TRENDS REPORT

The Seven Trends For US Healthcare Providers In 2026

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Summary

US healthcare provider organizations (HPOs) face a paradox: Consumers have unprecedented access to health data and digital tools, yet navigating, trusting, and affording care are harder than ever. Patients increasingly act as data brokers, but they struggle to access primary care. Traditional provider teams risk falling behind as digital health firms turn AI-driven navigation into a competitive edge. Virtual care is maturing, medical tourism is expanding, and dealmaking is shifting toward disciplined tuck-ins. This report outlines seven trends shaping the healthcare provider landscape in 2026 and the actions leaders can take to protect trust, improve patient retention, and drive sustainable growth.

Providers' High-Stakes Rebuild Of Trust And Access Remains Unproven

In 2026, healthcare provider organizations must rebuild trust, protect access, and deploy capital more deliberately as consumers, competitors, and regulators reshape the care landscape. AI-enabled navigation, consumer data sharing, and alternative care models are accelerating faster than workforce recovery and primary care reinvestment, forcing HPOs to rethink how they deliver, govern, and provide care. At the same time, heightened regulatory scrutiny is pushing leaders toward more disciplined digital investment, partnerships, and capability-led M&A. HPOs must navigate these shifts as they defend relevance, reduce care diversion, and demonstrate steadiness in an increasingly fragmented ecosystem (see Figure 1).

Figure 1

The Healthcare Industry Must Balance Competing Trends

Seven Trends Will Test Healthcare Providers' Stability And Strategic Control

In 2026, healthcare providers will face a convergence of access shortfalls, consumer workarounds, regulatory scrutiny, and rising expectations around digital, data, and AI stewardship. The following seven trends highlight where providers must stabilize core operations quickly and where they must assert greater strategic control to remain competitive in an increasingly fragmented healthcare ecosystem.

Underinvestment In Primary Care Undermines Longevity Gains

Nearly a third of the US population lives in a primary care health professional shortage area. Recent surges in preventable diseases are straining health systems and frontline clinicians, limiting access to providers while also exposing the implications of weakened primary care relationships. And because of policy changes, as many as 4.2 million uninsured patients will seek care at community health centers by 2034. At the same time, federal policies are prioritizing prevention over treatment, while state policies are centering on primary care. These policies are set against the backdrop of the US investing less than 5% of healthcare spending in primary care. This compromises prevention, trust, and continuity at a time when stronger provider-consumer relationships are most needed. HPO leaders must:

- **Offer convenience through on-demand care models.** HPOs would benefit from standing up an on-demand "continuity layer" that sits between routine primary care and urgent care. Penn Medicine accepted that on-demand care is inevitable and chose to own it operationally rather than outsource it to retail or national telehealth vendors. It replaced traditional primary care practice on-call coverage with Penn Medicine OnDemand, a 24/7 virtual care service staffed by Penn clinicians who have access to the patient's medical record. They route follow-up back to the PCP. The model removes the "life happens at night and on weekends" gap without breaking the primary care relationship. If providers don't offer on-demand services, consumers will continue to use alternative care offerings, increasing leakage and fragmentation.
- **Align provider capacity to patient needs.** Underinvestment forces clinicians into reactive, episodic work that amplifies preventable disease, downstream utilization, and clinician burnout. Initiate population-level coverage and risk. Shift care beyond traditional PCP visits by using tools like asynchronous check-ins for at-risk patients and clear protocols for prevention and chronic disease management. PCPs should focus their teams on small panels with higher acuity and use automation and team-

based care to efficiently care for larger, more medically stable panels. The Veterans Health Administration assigns each veteran to a Patient Aligned Care Team, designed to address both individual and population management, access, and prevention within multiple care delivery modalities.

With Limited Choices, Consumers Explore Alternative Care Delivery

Consumers increasingly find themselves with limited practical choices within the traditional healthcare system. Long wait times, difficulty accessing in-network providers, coverage uncertainty, and rising out-of-pocket costs routinely delay or derail care, even for insured patients. Faced with these barriers, many turn to direct-to-consumer (DTC) platforms like Hims & Hers, which offer faster, stigma-free, cash-pay access to common treatments. Others explore outbound medical tourism to bypass cost and access constraints altogether. As a growing share of consumers are willing to use alternative care sites or travel abroad for more affordable care, HPOs should:

- **Redesign access around speed to care, not just digital entry points.** Consumers are not leaving due to lack of digital tools but rather because digital access too often fails to translate into timely care. A polished front door that leads to weeks-long waits, unclear next steps, or repeated handoffs frustrates consumers and pushes them toward DTC platforms or care abroad. HPOs should redesign access end to end, aligning digital intake with real-time capacity, streamlined triage, and faster scheduling across virtual, in-person, and asynchronous modalities.
- **Offer transparent cash-pay and hybrid care pathways.** As costs rise and coverage complexity grows, consumers increasingly value predictability. Alternative care delivery succeeds because pricing is clear, access is guaranteed, and friction is low. HPOs can encourage consumer loyalty by offering transparent cash-pay and hybrid pathways for common conditions, elective procedures, and ongoing chronic care. McBride Orthopedic Hospital publishes bundled charges for the hospital, surgeon, and anesthesia as a package price with upfront payment. Cash pay can complement insurance-based care, giving consumers more control and faster options within a transparent system. By operationalizing these models, providers can prevent patient diversion, capture otherwise lost revenue, and meet consumers where they are.

Virtual Care Deepens Its Role In The US Health System

Forrester forecasts that in 2026, US tech spending (including staffing costs) will reach $69 billion in the healthcare industry, with 9% spent on telecommunications and 2% on communications equipment. While some of this spending will go elsewhere, there are

reasons to be optimistic about it going to virtual care: Hospital-at-home is finally moving toward longer-term stability. Proposed federal legislation would extend Medicare Acute Hospital Care at Home flexibilities through September 2030. CMS reimbursement and policy changes for remote monitoring and telehealth will enable scalable programs in chronic disease and postacute transitions. And 52% of US business and technology professionals working in healthcare plan to increase the use of edge technologies over the next year, making virtual care faster, safer, and more reliable. This will turn virtual care from episodic video visits into continuous, dependable, and clinically actionable care. As virtual care deepens its role in the industry, HPO leaders should:

- **Anchor virtual care strategy in demand, not policy stability.** HPOs should design virtual care strategies that assume volatility, not permanence, in reimbursement and regulation. Consumer signals are clear: Only 29% of US online adults are not interested in having a primary care appointment virtually, and 12% would rather use virtual care technology (like video) to interact with nurses and doctors throughout the day than stay at a hospital for multiple nights. HPOs should prioritize modular, hybrid virtual models that can scale up or down and anchor virtual care strategy in sustained consumer awareness and demand signals, not the temporary stability of reimbursement models or regulatory policy.
- **Identify partners to fill care delivery gaps.** Health systems can extend care through on-demand, virtual-first models. Imagine Pediatrics operates as a specialized, value-based care extension. Its clinicians help stabilize high-cost pediatric populations, improve outcomes, and lower total cost of care by reducing emergency department visits and hospitalizations. Partnerships like this offer HPOs a way to relieve capacity constraints and workforce pressure without fragmenting care. MD Integrations enables scalable, asynchronous virtual care by embedding it in core clinical operations, supporting ongoing patient relationships while reducing unnecessary visits. The benefits of virtual-first partnerships materialize when HPOs tightly integrate partners into clinical pathways and support them with aligned operations, data sharing, and reimbursement models that promote accountability.

Patients Become De Facto Data Brokers, And HPOs Are On The Hook For Trust

Patients are increasingly able to aggregate and redistribute their health data through consumer apps, wearables, AI tools, and interoperability frameworks. This empowerment increases risks: Uploading scans and medical data to consumer AI tools like Grok, outside HIPAA protections, raises accuracy and privacy concerns. Epic and

major health systems recently sued multiple companies, alleging that nearly 300,000 patient records were improperly accessed and sold via interoperability networks. This underscores a growing problem: Infrastructure designed to enable care coordination can also enable extraction and monetization. Thirty-seven percent of US online adults trust their healthcare provider's AI tools to handle personal health information securely, compared with 25% who trust public AI tools, underscoring both the trust advantage HPOs hold and how fragile it remains. As patient-directed data sharing accelerates, HPOs must decide whether they will remain passive infrastructure participants or evolve into trusted data stewards. Those that proactively guide and govern data sharing will preserve trust and relevance in an increasingly disintermediated health ecosystem. To respond, HPOs must:

- **Treat patient-directed data sharing as a product, not a side effect.** Most health systems still treat consumer data sharing as something that "just happens" via portals, APIs, and third-party apps. Some HPOs are beginning to turn experiences into products by offering clear guidance, guardrails, and value exchange. Mayo Clinic and Kaiser Permanente have already moved in this direction with curated digital health app libraries and consumer education, helping patients make informed choices rather than pushing them to navigate opaque ecosystems alone. Health systems should publish plain-language explanations of what data is and is not protected under HIPAA, create trusted app directories, and offer safeguards and risk-mitigation measures for consumer AI tools. By doing so, providers reinforce their role as advisors in a data-rich world.
- **Adopt auditable frameworks for trusted data sharing across the ecosystem.** Interoperability can no longer be a static technical achievement. Data sharing is critical to enable interoperability across the ecosystem. As risks of misuse, scraping, and monetization attempts inevitably occur, designing systems governance in a way that enables trusted data sharing becomes critical. This means continuously auditing access patterns across exchange frameworks, strengthening identity proofing for requesters, and implementing anomaly detection to flag nontreatment or unusual activity. To detect misuse early and ensure continued oversight, HPOs must adopt mature security postures, like Zero Trust principles and real-time monitoring across clinical and administrative systems. Cleveland Clinic's enterprisewide cybersecurity and access management investments are a model for aligning interoperability with ongoing risk management rather than engaging in episodic audits.
- **Offer patients a visible data control layer to rebalance trust.** A major driver of patient distrust is asymmetry: Data moves, but patients can't see how, why, where,

or by whom. Providers should close this gap by offering granular consent options, revocation capabilities, and “data receipts” that show who accessed what information, when, and for what purpose. Some HPOs are experimenting with enhanced consent management and audit transparency through patient portals, giving consumers clearer insight into data flows tied to care, payment, or operations. These approaches mirror practices emerging in financial services. Embracing these best practices can help providers position themselves as more credible stewards of patient data, even when data travels beyond their walls.

Digital Has Financial Impact Without Financial Accountability

Efforts to control costs often focus on restructuring RCM systems, overhead, or value-based care (VBC) delivery. But these efforts miss a more immediate opportunity. Digital channels influence an average of 35% of healthcare organizations’ revenue, shaping demand, utilization, and downstream costs long before VBC comes into the picture. At the same time, regulators mandating interoperability, transparency, and access are turning digital from a nice-to-have into a baseline requirement. Yet many digital teams remain in cost centers, lacking profit-and-loss (P&L) responsibility. Without accountability, maintaining financial discipline becomes increasingly difficult. HPOs should elevate digital teams from execution engines to accountable business leaders by:

- **Assigning them clear P&L ownership.** When digital health channels are treated as revenue-generating businesses, HPO digital leaders become accountable not just for experience but also for how digital drives demand, steers utilization, and reduces avoidable cost. This means measuring digital performance against hard outcomes, such as appointment capture, referral leakage, labor substitution, and downstream utilization, not vague metrics like clicks or downloads. P&L ownership also sharpens investment decisions, prioritizing capabilities that remove administrative and access barriers, shift care to lower-cost settings, and prevent unnecessary visits or treatments. Elevating digital leaders to business owners turns digital from a passive entry point into an active lever for advancing financial goals.
- **Hardwiring digital into core operating and clinical decisions.** Healthcare leaders should embed digital performance into the same operating cadence used for access, throughput, and capacity management. Digital demand signals should inform staffing models, clinic templates, referral routing, and site-of-care decisions in real time, rather than living in parallel dashboards. Operating digital teams downstream of clinical and operational planning constrains their ability to prevent leakage or steer utilization. Elevating digital inputs into daily and weekly

management forums ensures digital channels actively shape care delivery, not just reflect it. Integration turns digital from an intake layer into a systemwide coordination tool that reduces friction, mismatches in supply and demand, and unnecessary utilization.

Care Navigation Is The New Front Door, And Big Tech Knows It

Forrester's 2025 data shows that US online adults who categorize themselves as having poor mental or physical health struggle disproportionately with navigating the system. As digital health and AI accelerate, care navigation is emerging as the next competitive battleground. CMS is reinforcing this shift through new reimbursement codes, interoperability, and continuity initiatives that elevate digital navigation, identity matching, and cross-payer coordination. Consumers are becoming increasingly comfortable with using public AI tools for health guidance because these tools offer speed, convenience, and some confidence in their level of accuracy. But the risk is real: ChatGPT Health failed to recommend immediate hospital care in 51.6% of scenarios where physicians saw a true emergency. For HPOs, these are missed opportunities to help both tech-savvy and novice users navigate the system to a better outcome. If HPOs don't proactively own or shape care navigation, others who haven't taken an oath will step up and compromise outcomes and trust in providers. To avoid negative outcomes, HPOs should:

- **Champion the consumer's AI healthcare journey.** Healthcare leaders should actively shape how consumers use AI in and around care to avoid a two-tiered experience that benefits digitally confident patients but leaves vulnerable populations behind, or worse yet, misleads them. As AI becomes a frontline source of health information, organizations must anchor AI strategy in health equity and the Quintuple Aim, not convenience or novelty. Start by making AI outputs accurate, understandable, contextual, and appropriately cautious. Forrester's 2026 data shows only a marginal trust advantage for provider-branded AI, with 39% of US online adults believing their healthcare provider's AI tool would give care recommendations that are in their best interest, compared with 30% for public AI tools. This limited trust in AI recommendations, even when offered by providers, underscores the need for transparency and education. Proactive education on safe AI use, bias awareness, and escalation pathways can prevent harm while building trust. The goal is to guide consumers toward informed, equitable, and clinically grounded use that strengthens, rather than fragments, the care experience.
- **Prepare for new liability and accountability in AI-enabled navigation.** As HPOs take a more active role in guiding consumer AI journeys, they will inevitably

assume greater responsibility for outcomes. Provider-branded or -endorsed AI will be perceived as an extension of the organization, not a neutral tool, raising expectations around accuracy, safety, and escalation. Leaders should proactively establish governance, clinical oversight, and clear accountability for AI-driven navigation, including documentation standards, audit trails, and defined handoffs to human care teams. Partner closely with legal, risk, and compliance functions to anticipate malpractice, regulatory, and reputational exposure. Owning the front door means owning what happens when guidance goes wrong, not just when it works.

Regulatory Heat Forces A Smarter M&A Playbook

Policymakers are taking a harder line on healthcare M&A as concerns over consolidation, pricing, and access intensify. California's expanded oversight of PE-backed transactions signals what could be ahead. That scrutiny, combined with reimbursement uncertainty, tariffs, and rising costs, slowed M&A activity in 2025; 43% of M&A deals were driven by financial distress. As regulatory scrutiny raises the cost and risk of large-scale consolidation, HPOs are responding with more disciplined capital deployment, favoring carve-outs and partnerships that focus on core capabilities while limiting regulatory and reimbursement exposure. To prepare for continued regulatory pressure, HPOs must:

- **Treat regulatory uncertainty as a strategic variable, not a risk to avoid.** HPOs must develop robust scenario planning, using the three-narrative approach, to navigate regulatory uncertainty and anticipate different policy and compliance landscapes. This avoids overcommitting to strategies that only work under one policy outcome and gives leadership confidence to move forward despite uncertainty. Cook County Health explicitly planned for Medicaid and Medicare payment pressure by diversifying revenue away from pure fee for service and modeling alternative payment scenarios as federal and state funding tightened. Leadership publicly framed value-based care as a hedge against anticipated Medicaid cuts and reimbursement volatility, not as a guaranteed policy outcome. The goal is to create an agile organization that can quickly pivot when regulatory landscapes change, protecting patient care and organizational stability.
- **Use partnerships to share regulatory risk.** HPOs don't need to absorb all the uncertainty alone. HPO leaders should deliberately shift some regulatory exposure to partners while retaining strategic control. They should set clear guardrails that define nonnegotiable compliance, data, and risk standards, while allowing partners operational flexibility within those boundaries. Kaiser Permanente tiers vendors based on data access, clinical criticality, and operational risk, with stricter

oversight, audits, and contractual controls for core functions, such as EHR access, PHI handling, and payment systems. Joint dashboards that integrate financial, operational, and risk metrics give executives continuous visibility without the need to micromanage day to day. Monitor compliance with real-time validation tools like dashboards and alerts. By adopting these approaches, health systems can create a strategic vendor management system that balances risk mitigation with innovation, ensures regulatory compliance, and maintains robust control over partner relationships.

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