

Administrative Burdens in Healthcare Through Pillars of Race, Gender, Immigration Status, and Religion: A Literature Review

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ABSTRACT

The literature review examines how administrative burdens within the United States healthcare system function as systemic barriers that reinforce existing inequities, utilizing Herd & Moynihan's framework of learning, psychological, and compliance costs. The purpose of this paper is to synthesize how facially neutral "red tape" disproportionately marginalizes vulnerable populations by redistributing vital health resources to favored demographics. Methodologically, the review integrates empirical data, public policy research, and legal frameworks primarily from the 2010s and 2020s across four primary axes of identity: race, gender, immigration status, and religion. By applying Racialized Organization Theory, Feminist State Theory, and Policy Feedback Theory, the review tracks how structural barriers manifest across disparate circumstances. The findings conclude that administrative burdens effectively transform essential public resources into instruments of discrimination, validating Policy Feedback Theory by demonstrating that compounded institutional friction causes systemic service avoidance; finally, the paper identifies critical gaps in existing research regarding religious identity in public administration data and recommends future scholarship to transition from solely documenting disparities to evaluating successful mitigation strategies.

INTRODUCTION

The modern administrative state often presents itself as a neutral arbiter of rules and procedures, legislating equitable laws and policies to maximize the safety and well-being of citizens regardless of their identity. However, for many citizens, interacting with the government feels less like accessing a service and more like paying a "time tax," especially in fields of health services or urgent care. As Lowrey (2021) describes, this tax represents the "heavy, non-monetary, and underrepresented burden of time, paperwork, and cognitive effort required to access basic benefits or exercise legal rights." Rather than being a mere byproduct of inefficiency, Herd and Moynihan (2019) argue that administrative burden is actually "policymaking by other means." By deliberately implementing intricate, highly formalized pathways, institutions can effectively control who receives aid and who is deterred from it by

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characterizing themselves as bureaucratic actors merely “following the rules” (Ray et al., 2022). While Americans collectively spend over 11 billion hours annually navigating federal paperwork (Martin et al., 2023), these burdens are not being distributed equally across the population. Instead, the administrative state exploits procedural complexity to ration health resources to favorable demographics, imposing the temporal and cognitive task of healthcare navigation entirely onto the individual.

To evaluate how these burdens operate as mechanisms of exclusion, this paper utilizes Herd and Moynihan’s (2019) framework of the three costs of administrative burdens: learning, compliance, and psychological costs. Learning costs refer to cognitive labor required to navigate complex eligibility, compliance costs represent the financial and temporal burden of fulfilling rigid demands for application and documentation, and psychological costs encompass the stigma and stress induced by navigating hostile institutions. According to Ray et al. (2022), Racialized Organization Theory posits that bureaucratic legislators often obscure how the administrative state distributes resources in ways that favor dominant racial groups through “facially neutral rules.” The theory argues that organizations are shaped by historical and social ideas about race, which ascribes different levels of “costs” based on racial demographic, shifting the focus from individual prejudice to systemic inequality (Ray et al., 2022). This is complemented by Feminist State Theory, which posits that the state uses burdens to regulate “gendered bodies of labor,” resulting in higher structural frictions for women seeking reproductive or preventative care as well as a reinforcement of traditional heteronormative gender norms (Herd & Moynihan, 2024).

Ultimately, these burdens create a vicious cycle that discourages marginalized groups from accessing essential services. Organizations use stereotypes as a proxy for “costly” applicants and intentionally increase or obscure application methods to discourage them from seeking welfare services (Bell and Jilke, 2024). This reflects the Policy Feedback Theory, where the negative public perception of an administrative “output” leads to behavioral changes, specifically the systemic service avoidance of the healthcare system by marginalized communities (Zhu, Yang, and Wu, 2025; Van Beusekom, 2024). While foundational public administration research mostly utilizes these structural frameworks to evaluate the pillars of race and gender, a critical gap remains regarding less visible or non-demographic administrative vectors, such as immigration status and religion.

Methodologically, sources for this review were gathered through systematic searches across peer-reviewed databases, primarily including PubMed, Google Scholar, and Wiley Online Library, as well as leading health policy repositories, such as Kaiser Family Foundation, Centers for Disease Control and Prevention, and World Economic Forum. Targeted Boolean search strings including key terms were used to identify relevant literature: (“administrative burden” OR “procedural opacity” OR “time tax” OR “healthcare access”) AND (“race” OR “gender” OR “immigration status” OR “religiosity”). Inclusion criteria prioritized empirical studies, national cross-sectional analyses, and legal evaluations published primarily between 2010 and 2026 that directly examined administrative burdens in healthcare access. Studies were purposely excluded when they focused primarily on broad healthcare disparities without an identifiable administrative or procedural component, unless they provided significant demographic data.

Ultimately, this selection strategy integrates quantitative data with theoretical frameworks while maintaining a consistent focus on administrative burden as the central analytical framework.

While existing scholarship has applied Herd and Moynihan's (2019) framework to race or gender independently, this paper represents the first comprehensive literature review to integrate race, gender, immigration status, and religion into a single analytical model, serving as a novel contribution to public administration and health policy literature. By identifying common patterns in learning, compliance, and psychological costs through each demographic axis, the review also highlights areas in current literature where evidence remains limited, thereby providing a framework for identifying gaps and directions for future research in public administration and health policy. Ultimately, this review demonstrates that administrative burdens within the United States healthcare system function as systemic mechanisms of exclusion that manifests as fatal health inequities for minorities across four identity axes.

I. RACIALIZED BURDENS AND SYSTEMIC INEQUALITY

Racialized Organization Theory establishes that the administrative state frequently utilizes facially neutral "red tape" to mask disparate racial outcomes (Ray et al., 2022). However, rather than operating as objective arbiters, bureaucracies reflect historical hierarchies, ascribing racial meaning to every aspect of bureaucracy, even in everyday administrative processes. This systemic bias manifests as an uneven distribution of learning and time costs, a form of administrative burden where the "time tax" of finding and being qualified for healthcare services is unevenly distributed by race. For instance, research by Holt and Vinopal (2023) demonstrates that Black individuals consistently face longer delays for essential services, including mental healthcare, housing, and even voting, compared to their White counterparts. This indicates that street-level bureaucrats leverage racial stereotypes as a proxy for "cost" or "risk," intentionally slowing the process for marginalized applicants (Bell & Jilke, 2024).

This racialization is clearly visible in the "churn" of Medicaid enrollment and the subsequent disenrollment crisis. While the renewal process is presented as a standard compliance procedure, it disproportionately eliminates coverage from minority populations through administrative errors rather than a genuine change in eligibility. Recent national cross-sectional analyses reveal that Asian (24.2%), Black (21.5%), and Hispanic (21.4%) enrollees face significantly higher disenrollment rates compared to White enrollees (16.4%) (Marinacci et al., 2025). The most significant reason for disenrollment was that they "tried to stay in Medicaid but could not complete the renewal process," a factor that remained consistently higher for BIPOC individuals than the White baseline, suggesting the significance of procedural opacity (Marinacci et al., 2025). This is reflected in findings that 75% of disenrollments following the COVID-19 emergency were due to administrative issues, such as incomplete applications or application errors. It was also revealed that Black and Hispanic people are twice as likely to be disqualified for Medicaid for administrative reasons that can be improved through systemic changes (Van Beusekom, 2024).

This administrative disenrollment functions as a form of systemic exclusion, where the burden is so extreme that minority demographics are discouraged from accessing the very services created for them. The friction within these systems extends beyond administration, but also into life-changing circumstances. For example, insurance claim denials for preventive care show a clear racial hierarchy. Data indicates that while only 1.13% of White individuals experience insurance claim denials, the rates for Black (2.04%), Hispanic (2.44%), and Asian (2.72%) individuals are substantially higher (Hoagland et al., 2024). This insurance gatekeeping creates an effect where marginalized groups are not only burdened by learning costs of applying for insurance, but also experience genuine disparities through disproportionate insurance claim denials.

These hurdles contribute to the ongoing Black maternal mortality crisis, an illustration of how systemic bias and the resulting lack of trust can be fatal to such minorities. Pregnancy-related mortality rates for Black women remain over three times higher than those for White women: 49.4 versus 14.9 per 100,000 births (Hill et al., 2025). Crucially, literature suggests that wealth and education do not protect Black women from discrimination in healthcare that they do for White women; even Black women with high education and income levels have higher mortality rates than White women with less education (Lister et al., 2019). Such findings show that Black women are often treated with “lower quality indicators,” and that the “clinical gaze” is often obscured by implicit bias. Similarly, rates of uncontrolled hypertension were significantly higher for Black individuals compared to their White counterparts (82% versus 79%), and Black individuals with acute myocardial infarction (AMI) received a much lower quality of in-hospital care and displayed a higher rate of AMI readmissions than White individuals (Allouch et al., 2024; Raparelli et al., 2021). These experiences of bias oftentimes lead to a reluctance of Black individuals to seek care or trust the medical community (Lister et al., 2019).

When patients perceive the system as inherently inequitable, they often engage in “systemic service avoidance,” choosing to protect their dignity rather than subject themselves to further compliance costs like stress or discrimination (Herd & Moynihan, 2019; Hoang et al., 2022). Described in Policy Feedback Theory, this behavioral feedback creates a vicious cycle in which the administrative state discourages marginalized groups from accessing welfare services and essential care, reinforcing existing disparities they are supposed to mitigate (Zhu et al., 2025; Bell & Jilke, 2024). This lack of trust does not result from individual doubts, but from a collective response to a racialized system that exploits learning, compliance, and psychological costs to mentally and physically exhaust racial minorities (Herd & Moynihan, 2019).

II. GENDERED BURDENS AND THE “CEILING OF CARE”

Gender also serves as a primary factor for the distribution of administrative burdens, frequently functioning through the state’s regulation of “gendered” bodies and labor (Herd & Moynihan, 2024). According to Herd and Moynihan (2024), the administrative state is not a neutral entity. Rather, the “Feminist State Theory” suggests that the state utilizes gendered biases as tools to regulate reproductive bodies and enforce traditional gender roles. This is particularly evident in the high administrative hurdles

placed on abortion care and the compliance costs associated with childcare subsidies. These burdens often demand excessive reproductive labor from women, which increases the challenge of working as a mother, consequently reinforcing traditional gender structures that disadvantage women. Herd and Moynihan also state that such administrative hurdles reinforce traditional heteronormative notions, such as anti-LGBTQ stances by regulating gendered bodies (Herd & Moynihan, 2024).

This structural discrimination creates significant barriers for women to access essential services. Data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS) reveals that women are 1.26 times more likely than men to delay healthcare and 1.29 times more likely to be unable to see a doctor due to financial factors (Daher et al., 2021). These financial and structural obstacles are exacerbated for Black women, who face 1.24 times higher odds of cost-related medication non-adherence (Daher et al., 2021). This suggests that women experience an additional "caregiving tax," in which they constantly sacrifice their time and money to manage the unfair nature of the healthcare system, which is further worsened by the existing gender pay gap (Daher et al., 2021).

Even beyond administrative access, women often face a "ceiling of care" during treatment itself, where their symptoms are frequently minimized or undertreated. Research by Vromant et al. (2024) indicates notable gender biases in emergency medicine. In emergency settings, women were significantly less likely to be intubated than men (67.9% versus 71.7%) and received less aggressive treatment for acute coronary syndromes, which is the leading cause of death for women (Vromant et al., 2024). This disparity often stems from the general underestimation of female pain, where women's reports of pain are dismissed as emotional and psychosomatic, leading to insufficient care and treatment. This clinical prejudice serves as a secondary burden, a psychological cost that forces women to advocate more strongly for their health due to a system that defaults to male standards.

Additionally, the historical default to male standards has resulted in a global gender health gap (Irani et al., 2024). Currently, only 1% of global healthcare research is dedicated to female-specific conditions, leaving a massive underrepresentation of female healthcare and sex-disaggregated data. This lack of research means women spend approximately 25% more of their lives—roughly nine additional years—in poor health compared to men. The World Economic Forum (2024) states that this is not solely a social issue but a global economic failure. Addressing the gender health gap by investing in female-specific research could add an estimated \$1 trillion to global GDP annually (Irani et al., 2024; World Economic Forum, 2024).

The intersection of gender and race further intensifies these burdens, creating an environment where the representation of minority demographics is dangerously low. While women experience high rates of discrimination, Black women face the additional weight of both systemic racism and sexism. In the US, while 36% of physicians are women, only 3% are Black women (Pugh, 2021). This lack of representation contributes to a significant trust gap, with 1 in 5 women reporting gender-based discrimination in healthcare and 9% avoiding the system entirely to prevent further harm (Pugh, 2021). When the state utilizes administrative and clinical burdens to control gendered bodies, it creates a hierarchical healthcare

system that devalues female life and labor, reinforcing biologically and economically detrimental inequities.

III. IMMIGRATION STATUS: LEGAL AND FINANCIAL BARRIERS

Immigration status represents one of the most weaponized factors of administrative burden within healthcare access, serving as a mechanism for exclusion. This systemic discrimination is heavily rooted in legislative frameworks, such as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996. PRWORA established the restrictive definition and standards of being a “qualified alien,” effectively creating a deep divide through immigrant communities by only giving qualified aliens access to federal and state public benefits, including Medicaid (Alarcon, 2022). By classifying who is deserving of state-subsidized care, the state uses administrative burdens to construct “paper walls” that purposefully deny health resources to undocumented immigrants.

These legal circumstances generate a suppressing effect that influences beyond those who are legally ineligible. Many eligible immigrants, including naturalized citizens and lawful permanent residents, view the administrative state as a system of fear rather than support, discouraging them from seeking proper healthcare services. The 2023 KFF/LA Times Survey of Immigrants reports that 25% of immigrants have had a history of being treated unfairly in a clinical setting, for factors such as their insurance status or ability to pay (16%), accent or ability to speak English (15%), or their race, ethnicity, or skin color (13%). This institutional discrimination was experienced by half of undocumented immigrants and 18% of lawfully present aliens (Pillati et al., 2023). Apart from overt mistreatment, complex and opaque eligibility requirements combined with language barriers deter families from seeking necessary medical attention. Consequently, individuals engage in systemic service avoidance from psychological burdens, intentionally withdrawing from essential services to protect themselves from discrimination.

The reality of these barriers is reflected in structural insurance disparities. While approximately 90% of native-born citizens possess health insurance, only about 33% of undocumented immigrants have any form of insurance coverage (Gelatt, 2016). This significant disparity leaves a significant proportion of the American population unable to access proper healthcare, causing a majority of undocumented immigrants to rely on fragmented safety-net clinics for basic survival. As a result, the biological consequences are severe: only 27% of immigrant-born children have reported having excellent health, as opposed to nearly double the percentage present in native-born children (Gelatt, 2016).

In addition to such healthcare-specific hurdles, immigrants undergo a broader, more tedious path for legal status itself, which has been systemically engineered to exhaust the resources of applicants. Along with daily stigma experienced by the immigrant demographic, such as the susceptibility to racialized tropes or structural lack of power, empirical evidence has revealed that the process of documentation has been becoming more onerous. The backlog for citizenship applications has increased by over 80% since 2014, and wait times for visas have increased from five months to five years. Financial costs are also being

exacerbated, with citizen application fees rising from \$750 to \$1,170 (Moynihan et al., 2021). Compounding such financial and psychological costs, the time costs of unwarranted incarceration in migrant camps or detention centers additionally deter immigrants from seeking state-subsidized services. By turning legal validation into an exhausting and unfair battle, the administration effectively restricts essential resources into more favorable demographics.

IV. RELIGION AND SPIRITUALITY IN CLINICAL SETTINGS

While the administrative state often assumes a secular standard when operating in clinical settings, these neutral baselines frequently fail to accommodate the spiritual beliefs of religious patients. This structural lack of accommodation manifests as significant learning and time costs, as individuals are forced to navigate through rigid medical protocols that directly conflict with their beliefs (LeDoux et al., 2019). For instance, Muslim women undergo similar structural burdens when the state fails to accommodate their preference for same-sex healthcare providers, which operates as a procedural obstacle that significantly increases the time tax for them to actively search for providers aligned with their tenets (Padela & Zaidi, 2018). Similar obstacles arose from the “Bare Below the Elbows (BBE)” policy introduced in the UK in 2007, which required patients to keep their forearms uncovered to minimize healthcare-associated infections (HAIs), which directly clashed with the modesty practices of some religions (Blenkharn, 2019). These individuals must navigate through the default system that fails to provide transparent solutions for religious minorities, forcing them to undergo additional time costs.

For individuals who visibly display their religious beliefs, this institutional friction is compounded with discrimination. As a tangible and highly visible marker of Muslim identity, the hijab frequently exposes Muslim women to heightened personal and institutional microaggressions in clinical settings (Jasperse et al., 2012). Research by Murrar et al. (2024) shows that Muslim women wearing hijabs were highly likely to experience Islamophobia or stereotyping, with 29.8% of them reporting that doctors or nurses would not listen to them, and 24.3% reporting that healthcare providers frequently underestimated their intelligence. This notable marginalization directly correlates with higher psychological stress, poorer mental and physical health, as well as an overall avoidance of seeking healthcare services (Murrar et al., 2024). Attacks against the hijab as a “tangible marker of difference” attack Muslim women’s psychological, behavioral identity, eventually resulting in lower life satisfaction and higher psychological symptoms from external Islamophobia (Jasperse et al., 2012). Such discrimination is commonly manifested as double standards. When female Muslim clinicians introduced disposable plastic oversleeves as a solution to the BBE policy, the state argued that they introduced “incalculable infection risks,” such as potential cross-contamination though existing health equipment, such as non-sterile gloves, pose similar risks (Blenkharn, 2019). This demonstrates that the state’s commitment to facially neutral rules does not merely burden minority patients, but it actively penalizes minority practitioners trying to operate within the system.

When public health administrations completely isolate themselves from faith-based frameworks, they inevitably exacerbate these disparities by creating a vicious cycle of behavior withdrawal, posited by Policy Feedback Theory (Zhu et al., 2025). Because state-subsidized healthcare maintains secular protocols as a rigid baseline, they fail to leverage historically rooted religious support systems that naturally mitigate health disparities (Allouch et al., 2024). In predominantly Black churches, research by Allouch et al. (2024) shows that strong religious support structures are directly associated with improved mental health and positive cardiovascular health outcomes. Crucially, these faith-based networks function as effective healthcare providers that organically lower administrative burdens by enhancing patient health literacy (Allouch et al., 2024). The efficiency is directly reflected in health-seeking behaviors of religious individuals, with research proving religious Latinos consistently chose mental health services aligned with their religious practices, and higher levels of religiosity correlated to reduced visits to secular mental health therapists by a factor of 95% (Moreno & Cardemil, 2013; Boateng et al., 2023).

Therefore, elevated health risks among religious minorities cannot be attributed to their spiritual identities. Rather, they stem from a bureaucracy that systemically refuses to accommodate religious beliefs or grant spiritual communities legitimacy. By treating faith networks as improper and unprofessional rather than as essential solutions for mitigation, the state artificially increases the compliance and learning costs of seeking healthcare. Despite 48% of Americans identifying as religious and 27% as spiritual, healthcare systems still disregard religious beliefs when considering solutions, eventually leading to a collective distrust of the system (LeDoux et al., 2019). This trust gap validates Policy Feedback Theory, as the accumulation of administrative burdens after interacting with rigid, secular clinical standards exhausts religious minorities. As a result, they systemically avoid necessary healthcare systems and rely more on religious healthcare networks.

DISCUSSION

In the process of researching the impacts of administrative burdens in the healthcare system as they relate to race, gender, immigration status, and religion, several discrepancies between each pillar emerge. While intersections of race, gender, and immigration status are supported by sufficient statistical data regarding systemic marginalization during application and enrollment processes, such as Hoagland et al.'s (2024) analysis of insurance claim denials by race, this information was critically absent concerning religiosity. Existing research heavily concentrates on the procedural and learning costs of religious individuals within clinical settings, such as Muslim women experiencing additional time costs to locate caregivers that accommodate their beliefs (Padela & Zaidi, 2018). However, religion remains a largely overlooked factor when discussing systemic discrimination within insurance enrollment or institutional service denials. Additional research into how religious identity interacts with insurance approvals and bureaucratic service enrollments is essential to establishing a stronger background on religion as a structural barrier.

Additionally, the existing body of literature exhibits a clear abundance of resources relating to administrative burdens of Muslim individuals compared to other minority or conservative faith traditions.

This imbalance suggests a tendency within public administration research to prioritize groups that externally display their religious identity as well as obvious religious minorities, such as Muslim women displaying their faith through hijabs (Jasperse et al., 2012; Murrar et al., 2024). While tracking the psychological and compliance costs faced by highly visible minorities is critical, it leaves a significant gap regarding obstacles encountered by other communities. For instance, Orthodox Jews and Catholics also adhere to conservative spiritual and ethical tenets that directly intersect with various aspects of healthcare delivery, such as reproductive care and end-of-life protocols. Further investigation into a broader spectrum of religious beliefs would prevent generalizations and create a more comprehensive framework for understanding the relationship between religiosity and administrative burdens in healthcare.

Beyond addressing these gaps, administrative burden research must begin to confront the rapid digitalization of healthcare services. As public benefits like Medicaid transition to automated renewal systems, sorting algorithms powered by AI, and digital applications, the nature of learning and compliance costs are fundamentally shifting (Cohen, 2025). Future research must analyze whether this digital transition of healthcare delivery exacerbates existing structural inequities or introduces new forms of procedural opacity that disproportionately affect communities with limited resources. Additionally, while current literature clearly establishes that administrative burdens cause systemic service avoidance and behavioral withdrawal, there is a critical lack of evaluation on successful mitigation strategies, such as automatic enrollment policies. Future scholarship should transition from solely documenting disparities to evaluating the effectiveness of interventions to determine how the state can absorb existing burdens and promote health equity.

While this review provides a novel synthesis of administrative burdens in healthcare, several limitations must be acknowledged. First, because this paper relies on the synthesis of secondary literature and empirical studies, its scope is restricted by the sample sizes, reporting parameters, and data collection frameworks of the underlying sources. Similarly, a significant limitation stems from the scarcity of multi-variable datasets. As existing literature mainly documents identity axes in isolation, the lack of quantitative empirical data capturing intersections may cause data across each pillar to vary in terms of time range, sample size, and methodology. Additionally, the geographic focus of this review centers primarily on the decentralized, mixed-payer healthcare infrastructure of the United States. Because of these limitations, these findings may not fully apply to healthcare systems with alternative administrative architectures. Finally, considering the rapid post-pandemic evolution of public benefit policy and healthcare application mechanisms, academic literature may experience a lag in capturing real-time administrative burdens.

CONCLUSION

This review of literature demonstrates that the administrative state operates not as a neutral or objective arbiter of public welfare, but as a governing system where procedural complexity is systematically

utilized as a tool to regulate access to health resources. Across factors of race, gender, immigration status, and religion, literature consistently proves that the seemingly neutral “red tape” functions as a deliberate mechanism of structural exclusion (Herd & Moynihan, 2019; Ray et al., 2022). By redistributing healthcare services to majority demographics, the state imposes the administrative burdens of navigating rigid health systems onto marginalized individuals. The compounding of learning, compliance, and psychological costs deters vulnerable populations and transforms essential public services into procedural barriers.

The consequences of these burdens are not limited to minor inefficiencies; rather, literature indicates that they contribute directly to fatal and life-altering health disparities. Evidence regarding Medicaid disenrollment churn (Marinacci et al., 2025; Van Beusekom, 2024), insurance claim denials for BIPOC individuals (Hoagland et al., 2024), and the Black maternal mortality crisis (Hill et al., 2025; Lister et al., 2019) underscore how racialized bureaucracy significantly impacts racial minorities. Similarly, studies investigating the “ceiling of care” and normalized underestimation of female pain highlight how gendered administrative systems prevent women from accessing adequate healthcare (Vromant et al., 2024; Daher et al., 2021). Within immigrant communities, legislative barriers like PRWORA are shown to function as structural obstacles that induce systemic service avoidance among immigrant families, expanding the struggles of healthcare access to legal status (Alarcon, 2022; Pillai et al., 2023). Finally, the literature reveals that rigid secular standards in clinical settings impose significant learning and psychological costs on religious minorities, causing heightened stress and the additional time tax to find services that accommodate their spiritual beliefs (Blenkharn, 2019; Padela & Zaidi, 2018).

Accordingly, these barriers compound to strongly validate the Policy Feedback Theory, which indicates a self-perpetuating cycle of civic and medical alienation (Zhu et al., 2025; Bell & Jilke, 2024). When marginalized communities are forced to constantly utilize their cognitive and financial resources to secure basic care, the resulting exhaustion creates a significant trust gap. Consequently, this loss of trust drives behavioral withdrawal and pushes marginalized groups further away from healthcare and welfare networks (Döring & Madsen, 2022). As a result, the literature indicates that future policy interventions must expand beyond superficial optimization and address the institutionalized biases present in the existing frameworks. The consensus in the current research highly recommends that the administrative state should transition from an exclusive system serving certain demographics to one that promotes health equity; in order to achieve this transformation, the administrative burdens of healthcare need to shift away from vulnerable demographics and onto the system itself.

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