HEALTH MANAGEMENT TheAcademy

Strategy Catalyst

Service Line Portfolio Strategy in 2026

Where Health Systems Are Growing; How They Are Rationalizing; and What Leaders Regret the Most

June 2026

Survey Overview

The 2026 Strategy Catalyst Service Line Portfolio Strategy Survey[1] sampled 40 Chief Strategy Officers, Chief Operating Officers, EVPs/VPs of Strategy and Operations, and service line executives across U.S. health systems with over $500M in annual net patient revenue (NPR). The survey investigated how health systems balance financial performance with access, quality, and mission as they optimize their service line portfolios. It explored which service lines are sustained as core pillars for strategic or mission-critical reasons, the factors shaping portfolio decisions, and how service line strategy is evolving in practice.

40 Respondents

14 Service lines assessed

$5B Median NPR

Table of Contents

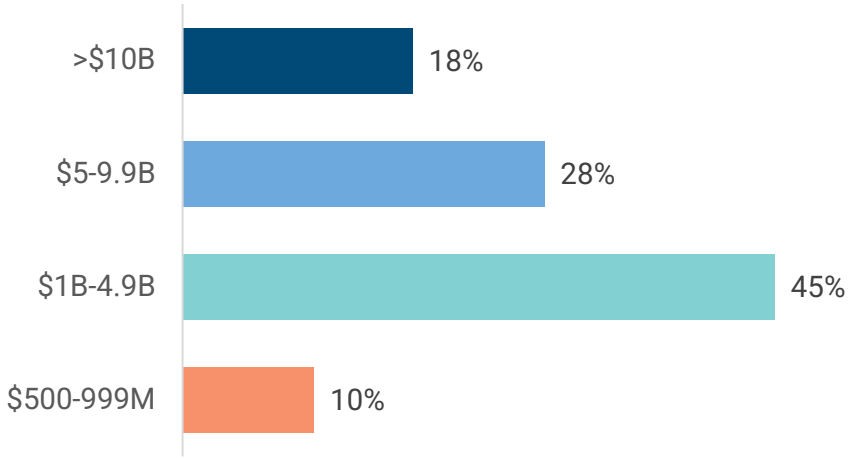
1. This survey was conducted in partnership with a vendor who fielded the survey. Strategy Catalyst members were also given the opportunity to participate.

Survey Demographics Snapshot

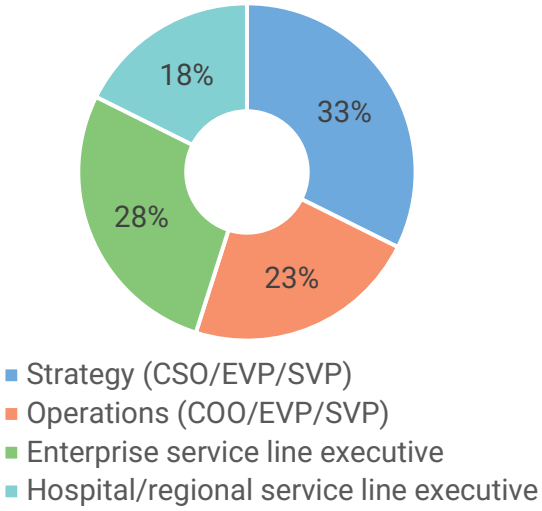
System characteristics: 95% not-for-profit | 48% include at least one academic medical center

Respondents' highest level of influence: 33% system-level decision maker | 25% provide input into system-level strategy but do not make final decisions | 18% local/regional decision maker | 25% provide input into local/regional strategy

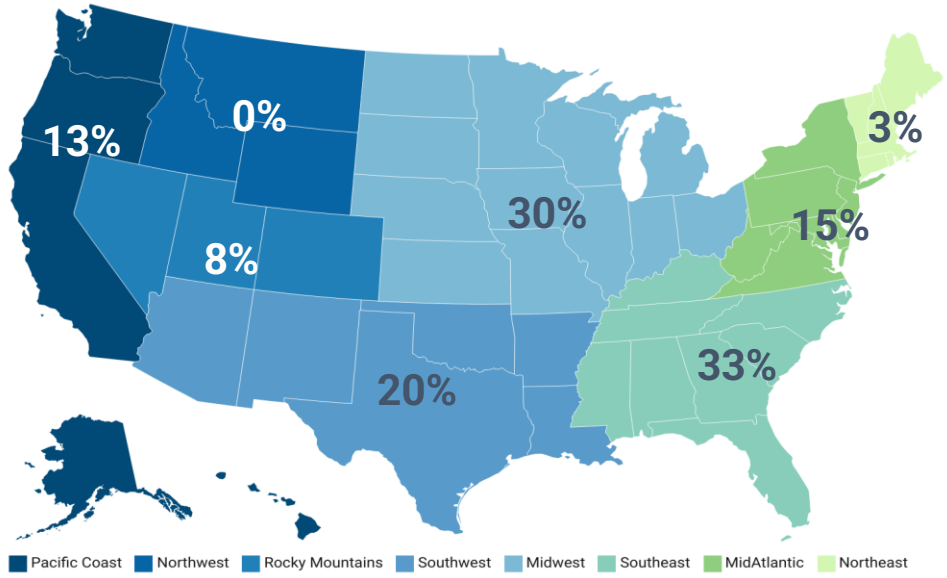
System Revenue Size (Annual NPR)



Respondents by Title



The survey data represents input from health systems operating across **7 regions**, with the Southeast (33%), Midwest (30%), and Southwest (20%) regions well-represented. [1]



1. Regional totals exceed 100% because some systems operate in multiple regions and selected more than one.

Service Line Definition and Governance

70% of systems agree on the top three defining elements of a service line.

#1 **A clinically integrated set of services with a cross-continuum footprint (83%)**

#2 **Accountability to financial performance (75%)**

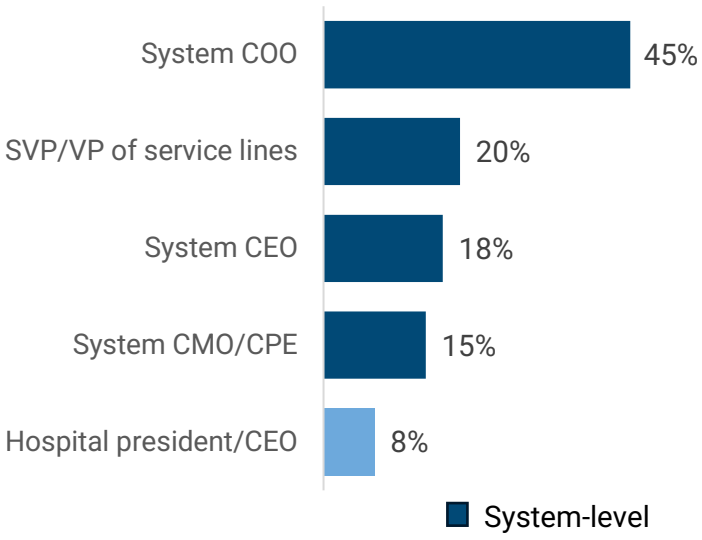
#3 **A defined clinical scope (70%)**

Reporting lines vary across service line leadership.

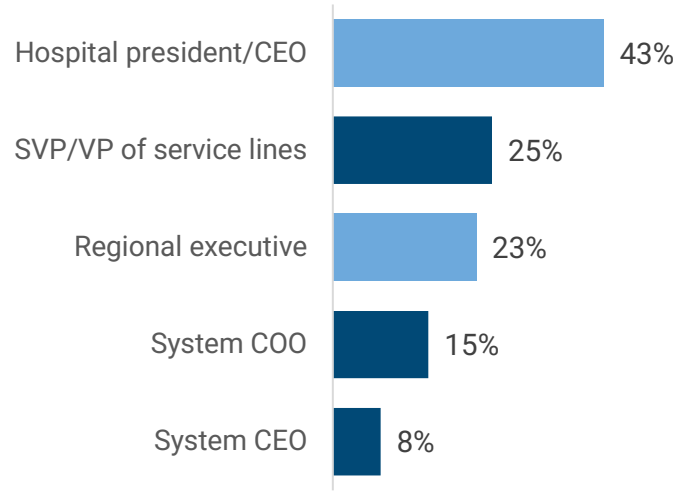
System-level service line executives report primarily to the system COO (45%), while hospital service line leaders report to the hospital CEO (43%)—creating structurally distinct accountability chains within the same service line depending on whether leaders sit at the system or local level.

System-level service line executives report to:

Percentage of respondents[1]



Hospital-level service line leaders report to:



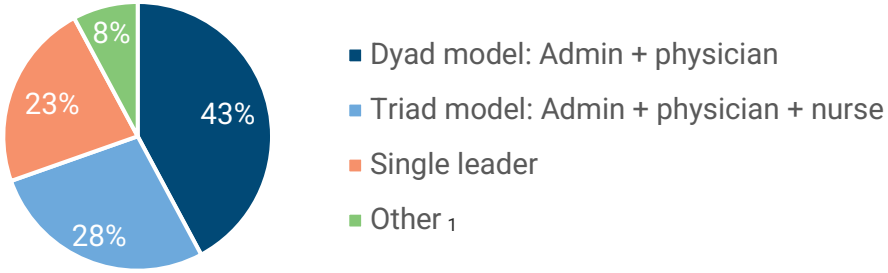
These split reporting chains risk fragmenting priorities between the system and facility levels, which makes alignment mechanisms essential: shared decision-making protocols, unified performance metrics, and incentives tied to system-level goals.

1. The graph shows the five most common roles to which service line leaders report.

Service Line Leadership Structure Is Still Evolving

A dyad leadership model is now the most common, but a quarter of health systems have not made the shift from the single-administrator leadership model.

Which of the following best describes the leadership team over the hospital service line level?



Findings in the Broader Market

The field shifted from majority-single-administrator to majority-dyad across the 2010s. [2] The current split in the market is whether to expand from dyad to triad.

2019

- Dyad adoption reached 72-77% across health systems.[3,4]

2026

- Only 5% of health system CXOs reported having no experience with dyads or triads.[5]
- 40% of leaders have worked with triads.[5]

So what?

For most systems, the question is no longer whether to share service line leadership. The more timely question is whether a triad model meaningfully improves service line governance beyond the benefits of a dyad.

- Triads effectively improve clinical outcomes and patient safety and quality. However, triads have less impact on financial and workforce challenges, areas that remain top system priorities.[5]
- The success of a triad model depends on navigating organizational barriers. Hierarchical culture, power dynamics, and overlapping responsibilities may limit triad effectiveness as they do in dyad models.[5]
- To fully realize the benefits of triad leadership, health systems must move beyond structure alone by clearly defining roles and decision rights, aligning financial and workforce outcomes, and building a shared vision.

1. Respondents who selected "Other" cited matrixed reporting with hospital CEOs/presidents or noted it varies across service lines.

2. AHA, 3. MGMA, 4. NEJM Catalyst Insights Council, 5. Jackson Physician Search and Kirby Bates Associates

Shared Authority: How Systems Actually Govern Service Lines

Only partnership decisions are made primarily at the system level. Because no decisions are owned solely by any one function, cross-functional coordination is central to how service line governance operates.

Which statement best describes the balance of system-level service line decision-making at your health system?

Percentage of respondents

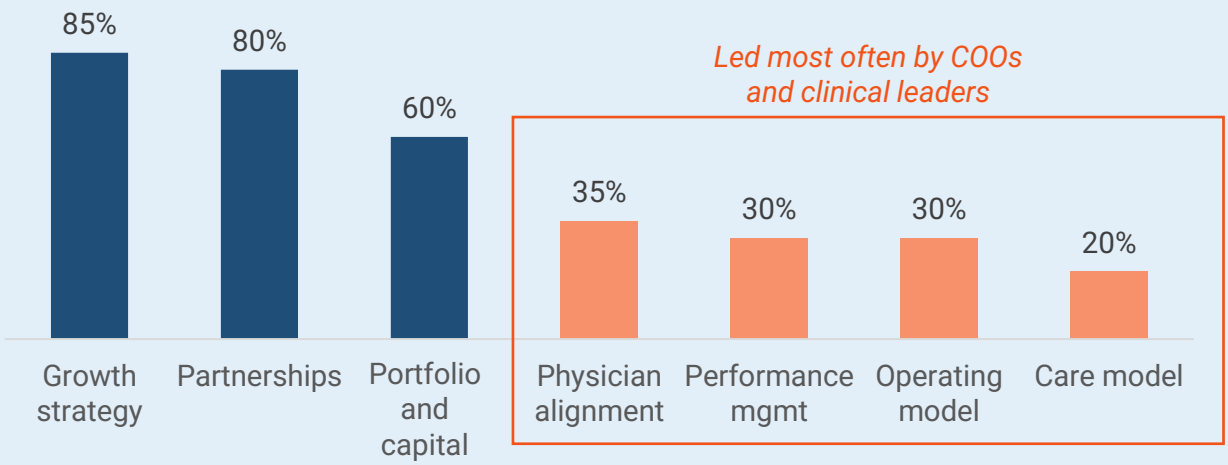
1. **System partnerships** (most centralized)
   45% system | 40% shared | 10% hospital
2. **Operating model & governance**
   38% system | 38% shared | 13% hospital
3. **Performance management**
   33% system | 50% shared | 13% hospital
4. **Enterprise growth**
   35% system | 50% shared | 8% hospital
5. **Physician alignment**
   28% system | 45% shared | 13% hospital
6. **Capital prioritization** (most shared)
   25% system | 58% shared | 10% hospital
7. **Care model standardization**
   18% system | 55% shared | 15% hospital

The Strategy Mandate: Growth, Partnerships, and Portfolio/Capital Decisions

CSOs and EVPs/VPs of Strategy are well-positioned to set direction on growth and partnerships but lack ownership over the core delivery levers (physician alignment, performance management, and care model decisions). Service line strategy execution depends on how effectively strategy, clinical, and operational leaders translate strategic priorities to operational decision-making.

Which decisions is the strategy function (CSO, EVP/VPs of Strategy) primarily responsible for?

Percentage of respondents



Section I:

The Valuation Paradox

Section Preview:

1. **Stated values vs. actual decisions:** Leaders say mission, quality, and margin matter equally; financial signals are what drive service line decisions in practice.

2. **Mission vs. margin:** Margin classification tracks with recent margin trajectory while mission is not a strong indicator. Health systems are expanding broadly, including lower margin service lines.

Survey Questions Covered in This Section

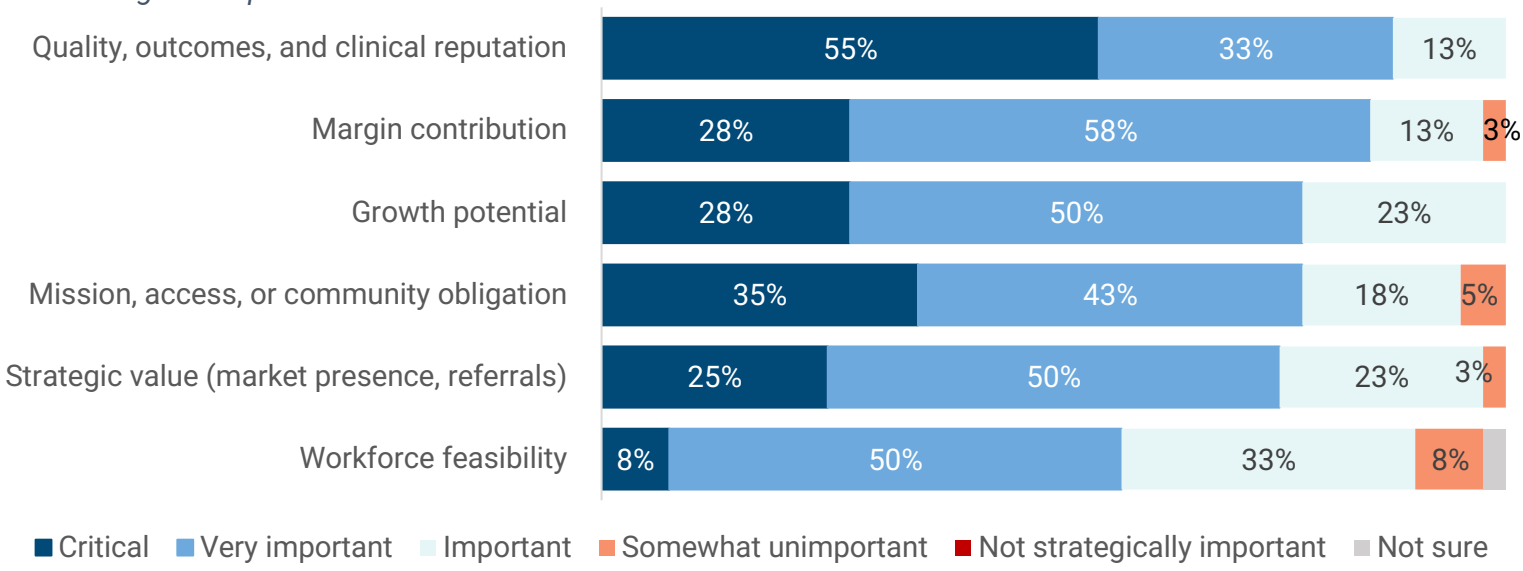
- How strategically important are the following factors—margin contribution, growth potential, mission/access/community obligation, quality/clinical reputation, workforce feasibility, strategic value—when assessing the value of a given service line in your overall system portfolio?
- Which factors most influence enterprise-level service line portfolio decisions?
- What are the trigger points that determine when your health system chooses to expand, divest, or partner within a given service line?
- How would you characterize the service line's role at your health system: core to mission, core margin contributor, strategically important but financially volatile, at risk/break even, structurally margin negative?
- How has the operating margin changed over the past 2-3 years for each service line?
- What are the strategic shifts underway within each service line: actively expanding, partnering/JV, consolidating locations, shifting site of care, reducing service scope, no material change, preparing to exit, exited within the last 24 months?

Finding 1: Leaders say mission, quality, and margin matter equally; financial signals are what drive service line decisions in practice.

Stated values are balanced. Decision drivers are not.

When asked to rate the strategic importance of factors contributing to a service line's value, leaders ranked "**quality, outcomes, and clinical reputation**" as the most critical. Three-quarters or more rated five of six strategic factors as "very important" or "critical."

How strategically important are the following factors when assessing the value of a given service line in your overall system portfolio today?
Percentage of respondents



Comparing that to the question about what most influences portfolio decisions, **payer mix** and **reimbursement sustainability** top the list. Quality still makes the top 5 but drops to 33%. At the abstract valuation level, mission and quality sit alongside margin in the top tier of importance. At the execution level, portfolio decisions are based almost entirely in financial and market signals.

Which factors most influence enterprise-level service line portfolio decisions today? Select up to 5.
Percentage of respondents selecting each factor

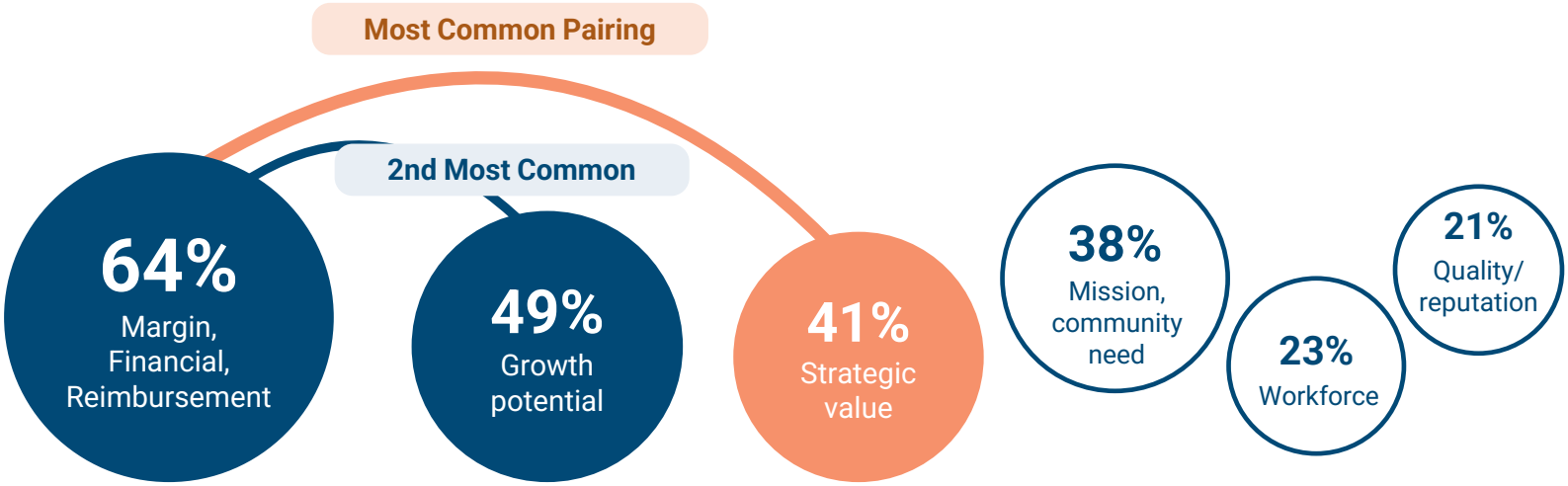
- #1 Payer mix and reimbursement sustainability (70%)
- #2 Physician supply, subspecialty depth, recruitment (60%)
- #3 Market share trends and outmigration (58%)
- #4 Downstream revenue or 'halo' effects (58%)
- #5 Volume-outcomes / quality thresholds (33%)

Portfolio decisions are a joint test of service line finances and strategic role.

While there is **no single trigger** that leads health systems to expand, divest, or partner within a given service line, **margin contribution** and **strategic value** (e.g., market presence, downstream revenue, referral capture) appeared most frequently together in responses. Margin contribution and growth potential were the second most common pairing.

What are the trigger points that determine when your health system chooses to expand, divest, or partner within a given service line?

The most common pairings in individual responses arc across the spectrum.
Percentage of open-text responses



*"Expand: **market share** falling below 20%; availability of strong clinical talent. Divest: repeated **margin pressures** below 2%; inability to achieve **quality/safety** volumes; loss of **physician leadership.**"*

— Chief Operations Officer

*"Expand: sustained **volume growth** above market average; favorable demographics; unmet **community need**; clear differentiation on **quality**, **access**, **reputation**."*

— EVP of Strategy

So what?

Mission obligations are non-negotiable for most non-profit systems, meaning mission-critical lines are rarely exited for financial reasons. Therefore, the question is never whether to cross-subsidize mission lines but whether the governance infrastructure exists to do it sustainably.

- Service lines whose value rests on margin or market signals are well-served by current decision machinery. Service lines whose value rests primarily on mission or quality are not.

- Portfolio discipline on mission-anchored lines must be intentionally built. The finding that systems might 'value' a service line because of mission or quality while still making business decisions based on margin is not necessarily a contradiction. However, health systems should consider:
  - Aligning stated valuation to actions or building the governance mechanisms to incorporate quality and mission in capital decisions.
  - Clearly naming where the organization will not achieve positive margin or invest, rather than continuing to signal priorities that aren't meaningfully supported by financial, strategic, or operational focus.

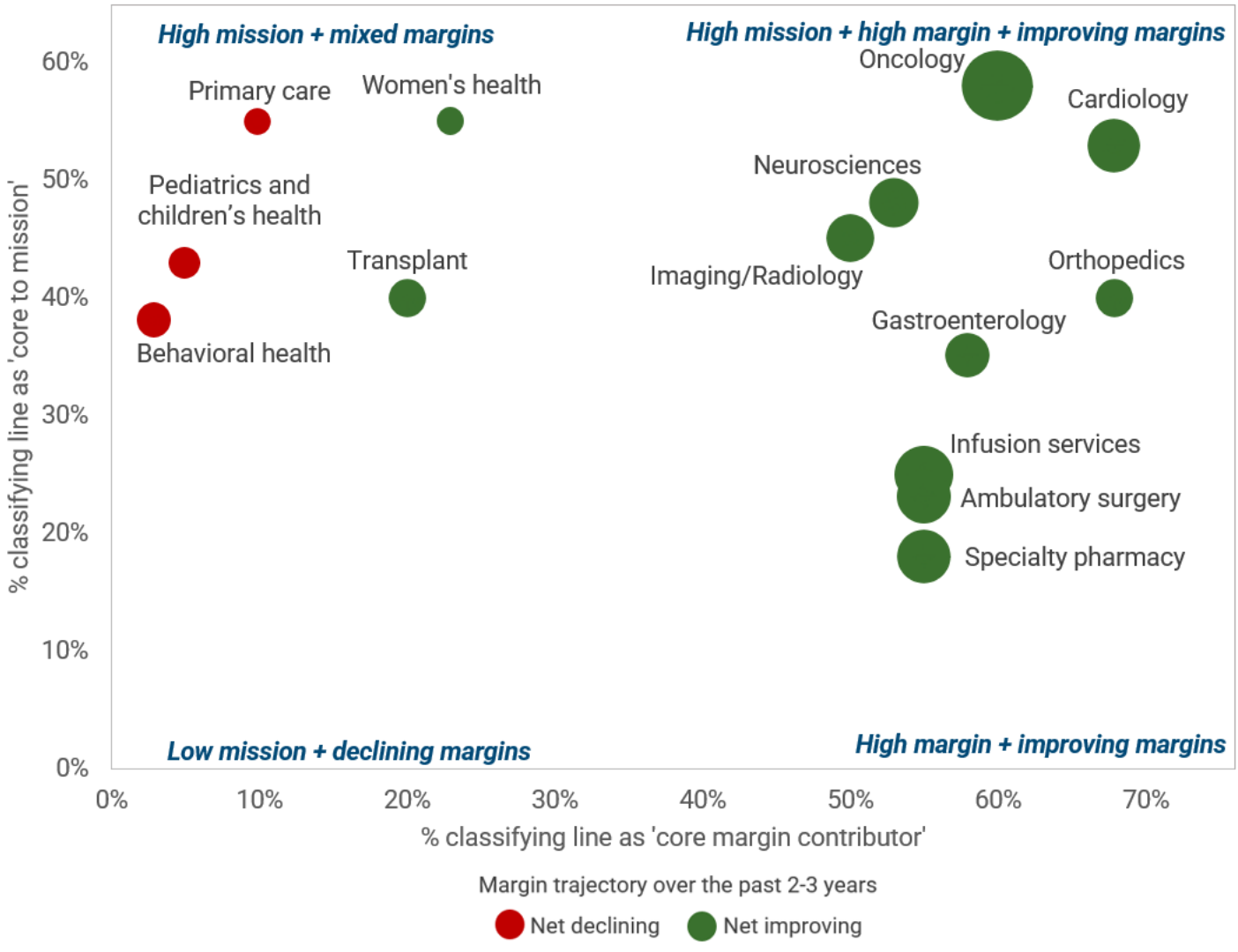
> *"We have to do enough of the well-paying services to fund our mission. That mission includes care that doesn't pay well, like behavioral health."*
>
> *— VP of Strategy*

Finding 2: Margin classification is a stronger indicator of margin trajectory than mission classification. That being said, systems are broadly expanding service lines, including some with lower margins.

Oncology and cardiology are key high-mission lines with strong margin performance. Primary care and pediatrics are high-mission lines with negative margin trajectory.

This chart maps how strongly leaders designated each service line as a margin contributor versus a mission obligation. The bubble color indicates whether margin has net improved (% of systems reporting margin improved minus % reporting margin declined) or net declined over the past 2-3 years. The bubble size corresponds to the magnitude of the net trajectory (e.g., oncology—the largest bubble—presents the greatest improvement-to-decline ratio).

How would you characterize the service line's role at your health system?

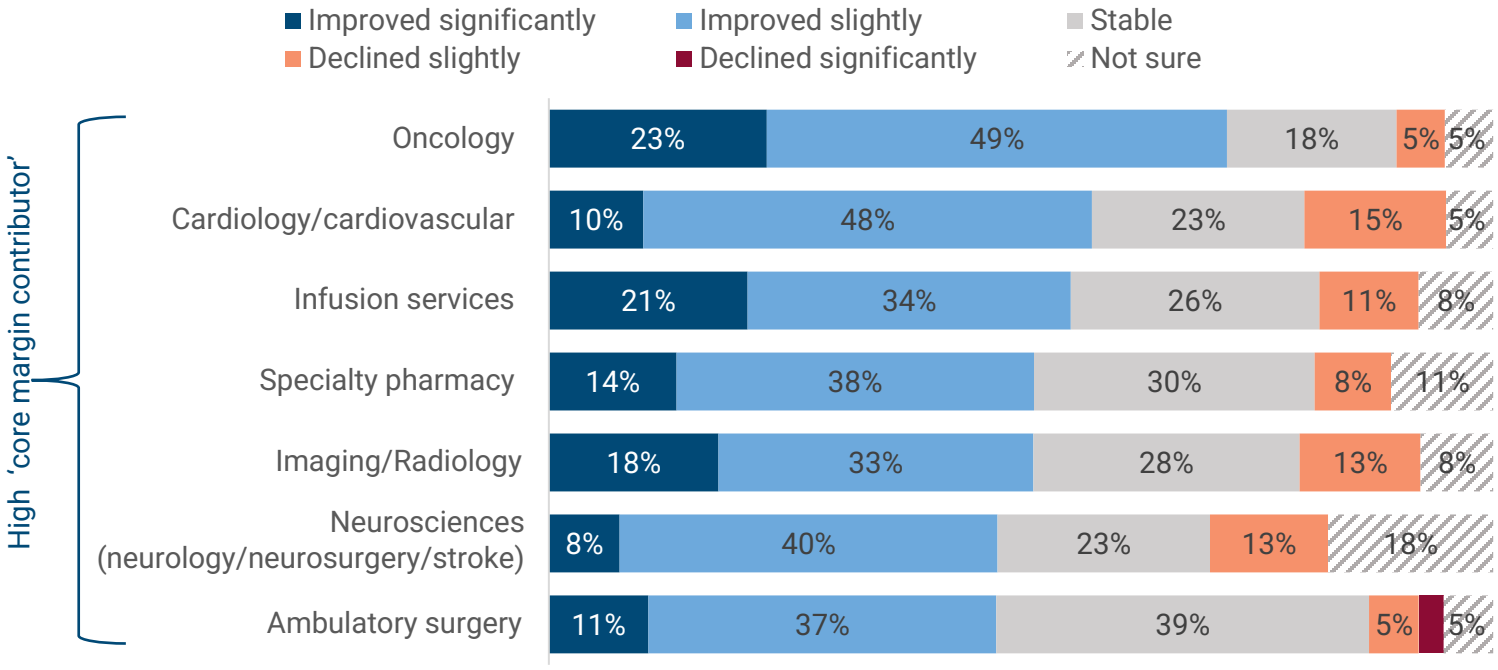


A subset of service lines strongly identified as 'core to mission' but not strongly identified as 'core margin contributors' are losing financial ground.

How has the operating margin changed over the past 2-3 years for each service line?

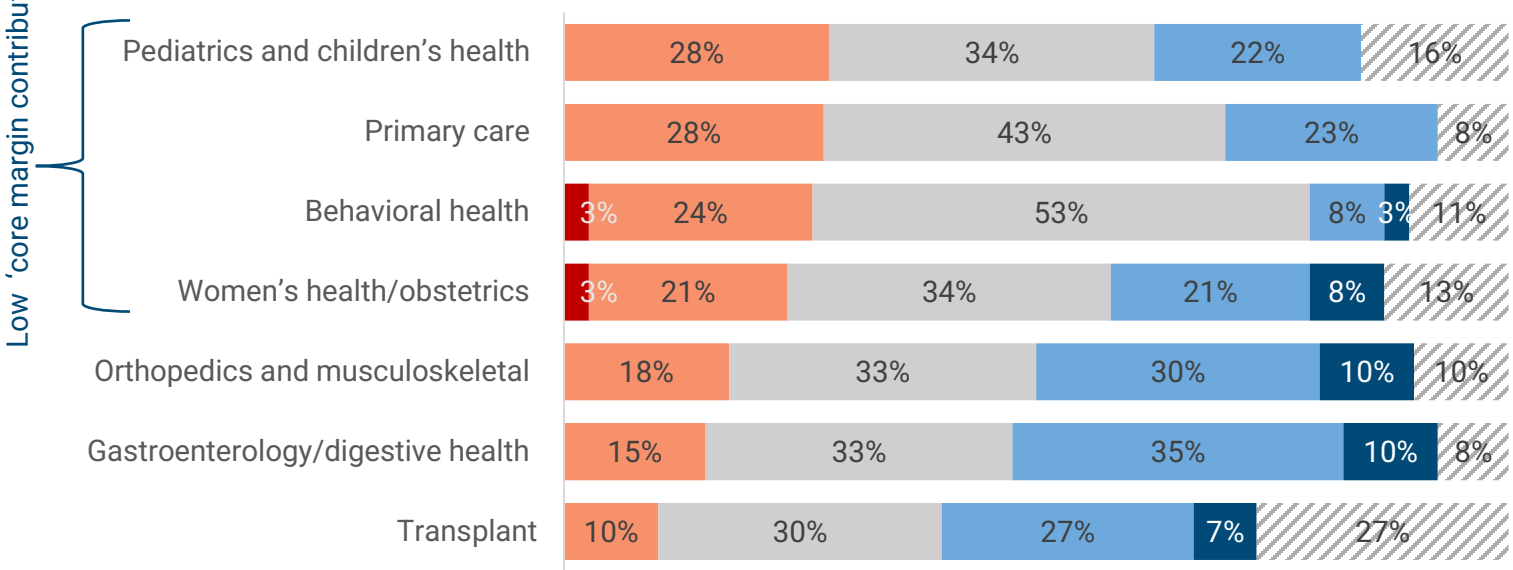
Percentage of respondents

Greatest improvements: Oncology, cardiology/cardiovascular, infusion



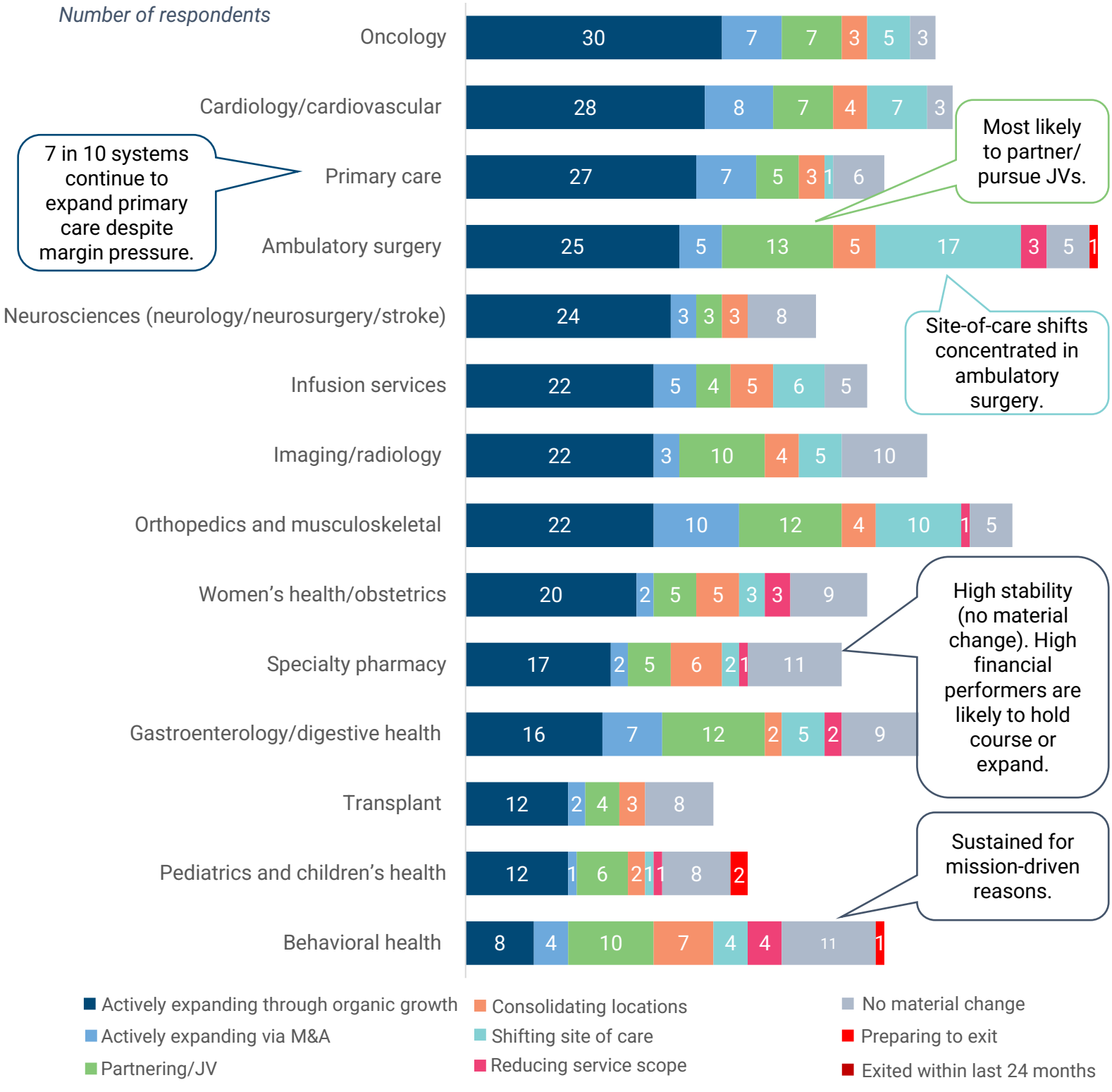
Greatest declines: Pediatrics and children's health, primary care, behavioral health. These mission-anchored lines are, at best, drifting towards stability.

- Transplant: Most positive trend of any mission line but with high uncertainty.
- Women's health: Volatile and effectively neutral.



Most systems are broadly expanding service lines. No system surveyed has exited a service line within the past 2 years, with portfolio adjustment favoring partnerships and consolidation over exits.

What are the strategic shifts underway within each service line? (Select all that apply.)



Where does each service line go from here?

Oncology, cardiology/cardiovascular, neurosciences, imaging	Mission and margin are aligned, making the expansion decision straightforward.
Gastroenterology, infusion services, ambulatory surgery, specialty pharmacy, orthopedics	Holding steady or expanding with uniformly improving margins.
Transplant, women's health	Sitting in an ambiguous middle. Transplant margins are reported with high uncertainty, while women's health is effectively flat and too close to call in either direction.
Primary care, pediatrics	Expanding despite declining margins, but the inflection point that shifted behavioral health's posture hasn't arrived yet.
Behavioral health	Financial pressure beginning to override expansion.

So what?

The valuation paradox raises a hard question: what, if anything, should trigger a formal review of portfolio decisions for service lines that are losing financial ground?

- Behavioral health is the one mission-anchored line where financial pressure has begun to slow growth—yet notably, most health systems have not exited. Instead, they are consolidating and deepening partnerships, signaling that mission commitment remains a floor even under strain.
- For primary care—and to a lesser extent pediatrics—continued growth against a negative financial trend points to the role of indirect and downstream revenue. These lines function as system entry points whose value is not fully captured in their own margins.