

5 myths on the path to
standing up provider
Global Capability Centers

Executive summary

Provider health systems are navigating a persistent financial squeeze: operating margins compressed to 1%–2%, rising labor and supply costs, and reimbursement rates that continue to lag. Yet a significant and underutilized lever remains largely untapped: Global Capability Centers (GCCs). Early adopters are already capturing 20%–50% cost savings by moving enabling functions to GCCs in the Philippines, India, Central and Eastern Europe, and Latin America. Many health systems, however, have yet to act—held back by a set of persistent myths.

This article examines five of the most common misconceptions that prevent health care leaders from pursuing GCC models and replaces each with the facts. Myth No. 1 addresses the fear that AI has made GCCs obsolete; the reality is that AI and GCCs are complementary, not competing, strategies. Myth No. 2 challenges the belief that labor arbitrage economics are eroding; evidence from the 2025 Deloitte GBS Survey shows that approximately 50% of organizations with GCC presence still achieve more than 20% savings. Myth No. 3 dispels the notion that standing up a GCC requires prohibitive up-front investment; BPO and BOTT models offer accessible, low-risk ramps. Myth No. 4 addresses contract and compliance concerns; with the right risk framework and tools, permissible paths exist even within complex payer environments. Myth No. 5 confronts data privacy fears: Modern access controls, VDI, and data de-identification techniques make compliant GCC delivery achievable.

For health care leaders who can move beyond these myths, the opportunity is material: sustainable cost advantage, a future-ready workforce, and the operational resilience to thrive in an increasingly complex environment. The time to act is now.

Global Capability Centers in health systems

Five myths on the path to effective Global Capability Centers (GCCs) keeping organization security and compliance intact, while boosting financial benefit

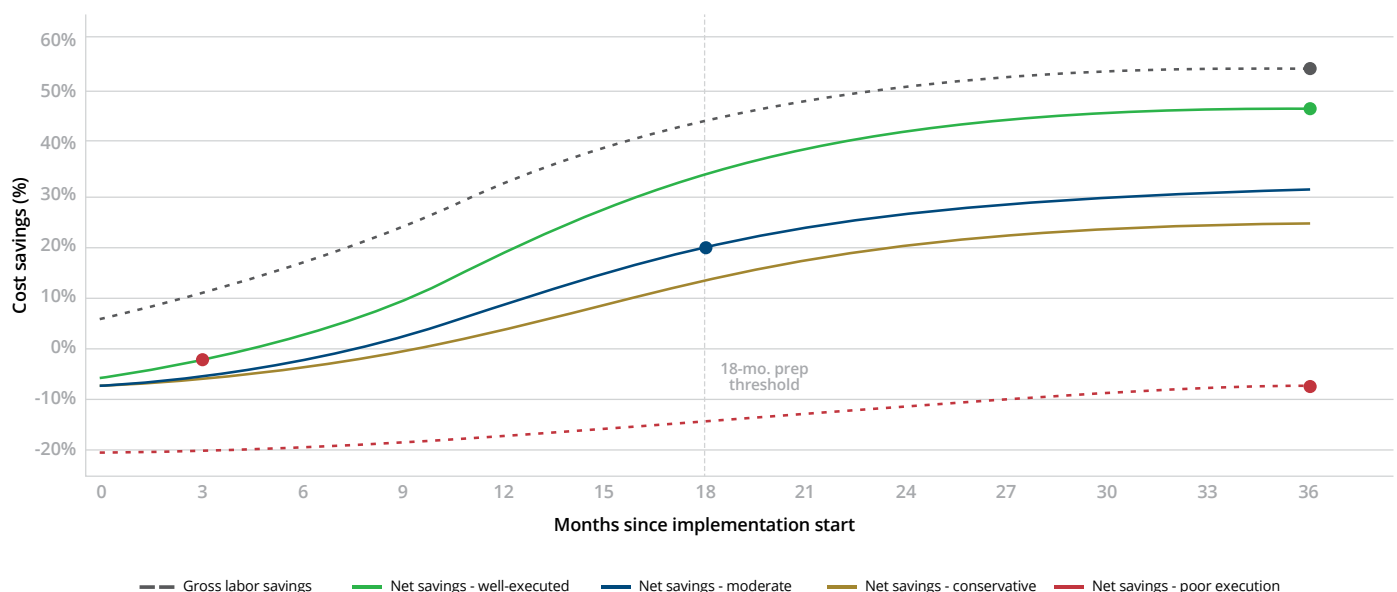
Health care leaders are experiencing improved post-pandemic financial conditions, yet margins remain lower than pre-pandemic levels with shifts from 2.3% operating margin to now 1%–2% ranges.¹ 2025 Centers for Medicare & Medicaid Services (CMS) updates provide a mixed bag of appreciated but inadequate reimbursements, coupled with elevated expenses, which continue to challenge leaders² and prompt them to seek cost-saving opportunities. A significant opportunity may lie within their enabling functions.

In recent years, innovative service delivery models for these functions have emerged, with a noticeable increase in GCCs in the Philippines, India, Central and Eastern Europe, and Latin America.³ However, many health systems have yet to explore these options. Leading health systems are beginning to explore and implement GCC models to combat rising costs with early adopters seeing roughly 20%–50% cost savings on average pending their implementation strength.

While anecdotal discussions often highlight barriers to the design and adoption of these global models, they are not always rooted in truth. The aim is to highlight these key frictions⁴ and assess their validity. Are these issues that still need resolution, or are they perpetuated myths? **Let's examine five truths versus myths on the provider path to GCCs and show why health care leaders cannot afford to ignore these global delivery solutions.**

Figure 1. Offshoring savings: Gross vs. net (after all costs)

Illustrative model anchored to published research benchmarks ·



Source: Compiled from Deloitte and industry analysis. See endnotes 5-10 for sources.

Myth No. 1: With the introduction of AI, there isn't value in establishing a GCC.

Myth: The arrival of advanced artificial intelligence (Generative AI/ agentic AI) is reshaping how health care organizations deliver back-office, clinical support, and transactional functions—but it does not render GCCs obsolete. In reality, the path forward is not a binary AI versus GCC proposition. Instead, value leaders do both in parallel—interweaving automation, global delivery, and onshore models to create resilient and cost-effective operating structures.

Hybrid operating models: The power of 'and'

Many health systems will achieve outsized value by combining GCC delivery and automation in a hybrid construct—selectively automating what is reliably digitized while routing tasks where human intervention remains critical to GCC teams, and keeping strategic decision-making onshore.

- **Ideal integration:** Organizations can route repeatable, transactional processes to their GCC that still require human oversight—such as claims adjudication, prior authorization audits, or provider directory maintenance—while automating highly structured tasks like data entry, duplicate detection, and initial eligibility checks. Strategic functions, risk management, and innovation efforts remain well-suited for the core onshore team.
- **Cost and efficiency:** Hybrid models maximize both labor arbitrage and the efficiency gains from automation. For midsize provider health systems facing persistent financial pressure, this dual-lever approach can deliver meaningful operating leverage—simultaneously reducing the number of transactions and the processing cost per transaction.
- **A future-ready workforce:** Investing in both, a flexible mix of global talent and digital capability can give organizations the ability to scale either lever as business needs or technologies evolve. If new regulatory constraints emerge or AI capabilities accelerate, the operating model can rebalance volume and investment accordingly—avoiding significant reliance on a single solution.

Key considerations: Where to start? This choice point is about where to start by process, and what must be true in order to scale.

Prioritize GCC delivery:

- A leading choice when the primary objective is near-term, defensible savings and the work is stable and repeatable
- Works well when you can enforce standard work, controls, and knowledge transfer
- Keep watch: Can create stranded cost/contract rigidity if AI later reduces volumes faster than capacity can flex

Prioritize AI and automation:

- A leading choice when the objective is work elimination + quality uplift (cycle time, defects, compliance), not just rate reduction
- Works well when process ownership, clean data, and digitized workflows are sufficiently mature to scale beyond pilots
- Keep watch: Requires strong governance and change capacity; value builds over time; workforce impacts must be managed

A common path is to start with a GCC for stability/cost, then pivot to AI on standardized, data-ready processes.

The bottom line

Far from rendering GCCs obsolete, AI can accelerate the imperative to rethink where, how, and by whom health care-enabling work gets done. High-performing organizations don't ask, "AI or GCC?" They architect agile, hybrid models that unlock the cumulative value of both. Those who can effectively combine automation, global delivery, and onshore operations will be well positioned to adjust costs, enhance compliance, and make their operations future-ready in a dynamic health care landscape.

Myth No. 2: The expected labor arbitrage is shrinking and economics no longer support GCC investment.

Myth: Regulatory uncertainty on labor arbitrage return does not eliminate the value of GCCs for health systems; rather, it necessitates smarter operating model design and targeted scope. By carefully assessing portfolios by function, location, and sourcing constructs, organizations can strategically minimize regulatory exposure while still achieving a favorable and sustainable total cost of ownership. In 2025, approximately 50% of organizations with offshore presence achieved more than 20% savings from labor arbitrage.¹¹ Through thoughtful segmentation of processes and diligent application of compliance controls, organizations can not only maintain, but often enhance cost efficiencies and operational resilience. This approach enables health systems to adjust resource allocation, leverage global talent, and enhance financial benefits—enabling GCCs to remain a viable strategy for driving long-term value despite evolving regulatory landscapes.

Benefits of GCCs can also expand beyond cost savings, with centralization and capability expansion. Centralization enables standardization and scale, and AI-driven automation reduces full-time equivalent (FTE) intensity and reliance on external services—strengthening economics under various regulatory scenarios. With centralized capabilities, many offshore delivery centers are transforming to become true GCCs—expanding their scope into new strategic, value-creating, or specialized capabilities (e.g., product engineering, analytics/AI, cybersecurity, advanced finance). Scenario planning and flexible contracting can further allow health systems to pivot delivery volumes across nearshore and offshore hubs without compromising capability or quality.

Typical labor arbitrage ranges:

Many health systems will achieve outsized value by combining GCC delivery and automation in a hybrid construct—selectively automating what is reliably digitized while routing tasks where human intervention remains critical to GCC teams, and keeping strategic decision-making onshore.

- **Farshore (e.g., Philippines, India) versus US:** 40%–50% labor cost savings for standardized finance and AP functions; 30%–40% for specialized accounting support.
- **Nearshore (e.g., Costa Rica, Mexico) versus US:** 20%–30% labor cost savings with stronger time zone overlap for finance operations and vendor engagement.
- **Wage inflation:** Offshore markets with significant demand for GCC talent, such as Hyderabad and Lisbon, have experienced annual wage increases of 8%–10%. However, in absolute US dollar terms, this growth is comparable to or lower than the 3%–4% wage growth observed in the United States. A similar pattern has been identified in mature GCC locations like San José and Manila, where wage inflation has stabilized between 2.5% and 5%.



Concrete examples in finance and accounting operations:

- **Accounts payable shared services:** Centralize invoice intake and three-way match processes; nearshore supplier queries; offshore invoice processing. Implement optical character recognition and AI validation to auto-extract fields, detect duplicates, and flag exceptions. Results: 30%–50% reduction in manual touches, improved on-time payment rates, and increased early-payment discount capture.
- **General ledger close and reconciliations:** Offshore standardized reconciliations (e.g., bank, payroll accruals, AP sub-ledger) while retaining judgment-heavy adjustments onshore. Utilize AI to auto-match transactions and identify anomalies. Results: 20%–30% faster close cycles and fewer post-close adjustments.
- **Supplier onboarding and compliance:** Centralize vendor creation; offshore validation checks (TIN, banking details, sanctions screening) using AI to detect inconsistencies. Results: Reduced fraud risk and cleaner vendor master data, improving AP efficiency.
- **Finance data and insights center of excellence (CoE):** Stand up a team of finance data engineers, analysts, and FP&A subject matter experts to build standardized data products (e.g., revenue bridge, margin waterfall, cost-to-serve), automate management reporting, and deploy driver-based forecasting models. Results: Results consistent with industry benchmarks: McKinsey reports 20%–30% faster forecast cycles from driver-based automation; The Hackett Group finds top-performing finance CoEs spend up to 57% less on planning and forecasting while increasing time on strategic analysis.¹²

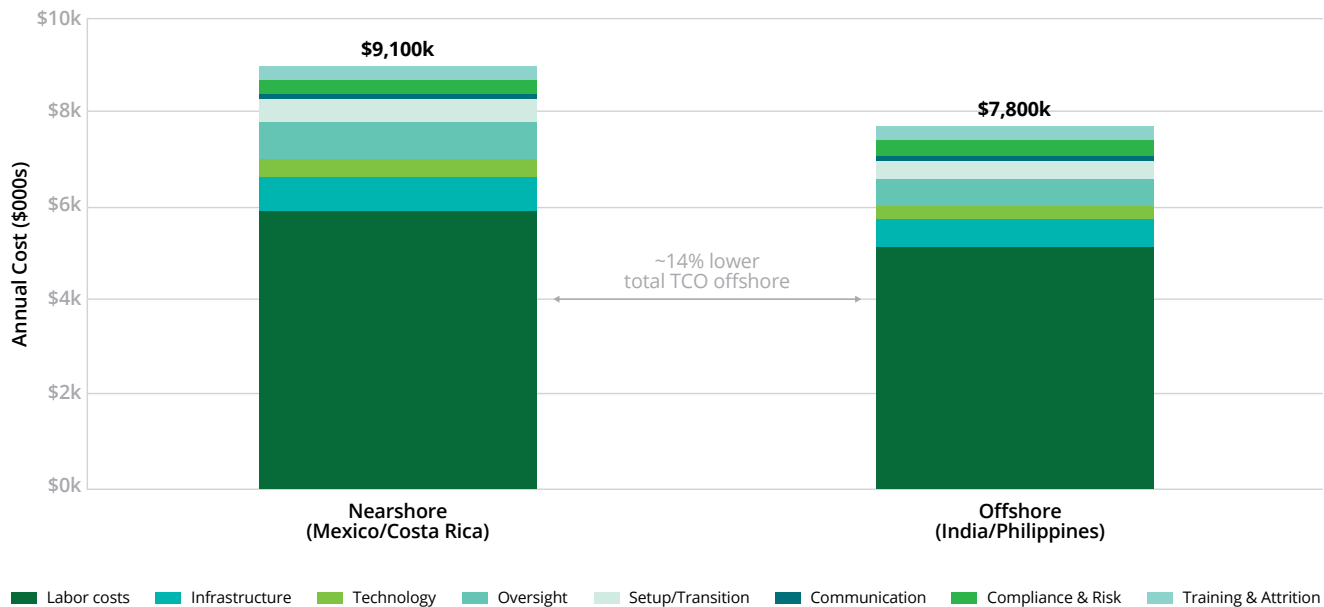
The tipping point:

- The choice between establishing a captive center or engaging a business process outsourcing (BPO) provider for back-office operations is primarily driven by considerations of scale, strategic significance, and control. Captive model is typically preferred when an organization possesses:
 - **Sufficient scale:** \$15M+ in annual processing costs or enough activity to warrant 150+ FTEs dedicated to back-office functions.
 - **Multi-year predictability:** Stable or growing volumes to support the 3-to-5-year investment horizon necessary to achieve captive center economics.
 - **Geographic footprint:** Multiple facilities or a large operation where process standardization delivers substantial value.

If these criteria are not met, a BPO solution generally delivers superior economics and speed-to-value by leveraging shared infrastructure across multiple clients. However, this comes with trade-offs in governance and control.

Figure 2. Total cost of ownership comparison: Nearshore vs. offshore

Annual TCO for 200 FTEs · Health care back-office functions · Illustrative model anchored to published benchmarks.



Source: See endnotes 13–18 for sources.

Myth No. 3: Without experience with global markets, the stand-up cost and effort is not worth the benefit.

Myth: Scaling operational processes is not constrained by the number of internal FTEs when health systems leverage a BPO or a BOTT (Build-Operate-Transform-Transfer) model and centralized standardization. By decoupling volume from headcount, organizations can scale capacity elastically, stabilize quality, and reduce cost-to-serve without overextending internal teams. The BPO approach enables smaller health systems to capture labor arbitrage, while the BOTT model expands capability further for medium-to-large-provider organizations through establishing standardized workflows, utilizing provider-operated capacity initially, and progressively transferring capabilities into a captive GCC construct as demand stabilizes.

While certain back-office functions and processes necessitate an onshore presence, the adoption of BPO and BOTT models plays a pivotal role in enhancing the strategic position of existing teams. By leveraging these models, organizations enable their onshore staff to transition from purely operational roles to those of strategic advisers who contribute across the enterprise.

This shift empowers the existing team to take on more significant responsibilities, guiding organizational transformation initiatives and supporting critical decision-making. As a result, the team becomes increasingly influential in shaping the direction of the organization, enabling operational improvements to align with broader business objectives.

How a BPO or a BOTT model unlocks scale:

- **Elastic capacity:** Access a pre-trained talent pool through unit-based or outcome-based solutions (e.g., per invoice processed, per reconciliation, per authorization), enabling organizations to manage volume fluctuations without incremental hiring.
- **Speed-to-value:** Providers can rapidly implement standardized processes, platforms, and quality assurance, accelerating operational readiness. Within the BOTT model, capabilities are transferred back once key performance indicators (KPIs) are stable and scale is reached.
- **Control via standards, not seat counts:** Define global playbooks, service level agreements (SLAs), and metrics (quality, turnaround time, first-pass yield) that persist through the transfer process, enabling consistent outcomes regardless of the operating entity.
- **Risk mitigation:** Strategies are established to facilitate an effective transition, protect operational standards, and ensure ongoing business continuity throughout the transfer of capabilities. During the initial phase, both the existing team and the provider-operated team function concurrently (parallel runs). Responsibilities and processes are transitioned incrementally, enabling effective performance monitoring, timely issue resolution, and consistent adherence to SLAs (phased cutover).

BPO lets organizations quickly implement core processes, seeing results in 8–12 weeks with trained teams and standard platforms, though it limits control. The BOTT model allows initial setup and dual operations in 3–6 months, transferring full capability as KPIs are met. This approach can help health systems save costs, minimize disruptions, and scale while maintaining strategic flexibility. Using captive or BOTT models helps retain process and intellectual property control, while reducing external payment risks.

Myth No. 4: Payer contracts prevent moving any enabling work to a GCC.

Myth: There is a common misconception that outsourcing or routing work to a GCC is not feasible for health care operators. While certain restrictions exist across various state, federal, and commercial contracts, there can be a path forward, albeit with constraints. The contract limitations on offshoring are often misunderstood, and the reality is more nuanced. Organizations must assess their individual, state, and federal contracts, as well as publicly available regulatory information, to understand data and information restrictions.

A broad approach to contract and compliance risk involves developing an organizational risk framework and aligning overall risk appetite with the necessary technology and compliance components. Contract permissibility must align with business decisions and technical capabilities through a coordinated effort. After conducting risk assessments, organizations can develop a deeper understanding of contractual limitations and state/federal regulations to uncover additional processes and opportunities to increase scope of their GCC model and simultaneously define governance and implement limitations on use of restricted data.

The below details two examples where permissibility for GCC delivery was found after conducting a risk review leveraging NavigAite¹⁹ AI tool to expedite the process (once data is available).

- **Large US payer and provider:** At a major US health system, an analysis was conducted on its state contracts, specifically regarding data access in GCC environments. It was found that while transaction-level protected health information (PHI) and personally identifiable information (PII) were initially prohibited from being offshored, waivers could be obtained, and some third-party administrators were already offshoring such data through these waivers. In addition, it was determined that summarized, nondescript data was not explicitly restricted, allowing its use offshore for activities like financial closes, as only totals and subtotals were needed, not transaction-level details. These findings gave the organization comfort to move forward with routing select finance back-office activities to a GCC.
- **Large US payer:** The organization's risk assessment team worked to identify potential risks of the use of AI in HR across its commercial insurance markets. They collaborated with project technical teams to understand transformation roadmap across prior authorization, grievances and appeals, behavioral health, and payment integrity to characterize potential applicability of state regulations. This resulted in conducting a scan of 10+ state regulatory and legislative environments to identify potential regulatory restrictions or prohibitions that would impact technical design and development. Among 250 contracts reviewed, only one state had exclusions specifically requiring bias audits and notices for automated hiring tools used for salary decisions in HR, including setting salary ranges or making recommendations. For this state in particular, the team decided to exclude salary-related AI functionality and handle it through traditional processes.

In summary, organizations can work through contract permissibility with alignment internally on the risk tolerance of the organization. A risk framework to assess and prioritize risks across state markets including applicability, provision details, risk mitigation strategies, and governance considerations is recommended.



Myth No. 5: Data privacy constraints make leveraging GCCs untenable.

Myth: Hosting of some PII, PHI, and financial data can be restricted to country of origin, but access to this data does not follow the same restrictions. A core distinction is required between “data residency” (i.e., geographic location) versus “data access,” with data access being the primary concern with offshoring. Validating data security is a significant effort, typically requiring a two-pronged assessment to understand internal landscape requirements for effective solutions.

Organizations should review their current data architecture and technology environment to understand how data is stored and processed to understand the types of sensitive data they handle, such as PII, PHI, and financial data. By identifying these elements, organizations can then apply appropriate de-identification methods like data masking, tokenization, and differential privacy to protect sensitive information from unauthorized access or exposure.

Organizations can also manage data access available to offshore resources through a number of controls such as role structuring, enabling virtual infrastructure, and additional technical safeguards. By setting up role-based access via Identity and Access Management (IAM) or Privileged Access Management (PAM) and following reduced privilege principles, organizations can ensure only necessary or permissible data (e.g., the last four digits of SSN) is accessible to offshore teams. This setup also manages authentication, provides granular audit trails of access and enables access just in time, if required, for temporary tasks.

Additionally, organizations can further enhance control by setting up virtual desktop infrastructure (VDI), which creates a virtualized desktop environment that offshore workers access remotely ensuring no data remains on the offshore user’s endpoint. Additional technical controls can be employed such as session recording, monitoring, and endpoint data loss prevention (DLP) to create forensic evidence if needed and enable random auditing to maintain a secure control environment and adhere to US Department of Health and Human Services guidance.²⁰

These approaches not only help in safeguarding data but also enable compliance with regulations like Health Insurance Portability and Accountability Act of 1996, General Data Protection Regulation, and Payment Card Industry Data Security Standard (PCI DSS). Across major BPO providers, there are likely more than 100,000 offshore FTEs²¹ handling some form of US health care data in back-office functions today. The predominant causes of US health care data breaches—hacking, ransomware, and IT incidents—are not unique to offshore environments; no published regulatory data specifically attributes elevated breach rates to properly governed offshore BPO operations.

Effective governance and collaboration among stakeholders are essential for effective data de-identification. By fostering a culture of compliance and leveraging technology solutions, organizations can protect sensitive data while meeting regulatory requirements and minimizing risks associated with data breaches.

Figure 3. Example data classification & offshore handling

Data Class	Examples	Offshore handling	Controls (illustrative)
Restricted — Identifiable Health	Full ePHI/PII (SSN, MRN, claim detail)	No direct access offshore unless contractually permitted + compensating controls	VDI only, masked fields, PAM/JIT, session recording, DLP, evidence logging
Confidential — Limited Identifiers	Last 4 SSN, truncated MRN, aging balances	Yes, with least-privilege access	RBAC, VDI, field-level masking, audit trail
Confidential — Aggregated	GL totals, claim counts, KPIs	Yes	Data mart with row-level security; no raw PHI
Public — De-identified	Synthetic data, published stats	Yes	Standard controls

See endnotes 22-25 for sources

Where do we go from here?

As health systems sharpen their focus on long-term financial sustainability, the myths surrounding GCCs—and more broadly, global operating models—can no longer be allowed to overshadow the realities of what is possible. Dispelling decades-old misconceptions is not just an academic exercise; it is a strategic imperative for organizations navigating persistent margin pressures and accelerating digital disruption.

Let's recap:

- **Myth No. 1:** The rise of AI does not diminish the value of GCCs. In fact, leading organizations can achieve gains from a hybrid model that leverages both automation and global talent.
- **Myth No. 2:** Labor arbitrage via GCCs remains viable but should be pursued through targeted operating model design and thoughtful scenario planning in light of regulatory complexity.
- **Myth No. 3:** Securing scale and value does not require a massive up-front investment or preexisting GCC footprint—models like BOTT and phased transformation offer practical ramps, leveraging provider experience.
- **Myth No. 4:** Contractual obligations and compliance concerns do not preclude GCC models—there can be viable, regulatory-aligned paths for enabling work to move to a GCC with the aligned frameworks.
- **Myth No. 5:** Sensitive data is not necessarily a deal-breaker—advanced access control, data masking, and governance allow for safe and compliant GCC delivery.

In summary

The landscape for provider health systems is shifting. Leaders who can see beyond the old GCC myths and embrace a new paradigm—one grounded in fact, possibility, and disciplined risk-taking—will be well positioned to deliver a sustainable cost advantage, operational resilience, and future-ready health care. Now is the time to move strategically, experiment with global models, and strengthen the foundation for growth.

Endnotes

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6. Year 1 transition overhead of roughly 15 to 25 percent of gross labor savings. Deloitte, "[Can Offshoring Help Health Systems Bulk Up Thin Margins?](#)" 2023.
7. Net savings above 20 percent in well-governed programs. See endnote 4.
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9. Mature net savings of 40 to 50 percent. Deloitte, [Global Business Services Perspectives](#).
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11. See endnote 4.
12. The Hackett Group, "[Digital World Class® finance teams operate at 45% lower cost and deliver faster, smarter insights](#)," press release, June 9, 2025.
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15. Infrastructure and technology. The Hackett Group, "[Bridging the Outsourcing Value Gap](#)," 2024; See endnote 4.
16. Oversight and setup/transition. McKinsey & Company, "[Getting more out of offshoring the finance function](#)," McKinsey on Finance, 2007; See endnote 5.
17. Compliance and risk. US Department of Health and Human Services, "[Guidance on HIPAA & Cloud Computing](#)," last updated December 23, 2022; See endnote 4.
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24. Confidential, aggregated, and de-identified tiers. 45 CFR § 164.514(e), limited data set; 45 CFR § 164.514(b)(2), Safe Harbor removal of 18 identifiers. See endnote 23.
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