

The High Stakes of Outsourcing in Health Care



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Abstract

Outsourcing in health care has become increasingly common as health system administrators seek to enhance profitability and efficiency while maintaining clinical excellence. When clinical services are outsourced, however, the outsourcing organization relinquishes control over its most important service value: high-quality patient care. Farming out work to an external service provider can have many unintended results, including inconsistencies in standards of care; harmful medical errors; declines in patient and employee satisfaction; and damage to clinicians' morale and income, and to the health organization's culture, reputation, and long-term financial performance. Research on outsourcing in the areas of emergency medicine, radiology, laboratory services, and environmental services provides concerning evidence of potentially large downsides when outsourcing is driven by short-term cost concerns or is planned without diligently considering all of the ramifications of not keeping key clinical and nonclinical services in-house. To better equip health system leaders for decision-making about outsourcing, we examine this body of literature, identify common pitfalls of outsourcing in specific clinical and nonclinical health services and scenarios, explore alternatives to outsourcing, and consider how outsourcing (when necessary) can be done in a strategic manner that does not compromise the values of the organization and its commitment to patients.

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Henry, a 6-month-old infant, was admitted to the hospital after acute onset of a fever and signs of sepsis. Empiric vancomycin and ceftriaxone were administered intravenously to rapidly control the infection while Henry's attending physician waited for blood culture results from an offsite laboratory service provider. The outside lab notified Henry's doctor that Gram-negative bacteria were growing from the culture — so the vancomycin, generally ineffective against Gram-negative bacteria, was stopped. Henry then developed seizures and respiratory failure, which resulted in his transfer to the pediatric ICU. Subsequent in-hospital culture of cerebrospinal fluid revealed that Henry's blood culture results were, in fact, mistaken: Gram-positive bacteria had been the source of Henry's

meningitis — so the vancomycin was restarted. The laboratory error was responsible for Henry's seizures and, ultimately, his permanent cognitive disability.¹

The medical error caused at the external laboratory had profound consequences for Henry and raises vital questions about the risks of outsourcing in health care.¹ Outsourcing, a business agreement in which an organization contracts out the procurement of products or services to an external firm,² first made its mark in the 1980s in manufacturing industries; the practice ballooned in health care in the early 2000s.³ In 2017 alone, outsourcing grew by 36% in the US health care sector.⁴ The basic rationale for outsourcing, in both health care and non-health care settings, is to partner with firms that offer expertise and economies of



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scale in a particular function in which they specialize (eg, laundry and laboratory services). The aims are often to lower costs, raise productivity, and improve quality.

The allure of potential cost reductions, increased productivity, and quality improvement has sparked hospitals' growing use of outsourcing.⁵ The US government plays direct and indirect roles in the outsourcing decision-making process. For example, a provision of the Protecting Access to Medicare Act, which took effect in 2018, cut reimbursement for routine lab tests by 30% over a 3-year period, leading many health systems (especially smaller ones) to explore outsourcing their laboratory services.⁶ Outsourcing in health care initially evolved in areas of nondirect patient care, such as information technology and revenue cycle services, with virtually every US hospital using outsourcing for at least one business function as of 2020. For example, the percentage of hospitals outsourcing cybersecurity services increased from 16% in 2015 to 86% in 2020.⁷

Research in other industries shows that the success of outsourcing depends on addressing and safeguarding against the potential risks.⁸ Outsourcing in health care is therefore best suited to services that do not directly affect patient care. Health care entities must be especially judicious about transferring control of clinical quality to other organizations without strong evidence of their clinical expertise, commitment to patient-centered service and safety, and compatibility as partners in delivering high-quality care.⁹ A diligent, proactive risk-management strategy, including close monitoring of service reliability and (when necessary) timely contract termination, is essential.¹⁰

A study of 14 highly successful service businesses in different industries revealed their reluctance to outsource services that could affect the value their customers received; putting control of their destiny in the hands of another company was anathema.¹¹ As one company executive stated, "It's hard for us to outsource. We don't like giving up control of anything. It's

difficult for us to describe to a partner what makes us different" (p. 119).¹¹ This reluctance is unsurprising given that, according to an international survey, unmet expectations cause nearly half of companies to terminate their outsourcing contracts early.¹²

Outsourcing in health care is quickly expanding from nonclinical services to include patient-facing clinical service specialties such as anesthesiology, emergency medicine, hospitalist medicine, radiology, neurological monitoring, and others.^{13,14} Aside from the high risks of loss of control over clinical quality — and from errors and potential harm to patients — outsourcing may not provide the anticipated financial benefits over time, especially when discounted pricing is used to secure an outsourcing contract with the intention to raise prices later.⁵ Another potential risk: damage to the health system's organizational culture, as outsourcing commonly involves an attempt to hastily merge cultures from organizations with differing priorities and practices.¹⁵ Outsourcing also may raise employees' doubts about senior management's confidence in their skills, thereby undermining their confidence in speaking up, or even management's willingness to keep workers on the payroll.¹⁶ In seeking to lower short-term costs, health care organizations engaging in outsourcing may jeopardize their reputation, brand, long-term performance, and viability. Outsourcing has an appropriate role, but its use requires rigorous consideration of the short-, medium-, and long-term risks, compared with the anticipated benefits (see [Table 1](#)).

In this article, we explore the high stakes of outsourcing health care services that directly affect patient care in emergency medicine, radiology, laboratory services, and environmental services. We chose these four services because (1) they are among the most commonly outsourced hospital services²⁷⁻²⁹; (2) they reflect the overall range of health care services that are being outsourced; and (3) they all are central to hospitals' responsibility to provide high-quality, safe patient care while posing

TABLE 1. Benefits and Drawbacks of Outsourcing

Benefits	Drawbacks
<p>Financials</p> <p>Outsourcing can lower short-term direct costs and long-term investments¹⁷ by enabling economies of scale (ie, increasing scale of operation leading to lower cost per unit).¹⁸ For example, American Express's consolidation of customer service call-center operations in India cut service costs per customer by 20% to 30%.¹⁹</p> <p>The organization is relieved of the responsibility for managing functions taken over by the outside vendor.</p> <p>Outsourcing can help firms reduce costs by restructuring entrenched departments that are reluctant to change.</p>	<p>Outsourcing often has hidden (sometimes ballooning) costs that are not considered in initial estimates:</p> <p>Search costs — gathering information to identify and assess suitable vendors.</p> <p>Contracting costs — negotiating and writing the outsourcing contract.</p> <p>Vendor management costs — monitoring the agreement to ensure that vendors fulfill their contractual obligations; bargaining with vendors and sanctioning them when they do not meet performance expectations; negotiating changes to contracts in unforeseen circumstances; and managing cost escalation.²⁰</p> <p>Switching costs — The short-term savings provided by the outsourcing contract could be negated in the future, should the organization find it necessary to reintegrate the outsourced function, perhaps because a vendor is unable to continue providing the service or otherwise cannot honor its contract.</p> <p>In outsourcing, the beginning of the contract is generally more beneficial to the client than the vendor.²¹ In time, the contract can become subject to negotiation and misunderstanding. Absent high levels of trust and a commitment to continuous improvement from both parties, outsourcing initiatives are often unsuccessful.²² Without contract enforcement when necessary, outsourcing can result in lost benefits.</p>
<p>Competitive advantage</p> <p>An outsourcing arrangement allows the firm to concentrate on its core business and most critical issues.²¹ By outsourcing peripheral functions, the firm can concentrate resources on a set of “core competencies” where it can achieve definable pre-eminence and provide unique value for customers.²³ Services not requiring high-level expertise can be relegated to the outsourcing vendor.</p> <p>In rapidly changing markets, outsourcing may shorten cycle times and create better responsiveness to customer needs because firms can take advantage of external vendors’ investments, innovations, and specialized professional capabilities, especially those that may be too time-consuming or expensive to develop internally.</p>	<p>By outsourcing core activities, organizations risk losing control over their quality. Outsourcing customer-facing functions can dampen customer satisfaction,²⁴ brand loyalty, customer commitment to the firm, and positive word-of-mouth.²⁵</p> <p>Outsourcing can lower employee morale, as employees often view outsourcing as an underestimation of their skills by senior management.</p> <p>Outsourcing may negatively affect employees’ confidence, sense of job security and loyalty, possibly leading to lower productivity or even dysfunctional actions such as strikes.</p> <p>Outsourcing can reduce an organization’s strategic flexibility to introduce new products/services when it wants, rather than when the outsourcing vendor permits.</p> <p>By outsourcing core activities, firms risk becoming “hollow corporations.”²⁶ In the US consumer electronics industry, poorly performing business units started outsourcing components manufacturing to suppliers overseas. Most of them had to teach their suppliers how to build components. As outsourcing lowered costs, it quickly spread throughout the US consumer electronics industry. Later some US manufacturers found that their suppliers were unable or unwilling to supply them as requested; however, the US firms had lost their manufacturing skills and could not prevent the suppliers from entering downstream markets on their own.</p> <p>Internal documents and data are most secure when they are maintained under one roof. Outsourcing may require internal data to be shared with the external entity providing the outsourced service, thereby increasing the security risk of potentially sensitive data being compromised by data breaches and other unauthorized uses.</p>

considerable risk to patients and the hospitals if performance is poor. These services offer an inclusive view of health care's use of outsourcing, ranging from more easily observed onsite services (emergency medicine, environmental services) to primarily offsite services (radiology, laboratory testing).

EMERGENCY MEDICINE

The emergency department — the “front door” to hospital care — is the critical staging area for severely ill patients and plays a key role in half of hospital admissions. Speed and accuracy in triaging and stabilizing a patient can dictate prognosis. High-quality emergent care is essential for patients and all other stakeholders. Two-thirds of US emergency departments use some form of outsourcing³⁰ and more than 50% of all practicing emergency physicians do not work for a hospital, but for a contract management group (CMG). The American Academy of Emergency Medicine, formed in the early 1990s because of some emergency medicine physicians' deep concerns about CMGs,³¹ reports a steady rise in the number of CMGs since.³²

Contract management groups are essentially hospital staffing companies, and many of them are private equity (PE) or publicly traded firms.³³ The PE health care model, in particular, is profit-maximizing: It assembles capital and uses it to buy medical practices and consolidate them, with the goals of increasing the company's value and selling it 3 to 7 years later for a sizable profit. CMGs' tactics can include reducing costs (often by reducing payroll), raising physician productivity metrics, taking a larger share of physicians' professional fees to cover overhead expenses than is warranted, and increasing prices and volume of services used.³⁴⁻³⁶ Emergency medicine appeals to CMGs because it is episodic care requiring minimal follow-up and is well compensated in the US clinical reimbursement system. Moreover, emergency clinicians are more mobile because emergency medicine does not involve ongoing patient care.

To be sure, CMGs can offer an efficient, streamlined means of locating, recruiting, and credentialing staff according to a facility's unique needs. These features encourage a hospital to consider outsourcing costly, labor-intensive physician recruitment and retention services.³⁷ Hospitals in smaller communities with lower volumes and revenues are especially tempted by CMGs' apparent potential for reducing staffing costs and addressing the constant challenge of recruiting emergency physicians. Indeed, it is not uncommon for CMGs to use physicians in the emergency department that are not board-certified in emergency medicine — a practice that, in smaller communities, may be necessary whether or not outsourcing is used.

However, as for-profit companies, CMGs have a laser focus on financial performance, potentially encouraging policies that put high-quality care at risk, for example, by establishing aggressive patient-per-hour quotas and rewarding more procedures and ordering of tests that add marginal value and may harm patients.³⁵ Physicians who work for a CMG often have to divide their loyalties between their employer and the outsourcing health system, navigating the two organizations' different value systems and priorities, which may lead not only to physicians' conflicted loyalties but also to organizational disunity and poor teamwork — an especially fraught dynamic in a medical specialty that frequently involves life-and-death clinical scenarios. In one study, 34% of CMG-employed emergency physicians reported concerns about losing their job if they raised questions about over-testing, quality of care, or patient treatment — compared with 18% of non-CMG physicians.³⁸ Contract management group physicians in this study also reported experiencing more-frequent pressures to admit to the hospital patients they believed could be treated as outpatients (18% vs 12%) and to discharge or transfer uninsured or medical assistance patients whom they believed should be hospitalized (22% vs 13%).

Given that physician groups not employed by a hospital can opt out of the

hospital's insurance contracts and charge what they wish, outsourcing to an out-of-network physician group often results in higher charges to insurers and patients, sometimes adding up to thousands of dollars per clinical encounter. In a study of nationally representative data from the Medical Expenditure Panel Survey for 2001 to 2016, privately insured patients receiving an out-of-network bill for emergency care were charged an average of 10 times more than other emergency patients.³⁹ Sick patients going to an in-network hospital are likely to be unaware when they receive care from an out-of-network provider, which may stun them and their families when they face medical charges they had assumed their insurance would cover.

The two largest PE emergency medicine outsourcing companies are TeamHealth (and its subsidiary Southeastern, both owned by the Blackstone Group) and Envision Healthcare (owned by Kohlberg, Kravis, Roberts & Co.). A group of Yale University economists found that when Envision (formerly known as EmCare) assumes management of a hospital emergency room, it raises out-of-network rates by more than 80 percentage points.⁴⁰ TeamHealth's rates were found to be 68% higher (even though they were in-network) than before it took over emergency room management.⁴¹

Contract management group ownership has contributed to surprise billing and aggressive collections. TeamHealth, for instance, filed more unpaid-bill lawsuits against patients in Memphis, Tennessee, in the first 6 months of 2019 than three local hospitals combined.⁴² Faced with negative publicity, the company reversed course and stopped suing patients and pursuing lawsuits that were underway. Envision Health has acted similarly in its surprise medical billing practices, and the company has faced class-action lawsuits from patients in Texas and Florida.^{30,43} (When the federal "No Surprise Act" takes effect in 2022, it may greatly curtail surprise medical billing.) Contract medical groups prioritize profitmaking to a degree well beyond health care organizations' need for reasonable margins that allow

them to keep their doors open and invest in their future.⁴⁴

In an outsourcing scenario, two organizations need to make a profit, which (in health care) can undermine commitment to doing what is best for the patient and to retaining stakeholders' trust in the health system that provides the service. A hospital's reputation is not captured in a financial statement, but it certainly contributes — for better or worse — to the financial bottom line. Dr Tom Scaletta, former president of the American Academy of Emergency Medicine, states, "The principles of great patient care are at odds with maximizing profit." (personal correspondence, January 14, 2021).

RADIOLOGY

The growth of outsourcing radiology services, primarily through teleradiology, has been driven by a demand for fast-turnaround image interpretation. Beginning with the transmission of radiographic images via telephone lines in 1948, teleradiology has grown rapidly since the 1970s with the advent of magnetic resonance imaging, computed tomography, and positron emission tomography.⁴⁵ Approximately 50% of radiologists report interpreting offsite external imaging examinations, services that often are necessary for small and rural health systems that lack resources to employ in-house radiologists around the clock.⁴⁶ For these smaller organizations, effective use of teleradiology is a sensible application of outsourcing that can provide access to expert radiological interpretation; reduce patients' length of stay, rehospitalizations, and transfers to other facilities; and lower the costs of capital and labor.⁴⁵ Select radiology services (eg, interpretation of images) are suitable for outsourcing; others (eg, image-guided procedures or any imaging that needs in-person radiologist involvement) are not.

Larger and financially stronger institutions should thoroughly evaluate the decision to outsource, given the potential for negative clinical and business consequences. For example, although radiologists with specialized expertise can offer more value

to a case than nonspecialists do, outsourcing companies may use uniform practices that do not distinguish well among radiologists' skill levels or manage case-complexity assignments accordingly.⁴⁷

The European Society of Radiology notes that radiologists provide greater value to patients when they are available for direct consultations with referring physicians and understand the clinical context in which their service is provided.⁴⁸ Poor or nonexistent communication between a referring physician and an offsite radiologist can compromise effective and safe care. Moreover, offsite radiologists often lack access to patients' prior imaging records or medical history, which aids in diagnosis and lowers the risks for interpretation errors and unnecessary further testing. In addition, when remote radiologists cannot attend in-house multidisciplinary meetings, trust is eroded and valuable lessons for future cases may be missed.⁴⁹ Communication and information-sharing are particularly challenging when outsourcing radiology services because the coordination between parties may not be sequential but reciprocal (ie, requiring ongoing, mutual adjustments across multiple reads). Indeed, outsourcing can exacerbate fragmentation of patient care in radiology. Consider this scenario: Outsourced radiologist A provides screening mammography interpretation; outsourced radiologist B interprets the diagnostic mammography and breast ultrasound scans; and onsite radiologist C performs the image-guided biopsy, with limited, delayed, or even no access to the outsourced radiologists if in-person review and discussion of the case would be helpful.

Physicians employed at organizations that use teleradiology may place less trust in the clinical accuracy of outsourced reports, causing them to spend extra time checking the reports, thereby partially eroding the expected financial savings from outsourcing.⁴⁹ Such reservations about quality are understandable, as it is challenging to maintain quality standards and accountability for outsourced work. For instance, one for-profit radiology practice serving

more than 15 US hospitals signed off on 71,512 radiology reports during an 8-month period, with radiologists viewing only 5840 of those images. Most of the images were reviewed by radiology practitioner assistants, who were inexpensive to hire but not fully qualified to review images or provide accurate diagnoses, putting at risk thousands of patients as well as the reputations of clinicians and the hospital that approved these services.⁵⁰ Writing about outsourced radiology examinations, Robert Wachter has noted that outsourcing may have virtue but that the practice can be harmful if it sacrifices quality.⁵¹

LABORATORY SERVICES

Laboratory services, generally seen as cost centers rather than as profit centers, are increasingly being outsourced to large, for-profit lab-service providers, such as Quest Diagnostics. Quest Diagnostics provides some level of lab service to half of US hospitals.⁵² In 2019 in North America, more than half of all health care private equity deals were either for physician practices or laboratory services.²⁸ Laboratory testing is a high-volume service whereby laboratory companies accrue economies of scale and market their services as a lower-cost alternative to hospitals. Larger firms also can spread the fixed costs of technology investments over their larger volume of business. As in the case of emergency medicine and radiology, the economics and technical complexity of laboratory testing give outsourcing an especially strong appeal to smaller hospitals. Yet, like these other services, outsourcing laboratory testing requires careful due diligence in comparing the potential benefits and drawbacks.

This article's opening story about "Henry" is not about any particular laboratory's shortcomings, but it illustrates the broader significance of decisions to outsource laboratory services.¹ Indeed, outsourcing may lead to adverse outcomes such as poor turnaround times for test reports, compromised specimens, incorrect tests, and problems with courier services.^{5,53} More than 85% of infectious disease physicians report that

having laboratory services onsite is crucial for timely diagnosis, care coordination, and communication with clinical microbiologists.⁵⁴ In a prospective study on the use of blood cultures, hospitals with offsite lab services experienced significantly longer transport times and total detection times for the presence of 12 different species of sepsis-causing bacteria and yeasts.⁵⁵

A study reporting interviews with 17 pathology department chairs at US academic medical centers revealed that the institutions that entered into joint ventures with lab service providers experienced unplanned, sizable cost increases over time, even though the primary reason for initiating the venture was financial.⁵ These overall cost hikes stemmed from increased test pricing; a lack of control over testing utilization, resulting in excessive and high-margin testing; and expensive management fees. Among the reasons some of the medical centers brought laboratory services back in-house were inconsistent and nonreproducible test results, as well as long test-turnaround times. Two of the hospitals that ended their outsourcing arrangements reported immediate first-year savings of \$1 million to \$4 million.⁵ As in Henry's meningitis case, medical errors may also lead to unnecessarily prolonged (and therefore more expensive) hospital stays and increased patient anxiety, beyond the clinical harm itself.

ENVIRONMENTAL SERVICES

Hospital housekeeping, often called environmental services (EVS), plays a critical role in the control of health care-acquired infections (HAIs), including coronavirus disease 2019 (COVID-19).⁵⁶ Health care-acquired infections are among the leading threats to patient safety, affecting about 1 in 31 hospitalized patients at any one time.⁵⁷ More than 1 million HAIs occur in the United States every year.

Hospital-acquired *Clostridium difficile* (*C. diff*) infections cost the US health care system \$4.7 billion, at an average cost of \$24,205 per case and several thousand deaths annually.⁵⁸ Estimates of costs related to methicillin-resistant *Staphylococcus aureus*

(MRSA) infections exceed \$30,000 per patient, also accounting for thousands of US deaths each year.^{59,60} Fortunately, hospitals that implement an antimicrobial stewardship program⁶¹ and use a checklist of best practices to improve their safety culture, teamwork, and communications⁶² can greatly mitigate the incidence of HAIs such as *C. diff* and MRSA. For instance, with rigorous daily cleanings and proper use of disinfectants, one hospital reduced the incidence of hospital-acquired *C. diff* by 85%, whereas another hospital observed a 48% decrease.⁶³

More than one-third of US hospitals outsource EVS.⁵⁶ Focused on the actual treatment of patients coupled with a desire to cut costs, hospital administrators may turn to an EVS firm that promises low cost and high quality cleaning. Viewing EVS as a relatively low-skill and easily implemented service can make outsourcing appear to be a smart solution. And it may be — but only if the right company is selected to perform the service. After all, EVS workers play an essential but often underappreciated role in patient safety. Nevertheless, funding for cleaning has continued to be cut since the mid-1990s, contributing to chronic understaffing and a rise in HAIs, including surgical-site infections.^{64,65} New staff may be trained for just a few days. Environmental service firms often use efficiency standards that give workers inadequate time to properly clean patient rooms, a particularly disturbing reality during the COVID-19 pandemic. Environmental service workers are underpaid,⁵⁶ often asked to do more with less, and struggle to gain access to adequate personal protective equipment.^{66,67}

One study correlated the number of *C. diff* infections in 297 California hospitals with “purchased services as a share of total direct expenses” (ie, degree of outsourcing); the investigators found that hospitals outsourcing EVS reported nearly twice as many *C. diff* infections.⁶⁵ A study of 126 acute care hospitals in England found that hospitals outsourcing cleaning services reported a nearly 50% higher incidence of MRSA infections compared with hospitals

with in-house EVS. In addition, hospitals outsourcing EVS had fewer cleaning staff per hospital bed and worse patient perceptions of cleanliness.⁶⁸

The short-term cost savings that hospitals may generate from outsourcing EVS work appear less appealing when the real costs — financial and human — of HAIs are considered. Another concern is if employed EVS workers feel more responsibility to report cleaning-process deficiencies than outsourced workers do. Outsourcing EVS can limit hospitals' control over cleanliness and increases the risk of needlessly exposing patients (and others, including staff) to dangerous infections.

BIG DECISION, BIG QUESTIONS, BIG RISKS

Outsourcing in health care has become increasingly common as administrators seek to improve profitability, efficiency, and quality. However, a careful examination of four services that directly affect the quality of patient care illustrates the potential risks of transferring responsibility for performing clinically relevant services to outside organizations. The more the outsourced service affects value and quality, the greater the risks to the outsourcing organization. Although a primary goal of outsourcing is cost efficiency, the resulting financials often do not meet expectations, especially if the indirect costs of lower quality are accurately calculated as contributing to poor outcomes such as medical errors, loss of employees' trust, and increased hospital readmissions.⁶⁹ Lower quality also damages an organization's reputation and can adversely affect referral patterns, patients' comments on social media, and even hospital accreditation. In addition, the outsourcing of health care work can weaken employee morale, team effectiveness, confidence in management, and organizational culture.

Another point to consider is whether to have the outsourced service conducted onsite or offsite. Surprisingly little research has compared these two general outsourcing strategies, and how and when each should be used.⁷⁰ Outsourcing clearly does have the potential to create value in certain health

care situations. Service providers may see an opportunity to benefit from another organization's deep expertise and consolidated volume, achieving the scale required to provide a service efficiently and effectively. But outsourcing must be used for the right reasons and the right services with the right partners — and with the right guidelines, interorganizational communications, and monitoring in place to further a health system's long-term success rather than risk diminishing it. When outsourcing is pursued to achieve short-term (usually financial) goals, long-term problems can ensue, including some that diminish the expected financial returns on investment.

Effective outsourcing requires that health systems maintain substantive oversight of the performance of the outsourced services. Transferring control of service performance to another organization need not result in relinquishing valuable influence. This is best accomplished with a “one organization” mindset, whereby a health system makes every effort to contract only with outsourcing entities whose core values and long-term goals are compatible so that the two organizations function as one and continually enhance their alignment.

Concerted efforts also should be made to integrate outsourced staff with insourced staff by, for example, including the former in hospital-community engagement activities, professional development programs, morbidity and mortality meetings, grand rounds sessions, organization-wide communications, and organizational celebratory events. Detailed contracts are standard practice in outsourcing and should include performance metrics such as indicators of clinical quality, business efficiency, patient satisfaction, and professionalism. However, if contracts are well crafted with regular audits and their terms well communicated — and if the right outsourcing partner is selected — the need to enforce compliance should be rare.

We urge health system executives to clearly articulate the outcomes they seek to achieve and diligently consider the following questions before embarking on an outsourcing arrangement:

TABLE 2. Levels of Risk to Hospitals When They Outsource Various Types of Services

Level 1 Nonclinical services (low risk)	Level 2 Support services (medium risk)	Level 3 Select clinical and support services (medium–high risk)	Level 4 Patient-facing clinical services (high risk)
Laundry	Laboratory (pathology and microbiology)	Diagnostic imaging service lines	Emergency medicine
Food and concessions	Information technology services	Environmental services	Cardiology
Coding reviews	Data analytics	Pharmacy	Anesthesia
Revenue-enhancement services	Medical facilities management	Surgery equipment sterilization	Mental health services
Patient transport	Training and education services	Dialysis	Physiotherapy and rehabilitation
Procurement		Pathology	Surgery
Security		Neuromonitoring	Critical care services
Gardening and ground management		Cybersecurity	Hospitalists

Will our patients benefit — and in ways they can perceive?

Will we enhance patient safety?

Will our employees benefit — or at least not be adversely affected?

Will our third-party payers benefit?

Will we strengthen our overall capabilities as we pursue a broader organizational strategy?

Will we increase our organization's flexibility and innovation?

Will we bolster our organization's reputation and brand?

Will we improve our long-term, not merely our short-term, financial performance?

ALTERNATIVES TO OUTSOURCING

It is clear that all decisions to outsource pose some combination of risks to an organization. Hospital executives must consider the associated risks, including the organization's capacity for change and the relative maturity of the outsourcing market in a particular function. When deciding whether to outsource a specific service, executives should always assess the potential consequences, as all outsourcing involves some risks (see Table 2). Deliberate efforts to weigh those risks against the expected benefits can help to mitigate the risk exposure.⁷¹

Outsourcing may be more beneficial in some sections or departments than in others, but the decision should be made by hospital

management, not an outside party, especially when that party has a vested interest in the outcome. One particular risk is that a vendor may stop being able to provide the service, perhaps because it underbid a contract, which it later finds itself unable to honor, or for other reasons. Although the costs of keeping a departmental function in-house may seem to outweigh the risk of an outsourcing vendor's unexpected exit or default, due-diligence research on the vendor's long-term viability and commitment is essential. After all, the costs of reintegrating an outsourced service in-house can be substantial. An alternative to outsourcing whole departments is to outsource specific tasks that another company may accomplish more efficiently. For instance, rather than outsourcing its entire billing department, California's ValleyCare Health System outsourced specific billing tasks that were valued under \$3000. ValleyCare found that outsourcing these smaller tasks was the more cost-effective approach.⁷²

Smaller hospitals' cashflow problems may make outsourcing the only viable option for certain services. These hospitals may consider teaming up with other nearby smaller hospitals to collectively garner more buying power and innovation capacity. Such a hospital group, for example, could invest in its own shared laboratory services department to better control costs and maintain high quality. One example of a multi-system shared laboratory joint venture is North Carolina-based Spectrum Laboratory Network, owned by Forsyth Memorial

Hospital, Moses H. Cone Memorial Hospital, and High Point Regional Health System; combined, these systems represent 2200 hospital beds. Another such venture is Virginia-based Shared Laboratory Services, owned by Chesapeake General Hospital, DePaul Medical Center, Obici Medical Center, Virginia Beach General Hospital, and American Medical Laboratory; American Medical Laboratory also is the reference laboratory for the shared lab company. The needs to reduce costs and eliminate unused core lab capacity will drive the creation of shared lab organizations, and the need to introduce and manage new diagnostic technology will make them increasingly important to health care.

Another alternative to traditional outsourcing arose during the COVID-19 pandemic response in New York City (and elsewhere), whereby private, public, and community hospital systems collaborated with one another. Despite variation in organizational and financial structures across these hospital systems, they were able to share vital resources during the crisis, with a particular focus on critical care physicians and nurses, as well as key equipment.⁷³

CONCLUSION

Health care is a unique and consequential service, and the decision to outsource should never be taken lightly. Patients must be at the center of care decisions, including those that pertain to how health services are delivered to them; after all, patients are the primary focus of the care being given. When outsourcing is used, efforts to work closely with the service provider can mitigate miscommunication and frustration, while nurturing trust and alignment between the two parties. The secondary aim of pursuing net revenue should itself take a long-term view that accounts for all potential high-stakes downsides of outsourcing core health care services. Only then will a health care organization avoid the greatest risks of outsourcing — and deploy it only when it is truly the best option for the institution itself, its staff, its third-party payers, and the patients it aims to serve with excellence.

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Abbreviations and Acronyms: **CMG**, Contract Management Group; **HAIs**, healthcare-acquired infections; **C. diff.**, *Clostridium difficile*; **MRSA**, methicillin-resistant *Staphylococcus aureus*; **EVS**, environmental services

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