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Americans Are Open to AI in Healthcare, but Want Humans Making Final Calls

U.S. adults are split on whether AI will improve patient health and pessimistic about its impact on patient-doctor relationships

BY Eileen Yam, Emma Kikuchi and Giancarlo Pasquini

FOR MEDIA OR OTHER INQUIRIES

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About this research

This Pew Research Center report looks at Americans' views of artificial intelligence's impact on U.S. healthcare.

Why did we do this?

Pew Research Center does research to help the public, media and decision-makers understand important topics. This research builds on our work studying Americans' views on AI in healthcare.

Learn more about [Pew Research Center](#) and our research on artificial intelligence, [health](#) and other topics at the [intersection of science and society](#).

How did we do this?

For this report, we surveyed 3,488 U.S. adults from June 22 to 28, 2026. Everyone who took part in this survey is a member of the Center's [American Trends Panel](#). The survey represents the views of the full U.S. adult population.

Here are the [survey questions](#) used for this report, the [detailed responses](#) and the [survey methodology](#).

Americans Are Open to AI in Healthcare, but Want Humans Making Final Calls

U.S. adults are split on whether AI will improve patient health and pessimistic about its impact on patient-doctor relationships

Key takeaways:

- Americans are generally open to AI handling administrative and medical tasks, but they largely don't want AI operating without human oversight.
- The largest share is open to AI - either on its own or with human review - translating for patients, and the smallest share is receptive to AI deciding on health insurance claims.
- A majority (60%) is uncomfortable with AI being used for healthcare tasks like diagnoses and treatments, double the share who says they're comfortable (30%).
- Americans are split on whether the use of AI in health and medicine would improve or worsen patient outcomes. Young adults have grown more pessimistic since 2022.
- About half say AI would worsen the patient-doctor relationship and security of patient health information, but about three-in-ten say it could improve healthcare access. And large shares are unsure about AI's impact.

At a time of robust [discussion](#) and [research](#) about whether artificial intelligence can do a better job than doctors, a new Pew Research Center survey finds that U.S. adults are open to AI use for certain healthcare tasks, particularly administrative work. But Americans still want a [human in the loop](#), reviewing what AI does.

This study explores Americans' views on how artificial intelligence may affect U.S. healthcare and their comfort with AI playing different roles at the doctor's office. This builds on our previous research looking at AI's impact on healthcare and health information. It's based on a survey of 3,488 U.S. adults conducted June 22-28, 2026.

Related: [Americans want transparency when AI is used in their healthcare](#)

Americans are generally open to AI in healthcare but want human oversight

Americans' openness to AI doing different healthcare tasks – either alone or with human review – depends on what's at stake.

When asked if they are open to AI use in eight healthcare tasks we asked about, solid majorities of Americans are receptive to AI translating for patients and scheduling, either on its own or with human review. But the largest shares want a human doing a final review when AI is used for these roles.

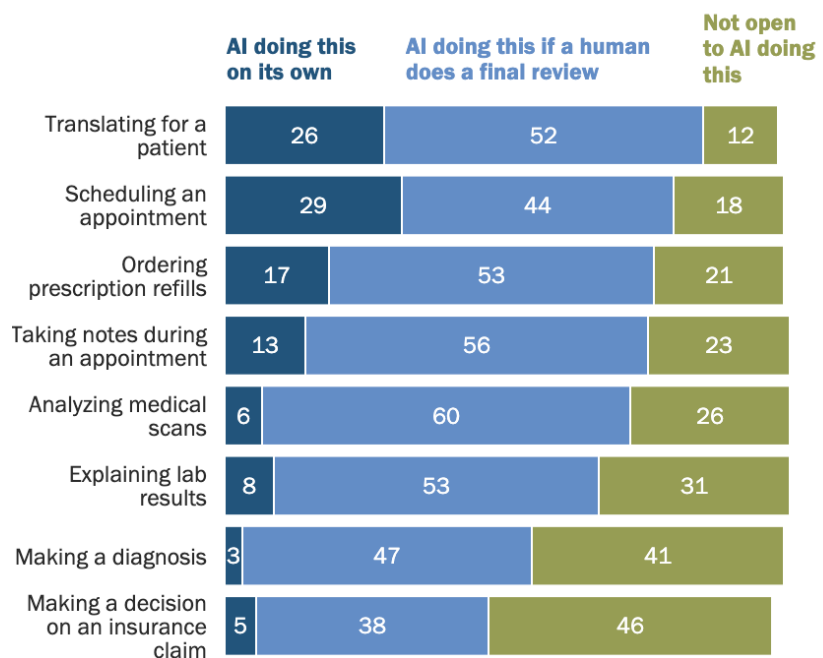
For instance, about eight-in-ten (78%) are open to AI translating for a patient either with a human final review (52%) or AI doing this totally on its own (26%). A small share (12%) says they don't want AI to have any part in translation.

Americans also are receptive to AI playing a role in analyzing and explaining results from medical scans and lab tests.

About half or more are open to AI handling these tasks with human review.

Americans generally want humans reviewing what AI does in healthcare

When it comes to AI doing each of the following as part of healthcare, % of U.S. adults who say they are open to ...



Note: Respondents who gave other responses are not shown.

Source: Survey of U.S. adults conducted June 22-28, 2026.

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The openness drops off for decisions that directly drive diagnoses or insurance decisions. For example, nearly half (46%) do not want AI to have anything to do with making insurance claim decisions. And just 5% are open to AI making these calls on its own, with no human review. There are similarly tepid views on AI making diagnoses on its own.

Previous Center research found a similar pattern in Americans' expectations about being informed about AI in their healthcare: They especially wanted transparency when AI is used in [more direct medical decisions](#), compared with back-office administrative tasks.

Greater openness among Asian Americans and those with higher education and income levels

Asian adults are more likely than those of other racial and ethnic groups to be open to AI being used for several healthcare tasks we asked about, including diagnoses and insurance decisions. For example, 65% of Asian adults are open to AI playing some role in decisions on health insurance claims, significantly higher than the shares of White (40%), Hispanic (45%) and Black Americans (39%) who are receptive. This finding aligns with previous Center research showing [more positive views of AI among Asian Americans](#).

For all eight healthcare tasks we asked about, Americans with higher education and income levels are more likely than those with the lowest levels to be open to AI being used, either with human review or by itself. For instance, 86% of upper-income Americans are open to AI being used for prescription refills, compared with 59% of lower-income adults.

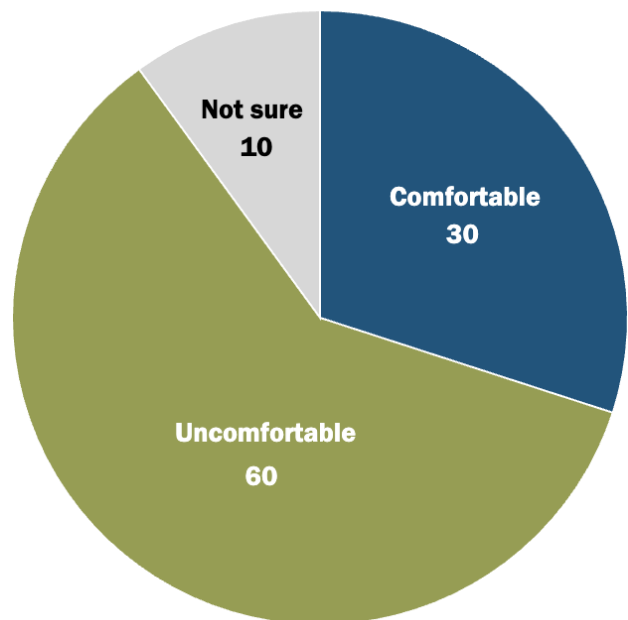
How comfortable are Americans with their own doctor using AI for things like diagnoses and treatments?

Echoing their mixed reactions to AI handling higher-stakes medical decisions, **a majority of Americans (60%) are uncomfortable with AI in their own healthcare for tasks like diagnoses and treatment.** That's double the share who says they're comfortable (30%).

Americans of higher education and income levels are more likely to say they're comfortable with AI playing this role in their healthcare. (Refer to [Appendix](#) for findings by demographic group.)

Majority of Americans uncomfortable with their doctor using AI for things like diagnoses and treatments

% of U.S. adults who say they would feel ___ if their doctor used AI for things like diagnoses and treatments



Note: Respondents who did not answer are not shown.
Source: Survey of U.S. adults conducted June 22-28, 2026.
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Will AI improve patient health outcomes?

Supporters say AI has the potential to [transform healthcare for the better](#). But while Americans express some openness to AI playing a role in healthcare, they are split on whether it will lead to better patient health outcomes.

Some 37% of Americans say the use of AI for things like diagnoses and treatments will lead to *better* health outcomes. A similar share (36%) says it will lead to *worse* health. And 26% say AI in healthcare will not make much difference one way or the other.

The public's views on this have largely [remained unchanged since we last asked this in 2022](#).

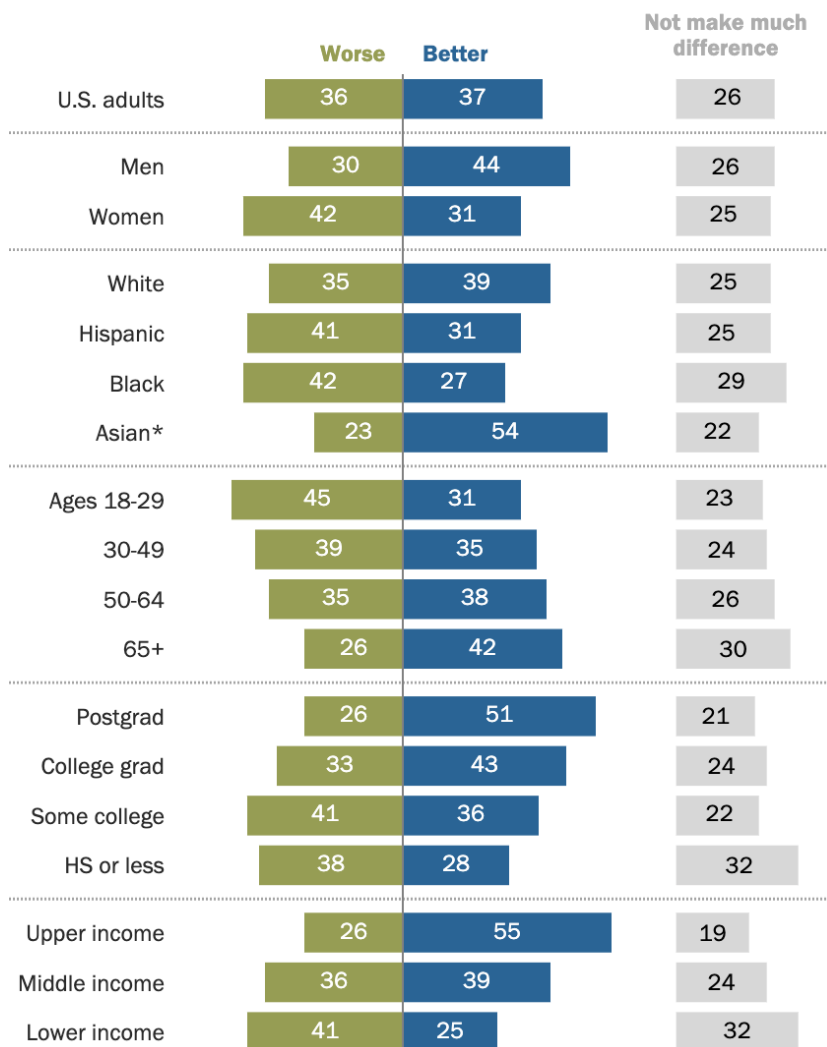
Some groups are more optimistic than others

Men, Asian adults, adults 65 and older, and those with higher levels of education and income are more positive than negative about the impact of AI on patient health.

For example, 55% of upper-income adults say AI will lead to better patient health outcomes.

Americans are split over whether AI will make patient health outcomes better or worse

% who say using AI for things like diagnoses and treatments will lead to ___ patient health outcomes



* Estimates for Asian adults are representative of English speakers only.

Note: Respondents who did not answer are not shown. White, Black and Asian adults include those who report being only one race and are not Hispanic. Hispanic adults are of any race. Family income tiers are based on adjusted 2024 earnings. Source: Survey of U.S. adults conducted June 22-28, 2026.

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Far fewer say it will lead to worse outcomes (26%) or will not have much of an impact (19%).

In comparison, a quarter of adults with lower incomes say the use of AI will lead to better health outcomes. A larger share (41%) says it will make it worse, and 32% don't think it will make much difference.

Young adults have grown more pessimistic

Younger adults are among the most pessimistic about the impact of AI on patient outcomes. For example, 45% of adults under 30 say the use of AI will lead to worse health outcomes, compared with 31% who say it will lead to better outcomes.

But this wasn't always the case. In 2022, younger adults were on balance more optimistic toward the use of AI in healthcare. There's been an uptick in negativity among the youngest adults – from 29% in 2022 to 45% in 2026.

Adults ages 65 and older take the opposite view: The largest share (42%) says the use of AI will better patient health. This share has increased 8 percentage points since we last asked this in 2022.

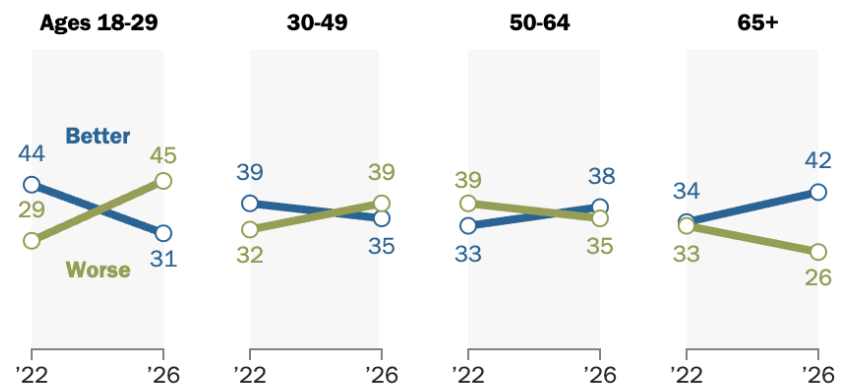
Still, the oldest adults are not wholesale positive: 26% still say AI will worsen patient health, and 30% say it will not make much difference.

Related: [*Young adults in the U.S. are increasingly wary of AI, concerned it will take jobs*](#)

Hispanic and Black adults have also become more pessimistic [since 2022](#), with the shares who say the use of AI will worsen health outcomes increasing 11 and 12 points, respectively.

Younger Americans have become more likely to say AI will lead to worse health outcomes since 2022

% of U.S. adults who say using AI in healthcare for things like diagnoses and treatments will lead to ___ patient health outcomes



Note: Respondents who answered "Not make much difference" or did not answer are not shown.

Source: Survey of U.S. adults conducted June 22-28, 2026.

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Do Americans think AI will worsen or improve healthcare availability, costs and patient-doctor relationships?

AI's impact on healthcare may extend beyond just health outcomes, potentially transforming [patient-doctor relationships](#) and [access and privacy](#).

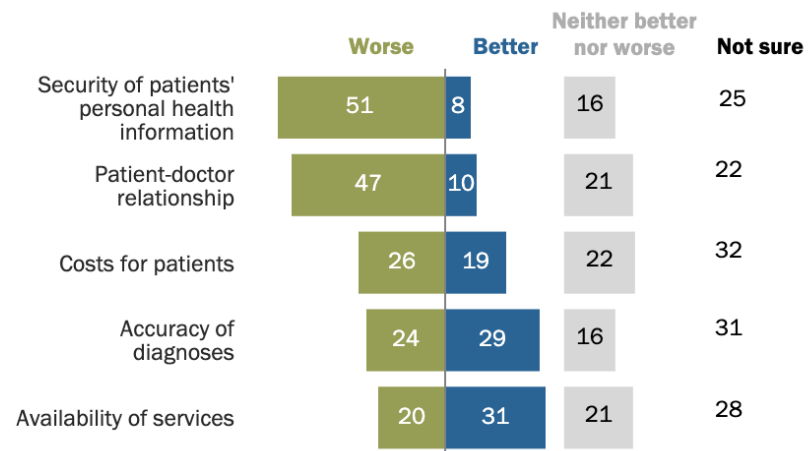
When asked about AI's impact on five dimensions of healthcare, 22% to 32% of Americans say they aren't sure how AI may affect them.

But when they do express opinions one way or the other, **Americans are especially pessimistic about AI's impact on the security of patients' health information and the patient-doctor relationship.**

Americans have [concerns about data privacy](#) when it comes to AI. When it comes to safeguarding sensitive patient data, Americans aren't confident their personal information will be protected as AI reshapes healthcare. Far more say AI will make the security of personal health information worse (51%) than say it will make it better (8%).

About half of Americans think AI will make the patient-doctor relationship relationship, security of patients' health information worse

% of U.S. adults who say that, thinking about healthcare in the U.S., AI will make each of the following ...



Note: Respondents who did not answer are not shown.

Source: Survey of U.S. adults conducted June 22-28, 2026.

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And at a time when many see AI [eroding human connection](#) in general, 47% say AI will make the relationship between patients and their doctors worse, compared with 10% who say it will make it better.

Views of AI's impact on the costs of healthcare also tilt negative, but by a much narrower margin: 26% say AI will make costs worse, while 19% say AI will make it better.

But it's not all negative. Americans see benefits to the use of AI in some areas of healthcare. **On the positive side, more say AI will improve access to healthcare services than worsen it (31% vs. 20%).** Views of AI's effect on the accuracy of medical diagnoses also lean more positively, though opinions are more closely divided.

Who do Americans trust to make sure AI is used in patients' best interest?

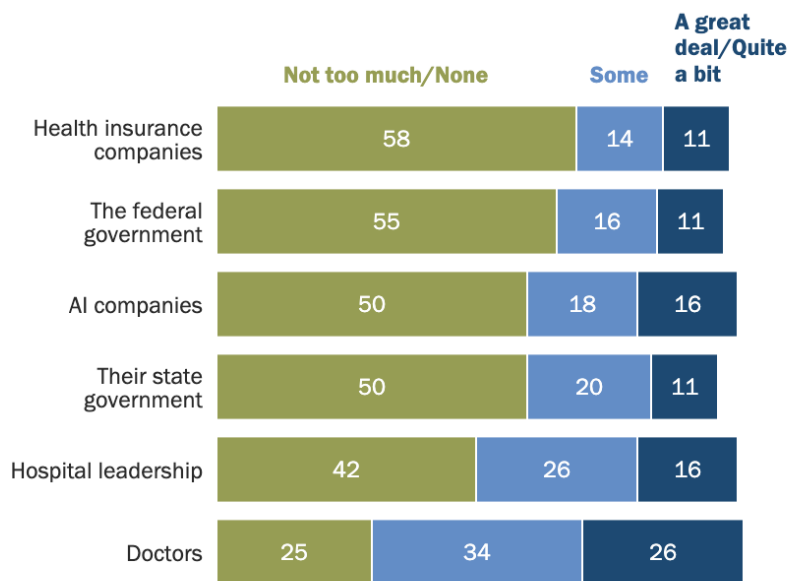
AI is being used in healthcare [faster than policies are being written to regulate it](#). And Americans don't have much confidence in many institutions and actors to make sure AI is used in patients' best interests.

For four of six actors we asked about – health insurance companies, federal government, AI companies and state government – half or more Americans have low or no confidence they can ensure healthcare AI is putting patients first.

Americans tend to express more confidence in doctors: 26% have a great deal or quite a bit of confidence in them, while 25% have not too much or none. The largest share (34%) has some confidence in doctors.

Low confidence in insurance and AI companies, government to ensure AI works in patients' interests

% of U.S. adults who say they have ___ (of) confidence in each of the following to make sure AI is used in the best interest of patients



Note: Respondents who gave other responses of "Not sure," "They don't have this responsibility" or did not answer are not shown.

Source: Survey of U.S. adults conducted June 22-28, 2026.

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Methodology

The American Trends Panel survey methodology

Overview

Data in this report comes from Wave 195 of the American Trends Panel (ATP), Pew Research Center’s nationally representative panel of randomly selected U.S. adults. The survey was conducted from June 22 to 28, 2026. A total of 3,488 panelists responded out of 4,069 who were sampled, for a survey-level response rate of 86%.

The cumulative response rate accounting for nonresponse to the recruitment surveys and attrition is 3%. The break-off rate among panelists who logged on to the survey and completed at least one item is 1%. The margin of sampling error for the full sample of 3,488 respondents is plus or minus 1.8 percentage points.

The survey includes an [oversample](#) of non-Hispanic Asian adults in order to provide more precise estimates of the opinions and experiences of this smaller demographic subgroup. These oversampled groups are weighted back to reflect their correct proportions in the population.

SSRS conducted the survey for Pew Research Center via online (n=3,362) and live telephone (n=126) interviewing. Interviews were conducted in both English and Spanish.

To learn more about the ATP, read “[About the American Trends Panel](#).”

Panel recruitment

Since 2018, the ATP has used address-based sampling (ABS) for recruitment. A study cover letter and a pre-incentive are mailed to a stratified, random sample of households selected from the U.S. Postal Service’s Computerized Delivery Sequence File. This Postal Service file has been estimated to cover 90% to 98% of the population.¹ Within each sampled household, the adult with the next birthday is selected to participate. Other details of the ABS recruitment protocol have changed over time but are available upon request.² Prior to 2018, the ATP was recruited using landline and cellphone random-digit-dial surveys administered in English and Spanish.

A national sample of U.S. adults has been recruited to the ATP approximately once per year since 2014. In some years, the recruitment has included additional efforts (known as an “oversample”)

¹ AAPOR Task Force on Address-based Sampling. 2016. “[AAPOR Report: Address-based Sampling](#).”

² Email pewsurveys@pewresearch.org.

to improve the accuracy of data for underrepresented groups. For example, Hispanic adults, Black adults and Asian adults were oversampled in 2019, 2022 and 2023, respectively.

Sample design

The overall target population for this survey was noninstitutionalized persons ages 18 and older living in the United States. It featured a stratified random sample from the ATP in which non-Hispanic Asian adults were selected with certainty. The remaining panelists were sampled at rates designed to ensure that the share of respondents in each stratum is proportional to its share of the U.S. adult population to the greatest extent possible. Respondent weights are adjusted to account for differential probabilities of selection as described in the Weighting section below.

Questionnaire development and testing

The questionnaire was developed by Pew Research Center in consultation with SSRS. The web program used for online respondents was rigorously tested on both PC and mobile devices by the SSRS project team and Pew Research Center researchers. The SSRS project team also populated test data that was analyzed in SPSS to ensure the logic and randomizations were working as intended before launching the survey.

Incentives

All respondents were offered a post-paid incentive for their participation. Respondents could choose to receive the post-paid incentive in the form of a check or gift code to Amazon.com, Target.com or Walmart.com. Incentive amounts ranged from \$5 to \$20 depending on whether the respondent belongs to a part of the population that is harder or easier to reach. Differential incentive amounts were designed to increase panel survey participation among groups that traditionally have low survey response propensities.

Data collection protocol

The data collection field period for this survey was June 22 to June 28, 2026. Surveys were conducted via self-administered web survey or by live telephone interviewing.

For panelists who take surveys online:³ Postcard notifications were mailed to a subset on June 22.⁴ Survey invitations were sent out in two separate launches: soft launch and full launch. Sixty panelists were included in the soft launch, which began with an initial invitation sent on

³ The ATP does not use routers or chains in any part of its online data collection protocol, nor are they used to direct respondents to additional surveys.

⁴ Postcard notifications for web panelists are sent to 1) panelists who were recruited within the last two years and 2) panelists recruited prior to the last two years who opt to continue receiving postcard notifications.

June 22. All remaining English- and Spanish-speaking sampled online panelists were included in the full launch and were sent an invitation on June 23.

**Invitation and reminder dates for web respondents,
ATP Wave 195**

	Soft launch	Full launch
Initial invitation	June 22, 2026	June 23, 2026
First reminder	June 25, 2026	June 25, 2026
Final reminder	June 27, 2026	June 27, 2026

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Panelists participating online were sent an email invitation and up to two email reminders if they did not respond to the survey. ATP panelists who consented to SMS messages were sent an SMS invitation with a link to the survey and up to two SMS reminders.

For panelists who take surveys over the phone with a live interviewer: Prenotification postcards were mailed on June 18. Soft launch took place on June 22 and involved dialing until a total of 11 interviews had been completed. All remaining English- and Spanish-speaking sampled phone panelists' numbers were dialed throughout the remaining field period. Panelists who take surveys via phone can receive up to six calls from trained SSRS interviewers.

Data quality checks

To ensure high-quality data, Center researchers performed data quality checks to identify any respondents showing patterns of satisficing. This includes checking for whether respondents left questions blank at very high rates or always selected the first or last answer presented. As a result of this checking, two ATP respondents were removed from the survey dataset prior to weighting and analysis.

Weighting

The ATP data is weighted in a process that accounts for multiple stages of sampling and nonresponse that occur at different points in the panel survey process. First, each panelist begins with a base weight that reflects their probability of recruitment into the panel. These weights are then calibrated to align with the population benchmarks in the accompanying table to correct for nonresponse to recruitment surveys and panel attrition. If only a subsample of panelists was invited to participate in the wave, this weight is adjusted to account for any differential probabilities of selection.

Among the panelists who completed the survey, this weight is then calibrated again to align with the population benchmarks identified in the accompanying table and trimmed at the first and 99th percentiles to reduce the loss in precision stemming from variance in the weights. Sampling errors and tests of statistical significance take into account the effect of weighting.

American Trends Panel weighting dimensions

Variable	Benchmark source
Age (detailed)	2024 American Community Survey (ACS)
Age x Gender	
Education x Gender	
Education x Age	
Race/Ethnicity x Education	
Race/Ethnicity x Gender	
Race/Ethnicity x Age	
Born inside vs. outside the U.S. among Hispanics and Asian Americans	
Years lived in the U.S.	
Census region x Metropolitan status	
Volunteerism	2023 CPS Volunteering & Civic Life Supplement
Frequency of internet use	2025 National Public Opinion Reference Survey (NPORS)
Religious affiliation	
Party affiliation x Race/Ethnicity	
Party affiliation x Age	
Validated 2024 presidential election turnout and vote choice	Candidate vote share is based on official results from the Federal Election Commission. Turnout is based on estimates from the Election Lab at the University of Florida. The size of the voting-eligible population is based on the 2023 ACS.

Note: Estimates from the ACS are based on noninstitutionalized adults. For weighting to the 2024 presidential election results, panelists are considered validated voters if their self-report of having voted was confirmed after matching to a national voter registry.

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The following table shows the unweighted sample sizes and the error attributable to sampling that would be expected at the 95% level of confidence for different groups in the survey.

Sample sizes and margins of error, ATP Wave 195

Group	Unweighted sample size	Plus or minus ...
U.S. adults	3,488	1.8 percentage points
White	1,920	2.3 percentage points
Hispanic	501	4.8 percentage points
Black	349	5.9 percentage points
Asian	540	5.9 percentage points
Ages 18-29	569	4.7 percentage points
30-49	1,256	3.1 percentage points
50-64	902	3.5 percentage points
65+	756	3.9 percentage points
Postgrad	648	4.4 percentage points
College grad	820	3.8 percentage points
Some college	988	3.4 percentage points
HS or less	1,019	3.4 percentage points
Upper income	726	4.0 percentage points
Middle income	1,657	2.6 percentage points
Lower income	939	3.6 percentage points

Note: This survey includes an oversample of non-Hispanic Asian respondents. Unweighted sample sizes do not account for the sample design or weighting and do not describe a group's contribution to weighted estimates. See the Sample design and Weighting sections above for details.

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Sample sizes and sampling errors for other subgroups are available upon request. In addition to sampling error, one should bear in mind that question wording and practical difficulties in conducting surveys can introduce error or bias into the findings of opinion polls.

Dispositions and response rates

Final dispositions, ATP Wave 195

	AAPOR code	Total
Completed interview	1.1	3,488
Logged in (web)/Contacted (CATI), but did not complete any items	2.11	118
Started survey; broke off before completion	2.12	48
Never logged on (web)/Never reached on phone (CATI)	2.20	413
Survey completed after close of the field period	2.27	0
Other non-interview	2.30	0
Completed interview but was removed for data quality	2.90	2
Total panelists sampled for the survey		4,069
Completed interviews	I	3,488
Partial interviews	P	0
Refusals	R	166
Non-contact	NC	413
Other	O	2
Unknown household	UH	0
Unknown other	UO	0
Not eligible	NE	0
Total		4,069
AAPOR RR1 = $I / (I + P + R + NC + O + UH + UO)$		86%

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Cumulative response rate, ATP Wave 195

	Total
Weighted response rate to recruitment surveys	12%
% of recruitment survey respondents who agreed to join the panel, among those invited	74%
% of those agreeing to join who were active panelists at start of Wave 195	40%
Response rate to Wave 195 survey	86%
Cumulative response rate	3%

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A note about the Asian adult sample

This survey includes a total sample size of 540 Asian adults. The sample primarily includes English-speaking Asian adults and, therefore, may not be representative of the overall Asian adult population. Despite this limitation, it is important to report the views of Asian adults on the topics in this study. As always, Asian adults' responses are incorporated into the general population figures throughout this report.

How family income tiers are calculated

Family income data reported in this study is adjusted for household size and cost-of-living differences by geography. Panelists then are assigned to income tiers that are based on the median adjusted family income of all American Trends Panel members. The process uses the following steps:

1. First, panelists are assigned to the midpoint of the income range they selected in a family income question that was measured on either the most recent annual profile survey or, for newly recruited panelists, their recruitment survey. This provides an approximate income value that can be used in calculations for the adjustment.
2. Next, these income values are adjusted for the cost of living in the geographic area where the panelist lives. This is calculated using price indexes published by the U.S. Bureau of Economic Analysis. These indexes, known as [Regional Price Parities](#) (RPP), compare the prices of goods and services across all U.S. metropolitan statistical areas as well as non-metro areas with the national average prices for the same goods and services. The most recent available data at the time of the annual profile survey is from 2023. Those who fall outside of metropolitan statistical areas are assigned the overall RPP for their state's non-metropolitan area.
3. Family incomes are further adjusted for the number of people in a household using the methodology from Pew Research Center's previous work on [the American middle class](#). This is done because a four-person household with an income of, say, \$50,000, faces a tighter budget constraint than a two-person household with the same income.
4. Panelists are then assigned an income tier. "Middle-income" adults are in families with adjusted family incomes that are between two-thirds and double the median adjusted family income for the full ATP at the time of the most recent annual profile survey. The median adjusted family income for the panel is roughly \$77,800. Using this median income, the middle-income range is about \$51,900 to \$155,600. Lower-income families have adjusted incomes less than \$51,900 and upper-income families have adjusted

incomes greater than \$155,600 (all figures expressed in 2024 dollars and scaled to a household size of three). A panelist is assigned “no answer” in the income tier variable if they did not provide all three pieces of information needed to calculate their tier (family income, household size and residential address).

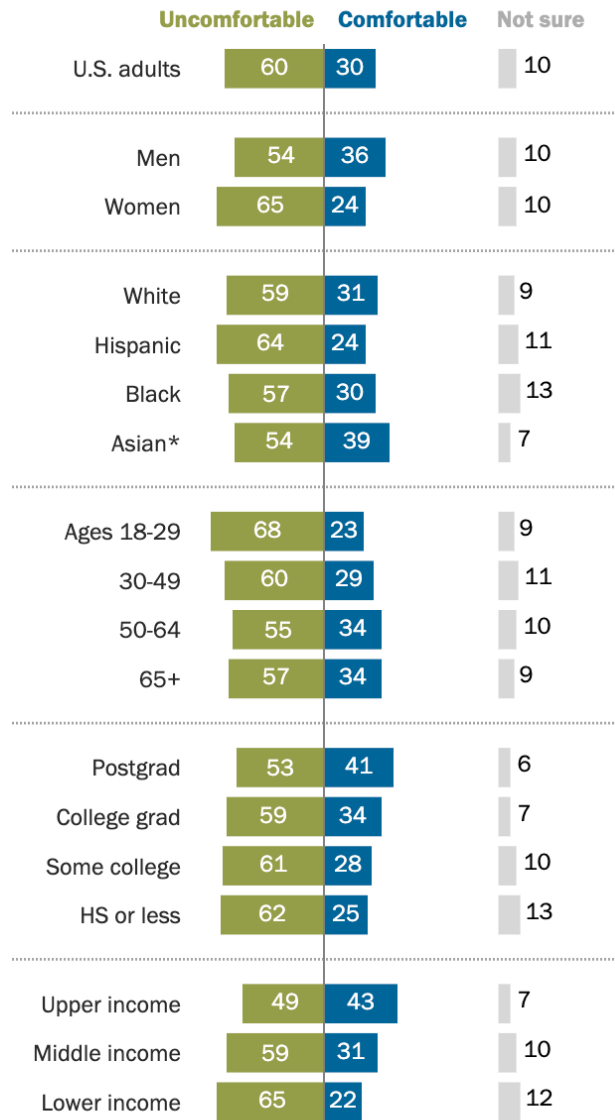
Two examples of how a given area’s cost-of-living adjustment was calculated are as follows: the Pine Bluff metropolitan area in Arkansas is a relatively inexpensive area, with a price level that is 19.7% less than the national average. The San Francisco-Oakland-Berkeley metropolitan area in California is one of the most expensive areas, with a price level that is 18.2% higher than the national average. Income in the sample is adjusted to make up for this difference. As a result, a family with an income of \$40,200 in the Pine Bluff area is as well off financially as a family of the same size with an income of \$59,100 in San Francisco.

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Appendix

Adults with more education and higher incomes are slightly more comfortable with doctors using AI in their healthcare

% who say they would feel ___ if their doctor used AI for things like diagnoses and treatments



* Estimates for Asian adults are representative of English speakers only.

Note: Respondents who did not answer are not shown.

Family income tiers are based on adjusted 2024 earnings.

White, Black and Asian adults include those who report being only one race and are not Hispanic. Hispanic adults are of any race.

Source: Survey of U.S. adults conducted June 22-28, 2026.

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