

The Choices Forced by the Coming Healthcare Revolution

By Mike Eaton
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This is Part 2 in a series about the future of American healthcare. Read Part 1 here.

SCALE WITHOUT STRATEGIC CLARITY WILL NOT SAVE YOU

For decades, healthcare leaders operated under a comforting assumption: structural change would happen slowly.

That assumption no longer holds.

In *The Coming Healthcare Revolution: 10 Forces That Will Cure America's Health Crisis*, David W. Johnson and Paul Kusserow argue that the timeline for transformation has compressed from a decade to the next five years, perhaps sooner. The forces reshaping healthcare are moving faster than most organizations can adapt, exposing weaknesses that have been building for years.

Part 1 of this series argued that the traditional healthcare business model is losing its economic foundation. Demand is moving away from hospitals while cost structures remain anchored to inpatient utilization patterns built for a different era. Margin is migrating toward organizations that manage risk, control patient flow and coordinate care across distributed networks.



These are not trends but rather changes in the underlying economics of healthcare.

And when the economics change, strategy must follow.

THE END OF BEING EVERYTHING TO EVERYONE

Many of the assumptions that produced success over the last three decades are now working in reverse. Growth, diversification, geographic expansion and physician acquisition once strengthened the enterprise.

Today, they often increase complexity faster than they create value as enterprises grow larger without being clear about the business model and source of market advantage.

That emphasis on growth is anchored in a legacy belief that health systems became indispensable by acquiring or building hospitals, adding specialists and expanding into new markets. That belief drove systems to align primary care groups to feed those hospitals and specialists and to allocate strategic capital to offer more clinical services than competitors.

That model worked because hospitals sat at the center of the economic equation. High-margin service lines subsidized lower-margin activities. Volume growth covered inefficiency while scale created leverage.

Those conditions no longer exist.

Demand is shifting across settings and consumers have more options. Capital is flowing toward focused business models.

New competitors are entering healthcare without the burden of maintaining large physical infrastructure.

Most importantly, value is increasingly being captured by organizations that manage risk and orchestrate access across networks rather than simply owning the most assets.

The traditional department store offers a useful analogy. For decades, its breadth looked like an unbeatable advantage. Then focused competitors attacked individual categories with better economics and sharper execution. What once appeared to be strength became a collection of businesses held together by history rather than strategy.

Healthcare is entering a similar period of separation. Ambulatory surgery centers are capturing procedures while specialty platforms are consolidating high-value service lines. Risk-bearing primary care organizations are managing populations. Digital and retail entrants are competing for access and navigation.

The lesson is not that breadth and scale are bad, but that scale without a clear economic purpose becomes expensive. The strategic question is no longer how to offer more. It is deciding what role the organization intends to play in the emerging market.

CHOICE 1: WHAT BUSINESS ARE YOU ACTUALLY IN?

Most health systems answer this question reflexively: healthcare.

Ten years ago, that answer was sufficient. Today, it is not.

The market is organizing around three distinct economic models. One manages risk. One delivers specialized services with exceptional efficiency. One controls access and navigation.

Most health systems participate in all three. Few have decided which one defines the business they are in or its economics.

That matters because these models reward fundamentally different behaviors. Risk-bearing organizations win by reducing unnecessary utilization and managing total cost of care. Specialty platforms win through focus, standardization and operational excellence. Care orchestrators win by controlling patient relationships and directing demand.

The tension is obvious. One part of the organization is rewarded for filling beds. Another is rewarded for keeping people out of them. One side benefits from a broad clinical scope while the

other benefits from a performance-based focus. One succeeds by owning assets, and another succeeds by directing patients to the most efficient assets available — regardless of ownership.

Those are not complementary objectives. They are competing priorities.

The question is not whether organizations participate in all three models. Most will. The question is which model ultimately determines where margin comes from and how capital gets deployed.

A useful test is simple:

If 80% of future margin had to come from one model, which would it be and what would the organization stop doing to make that true?

The second half of that question is the important one because strategy is revealed less by what leaders choose than by what they are willing to stop doing.

CHOICE 2: OWN RISK OR BE PRICED BY THOSE WHO DO

If the first decision determines strategic identity, the second determines economic power.

For decades, hospitals possessed meaningful pricing leverage. Market position, physician alignment and geographic dominance translated into negotiating strength. That leverage is migrating.

Organizations that manage risk increasingly control the economic rules of healthcare. They establish total cost targets, design networks, orchestrate utilization and determine where care is delivered and what it is worth.

Everyone else operates within those constraints.

The rapid growth of Medicare Advantage illustrates the point. Success in that market is not primarily determined by ownership of hospitals. It is determined by control of the budget.

Once a budget is established, pricing becomes a consequence rather than a negotiation. Hospitals that cannot deliver care within those parameters face difficult choices. They can lower costs, accept lower reimbursement, lose volume or risk exclusion from preferred networks. That is what it means to be priced.

This is not an ideological debate about value-based care. It is a question of economic position.



CHOICE 3: ARE YOUR ASSETS AN ADVANTAGE OR CONSTRAINT?

This may be the most uncomfortable question because it challenges assumptions that have shaped health system strategy for decades.

Historically, assets represented strength. Hospitals, physician networks, facilities, technology and market presence created barriers to entry and supported growth.

Many still do. The problem is that assets move more slowly than markets.

Facilities cannot be resized overnight. Workforce structures are deeply embedded and community obligations, regulatory requirements and capital constraints limit flexibility. Meanwhile, many of the fastest-growing opportunities in healthcare require different economics, different operating models and different investments.

As a result, many organizations find themselves funding tomorrow's business while carrying the cost of yesterday's infrastructure. That tension is unavoidable. The strongest organizations do not eliminate it. They manage it better than their competitors.

Doing so requires confronting realities many leadership teams would rather postpone. Not every asset deserves

protection and not every business line deserves additional investment. There are limits to the number of opportunities that can be funded.

Capital allocation is becoming a strategy in its purest form. The organizations that outperform will not necessarily have more resources. They will simply be more disciplined about where those resources go.

WHEN AVOIDANCE BECOMES STRATEGY

Faced with these choices, many organizations default to a familiar response: preserve optionality.

They pursue fee-for-service growth while preparing for risk. They expand ambulatory capacity while protecting inpatient utilization and form partnerships without defining their strategic role.

The instinct is understandable. The consequences are not.

Different economic models require different operating systems, incentives and performance management capabilities and goals. Getting the right mix of models, incentives and goals requires systems to know what business they are in and how they will show up in the market and succeed. That requires choices to be made and is why the greatest risk is not choosing the wrong strategy but refusing to choose at all.

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Mike is widely recognized for his ability to help boards and executive teams navigate periods of disruption and change. He has successfully brought two healthcare IT companies from concept to market exit and is a frequent advisor to organizations exploring new operating models, digital health strategies, AI-enabled care delivery, and consumer-centered transformation.