EFFICIENCY FOR WHOM? ARTIFICIAL INTELLIGENCE AND THE POLITICAL ECONOMY OF REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE CLAIMS

Ayodeji Peter ADESANYA
Department of Political Science,
University of Ibadan
ayopeteradesanya@gmail.com

Mike OMILUSI, PhD
Department of Political Science,
Ekiti State University
watermike2003@yahoo.co.uk

ABSTRACT

Artificial intelligence (AI) is marketed as a solution to administrative burden in healthcare, arguing that automation will lead to less paperwork, fewer workflows, and allow clinicians more time. Although these assertions are prominent in policy and vendor and organisational discourse, the manner in which the concept of administrative burden, is framed, measured, and mobilised in justifying AI adoption has received less focus. This paper explores administrative burden reduction, however, not as a neutral technical result, but rather as a political-economic narrative that defines whose work is counted, which expenses are taken into consideration, and who are the beneficiaries of technical change. The study is based on qualitative document analysis of AI vendor web materials, selected users case-studies and hospital-sector reports on administrative burden. Instead of evaluating the efficiency of AI systems, the analysis is based on the construction of claims regarding the reduction of burdens. The results indicate that administrative burden has always been characterised as routinised, measurable and process-based work. The arguments of reduced burden are directed more towards organisational performance and clinicians, whereas administrative staff and patients are in a more ambiguous position. Simultaneously, AI adoption creates new types of labour, including system oversight, exception handling, and patient self-management, which are mostly not included in burden definitions. This paper holds that the reduction of administrative burden operates as a political-economic discourse that reallocates and obscures work, with significant consequences on the reorganisation of AI in healthcare labour and governance.

Keywords: Artificial Intelligence, Political Economy, Administrative Burden, HealthCare

INTRODUCTION

Artificial intelligence (AI) has recently emerged as a more prominent field of academic research in the area of healthcare studies, as part of a wider shift in digital technology and data-driven decision-making in the context of complex service systems. The scope of AI applications in healthcare has been growing in the literature; these

applications are in the fields of clinical decision support, diagnostic support, natural language processing, and workflow automation (Ali et al., 2023; Gjini & Fetahi, 2025). AI is often characterised as a general-purpose technology that can redefine the clinical and non-clinical spheres of healthcare delivery, especially in high-information-intensity and organisational and complex environments (Aiwerioghene & Osuchukwu, 2025). In this regard, it is common to describe AI as a continuation of a digitalisation process that seeks to enhance performance, coordination, and efficiency in health systems.

Coupled with this increasing attention on AI, a significant amount of health services literature has found administrative burden to be a consistent and increasingly difficult problem in healthcare facilities. Jonsson, (2025) and Olson et al., (2025) pointed to the proliferation of administrative burden related to documentation, billing, reporting and compliance, especially after the extensive implementation of electronic health records and the increasingly complicated payment systems. Moreover, empirical studies associate administrative burden with time pressure, fragmentation of workflow, and work-related dissatisfaction in healthcare personnel, particularly clinicians who have to combine administrative with direct patient care (Olson et al., 2025). Consequently, the concept of administrative burden has come to occupy a central position in the healthcare management literature, and it has been a common topic in the discourse of workforce sustainability and system performance.

Recent studies (Almagadi et al., 2025; Sharma, 2021) have continued to place artificial intelligence as a solution to these burdens. The reviews of AI-enabled administrative tools point to such applications as automated clinical documentation, coding and billing decision-support systems, and operational robots in performing routine tasks of the work. Studies (Biswas & Talukdar, 2024; Olson et al., 2025) also indicate that AI-based transcription and summarisation systems can potentially change the nature of the documentation burden in a clinical environment. Overall, administrative burden is commonly viewed through the lens of time wasted, redundancy, and ineffective processes, and AI has been presented as a means of streamlining or accelerating these processes.

Based on the increasing amount of literature that investigates the applications of AI in the administrative context, the available literature remains focused on functionality, implementation, or some other quantifiable measure, like productivity or workload

decrease (Ali et al., 2023; Almagadi et al., 2025). There has been less focus on the conceptualisation of administrative burden itself in these debates or on the manner in which arguments of burden reduction are formulated. With the progressive introduction of AI into healthcare systems, the definition and operationalisation of administrative burden in academic literature need to be clarified to place existing empirical evidence and inform future studies. Such a background offers a crucial framework to study how the assertions regarding the decrease in administrative burden are expressed in recent discussions of AI in health care.

CONCEPTUAL FRAMEWORK

The concept of administrative burden is generally referred to as the experience of the implementation of the policies in the form of learning, compliance, and psychological costs incurred by individuals and organisations. A framework by Sun et al., (2025) found administrative burdens with three costs, including "learning costs, compliance costs, and psychological costs". In the same vein, Lovell, (2022) added that administrative burdens are "barriers placed on citizens to achieve or make use of a public good or service". Although the concept was originally used to describe the relationships between the citizens and the state, it has more frequently been applied to the organisational context, such as healthcare, where day-to-day activities are being organised as a consequence of documentation, reporting, billing, and regulatory policies (Jonsson, 2025; Olson et al., 2025). In health services research, administrative burden is normally operationalised in terms of time devoted to non-clinical activity, disruption of the workflow, or bureaucratic complexity. Based on this, Heuer, (2021) states that:

> Administrative burden refers to documentation and administrative reporting duties imposed on clinicians due to organisational policies as well as governmental and oversight reporting requirements. These non-patient-care activities have increased over the past few decades because of many factors, which include a variety of quality initiatives stemming from well-publicised quality issues and increased emphasis on value-based quality metrics (Heuer, 2021).

These definitions have a strong focus on quantifiable workload and efficiency effects, with burden being largely a technical issue of excessive process, excessive duplication

or friction in systems. Nevertheless, the reduction of administrative burden to time inefficiency can be deceptive and lead to a failure to address the issue of how the work is appreciated, shared, and represented in organisations. Ali et al., (2023) and Biswas & Talukdar, (2024) added that digital transformation often reorganises instead of eliminating burden and shifts the tasks of coordination, oversight, and verification to other actors. Also, Aiwerioghene & Osuchukwu, (2025) noted that automation alters task delimitation and creates new relationships between people and machines. These observations indicate that administrative burden is not merely a fixed amount that awaits being cut down, but a type of category influenced institutionally by what is considered productive, clinical, or managerial work.

The perception of administrative burden as a political-economy issue draws attention to how claims of efficiency are incorporated within the larger context of resource distribution and institutional power dynamics. In this sense, burden can be seen as a site of valuation and an operational indicator, which entails making decisions about the relative cost of the time of various actors, the division of core and peripheral tasks and the prioritisation of specific types of labour in performance appraisals. The study on AI enabled administrative systems regularly evaluates performance through measures of time savings, productivity gains, or return on investments (ROI) (Almagadi et al., 2025; Gjini & Fetahi, 2025), thereby linking burden reduction to economic rationality. The administration burden, when framed from a political-economic perspective, can thus be studied to investigate how burden is conceptualised and mobilised and how efficiency discourse constitutes how work is understood in healthcare.

DATA AND METHODS

The study adopts a qualitative method to understand how the arguments regarding administrative burden alleviation in healthcare are framed. The empirical data sources comprises AI vendor web pages and case studies of IBM, Notable Health, and Google Cloud users such as Gillette Children (Gillette), North Kansas City & Meritas Health, Humana, Oncoclínicas & Co, Phoenix OCR and Manipa Hospitals among others. In addition, policy documents and hospital-sector reports were reviewed in order to obtain how administrative burden is measured in non-vendor settings. Qualitative discourse and narrative analysis were used to analyse all documents, and the

definitions, measurements, and justifications of administrative burden in relation to the adoption of AI were considered, but not the technical effectiveness of the AI systems themselves.

FINDINGS I: WHAT COUNTS AS "ADMINISTRATIVE BURDEN"?

The most prevalent definition of administrative burden is routinised, repeatable, time-consuming information processing processes, as opposed to decision-making. Activities that involve patient intake, eligibility verification, documentation, prior authorisation, automated scheduling and call handling are recurrent functions mentioned in vendor documents as the main constituents of administrative burden (Getsay, n.d.; Google Cloud, n.d.; IBM, 2024b, 2025). They are framed as necessary but inefficient, which makes them consume organisational capacity. Administrative burden in this construction is not specified by its source in the regulations or social role, but by its perceived redundancy, mass, and automation appropriateness.

A defining characteristic of administrative burden narratives in vendor case studies is its quantifiable nature. The measures of burden are in the form of minutes per task, calls processed, staff time devoted, or full-time equivalent (FTE) jobs saved. As an illustration, administrative burden in the case study of one of the IBM users and one of the largest insurance providers in the United States, *Humana*, is defined in terms of call volume and time spent handling a call, minimised by conversational AI systems (IBM, 2024a, 2025), whereas Notable Health (NH) in the casestudy of *How North Kansas City Hospital and Meritas Health automated 80 open roles* frames burden as manual scheduling and registration work quantified through staffing gaps and role vacancies (Guillaume, 2023). Specifically, *Humana*, alluded that its call handling burden was radically reduced with the employment of IBM Watson conversational artificial intelligence. IBM, (2024), in its case study on *Humana*, states that;

> "Humana's Voice Agent with IBM Watson provides a faster, friendlier and more consistent way for administrative staff at healthcare providers to access pre-service, medical eligibility, verification, authorization and referral information without the need to speak with a live agent. The solution relies on AI to understand the intent of a provider's call, verify they are permitted to access the system and member

> information, and then determine how best to provide the information requested".

Similarly, Google Cloud materials define administrative burden through survey-based estimates of time spent on documentation and reporting, positioning burden as an aggregate productivity loss across healthcare organisations (GCPC, 2024). Across these documents, what counts as burden is what can be counted.

Policy and system-level documents reinforce this task-based and process-oriented definition. The U.S. Centers for Medicare & Medicaid Services., (2025) defines administrative burden as "redundant, outdated, or overly complex requirements or processes that may inhibit or delay the ability to deliver or access equitable, quality, safe, and affordable care" explicitly linking burden to documentation, reporting, prior authorization, and care coordination activities. Other reports similarly operationalise burden through administrative cost growth, process steps, and insurer-driven requirements that increase paperwork and staff time (American Hospital Association, 2024; Wu et al., 2025). Administrative burden in these reports is built as a system inefficiency issue, as something that is inherent in workflows and policies, not professional judgment or power relationships within an organisation.

It is also interesting to note that in vendor, policy and professional reports, some forms of work are not present in the definitions of administrative burden. Monitoring automated systems, error correction based on AI outputs, coordination between fragmented digital spaces, or helping patients to navigate administrative technologies are tasks that are never listed on the burden list itself. Rather, the administrative load is always delimited around repetitive, standardizable and legible activities that can be measured using managerial metrics. This construction indicates that administrative burden is not an unbiased characterisation of all non-clinical labour, but a selective term of only that which can be automated, quantified, and streamlined within the current organisational and policy structures.

FINDINGS II: BURDEN REDUCTION FOR WHOM?

Arguments of reduction of administrative burden are most frequently expressed at the organisational and systems level instead of being expressed in the categories of workers. The vendor materials reiterate the field of benefits as enhanced "capacity,"

"throughput," and operational efficiency, in which the healthcare organisation is the major beneficiary of AI-enabled reduction of burden (Google Cloud, n.d.; Gupta & Maniar, 2025). Metrics like hours saved, calls deflected, or administrative costs reduced are aggregated at the organisational level, indicating that the reduction of burden is largely committed to the performance of an institution and its scalability rather than to particular forms of labour.

In the case study on *How North Kansas City Hospital and Meritas Health automated 80 open roles*, Guillaume, (n.d.) alluded to this to state that “whether we couldn’t find people to fill positions, or we didn’t want to spend 20 minutes doing a task that we could automate”, the case study reports that “according to MGMA staffing benchmarks, the health system would otherwise need to hire 80 additional FTEs, about 10–15% of their administrative workforce,” resulting in “80 open roles that didn’t need to be filled.” According to the case study, burden reduction is quantified through aggregate efficiency metrics, including “a more than 90% reduction in check-in time,” with check-in reduced “from approximately 4 minutes to about 10 seconds,” alongside a “34% decrease in no-shows”. Another case study on call expertise by IBM, (2024b) added that “Humana receives over one million provider calls every month,” more than “60% of these calls were related to routine, specific, pre-service questions.” After the implementation, the AI system could respond to inquiries at approximately one-third the cost of the current system, serving over “7,000 voice calls per business day”, and allowing providers to respond to inquiries without having to wait to be connected to a call centre representative (IBM, 2024b).

Similar pattern appears in Manipal Hospital case study highlighting Google Cloud powered “Nurse Handoff solution” leading to “significant reductions in the time required for handovers from 90 minutes to around 20 minutes per nurse” and ePharmacy “reduced order-taking time from 15 minutes to less than five minutes” (GoogleCloud, n.d.). In this framing, the potential central subjects whose administrative burden is of most importance are organisations like hospitals, health systems, payers, or public agencies. In instances where individual actors are specifically named, clinicians, particularly physicians, are often the beneficiaries. Also, freeing doctors, pharmacist and nurses from the burden of documentation and paperwork, as indicated by vendor blogs and industry case studies, is frequently

associated with the reduction of the burden, which is subsequently associated with better focus on patient care and professional satisfaction (GCPC, 2024). Equally, policy approaches have defined administrative burden reduction as a health workforce sustainability and efficiency tool, implicitly matching AI implementation to issues typically involved with clinician burnout, workforce pressure, and making clinicians the perceived users and ethical grounding on technological spending (U.S. Department of Health and Human Services, 2021). Nevertheless, these documents have a tendency to view clinicians as a homogenous group, which is often not subdivided into professional hierarchies, specialities, or employment terms.

On the contrary, the administrative and support personnel are manifested in the analysed reports and case studies not as beneficiaries, but rather as the locations of efficiency. Reductions in manual scheduling, call handling, or registration work are often framed in vendor case studies without necessarily presenting these changes as benefiting the workers who do such jobs (Getsay, n.d.; IBM, 2024b). In other instances, the concept of burden reduction is expressed by avoiding new employees or automating vacant positions, implicitly positioning the administrative workforce time as a cost to be minimised instead of a type of work whose quality or sustainability deserves some consideration (Guillaume, 2023). In this case, the optimality of the organisation is said to be enhanced by the reduction of its burdens, but the effects that this measure will have on people working in the administration are mostly less discussed. The patients are mentioned only indirectly and instrumentally as beneficiaries. Administrative burden reduction is frequently associated with better access and reduced waiting times or more seamless experiences, especially via automated systems of communication and scheduling (IBM, 2025; U.S. Centers for Medicare & Medicaid Services., 2025). Nonetheless, patients are not often referred to as those individuals who receive the administrative burden in the first place; rather, they are placed as downstream beneficiaries of organisational efficiency gains. The patient has to grapple with the burden of learning to interact with machines as opposed to the usual human-to-human interactions. These trends indicate that arguments of reduction of administrative burden are more focused on organisational performance, whereas other stakeholders, especially administrative employees and patients, occupy a low-priority place in the discourse of who gains access to AI usage in healthcare.

FINDINGS III: AT WHOSE EXPENSE? BURDEN DISPLACEMENT AND INVISIBILITY

The claims of administrative burden reduction are complemented by the remarkable silence in terms of the redistribution of the work that is being accompanied by the implementation of AI. Although case studies and other reports focus on the tasks that were removed or the time that was saved, they seldom consider new types of labour brought about by AI-enabled systems. The implementation of algorithms, controlling the performance of systems, error correction, exception management, and integrating outputs in the workflows to a large extent do not receive formal definitions as administrative burden (Google Cloud, n.d.; Phoenix, 2025). These types of work that are necessary to support AI-based processes are analytically non-existent due to their lack of definition as administrative work that can be reduced.

Vendor case studies also indicate that the reduction of burden tends to rely on the repositioning of responsibilities as opposed to the elimination. As an illustration, conversational AI implementations outlined in IBM case studies mention the decrease in call rates and the time spent on calls, but do not specify how the unresolved questions, call escalations, or system malfunctions are resolved when automated pathways fail (IBM, 2024b, 2024a). Similarly, automation of intake, scheduling, and registration in the case studies of *North Kansas City & Meritas Health (Notable Health)* and *Gillette Children's (Gillette)* is introduced as an eradication of manual labour, but both articles discuss little of how employees learn to manage automated workflows or address the unusual cases (Getsay, n.d.; Guillaume, 2023). In such narrative, administrative burden is shifted to forms of supervision and exception management which do not lie within the categories that are directly quantified as burden.

Patients also become sites of burden displacement. The use of automated communication systems, self-service portals, and AI-mediated scheduling tools is often characterised as enhancing access and experience, but instead of human staff handling the communications, patients have to work with new interfaces, interact with machines, organise information, and process interactions (Gupta & Maniar, 2025; IBM, 2025). These are other requirements that cannot be classified as administrative burden in the reviewed reports, policies and case studies, although they require time, learning, and adherence, among the patients. Such findings indicate that the reduction

of administrative burden is commonly carried out by the redistribution and blurring of labour across actors and domains.

DISCUSSION

This paper investigated the construction, definition and dissemination of claims regarding the ability of AI to alleviate administrative burden in healthcare in vendor materials, policy frameworks, user case studies and reports. Instead of assessing the reduction of burden by AI, the analysis focuses on the definition and mobilisation of the concept of administrative burden as a problem needing to be addressed by technology. Administrative burden is always put in terms of routinised, measurable, and process-based work, such as documentation, scheduling, prior authorisation, reporting, and call handling, which can be measured in hours, costs, or workflow steps. Such a structured construction implies that administrative burden is not only a descriptive category, but also a managerial measure in line with productivity, efficiency, and return on investment.

The results also indicate that the arguments of reduced burden are geared toward the performance of organisations and selected professional bodies, especially clinicians. The creation of more time to physicians and nurses, capacity enhancement and ability to reduce burnout remained the core justification by vendors and policy players for the adoption of AI in healthcare systems. However, the employees carrying out administrative duties and the patients are incorporated in the narratives in an ambiguous manner. The patient are often described as an indirect beneficiaries of the the better access and reduced wait times because of the administrative functions of automation and cost savings of AI adoptions. The allocation of attention in these texts indicates an inferred distribution of whose time is rewarded, whose labour is enumerated, and whose experience is foreshadowed in the process of legitimating AI adoption.

Also, the silences that were discovered during the analysis are equally important. Though they highlight the tasks that are removed or sped up, less attention is paid to the new types of work related driven by AI implementation, including monitoring the system, exception management, governance, compliance, and helping patients navigate digital interfaces. Consequently, some types of labour were still analytically

invisible, which are diffuse, relational and immeasurable. Such selective visibility strengthens a political-economic process in which work that is measurable and optimizable is given precedence, and other forms of work are relegated to the background. The interpretation of administrative burden reduction as a political-economic discourse, and not necessarily a technical consequence, explains in effect why the definition of efficiency, productivity and value determines the nature of AI implementation in healthcare systems.

CONCLUSION

This paper has demonstrated that the arguments of AI-supported administrative burden reduction in healthcare are not simply technical accounts of efficiency improvement, but are politically and economically framed narratives, which affect the ways work, cost, and value are conceived. The analysis reveals that administrative workload is selectively constructed around routinised and measurable work, which can be represented using managerial and economic indicators, while other types of labour, including oversight, coordinating, exception work, and patient self-management, are mostly invisible. The majority of claims of the reduction of the burden are focused more on the organisational performance and the choice of professional groups, but administrative workers and patients are placed at the periphery or as instruments. These narratives are also anchored by policy regimes through institutionalising the reduction of burden into policy-making agendas and reimbursement schemes, and complementing a popular definition of the administrative burden as a calculable inefficiency, which is most effectively addressed by digital efficiency. This implies that the concept of administrative burden reduction is a political-economic discourse that favours some types of labour and some types of cost at the expense of others. This dynamism is imperative to the realisation of the implications of the adoption of AI in the healthcare sector and the design of more accommodating methods to assess the efficiency, workload, and technological change.

REFERENCES

Aiwerioghene, E. M., & Osuchukwu, V. C. (2025). The Role of Artificial Intelligence in Healthcare Quality Improvement: A Scoping Review and Critical Appraisal of

Operational Efficiency, Patient Outcomes, and Implementation Challenges. *Hospitals*, *2*(4). https://doi.org/10.3390/hospitals2040027

Ali, O., Abdelbaki, W., Shrestha, A., Elbasi, E., Alryalat, M. A. A., & Dwivedi, Y. K. (2023). A systematic literature review of artificial intelligence in the healthcare sector: Benefits, challenges, methodologies, and functionalities. *Journal of Innovation & Knowledge*, *8*(1), 100333. https://doi.org/10.1016/j.jik.2023.100333

Almagadi, M. A. S., Hazazi, A. J. A., Shabi, L. F. A., Alzhrani, F. Y., Barnawi, K. B. O., Alymani, R. N., Altalhi, M. M., & Alghamdi, Ibtihal M. (2025). The Impact of Artificial Intelligence on Administrative Productivity in Healthcare: A Systematic Review of Operational Efficiency and Burden Reduction. *The Bioscan*, *20*(1), 722–726. https://doi.org/10.63001/tbs.2025.v20.i01.pp722-726

American Hospital Association. (2024). *Skyrocketing Hospital Administrative Costs, Burdensome Commercial Insurer Policies are Impacting Patient Care*. https://www.aha.org/system/files/media/file/2024/09/Skyrocketing-Hospital-Administrative-Costs-Burdensome-Commercial-Insurer-Policies-Are-Impacting-Patient-Care.pdf

Biswas, A., & Talukdar, W. (2024). Intelligent Clinical Documentation: Harnessing Generative AI for Patient-Centric Clinical Note Generation. *International Journal of Innovative Science and Research Technology (IJISRT)*, 994–1008. https://doi.org/10.38124/ijisrt/IJISRT24MAY1483

GCPC. (2024). *New Study from Google Cloud and The Harris Poll Reports How Generative AI Can Tackle Administrative Burdens in U.S. Healthcare*. Google Cloud Press Corner. https://www.googlecloudpresscorner.com/2024-10-17-New-Study-from-Google-Cloud-and-The-Harris-Poll-Reports-How-Generative-AI-Can-Tackle-Administrative-Burdens-in-U-S-Healthcare

Getsay, T. (n.d.). *Notable | Gillette Children's*. Notable Health. Retrieved February 15, 2026, from https://www.notablehealth.com/customer-stories/gillette-childrens

Gjini, I., & Fetahi, B. (2025). Applications of Artificial Intelligence in Healthcare Management: A Systematic Review of Operational Efficiency and Challenges. *Open Access Macedonian Journal of Medical Sciences*, *13*(4), 199–202. https://doi.org/10.3889/oamjms.2025.12096

Google Cloud. (n.d.). *Artificial intelligence (AI) in healthcare*. Google Cloud. Retrieved February 15, 2026, from https://cloud.google.com/use-cases/ai-in-healthcare

GoogleCloud. (n.d.). *Manipal Hospitals case study*. Google Cloud. Retrieved February 21, 2026, from https://cloud.google.com/customers/manipal-hospitals

Guillaume, K. (2023). How North Kansas City Hospital and Meritas Health automated 80 open roles. *Notable Health*. https://assets-global.website-files.com/628b58b14c93b92656929a99/653bed7826d5d4144e5fb486_Notable_NKCHLongitudinalStudy_Oct2023.pdf

Gupta, A., & Maniar, S. (2025). *The ROI of AI in healthcare and life sciences*. Google Cloud Blog. https://cloud.google.com/transform/healthcare-and-life-sciences-ai-innovation-gen-ai-agents

Heuer, A. J. (2021). More Evidence That the Healthcare Administrative Burden Is Real, Widespread and Has Serious Consequences Comment on "Perceived Burden Due to Registrations for Quality Monitoring and Improvement in Hospitals: A Mixed Methods Study. *International Journal of Health Policy and Management*, 1. https://doi.org/10.34172/ijhpm.2021.129

IBM. (2024a, May 14). *City of Austin | IBM*. IBM Corporation. https://www.ibm.com/case-studies/city-of-austin-watson

IBM. (2024b, May 14). *Expertise on call*. IBM Corporation. https://www.ibm.com/case-studies/humana

IBM. (2025, December 18). *Facilities management for healthce goes digital*. IBM Corporation. https://www.ibm.com/case-studies/oncoclinicas

Jonsson, V. (2025). Reduce Healthcare Administration through Digitalization and AI. *KTH Industrial Engineering and Management Industrial Economics and Management*.

Lovell, D. (2022). *Administrative Burden in the Classroom: An Embedded Mixed Methods Study of How External Pressure Impacts the Burden of Student Success at the Community College Level*. https://doi.org/10.26153/TSW/41903

Olson, K. D., Meeker, D., Troup, M., Barker, T. D., Nguyen, V. H., Manders, J. B., Stults, C. D., Jones, V. G., Shah, S. D., Shah, T., & Schwamm, L. H. (2025). Use of Ambient AI Scribes to Reduce Administrative Burden and Professional Burnout. *JAMA Network Open*, *8*(10), e2534976. https://doi.org/10.1001/jamanetworkopen.2025.34976

Phoenix. (2025, July 24). *Phoenix OCP | IBM*. https://www.ibm.com/case-studies/ocp

Sharma, V. (2021). AI and RPA in Healthcare: Transforming Administrative Operations for Better Outcomes. *International Journal For Multidisciplinary Research*, *3*, 18. https://doi.org/10.36948/ijfmr.2021.v03i02.36362

Sun, Y., Mi, J., & Liu, L. (2025). Administrative Burden and Business Satisfaction with Public Services. *Transylvanian Review of Administrative Sciences*, (74 E), 151–171. https://doi.org/10.24193/tras.74E.8

U.S. Centers for Medicare & Medicaid Services. (2025). *Optimizing Care Delivery Framework | CMS*. CMS U.S. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/burden-reduction/overview/optimizing-care-delivery-framework?utm_source=chatgpt.com

U.S. Department of Health and Human Services. (2021). *Artificial Intelligence (AI) Strategy*. U.S. Department of Health and Human Services. https://www.hhs.gov/sites/default/files/hhs-artificial-intelligence-strategy.pdf

Wu, N., Whitelaw, H., Wang, Q., Phelps, A., Sivanesanathan, T., DeMaio, P., Ali, A., Chen, K., Dass, R., Grewal, E., & Moat, K. (2025). *Rapid evidence synthesis 129: Artificial intelligence tools for reducing administrative burden among front-line healthcare providers*. http://hdl.handle.net/11375/32617