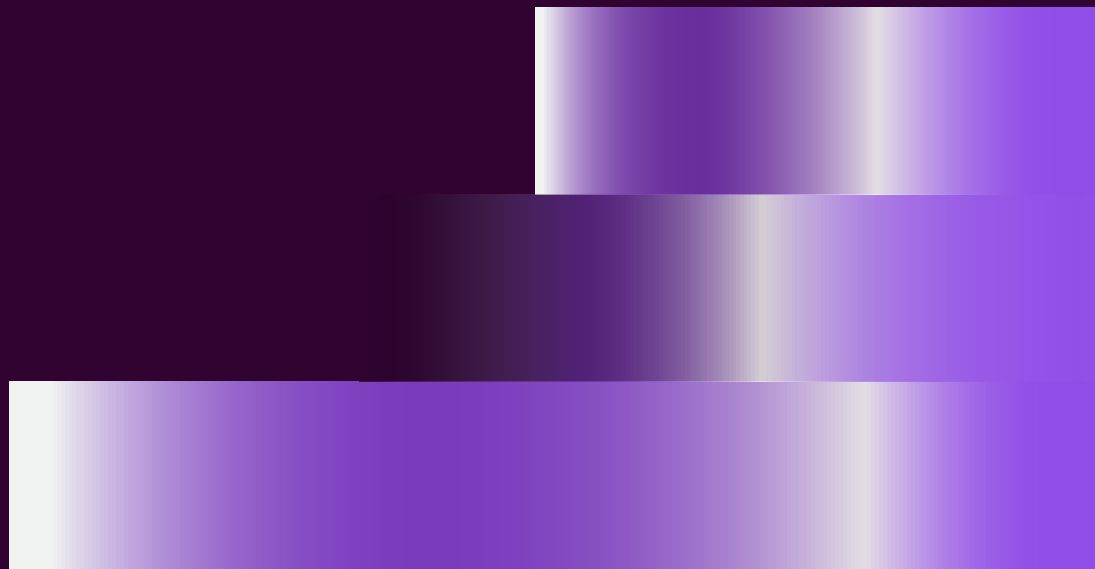




The Silent Bottleneck

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# Why Healthcare Can't Move Patients Faster



# Executive Summary

Healthcare organizations have historically viewed access to care as a clinical capacity problem; a function of physician supply, facility availability, and patient demand.

New data indicates that this framing is incomplete.

Edge's Healthcare Administrative Workforce Survey reveals that many healthcare systems are now constrained not by clinical capability, but by administrative throughput—the ability to reliably move patients through scheduling, authorization, documentation, billing, and compliance processes required before and after care.

More than three-quarters of healthcare leaders report high administrative workload, and over half experience operational backlogs on a weekly or daily basis. These delays directly translate into reduced appointment availability, delayed treatment initiation, increased clinician burden, and patient dissatisfaction. At the same time, nearly half of organizations report documentation errors identified during compliance audits, and most report measurable revenue leakage tied to administrative inefficiencies.

The data suggests that the industry has entered a new operating condition: patient access is increasingly governed by operational execution rather than clinical supply. Even when clinicians are available, patients cannot move through the system at the pace that demand requires.

Organizations are attempting to close this gap primarily through labor expansion—redistributing work internally, extending overtime, and hiring additional administrative staff. However, hiring remains difficult, ramp times are slow, and regulated workflows require specialized training and oversight. Automation and AI tools are expanding in scope, but their effectiveness remains concentrated



in structured, rules-based tasks. They are less reliable in exception-driven workflows that require contextual judgment, documented accountability, and regulatory oversight.

As a result, many healthcare providers are operating in a persistent queue state: demand continues to grow, but throughput expands incrementally. Backlog becomes the mechanism through which operational constraints manifest as access delays, financial variability, and compliance exposure.

Healthcare leaders are increasingly open to alternative workforce models, but adoption depends less on geography and more on governance—performance monitoring, compliance oversight, and quality assurance rank above cost savings as decision factors.

Taken together, the findings point toward a structural shift in healthcare operations. Administrative work can no longer be treated as support overhead scaled linearly with volume. It functions as operational infrastructure that must be deliberately designed, monitored, and integrated with technology.

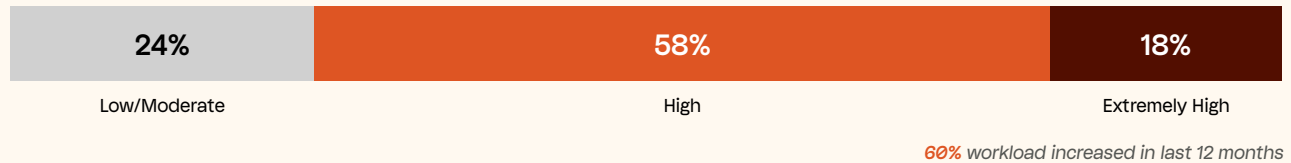
Organizations that continue treating administrative capacity as a staffing challenge may stabilize workload in the short term, but remain exposed to access delays and operational risk as demand rises. Those that redesign administrative execution as managed, accountable capacity are better positioned to maintain patient access, protect revenue integrity, and operate reliably in an increasingly regulated environment.

The next phase of healthcare efficiency will be determined less by clinical innovation and more by how effectively organizations engineer the operational systems that allow patients to move through care.

# Key Findings

## Healthcare operations are structurally overloaded

76% report high or extremely high administrative workload and 76% say workload increased year-over-year.



## Backlogs are now a permanent operating condition

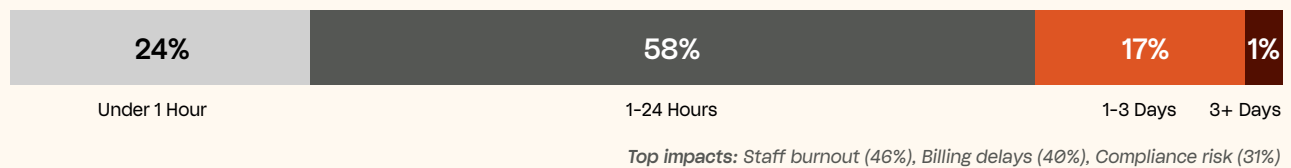
56.3% experience administrative backlogs weekly or daily, most often in scheduling, billing, documentation, and prior authorization.

### Backlog Frequency



## Administrative capacity now determines patient responsiveness

74% of patient inquiries take more than one day to resolve due to operational workload.



## Operational pressure is creating regulatory exposure

48% experienced compliance issues and 53% identified documentation errors during audits.



## Skilled labor is consumed by administrative execution

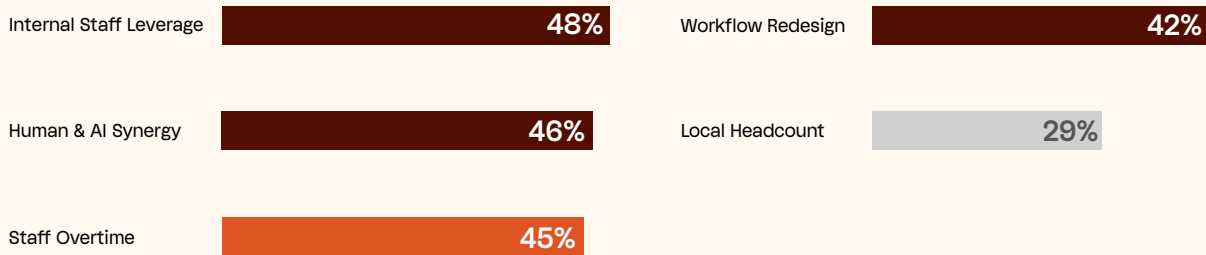
69% of staff spend more than 10 hours weekly on manual administrative tasks.



## Traditional hiring strategies are not solving the problem

Organizations are already hiring and outsourcing, yet workload and backlog remain elevated.

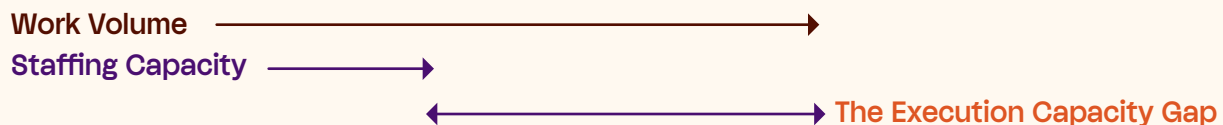
### Backlog Frequency



Yet 56% still experience weekly/daily backlogs

## Healthcare faces an execution capacity gap, not a hiring shortage

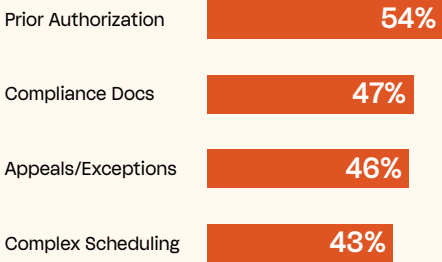
Demand scales continuously while staffing scales stepwise, creating delays, burnout, and compliance risk.



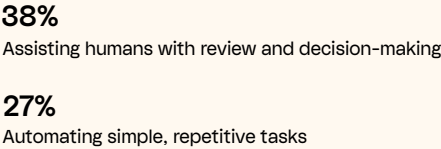
# Technology adoption has not eliminated manual work

Key workflows remain largely manual despite growing AI usage.

## Workflows still largely manual



## How AI is currently used



## Executive Takeaway

Healthcare organizations are not failing to hire enough people. They are attempting to manage continuously growing operational work with discretely scaling staffing models.

**The result is a structural execution capacity gap driving delays, staff strain, and regulatory exposure.**



# Administrative Throughput Has Become the Limiting Factor in Patient Access

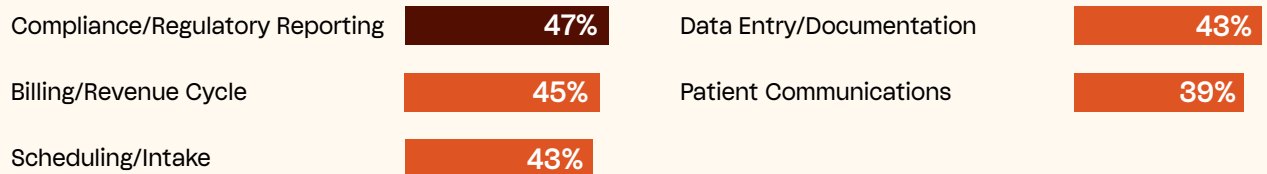
Healthcare demand is no longer constrained by clinician availability but by the operational processes required to deliver care.

Administrative work in healthcare functions as operational infrastructure. It determines how quickly patients can access care, how reliably services convert to revenue, and how consistently organizations meet regulatory obligations. When administrative capacity tightens, throughput slows.

The data indicates that demand for this infrastructure is elevated across the industry and continuing to rise.

More than three-quarters of healthcare leaders rate their current administrative workload as **high or extremely high** (76.4%). Over the past 12 months, 75.5% report that **workload has increased**, including 22.0% who say it has increased significantly.

This growth is not confined to a single function. Strain is concentrated in the core operating processes that directly shape patient access, financial stability, and compliance performance:



Administrative work also remains heavily manual. Forty-one percent of respondents report that staff spend between 10 and 20 hours per week on manual administrative tasks. At the same time, 56.3% of organizations experience administrative backlogs on a weekly or daily basis.

The forward outlook suggests continued expansion. Nearly three-quarters of leaders (74.8%) expect the administrative workload to increase next year, with an additional 19.7% expecting it to remain at current levels.

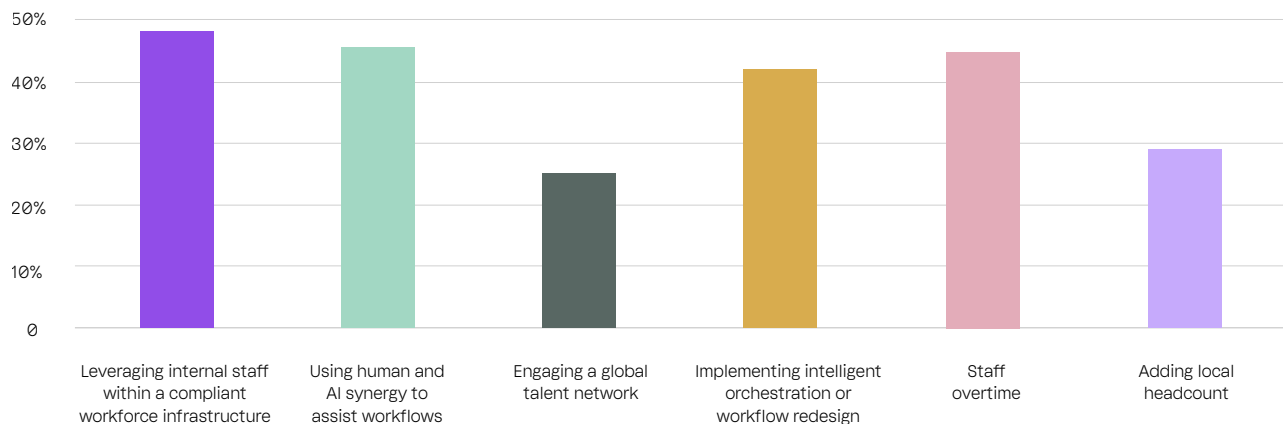


# Healthcare Is Scaling Volume With Overtime, Not Capacity

Providers are buffering demand with human effort rather than redesigning how work flows through the system.

As administrative demand increases, most healthcare organizations are responding by adding human effort rather than changing how work flows through the system.

Edge’s Healthcare Administrative Workforce survey shows that the primary strategies employed to expand capacity in regulated workflows rely on internal labor. Nearly half of respondents (48%) report leveraging existing staff within their current workforce infrastructure to manage increased demand. An additional 45% rely on staff overtime to absorb workload spikes. By contrast, only 25% report engaging global talent network support as part of their capacity strategy.



This pattern reflects a common operating posture: when volume rises, teams redistribute work, extend hours, or add headcount where possible. In the short term, this can stabilize output. Over time, however, it places sustained pressure on the same workforce layer that is already operating near capacity.

Hiring does not provide immediate relief. Seventy percent of leaders describe hiring qualified administrative or operational staff as difficult, including nearly half who characterize it as moderately difficult. The most frequently cited barriers include a lack of qualified candidates (59.1%), compensation expectations (45.3%), lengthy hiring processes (43.7%), high turnover (40.6%), and compliance or regulatory training requirements (40.2%).



After a role is filled, productivity continues to lag. Only 7.1% report that new administrative hires reach full productivity in less than two weeks. The majority require between two and eight weeks to ramp, and nearly 17% report ramp times of nine weeks or longer. In practical terms, vacancies create extended capacity gaps that persist beyond the hiring decision.

**Only 7.1%**

report that new administrative hires reach full productivity in less than two weeks.

Training requirements further constrain flexibility. When asked which areas require the most training, leaders most frequently cite **compliance and documentation (58.7%)**, **billing and revenue cycle (46.1%)**, **scheduling and front desk operations (40.2%)**, and **prior authorizations (38.6%)**. These are precisely the workflows under the greatest strain. Expanding headcount without structured training and oversight does not immediately expand reliable throughput.



The result is a labor-buffer model. As demand grows, more work is pushed onto existing teams or newly hired staff who require time to reach full effectiveness. Overtime becomes a structural element rather than a temporary response. This dynamic contributes directly to burnout and turnover, which 43% of respondents identify as one of the most common consequences of administrative overload.

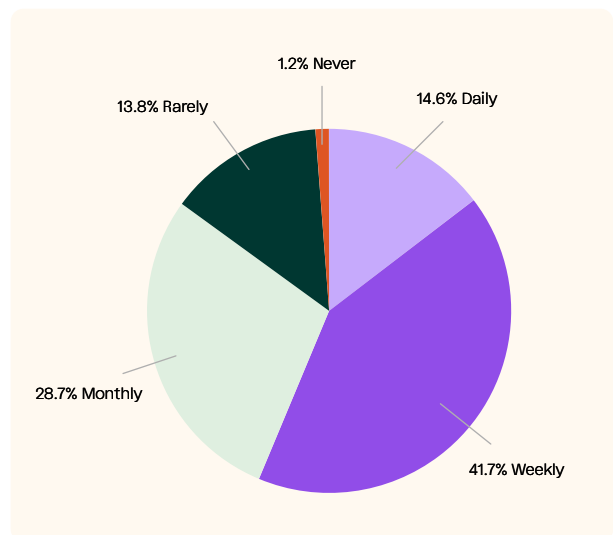
This approach absorbs work, but it does not fundamentally increase system capacity. The underlying workflows remain unchanged. As volume continues to rise, reliance on labor alone becomes increasingly difficult to sustain.

# Healthcare Has Entered a Permanent Queue State

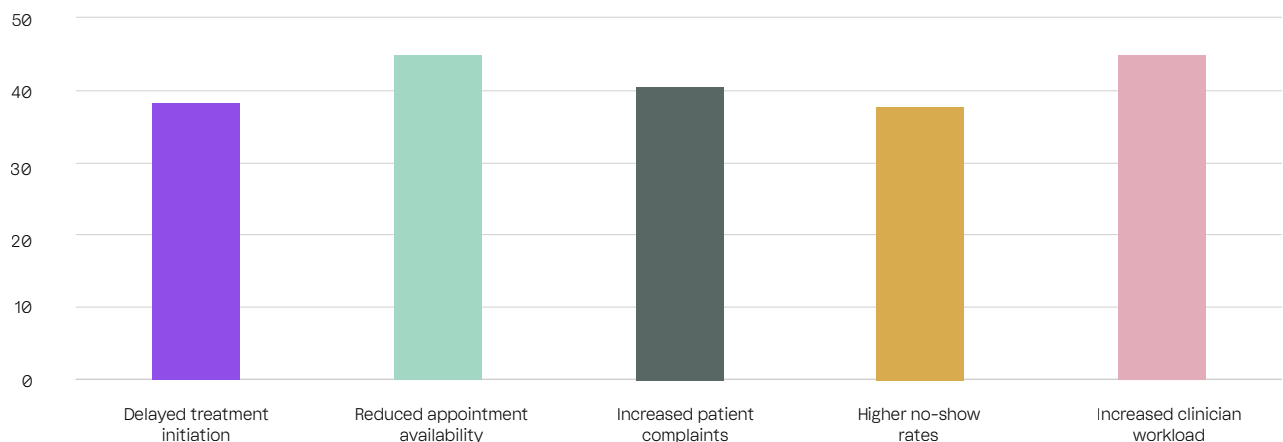
Backlog is no longer a disruption – it is the operating condition through which access delays emerge.

Across organizations, administrative backlogs have become routine. More than half of healthcare leaders (56.3%) report experiencing administrative backlogs weekly or daily. Only a small minority reports that backlogs are rare or nonexistent. This indicates that constrained throughput is no longer episodic; it is embedded in day-to-day operations.

Backlog in administrative workflows directly affects how patients move through the system. The most strained areas – scheduling and intake (42.9%), billing and revenue cycle (44.5%), compliance and regulatory reporting (47.2%), and documentation (42.5%) – are the same processes that determine appointment availability, treatment initiation, and reimbursement timing. When these workflows slow, access slows.

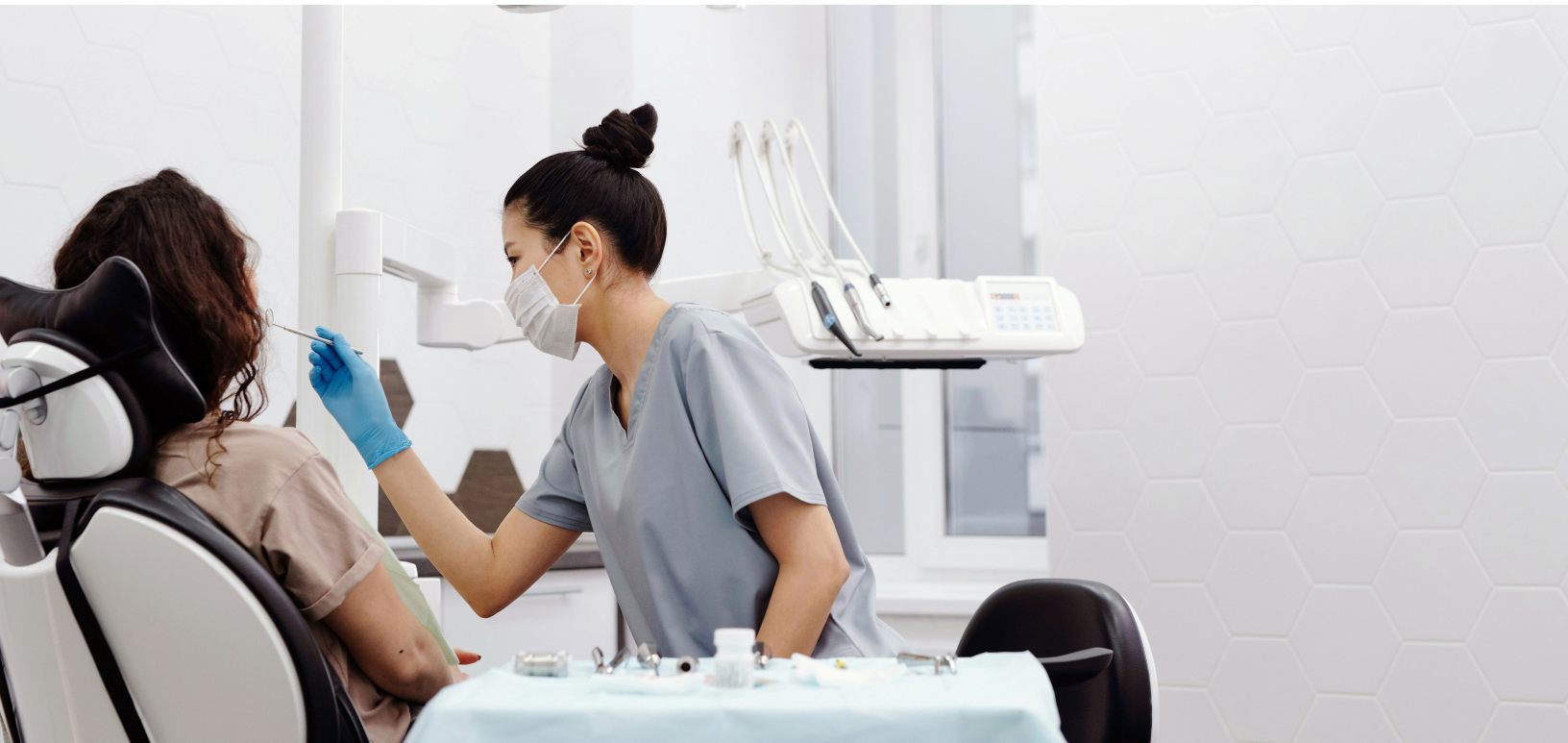


The downstream effects are measurable. Leaders report that administrative delays have resulted in:



These outcomes reflect throughput constraints, not clinical deficiencies. When scheduling queues extend, patients wait longer to be seen. When prior authorizations and documentation lag, treatment initiation is delayed. When compliance reporting strains, audit exposure increases. When response times lengthen, patient frustration increases and engagement declines.

Importantly, these access impacts occur before more visible quality breakdowns. Clinical teams may continue delivering appropriate care once patients are seen, but the path to that encounter becomes slower and less predictable. Over time, this erodes patient experience and increases strain on clinicians who must compensate for upstream administrative friction.



In capacity terms, backlog is an early warning signal. It reflects a system operating beyond its sustainable throughput. As demand continues to expand and organizations rely primarily on labor to absorb it, backlog becomes the mechanism through which administrative constraints translate into delayed access.

Edge’s data suggests that many healthcare organizations are already operating in this state. Access is slowing not because clinical capability is insufficient, but because administrative throughput cannot keep pace with demand.

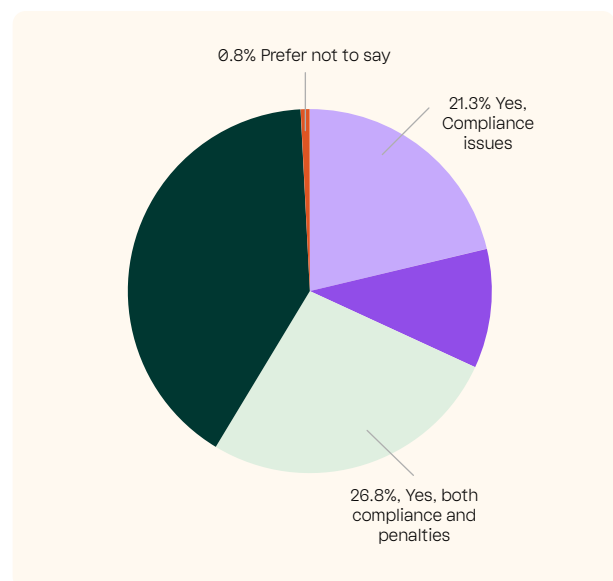


# Administrative Delay Now Creates Financial and Compliance Exposure

Throughput instability translates directly into revenue variability and audit risk.

As administrative workflows strain, the impact extends beyond delayed access. It begins to affect financial reliability, compliance posture, and organizational stability.

Nearly half of healthcare leaders (48.0%) report that compliance audits have uncovered documentation errors within the past 12 months. Administrative error rates, while often perceived as marginal, are material at scale: 42.9% estimate their error rate falls between 1–3%, and 31.9% estimate it between 4–7%. Even low single-digit error rates, when applied across thousands of transactions, translate into denied claims, rework, audit exposure, and revenue variability.



Revenue cycle inefficiencies are already visible. **Forty-four percent of respondents estimate losing between \$50,000 and \$250,000 annually due to administrative inefficiencies. An additional 24.4% estimate losses exceeding \$250,000 per year.** These figures reflect cumulative friction — delayed billing, documentation errors, rework cycles, and missed follow-ups.

The financial consequences compound when billing and revenue cycle workflows are among the most strained functions (44.5%). Overload in these areas leads to reimbursement delays, cash flow variability, and increased administrative rework. Leaders identify billing or reimbursement delays (39.8%) as one of the most common downstream effects of administrative overload.

Regulatory exposure follows a similar pattern. Compliance and regulatory reporting is the single most strained administrative area (47.2%). At the same time, 58.7% of leaders report that compliance and documentation require the most training among administrative functions. This combination — high strain and high training demand — increases the probability of documentation inconsistencies and audit findings when capacity is constrained.



Risk does not emerge because organizations lack awareness of regulatory requirements. It emerges when volume outpaces controlled execution.

Workflows such as prior authorization escalations, compliance documentation, billing review, and exception handling require structured oversight and accountability. They are not purely repetitive tasks; they involve judgment, context, and regulatory sensitivity. When these processes are absorbed through overtime or distributed across already strained teams, variability increases.

Over time, financial leakage and compliance risk reinforce operational instability. Revenue uncertainty constrains reinvestment in staffing and technology. Audit findings require corrective action and additional oversight. Rework consumes capacity that could otherwise expand throughput.

Administrative overload therefore operates as both an access constraint and a risk multiplier. As demand continues to expand, organizations face a dual pressure: maintaining throughput while preserving accuracy and compliance in regulated workflows.

In this environment, reliability becomes as important as volume. Without controlled, accountable execution, expanding labor alone does not reduce exposure. It can amplify it.



# More Hiring and More Automation Increase Activity, Not Throughput

Without coordinated execution, organizations accelerate tasks but not outcomes.

As administrative pressure intensifies, most organizations pursue two familiar responses: hire more staff or automate more tasks. The survey findings suggest that neither approach, on its own, resolves the underlying capacity constraint.

## Hiring expands labor, not throughput design

Hiring remains the default lever for expanding capacity. Yet the data indicates structural friction in the labor market.

**70%**

of healthcare leaders report that hiring qualified administrative or operational staff is difficult.

The most frequently cited barriers include a lack of qualified candidates (59.1%), compensation expectations (45.3%), lengthy hiring processes (43.7%), high turnover (40.6%), and compliance or regulatory training requirements (40.2%). Even when positions are filled, productivity ramps slowly. Only 7.1% report that new administrative hires reach full productivity in less than two weeks. The majority require between two and eight weeks to ramp, and nearly 17% require nine weeks or longer.



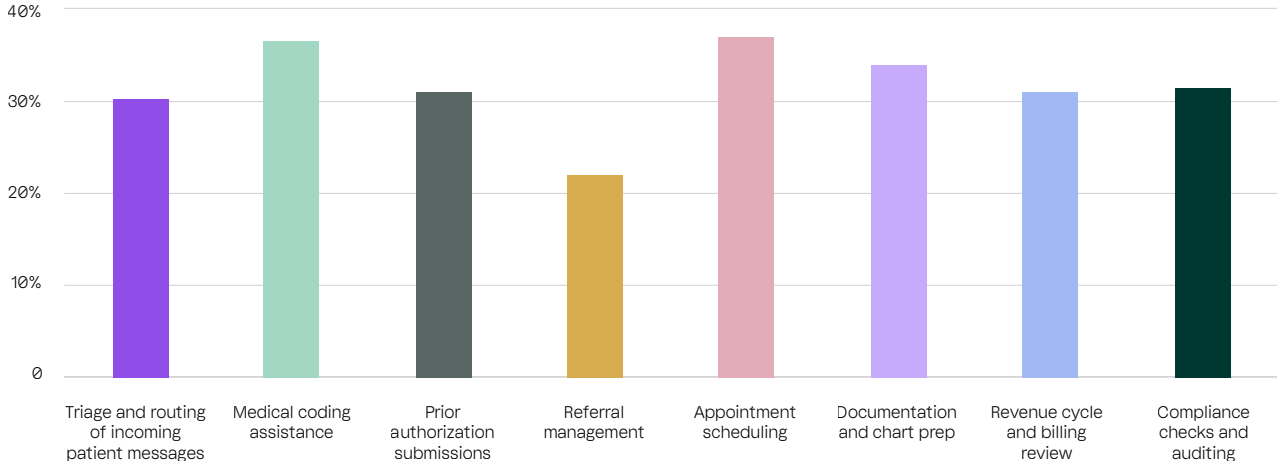
Even when positions are filled, productivity ramps slowly. **Only 7.1%** report that new administrative hires reach full productivity in less than two weeks. **The majority require between two and eight weeks to ramp, and nearly 17% require nine weeks or longer.**

Training demands compound the issue. Compliance and documentation (58.7%), billing and revenue cycle (46.1%), and prior authorizations (38.6%) are among the areas requiring the most training. These are also the workflows under the greatest strain. Expanding headcount without coordinated onboarding, oversight, and workflow redesign does not immediately expand reliable capacity.

Hiring increases labor supply, but it does not inherently improve how work is sequenced, monitored, or governed. In regulated workflows, accountability and consistency matter as much as task completion.

### Automation accelerates tasks, but not accountable execution

Automation and AI tools are increasingly embedded in administrative processes. Nearly half of organizations report that AI supports specific workflows with humans in control (48.8%), and 20.9% say AI is fully embedded in daily operations.



However, AI’s current impact is primarily assistive. The most common use cases include appointment scheduling (37.0%), medical coding assistance (36.6%), documentation and chart preparation (33.9%), compliance checks (31.5%), and prior authorization submissions (31.1%). These functions benefit from structured, repetitive automation.

The constraint emerges in exception-heavy, high-accountability workflows. Despite the availability of AI tools, the following areas remain largely manual:

- Prior authorization follow-ups and escalations (53.9%)
- Compliance documentation (46.9%)
- Appeals and exceptions (45.7%)
- Complex scheduling (43.3%)



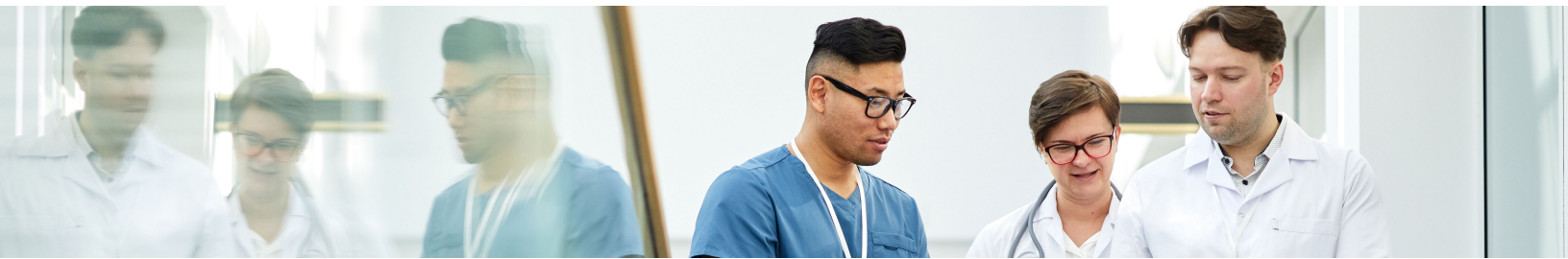
Leaders also identify these same workflows as areas where human-AI interaction remains critical to maintain accuracy and compliance. Prior authorization approvals and escalations (44.1%), billing review and exception handling (41.3%), compliance documentation and audits (39.4%), and coding review (38.6%) require judgment, oversight, and regulatory sensitivity.

AI tools can accelerate inputs and reduce repetitive work. They cannot assume regulatory responsibility. When workflows involve appeals, documentation for audits, reimbursement exceptions, or patient communications tied to clinical decisions, accountable execution remains essential.

The survey also highlights integration friction. **More than a quarter of respondents (27.2%) report that AI is difficult to integrate into existing workflows, and 22.0% say it lacks sufficient context or judgment.**

These findings suggest that automation alone does not resolve coordination and governance gaps.

## The Missing Layer: Orchestrated Capacity



Both hiring and automation address components of the problem. Hiring adds labor. Automation accelerates discrete tasks. Neither, independently, redesigns how administrative work is governed, monitored, and scaled across regulated workflows.

In capacity terms, the constraint is not only the number of people or tools available. It is the system through which work is routed, executed, reviewed, and held accountable.

Without structured orchestration — clear ownership, performance monitoring, compliance oversight, and integration

between technology and trained execution — expanding labor or deploying tools can increase variability rather than reliability.

As administrative demand continues to expand, the limitation becomes more visible. Capacity is not solely a staffing question or a technology question. It is a question of controlled, accountable execution at scale.

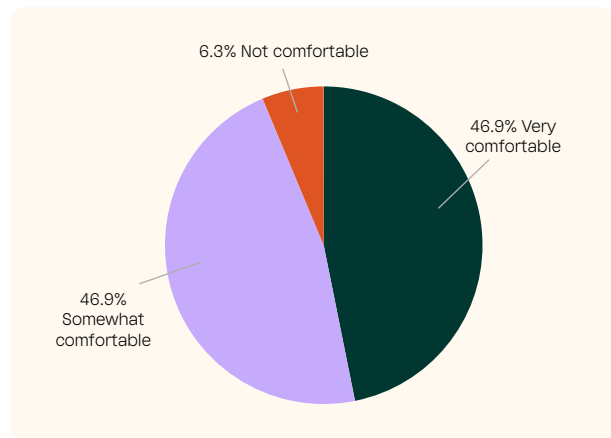
The data suggests that resolving the administrative bottleneck requires moving beyond incremental additions of labor or automation toward a more deliberate operational design.

# Healthcare Leaders Will Adopt New Workforce Models – If They Trust the Controls

Adoption depends on governance, not geography or cost.

If traditional fixes were sufficient, organizations would not be reporting sustained backlog, hiring friction, and compliance strain at current levels. Edge’s survey findings suggest that healthcare leaders recognize the need for a different approach to expanding administrative capacity. At the same time, they are clear about the conditions under which that shift is acceptable.

Openness to alternative workforce models is high. More than 93% of respondents report being somewhat or very comfortable leveraging a global talent network to expand capacity in regulated workflows. Similarly, 82.3% say they are somewhat or very likely to consider alternatives to U.S.-based hiring due to rising labor costs.



This openness is not primarily cost-driven. When asked about the top benefit expected from a workforce partner leveraging intelligent orchestration and blended workforce strategies, responses were distributed across several dimensions: cost savings (29.1%), access to more qualified talent (24.4%), faster hiring or vacancy reduction (24.0%), and reduced staff burnout (22.4%). The spread of responses indicates that leaders are seeking stability, reliability, and capacity expansion – not simply lower wages.

However, willingness to consider new workforce models is paired with explicit governance requirements.

The most frequently cited concerns about using a global talent network to support regulated workflows are:

<b>Quality and accuracy of work</b> (66.9%)	<b>Compliance and regulatory risk</b> (52.0%)	<b>Oversight and management</b> (50.8%)
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These responses indicate that resistance is not rooted in geography. It is rooted in governance. When asked what support would make leveraging a blended workforce easier, leaders prioritize:

Performance monitoring and reporting (61.8%)	Compliance and regulatory oversight handled (54.7%)	Training handled (54.3%)
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Recruiting support ranks lower (35.8%), reinforcing that sourcing alone is not the constraint. Organizations are not seeking fewer controls. They are seeking structured systems that allow them to expand capacity without increasing unmanaged risk.

This is where model design becomes critical.

Workforce approaches that simply add remote labor without integrated oversight are unlikely to address leaders' primary concerns. By contrast, models that combine trained, compliance-ready administrative professionals with embedded performance monitoring and regulatory safeguards align more directly with what healthcare operators say they need.

**The survey findings make clear that the market is prepared for alternative workforce strategies.** Adoption, however, depends on whether those strategies are architected around governance, transparency, and quality assurance.

Healthcare leaders are not resisting new models; they are evaluating them against the realities of regulatory risk, patient trust, and operational reliability. Any scalable solution must address those factors directly.



# Administrative Work Is Becoming Managed Infrastructure

Sustainable access requires engineered capacity integrating technology, trained execution, and oversight.

The survey findings, combined with the industry’s governance requirements, point toward a structural shift in how administrative capacity must be designed.

Healthcare organizations are not simply looking for additional labor. They are looking for capacity that is scalable, accountable, and aligned with regulated workflows. This distinction moves the conversation from staffing expansion to capacity engineering.

Under a traditional staffing model, administrative capacity grows linearly: **more volume requires more people**. Automation is layered in to accelerate discrete tasks, but responsibility for execution remains distributed across teams without unified oversight.

Capacity engineering approaches the problem differently. It treats administrative execution as infrastructure that must be deliberately structured across three interdependent layers:



## Technology Layer

Tools that automate structured, repetitive components of work and reduce manual rework. AI accelerates scheduling, documentation preparation, coding support, and standardized submissions, but does not operate without human accountability.



## Trained Execution Layer

Administrative professionals specifically trained in regulated healthcare workflows — including compliance documentation, revenue cycle processes, prior authorization management, and exception handling. Execution is not ad hoc; it is standardized and aligned to defined quality expectations.



## Governance Layer

Performance monitoring, quality assurance, compliance oversight, and clear ownership of outcomes. This layer ensures that work is completed accurately, within regulatory requirements, and with visibility into throughput and error rates.



The survey data reinforces the importance of this integrated model. Leaders prioritize performance monitoring (61.8%), compliance oversight (54.7%), and structured training (54.3%) when evaluating blended workforce strategies. Quality and accuracy (66.9%) and regulatory risk (52.0%) are the primary concerns. These findings suggest that a governance-free scale is not viable in healthcare operations.

As administrative demand continues to rise, healthcare organizations face a design decision. They can continue layering labor and tools onto existing workflows, or they can re-architect how administrative capacity is structured, monitored, and scaled.

Administrative execution is no longer a peripheral function. It is the core operational infrastructure. Treating it as engineered capacity — rather than incremental staffing — determines whether organizations can sustain access, protect revenue integrity, and maintain regulatory confidence as demand expands.

## The Next Era of Healthcare Efficiency Will Be Operational, Not Clinical.

Healthcare organizations are not facing a temporary spike in administrative workload. They are operating within a system where demand for scheduling, billing, compliance reporting, documentation, and patient communication continues to expand. At the same time, hiring remains constrained, ramp times delay productivity, and exception-heavy workflows resist full automation.

The result is visible in backlog, access delays, reimbursement variability, audit findings, and staff burnout. These outcomes are not isolated issues. They are symptoms of a throughput constraint within the administrative infrastructure.

For years, administrative work has been treated as overhead; necessary, but secondary to clinical delivery. The data suggests that framing no longer holds. Administrative execution determines how quickly patients enter the system, how reliably revenue is captured, and how confidently organizations meet regulatory obligations.

Addressing this constraint requires more than incremental hiring or task-level automation. It requires deliberate design. Technology must accelerate structured components of work. Trained professionals must execute regulated workflows with defined accountability. Governance mechanisms must provide visibility into performance, accuracy, and compliance outcomes.

Healthcare leaders are signaling readiness for this shift. They are open to alternative workforce models, provided those models are built with guardrails — quality controls, compliance oversight, and measurable performance standards. The opportunity is not simply to lower cost, but to increase reliable capacity.

Organizations that continue to treat administrative expansion as a staffing exercise may stabilize workload in the short term, but remain exposed to backlog, variability, and risk as demand grows. Those that treat administrative execution as engineered infrastructure — structured, monitored, and integrated — are better positioned to sustain access, protect revenue integrity, and maintain regulatory confidence.



*Administrative capacity is no longer a background function. It is the operational foundation that enables care delivery. Designing it deliberately will determine how effectively healthcare organizations navigate the next phase of growth and regulatory complexity.*

# Methodology

This report is based on findings from the Edge Workforce Bottleneck Survey conducted in January 2026.

The survey collected responses from 254 healthcare leaders across the United States. All respondents work in healthcare organizations. Participants were required to have direct involvement in operational and administrative decision-making within their organizations.

The respondent group reflects active decision-makers:

- 61.8% identify as the primary decision-maker for major operational decisions
- 26.4% share decision-making responsibility
- 72.8% report authority over day-to-day operations
- 63.8% influence staffing and hiring decisions
- 65.7% influence practice policies and procedures
- 48.4% influence budgeting or expense approvals

Respondents represent a range of organization types and ownership structures, including independent medical practices, group or multi-site practices, hospital-owned outpatient practices, community health clinics, and nonprofit or government-run organizations.

Practice sizes vary:

- 30.3% represent practices with 6–10 providers
- 23.6% represent practices with 11–25 providers
- 29.1% represent practices with more than 26 providers

Ownership structures include hospital- or health system-owned organizations (48.8%), physician-owned practices (22.0%), privately owned organizations (18.9%), and smaller representation from private equity-backed and nonprofit entities.

Respondents are geographically distributed across multiple U.S. states, with representation from California, Florida, Texas, New York, North Carolina, Ohio, Virginia, Pennsylvania, Tennessee, Georgia, Massachusetts, New Jersey, and additional states nationwide. The survey was designed to assess administrative workload, workflow strain, hiring challenges, automation adoption, compliance exposure, financial impact, and openness to alternative workforce models. All data presented in this report reflects aggregated responses.



# The bottleneck is measurable. Let's find yours.

Schedule a 30-minute operational capacity diagnostic.

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We'll uncover where backlog, risk, or financial leakage may be accumulating.



Scan to meet with an expert

**EDGE**

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