself, with practitioners whose client load fell over the past year reporting 22.6% leave intent, against 7.6% for practitioners whose caseload grew slightly.

Related numbers show up outside allied health: the AMA reports that 31.1% of physicians have a definite, likely, or moderate likelihood of leaving their current workplace within two years,[2] and Medscape's 2026 report found that 14% of physicians with burnout say it is severe enough that they are considering leaving medicine altogether.[3]

If even a fraction of practitioners who say they're leaving actually follow through, that's significant capacity removed from a system already showing signs of strain. Fewer practitioners generally means more pressure on whoever's left, which is exactly the kind of condition that produces the isolation, admin load, and financial strain (the same pressures linked to burnout in the first place).



SECTION 3

Isolated practitioners are 5x more likely to burn out, but they won't say that

Practitioners who feel professionally isolated "very often" report a 51.6% burnout risk. Practitioners who never feel isolated report only a 9.9% burnout risk. That's a fivefold gap, larger than pay, larger than workload, and larger than admin burden on their own.

51.6%

burnout risk in practitioners who feel professionally isolated "very often"

The other six factors in this report (admin hours, documentation load, pay, financial decline, tech overwhelm, AI-replacement fear) are all burdens. Isolation is categorically different, since it describes the absence of the thing that would normally help someone carry a burden. A practitioner buried in admin hours who has a colleague to vent to, compare notes with, or just be witnessed by, experiences that load as heavy but survivable. Remove the colleague, and the same admin hours compound, because there's no longer anywhere for that pressure to go.

Interestingly, out of hundreds of written responses to two separate open-ended questions, not one practitioner used the word "isolated" or "lonely." But they described it. Asked what one thing they would change about their practice if they had a magic wand, many practitioners wished for less admin or more clients. Some wished for people:

- "[I wish] I had another practitioner to bounce ideas off." – Australian psychologist
- "[I wish for] more quality colleagues." – UK psychologist
- "I'd have a lovely team of colleagues and my own clinic." – UK psychologist
- "I would have someone to help me make business decisions." – UK psychologist
- "[I wish] to be able to employ staff so when I take time off there is someone to look after my clients." – Australian massage therapist
- "[I wish for] more time being mentored and [to] non-judgementally speak with supervisors and colleagues." – Australian psychologist

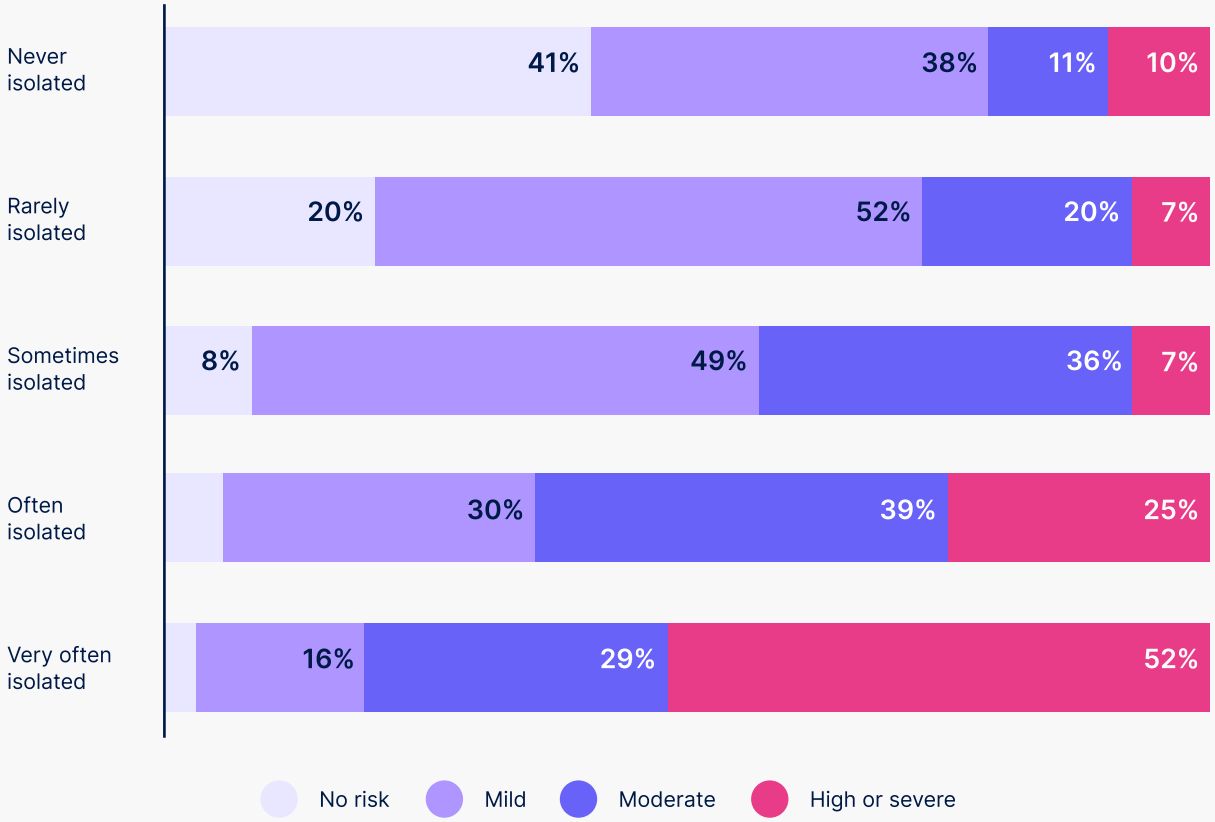
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practitioners quoted here say they feel professionally isolated often or very often

Isolation is the strongest predictor in the whole dataset, and the WHO's own definition of burnout includes "increased mental distance" and cynicism as core dimensions of burnout itself[1]. That raises the question: does isolation drive burnout, or does burnout drive isolation, as someone withdraws further the more depleted they get? Almost certainly some of both, and this data can't cleanly separate them.

Half of very isolated practitioners are at high/severe burnout risk

Self-rated burnout risk, by how often practitioners feel professionally isolated



Segment labels rounded; shown where 7% or more.

Isolation isn't about practice size

Isolation shows up whether a practitioner works alone or inside a practice of 31 or more people. Non-owner practitioners report it most often (40.0%), ahead of owner-practitioners who also treat clients (33.3%) and owners who focus on running the business (31.5%).

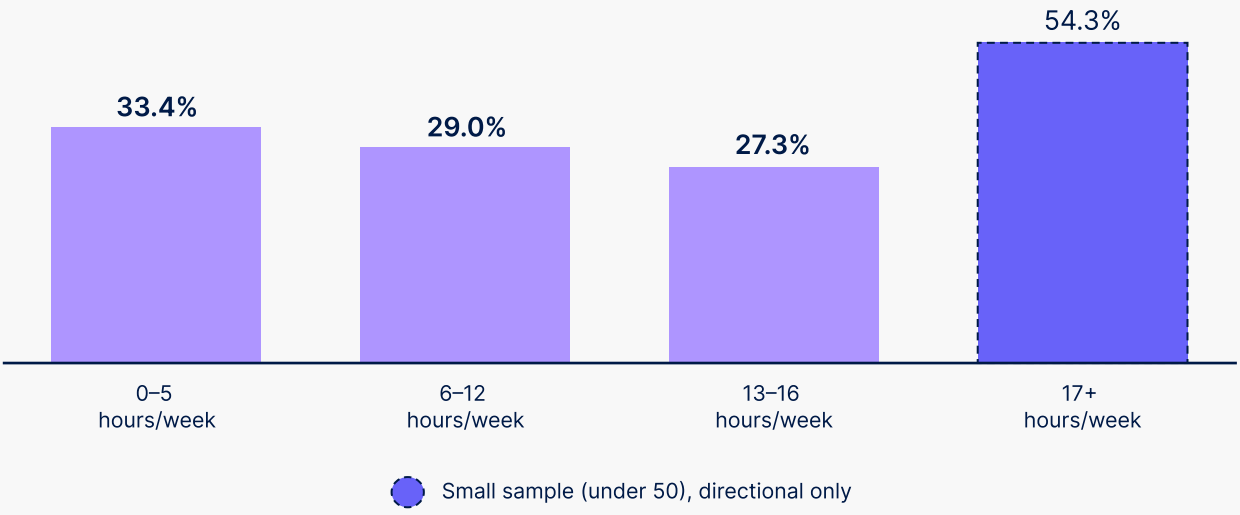
A practitioner can be surrounded by colleagues all day and still go days without substantively discussing a case with a peer, and practice size alone doesn't appear to change that.

> *"[I wish for] someone else [to] handle all the scheduling and paperwork. Also someone [to] help me turn my ideas into professional tools."*
>
> — US psychologist

Isolation looks much the same across most documentation loads, then climbs at the extreme end: 54.3% of practitioners spending 17 or more hours a week on documentation feel isolated often or very often, against 31.6% of everyone else. It makes sense once you sit with the mechanics of the job itself, since every hour spent alone on paperwork is an hour not spent with a client or a colleague.

Isolation jumps for practitioners doing 17+ hours of documentation per week

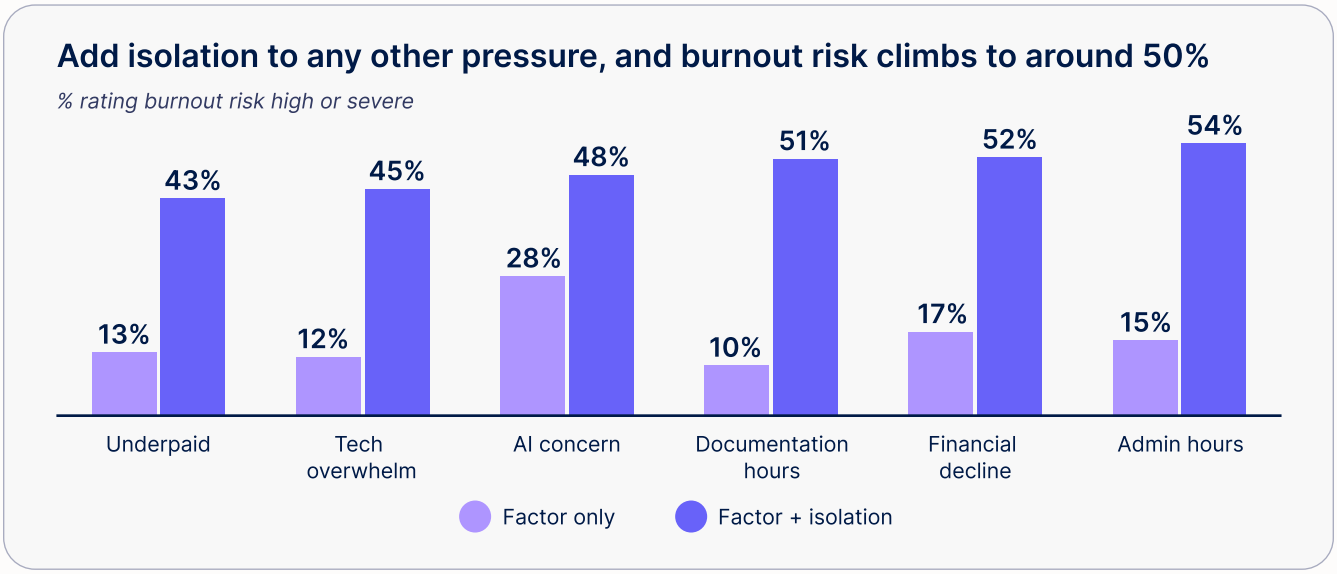
% feeling professionally isolated often or very often, by documentation hours per week



Isolation also predicts whether a practitioner feels their workload is sustainable. Among practitioners who feel isolated "very often," 25.0% describe their workload as completely unsustainable. Among those who never feel isolated, that's only 2.7%.

Isolation amplifies every other pressure

Isolation isn't just the strongest single factor in this dataset, it's the strongest multiplier too. Pair it with any of the other six risk factors, and the combination outperforms every pairing that doesn't include it: isolated plus heavy admin hours is linked to an 8.6x jump in burnout risk, isolated plus financial decline, 8.1x, isolated plus underpaid, 7.4x. Every pairing without isolation in it tops out closer to 4x or 5x.



Some of the free-text responses describe practitioners moving toward solo or independent practice specifically to escape corporate group models, chasing autonomy and workload control. If that shift continues, and if isolation is as structurally embedded in this work as the data suggests, the field may be solving one problem while deepening another one nobody's named yet.

Isolation is the strongest predictor of burnout in this dataset, the strongest multiplier of every other pressure a practitioner carries, and the one thing practitioners never once named in their own words. That combination is exactly why it's solvable once it's named.

Making room for connection

The solution is in how practitioners spend and structure their time. Hours currently lost to admin and documentation can be redirected toward case discussions and peer contact, and practices, professional bodies, and licensing structures can treat that contact as a built-in part of the job instead of something each practitioner has to find on their own. Supervision, mentoring, and peer case discussion already exist in allied health, so the work ahead is making room for them. Isolation is the one problem in this report that doesn't require inventing a new solution. It requires making room for one that already exists.

Practitioners who rate their burnout risk as none or mild are far less likely to feel isolated (19.1% report feeling isolated often or very often, against 67.6% of those at high or severe risk), which suggests connection is something practices can build in as part of how the work is set up.

The practitioners who feel most connected at work (only 9.9% of those who are never isolated rate their burnout risk as high or severe) are a good picture of what that kind of structure delivers.

> *"We compromised on the number of consult rooms to build a shared open space instead, because most practices maximize consult rooms to maximize billables, and then everyone just stays in their room all day and the loneliness creeps in."*
>
> — Damien Adler

SECTION 4

Underpaid practitioners are nearly five times more likely to burn out

Practitioners who strongly agree they're paid adequately report a 7.7% burnout risk. By contrast, practitioners who strongly disagree they're paid adequately report 35.3% burnout risk, nearly five times higher. And for most of them, it isn't because their practice is failing: 64.2% of the most underpaid group aren't seeing declining revenue at all, 31.3% report stable revenue, 32.8% report growth.

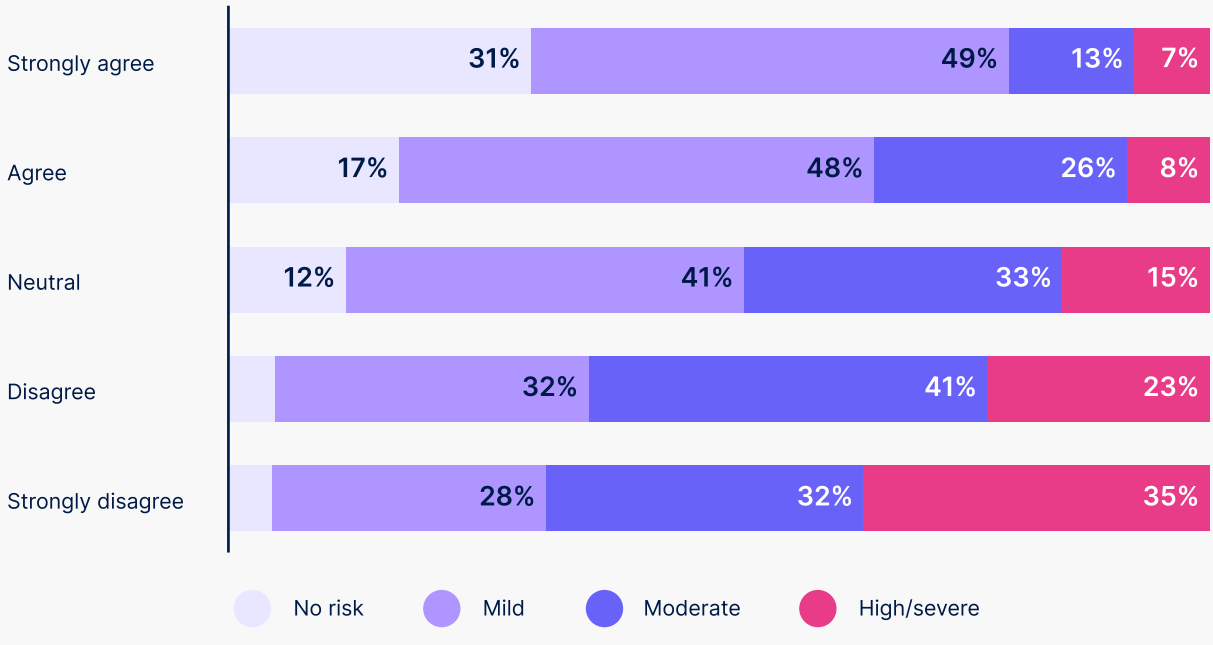
Pay dissatisfaction is probably less about the number earned on its own than about a felt mismatch between effort and reward. If pay dissatisfaction were purely about income level, working harder should reduce it.

35.3%

burnout risk among practitioners who strongly disagree that they're paid adequately

Burnout risk climbs as pay feels less adequate

Self-rated burnout risk, by agreement with 'I am paid adequately for the work I do'.



Segment labels rounded; shown where 7% or more

When revenue holds but margins slip

Profit margin shows the gap more literally. It's declining for 47.5% of the most underpaid group, including 28.9% of those whose revenue is stable or growing, so a practice can look healthy on revenue while the practitioner behind it feels underpaid. Rising costs between gross revenue and personal income, such as compliance, insurance, and rent, are one likely reason (the survey didn't ask about costs directly), and a revenue figure on its own wouldn't show it.

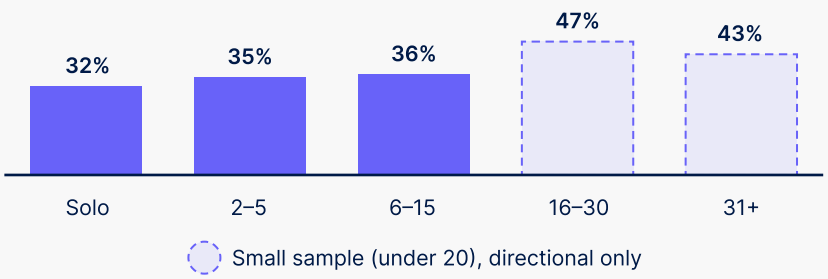
Pay dissatisfaction climbs with practice size: the bigger the team, the less fair the pay feels. Scale adds financial distance: the bigger the practice, the more likely a practitioner's income runs through a fee-split or a salary someone else set, rather than being earned and kept directly (the survey didn't ask about pay structure directly).

"I fear that income expectations do not measure up to the rise in cost of living in the UK."

— UK psychologist

Pay dissatisfaction rises with practice size

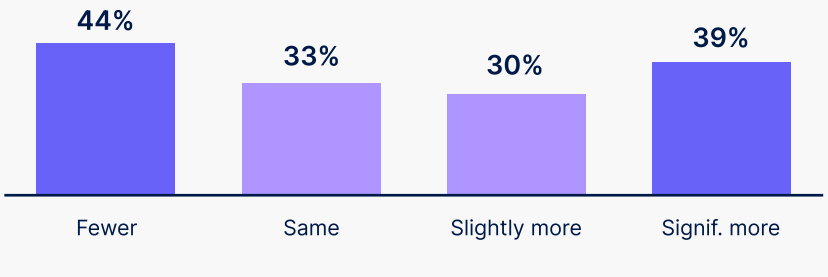
% who disagree or strongly disagree they are paid adequately for their work



Client load draws a related but distinct pattern. A shrinking client base tracks with pay dissatisfaction most likely through straightforward financial anxiety since less is coming in. A significantly heavier caseload tracks with it too, most likely through the same broken-reciprocity mechanism as the finding above, effort outpacing reward. Different causes, same symptom, and it's the steady middle ground, slightly more clients than last year, that feels fairest.

Pay feels least fair when client load shifts sharply either way

% who disagree or strongly disagree they are paid adequately for their work

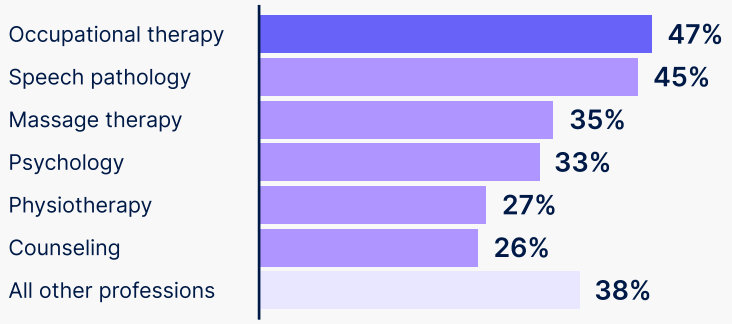


Occupational therapists and speech pathologists show the highest rates of pay dissatisfaction in this sample, though these are among the smaller sample sizes of professional groups surveyed. Interestingly, pay dissatisfaction barely shifts by role: 33.5% of owner-practitioners feel underpaid, against 36.4% of owners focused on running the business and 33.3% of non-owner practitioners.

> *"If insurance companies don't increase reimbursement, I feel fewer people will join the profession. Because speech pathology is typically reimbursable by insurance, private pay is difficult unlike our colleagues in the mental health profession. Therefore, we are held to the poor reimbursement rates set by insurance."*
> — US speech pathologist

Pay dissatisfaction, by profession

% who disagree or strongly disagree they are paid adequately, by profession (segment labels rounded)



> *"We are grossly underpaid for what we do. The reimbursement rates are falling and it's leading to burnout and poor quality healthcare."*
> — US physical therapist

Different countries and regulations, but the same pay problem

The strongest evidence that this isn't about any single practice succeeding or failing sits in the country data. The rate of pay dissatisfaction is evident across three different regulatory and payer systems (42.6% in the US, 33.4% in Australia and 30.1% in the UK), but the named cause changes entirely depending on where a practitioner works.

US practitioners point directly at insurance companies. UK practitioners point at cost of living and the National Health Service. Australian practitioners point at Medicare and the NDIS. If pay dissatisfaction were a local policy problem, it wouldn't show up so consistently in three unrelated systems. What remains the same across all three countries is the structure of the arrangement itself, a third-party payer standing between the practitioner and the person receiving care, in whatever local form that takes. Fixing any one country's reimbursement rates wouldn't fully fix the pattern already showing up everywhere else it exists.

SECTION 5

Heavy documentation load is linked to nearly four times the burnout risk

Most admin tasks (scheduling, invoicing, marketing) can be delegated to another person. Documentation can't be handed off in the same way. A clinical note has to reflect what the treating practitioner actually observed and decided, and in most jurisdictions it legally has to be authored or signed by them.

Significant documentation time (9 or more hours a week) is one of the seven pressures linked to burnout risk. This section takes a closer look at why it carries as much weight as it does.

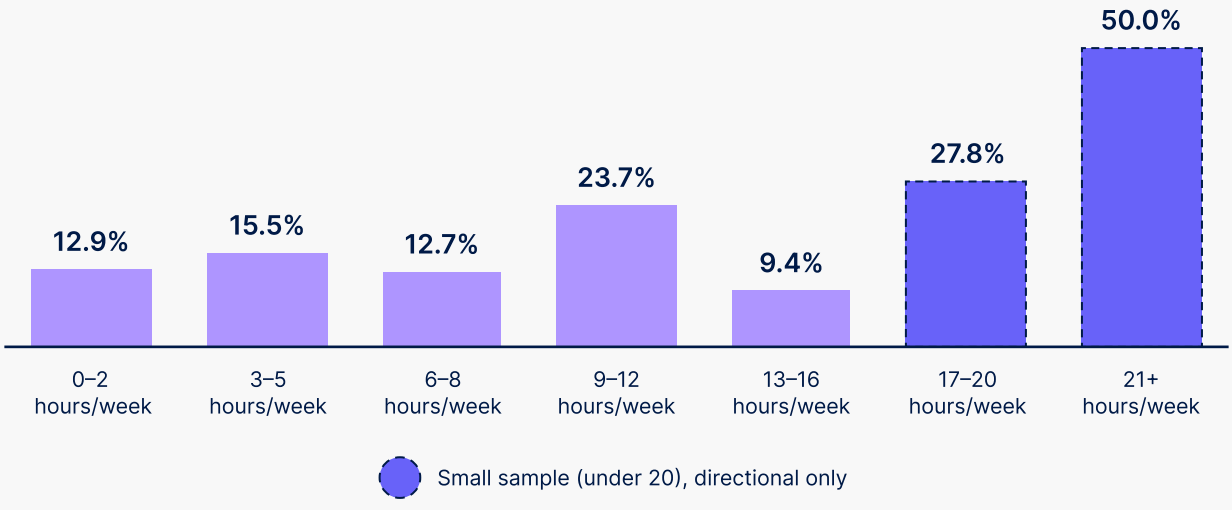
Practitioners spending 21 or more hours a week on documentation report a 50% burnout risk. Practitioners spending 0 to 2 hours report 12.9%. That's a 3.9x gap, the sharpest single workload-driven finding in this report.

50%

burnout risk for practitioners spending 21+ hours a week on documentation

Burnout risk is highest at the heaviest documentation loads

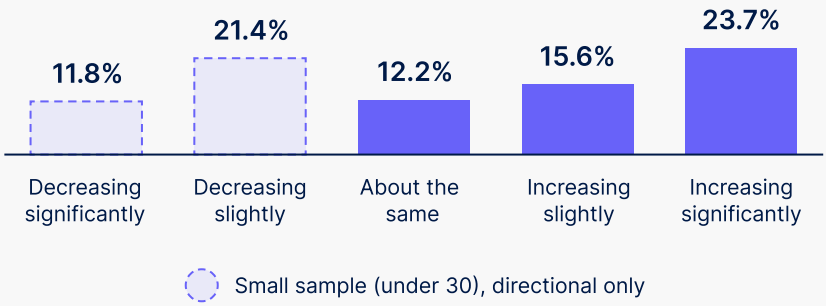
% at high or severe burnout risk, by hours per week personally spent on clinical documentation



The documentation load behind that 3.9x gap keeps growing. Nearly all practitioners say documentation requirements are the same or higher than three years ago, and burnout risk climbs with each step up, from 12.2% where requirements are unchanged to 15.6% where they've increased slightly and 23.7% where they've increased significantly.

Burnout risk is highest where documentation requirements have grown most

% at high or severe burnout risk, by how documentation requirements have changed over the past 3 years



"For me, it's not about cramming in more patients. It's about finishing on time, being able to switch off at the end of the day, and not lying awake thinking about a note you haven't written yet."

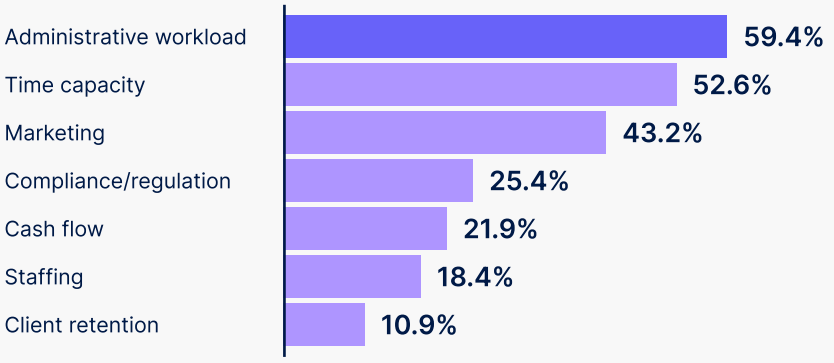
— Damien Adler, on what a sustainable workload looked like in his own practice

Admin tops every other operational constraint

Nearly six in ten practitioners, 59.4%, named administrative workload as one of their top three operational constraints, more than any other option we offered, including time capacity (52.6%), marketing (43.2%), and cash flow (21.9%).

Admin workload is the most common operational constraint

% naming each as one of their top 3 operational constraints



Respondents could select up to three, so totals exceed 100%

59.4%

named administrative workload as one of their top three operational constraints

When asked what they'd change about their practice, the instinct is often more hands:

> *"[I would love to have] an admin person but as a sole practitioner I can't afford this. I've already changed my administrative processes as much as I can to be efficient with my time... the NDIS with all of its reports and administrative processes, is designed for you to need a full staff."*
>
> — Australian occupational therapist

Hiring helps with admin, but not with documentation

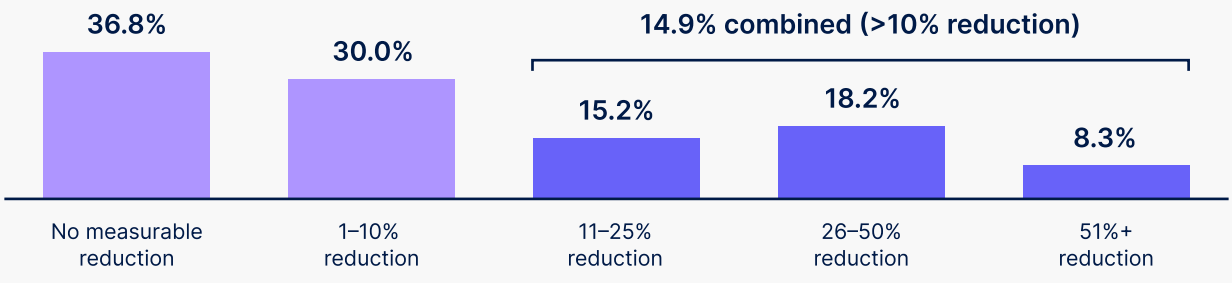
For some practices, hiring additional support staff may be the right move, but it's important to consider that a new hire adds a recurring cost, and one in six practices with stable or growing revenue (16.9%) already report a declining profit margin. Documentation hours stay with the treating practitioner either way, and business training shows little link to burnout risk: 15.1% of formally educated practitioners rate theirs high or severe, against 15.5% of those with no formal training.

Where AI makes a difference

A practical first step is to look at where the hours are going and put systems and processes in place to reduce admin and documentation time at the source. AI is one tool for that. Among practitioners who spend 9 or more hours a week on documentation, those who have reduced their documentation time with AI are less than half as likely to rate their burnout risk as high or severe. For practitioners buried in notes, that is welcome news: burnout risk falls from 36.8% among those whose time hasn't changed to 14.9% among those who cut it by more than a tenth.

Burnout risk is lower where AI has cut documentation time

% at high or severe burnout risk among practitioners spending 9+ hours a week on documentation, by how much AI has reduced their documentation time



> *"[I'd wish for] confidence in myself. Being able to take written notes with my mind so I don't have to do all the documentation after the session."*
>
> — Australian physiotherapist

Confidence matters as much as access. Among practitioners who use AI, those who feel not at all confident with it report feeling overwhelmed by technology at a rate of 60%, compared with 7.5% of those who feel extremely confident. The rate falls steadily in between: 25.0% for slightly confident, 20.4% for moderately confident and 9.7% for very confident. That points to a learning gap more than a technology one. Practitioners still finding their footing with a new tool feel the weight of it, and those who get comfortable with it feel much less, which suggests training and support matter alongside the tool itself.

A similar pattern shows up in how often practitioners use AI. Of the seven burnout pressures measured in this report, daily AI users carry an average of 1.30, compared with 1.73 for occasional users (less than weekly) and 1.41 for practitioners who don't use AI at all. Occasional users may be partway up the learning curve, still building the confidence that makes the tool pay off.

A 2025 study published in JAMA Network Open found that burnout among ambulatory clinicians dropped from 51.9% to 38.8% after 30 days of using an ambient AI scribe.[4] It was a single intervention, and it points the same way as the rest of this data: less load to carry in the first place.

> *"[I wish I had] reliable, accurate and better AI progress notes."*
>
> — US psychologist

> *"[I wish I could spend] more time with the client and less on marketing and paperwork."*
>
> — UK psychologist

Documentation doesn't behave like the rest of a practice's admin work. Invoicing can wait for a slow afternoon, while documentation can't. It happens after every single session, all day, woven into the clinical rhythm rather than sitting in a separate administrative block that a hire could simply take off someone's plate. That's the throughline of this section: the instinct to add staff misreads what kind of problem this is. The hours themselves are the problem, and the pattern in this data points toward tools that remove the work rather than people who redistribute it.



Concluding thoughts

This report set out to understand burnout among allied health practitioners, and six findings stand out:

1. **Seven everyday pressures are closely linked to burnout.** They are feeling isolated, feeling underpaid, heavy admin hours, heavy documentation hours, overwhelming technology, worry that AI will replace part of the role, and revenue and margin falling together.

2. **Pressures stack.** Practitioners with none of the seven pressures measured in this report rate their burnout risk as high or severe at a rate of 4.3%, compared with 62.8% of those carrying four or more.

3. **The most burned-out are considering leaving.** Among practitioners at severe burnout risk, 51.9% say they are likely or very likely to leave the profession within three years, compared with 6.0% of those at no burnout risk.

4. **Isolation goes unnamed.** Practitioners who feel professionally isolated very often rate their burnout risk as high or severe at a rate of 51.6%, compared with 9.9% of those who never do.

5. **Pay and burnout move together.** Practitioners who strongly disagree they are paid adequately rate their burnout risk as high or severe at a rate of 35.3%, against 7.7% of those who strongly agree, and most of the underpaid group report stable or growing revenue.

6. **Documentation hours track with burnout.** Practitioners spending 21 or more hours a week on documentation rate their burnout risk as high or severe at a rate of 50%, compared with 12.9% of those spending 0 to 2 hours.

Read together, these findings point to a workforce closer to the edge than the industry has had the data to say plainly. Nearly half of practitioners, 47.1%, already report moderate burnout risk or worse, and the highest risk sits with those carrying several pressures at once. Documentation shows where things are heading: 49.1% of practitioners say documentation requirements have increased over the past three years, and only 6.9% say they have decreased.

Documentation is also the one administrative task that can't be handed to someone else. A clinical note has to reflect what the treating practitioner observed, and in most jurisdictions it has to be authored or signed by them, so those hours stay with the practitioner regardless of who else is in the building. Formal business training doesn't appear to change the picture, but time does. Among practitioners spending 9 or more hours a week on documentation, burnout risk is lower where AI has cut the time they spend on notes.

That points to a clear next step for the industry. Reducing administrative burden is more than a wellness perk or a nice-to-have alongside clinical work, because documentation hours are linked to both burnout risk and isolation in this data.

Damien Adler is clear that time saved shouldn't simply become more appointments. "Giving people time back isn't just about seeing more patients," he says. "It's about giving people a choice in how they use it, because that choice is personal to them."

The practitioners who aren't burning out share six things

When we compared the 52.9% of respondents who rate their burnout risk as none or mild, with the 16.1% who rate theirs high or severe, we found six clear differences:

- **Connection.** Just 19.1% of low-risk practitioners feel isolated often or very often, against 67.6% of the high-risk group.
- **Fair pay.** More than half (52.6%) agree they're paid adequately, against 21.2%.
- **A workload that lasts.** Three in four (75.6%) call their workload mostly or completely sustainable, against 9.3%.
- **Lighter admin.** Most (60.8%) spend 10 hours a week or less on admin, against 34.3%.
- **Technology that helps.** Nearly two-thirds (63.6%) say technology has made their work more efficient (against 42.5%), and only 18.3% feel more overwhelmed by it (against 44.3%).
- **A steady client base.** They're half as likely to be seeing fewer clients (15.0% vs 30.1%) and to have declining revenue (18.3% vs 35.6%).

Importantly, practitioners who aren't burning out are also staying in the industry. Four in five (80.1%) are unlikely to leave within three years, against 36.4% of the high-risk group, and they're more likely to run their own practice, whether solo (73.3% vs 58.0%) or as an owner-practitioner (79.1% vs 63.3%). Each of the six describes how the work is set up rather than who is doing it, which makes each one something a practice can change.

The industry doesn't need practitioners to become more resilient. It needs less of the work that was never supposed to be there in the first place.

References

[1] World Health Organization (2019). "Burn-out an 'occupational phenomenon'."

[2] American Medical Association (2026). "Physicians in these 10 specialties are less likely to quit."

[3] Medscape (2026). "You're Not Alone: Medscape Physician Burnout & Depression Report 2026."

[4] JAMA Network Open (2025). "Use of Ambient AI Scribes to Reduce Administrative Burden and Professional Burnout."

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About Zanda: Zanda is a complete practice management system for health practices, with clinical notes, insurance claiming, integrated telehealth, online bookings, client communications, automated reminders, AI scribe and more. Founded by brothers Damien and Paul Adler, it is consistently ranked among the top five medical practice management systems on G2. Zanda has operations in the US, UK and Australia, and more than 44,000 users in over 20 countries, from sole practitioners to large multi-location clinics. Together, they process more than 1.6 million invoices and write more than 900,000 clinical notes a month through the platform. Zanda is ISO 27001 certified and HIPAA and GDPR compliant, and its mission is to make health practice management easy and enjoyable.