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Letter to Editor

Benchmarks in Healthcare, Polaris or Mirage?

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The term 'benchmark' is used for centuries, whether originated from land surveying when a permanent position was chiseled in stone and served as a reference point, or from the firearms industry, where a marksman would fire diverse firearms from the same point on a bench, a benchmark became a common language when measuring and/or comparing one thing against another [1].

Nowadays, we use benchmarks to compare performance, results and outcomes to evaluate one's position compared to others.

When comparing returns on investments, performance of a computer or accuracy of a chronometer we use percentage, speed or seconds per day. However, mortality and complication rates, disease free survival and physical functioning, are much more complicated, difficult to calculate and easily affected.

For example:

The Center for Medicare/Medicaid Services is a comprehensive source for administrative studies that established and defined national and international benchmarks. Due to its vast number of beneficiaries (approximately 34 million are enrolled in original Medicare) and meticulous documentation, these reports, justifiably, become a worldwide standard. However, since most beneficiaries are over 65-year-old, we do not get a comprehensive understanding about the majority of the younger population [2,3].

The Rate of adverse events per admission days is used to compare quality and publically shared with providers and patients. However, adjustments are often performed, like including only significant and life threatening events, adding ambulatory admissions to the total number of days, or including charge elements. While absolutely legitimate, the methodology is uncommonly explained, making it difficult or even impossible for comparison between institutions [4].

When reporting readmission rate, does it include solely admissions to the same department or division? Is it analyzed clinically? If every institution, decides to measure readmission rates differently, how can even begin to compare?

During the industrial revolution, benchmarks were used by business owners to study the competitors, thus determining their own techniques efficiency. In healthcare benchmark is considered the perfect number we should strive to achieve. Profound understanding of the methodology raises substantial questions about the rationalization to make the comparison. We must be certain that we undeniably compare "apples to apples".

The history of benchmarking indicates that true value lies in how leadership leverage the insights and gain improvements. No matter how much the process of benchmarking changes, we believe the future of benchmarking will be not what is benchmarked, but how leaders use benchmarks to improve healthcare outcomes and improve quality of care.

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