

The Role of Benchmarking in Healthcare Management: Beyond Measurement, a Strategy for Learning and Improvement

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ABSTRACT

Introduction: benchmarking has become a key strategic tool in healthcare management, aligned with the principle that what is not measured cannot be improved. Although the term is an anglicism, its use is fully accepted in the scientific and healthcare literature. Understood as a systematic process of measurement, comparison, and learning, it allows for the evaluation of organizational performance based on valid and comparable indicators. In a context of increasing demand for efficiency, safety, and patient-centered outcomes, benchmarking facilitates the continuous improvement of healthcare quality and institutional positioning through transparency and organizational learning.

State of the art: evidence shows that benchmarking in healthcare relies on the use of structure, process, and outcome indicators, according to the Donabedian model. Several systematic reviews have demonstrated a positive association between the implementation of benchmarking and improvements in healthcare quality, both in processes and clinical outcomes. However, its impact is usually enhanced when combined with complementary interventions such as audits, feedback, improvement plans, or incentives, which makes it difficult to isolate its specific effect. Furthermore, significant methodological challenges persist, such as comparability between institutions, the need for risk adjustments, data quality and availability, and the long-term sustainability of improvements. Within this framework, the integration of patient experience indicators and qualitative data is gaining increasing importance, broadening the traditional performance evaluation toward a more holistic and person-centered perspective.

Discussion: this should not be understood as a simple comparison or a substitute for quality programs, but rather as an essential component of them. Its effective implementation requires robust information systems, well-defined indicators, interdisciplinary teams, institutional leadership, and an organizational culture oriented toward learning and continuous improvement. In conclusion, implementation science is key to bridging the gap between evidence and practice, and benchmarking based on high-quality data has become virtually mandatory in modern healthcare systems.

Keywords: benchmarking, health information management, quality of health care, management indicators, quality improvement, patient satisfaction.

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El papel del benchmarking en la gestión sanitaria: más allá de la medición, una estrategia para aprender y mejorar

RESUMEN

Introducción: el *benchmarking* se ha consolidado como una herramienta estratégica clave en la gestión sanitaria, alineada con el principio de que aquello que no se mide no puede mejorarse. Aunque es un anglicismo, su uso está plenamente aceptado en la literatura científico-sanitaria. Entendido como un proceso sistemático de medición, comparación y aprendizaje, permite evaluar el desempeño organizacional a partir de indicadores válidos y comparables. En un contexto de creciente demanda de eficiencia, seguridad y resultados centrados en el paciente, el *benchmarking* facilita la mejora continua de la calidad asistencial y el posicionamiento institucional mediante la transparencia y el aprendizaje organizacional.

Estado del arte: la evidencia muestra que el *benchmarking* en salud se apoya en el uso de indicadores de estructura, proceso y resultado, según el modelo de Donabedian. Diversas revisiones sistemáticas han demostrado una asociación positiva entre la implementación de *benchmarking* y mejoras en la calidad asistencial, tanto en procesos como en resultados clínicos. No obstante, su impacto suele potenciarse cuando se combina con intervenciones complementarias como auditorías, retroalimentación, planes de mejora o incentivos, lo que dificulta aislar su efecto específico. Asimismo, persisten desafíos metodológicos relevantes, como la comparabilidad entre instituciones, la necesidad de ajustes por riesgo, la calidad y disponibilidad de los datos, y la sostenibilidad de las mejoras a largo plazo. En este marco, adquiere creciente relevancia la integración de indicadores de experiencia del paciente y datos cualitativos, que amplían la evaluación tradicional del desempeño hacia una perspectiva más integral y centrada en la persona.

Discusión: no debe entenderse como una simple comparación ni como un sustituto de los programas de calidad, sino como un componente esencial de estos. Su implementación efectiva requiere sistemas de información robustos, indicadores bien definidos, equipos interdisciplinarios, liderazgo institucional y una cultura organizacional orientada al aprendizaje y la mejora continua. En conclusión, la ciencia de la implementación resulta clave para cerrar la brecha entre la evidencia y la práctica, y la evaluación comparativa basada en datos de alta calidad se ha vuelto una práctica prácticamente obligatoria en los sistemas de salud modernos.

Palabras clave: benchmarking, gestión de la información en salud, calidad de la atención en salud, indicadores de gestión, mejoramiento de la calidad, satisfacción del paciente.

INTRODUCTION

This narrative review aims to integrate and analyze the main conceptual, methodological, and organizational components that determine the usefulness of benchmarking in healthcare management. Although systematic measurement and comparison of performance are essential tools for identifying quality gaps and guiding improvement processes, their usefulness depends not only on the availability of indicators but also on their relevance, quality, and comparability, as well as on the appropriate interpretation of observed differences in their context. From this perspective, this article examines the conceptual foundations of benchmarking and its main applications in healthcare, including the role of key performance indicators (KPIs), the challenges of performance measurement and comparability, and the incorporation of patient-experience dimensions. It also analyzes the organizational conditions required for comparative findings to go beyond identifying differences and translate into learning, adoption of

best practices, and sustainable improvement initiatives. Indicator measurement quantifies specific aspects of performance; performance monitoring systematically tracks these indicators over time; management dashboards visualize and communicate performance information; and quality improvement programs include interventions aimed at modifying processes and outcomes. In contrast, benchmarking is a systematic process of comparing performance against a reference standard to identify gaps, understand differences, and foster learning and improvement.

This review contributes by integrating these dimensions from a healthcare management perspective, emphasizing that benchmarking should be understood not merely as a measurement tool but as a mechanism for organizational learning and continuous improvement that enables organizations to identify benchmarks, understand observed differences, and analyze the processes that may explain them. Its value lies not in identifying who achieves better results, but in

understanding differences, interpreting the factors that account for them, and determining which practices can be adapted to the local context. This review seeks to provide a more pragmatic conceptual framework for understanding the conditions under which benchmarking can serve as an effective tool to improve performance and promote more equitable, transparent healthcare focused on continuous improvement.

STATE OF THE ART

BENCHMARKING IN HEALTHCARE: DEFINITION AND FOUNDATIONS

The phrase “What cannot be measured cannot be improved” is often attributed to Peter Drucker, based on conceptually similar statements in his works emphasizing the importance of measurement for management. However, it was first published by Ridgway in 1956.¹ In healthcare, benchmarking is a process based precisely on measurement, comparison, and learning. First, we acknowledge that *benchmarking* is an English term that could be translated into Spanish as “evaluación comparativa” or “comparación con estándares de referencia,” although neither is fully equivalent nor accurately captures the term’s established use in the international literature on healthcare management and evaluation. Because *benchmarking* is a technical concept widely accepted in the scientific and healthcare community, we will retain the original English term throughout this article.

In healthcare, benchmarking can be understood as a systematic process of measuring, comparing, and interpreting performance against defined benchmarks, with the aim of fostering learning and improvement. It is a growing field and has been adopted as a strategic management tool for the continuous improvement of quality of care. Etymologically, the term derives from the concept of a “benchmark” or “reference point.” Its use expanded from the business sector and was systematically developed as a management tool based on Xerox’s experience during the 1970s, later documented by Camp in 1989.²

In an increasingly demanding environment for efficiency, safety, and patient-centered outcomes,³ benchmarking provides a structured framework for organizational assessment and learning. Beyond driving internal improvements, it helps institutions strengthen their position by demonstrating transparent, sustained results in quality, safety, and patient experience.

Recently, Byrne and Haut reminded us that patient care should meet the same standard regardless of where the illness or injury occurs, the healthcare facility, or the treating clinical team.⁴ In other words, appropriate treatment should always be provided at the right place and the right time to achieve the best possible outcome.⁵ Unfortunately, persistent variations in healthcare performance highlight the need for methods that allow these differences to be systematically measured, compared, and interpreted. Benchmarking promotes the use of valid and comparable indicators, appropriately

adjusted for risk factors, complexity, or health conditions. It is not simply a matter of comparison; rather, it requires critical analysis, contextual interpretation, and the ability to adapt findings to the local setting. Its use also extends to management (e.g., redesign of processes and spaces, communication, and patient experience), as it facilitates continuous improvement and evidence-based decision-making, helps prioritize opportunities for improvement, and promotes organizational learning from both internal experience and that of other institutions, thereby contributing to a better experience for patients, caregivers, and healthcare teams.

Its effectiveness increases when teams actively participate in defining and interpreting indicators (measurement tools) and when institutional leadership translates findings into improvement initiatives.⁶ This methodology uses indicators corresponding to the three dimensions of quality —structure, process, and outcomes— to systematically assess and compare performance across organizations, services, or processes, establish benchmarks, and identify potentially transferable practices whose adaptation to the local context can then be evaluated.⁷

TYPES OF BENCHMARKING

As early as 1994, Benson described four different types of benchmarking⁸ (Table 1).

- **Internal benchmarking**, which compares functions within an organization.
- **Competitive benchmarking**, which directly compares products or services offered by organizations operating in the same market.
- **Functional benchmarking**, which compares a specific aspect or function, such as payroll or purchasing (e.g., appointment scheduling), with organizations that do not necessarily belong to the same sector but perform that process particularly well.
- **Generic benchmarking**, which allows for broader comparisons by seeking to identify and adapt management principles, strategic approaches, or cross-cutting methodologies applicable to any organization. It involves examining how other organizations perform activities efficiently and considering how those methods might be adapted to the local context. Lean thinking, inspired by the Toyota Production System, seeks to maximize value for the user by identifying and eliminating non-value-added activities, reducing waste, and continuously improving processes.⁹

INDICATORS AND KPIS: SELECTION, DEFINITION, AND STANDARDIZATION

According to the Donabedian model, indicators fall into three categories: structure, process, and outcomes.¹⁰ Table 2 provides examples from the clinical care of patients with diabetes.

Its application in healthcare requires a team-based approach that includes a physician specializing in the topic, condition, or population being evaluated, as well as other team members with technical expertise (e.g., health

Table 1. Types of Benchmarking According to Benson, with Clinical and Management Examples

Type	Clinical example	Management example
Internal	Comparison among different emergency departments within the same institution (Hospital Italiano)	Comparison of appointment scheduling efficiency across different administrative units within the same institution
Competitive	72-hour revisit rate at the Adult Emergency Department: main campus vs. San Justo. Comparison of wait-list mortality or time to surgery among hospitals within the same network	Delay (in days) in scheduling routine outpatient appointments: Gynecology/Obstetrics vs. Hematology
Functional	Comparison of critical patient flow management with emergency centers in another healthcare system that have optimized triage and referral processes	Comparison of cost per patient treated among healthcare centers in the same region. Comparison of appointment scheduling or supply logistics with external organizations
Generic	Reducing waiting times for outpatient visits or improving patient flow	A hospital could draw on supermarket logistics to organize medication dispensing

Source: Authors' own elaboration

Table 2. Classification of Indicators According to the Donabedian Model

Category	Definition	Example
Structure	Physical, human, and organizational resources available for healthcare delivery	Percentage of outpatient centers with at least one professional certified in diabetes education.
		Proportion of centers with laboratory HbA1c testing available
Processes	Activities and procedures through which care is delivered	Percentage of patients whose HbA1c was measured at least twice in the past 12 months.
		Percentage of patients who underwent an annual fundus examination
		Proportion of patients with HbA1c <7% (or meeting individualized targets).
Results	Changes in health status attributable to the care received	Percentage of patients with LDL <100 mg/dL (or <70 mg/dL in high-risk patients)

Source: Authors' own elaboration

informatics, epidemiology, biostatistics, data analysis, and related disciplines that enable the appropriate reuse of information derived from electronic health records), expertise in communication –for quantitative measurement and dissemination– and experience in project management.¹¹

The main objectives of the metrics most commonly used in healthcare (productivity, quality, time, and costs) are to:

- Identify opportunities for improvement in clinical processes (e.g., time to antibiotic administration, mortality) and in administrative or management processes (e.g., readmissions).
- Adopt best practices that have proven effective in similar settings (e.g., outcomes of complex procedures such as liver transplantation).
- Reduce unwarranted variation across units, departments, or institutions.
- Improve decision-making through comparative data and evidence.
- Foster a culture of quality focused on organizational learning (e.g., establishing improvement plans after analyzing deviations).

Because outcome measures are complex and costly to assess, many healthcare systems have tended to rely on simpler, indirect measures, such as structure and process measures.¹²

Key Performance Indicators (KPIs) and their development should be considered among the main steps in establishing a continuous monitoring system to assess performance, identify gaps, and guide improvement initiatives.¹³ When designing hospital management dashboards, involving the primary users in indicator selection and prioritization contributes to their successful implementation.¹⁴

A 2024 systematic review identified and classified 64 key indicators –financial, managerial, and clinical–used to measure hospital supply chain performance.¹⁵

The study emphasized that identifying and developing these indicators poses a major challenge for hospitals because complete and comparable data sources are often lacking. The main issue is that indicator validity and reliability depend on the availability of high-quality data, particularly the relevant elements of the minimum data set.¹⁶

A 2013 Italian study reviewed the evidence and hospital data to examine the relationship between activity volume (number of cases treated) and health outcomes, particularly 30-day in-hospital mortality.¹⁷ However, the authors cautioned that it was not always possible to establish universal thresholds and that differences across clinical conditions or diseases require a context-specific approach.¹⁷

From a patient experience perspective, benchmarking incorporates an additional population-level dimension by including indicators of patient and family perceptions and participation. The systematic integration of this qualitative information into dashboards not only enables comparison of clinical and process outcomes but also

provides insight into how users experience and interpret them.

Therefore, it is essential to integrate qualitative data (e.g., the patient voice, experience surveys, and patient narratives) into outcome indicators.¹⁸ These inputs provide dimensions that cannot be captured by quantitative measures alone and allow for a deeper understanding.¹⁹ However, their interpretation requires appropriate contextualization according to the characteristics of the population served, the type of service, and the specific features of each process. This approach broadens the traditional interpretation of institutional performance by providing contextual, subjective, and relational information essential to a comprehensive, person-centered assessment of quality of care.

Initiatives aimed at standardizing patient-relevant outcomes, such as the International Consortium for Health Outcomes Measurement (ICHOM),²⁰ shift the focus from comparisons based exclusively on activity or operational performance to comparisons of outcomes that matter to those receiving care, helping operationalize which outcomes should be measured. In this regard, ICHOM has developed standardized outcome sets for specific conditions (e.g., atrial fibrillation, chronic kidney disease, and heart failure).^{21–23}

Similarly, patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) provide information for developing performance measures that incorporate the patient perspective.²⁴ PROMs assess the impact of disease or healthcare on a person's health from their own perspective (e.g., quality of life and functional capacity)²⁵. In contrast, PREMs address how patients experienced the care they received.¹⁸ Thus, PROMs and PREMs provide mechanisms for directly capturing the patient perspective. According to Jamieson Gilmore et al.,²⁶ PREMs are used primarily at the “micro level” to improve quality of care, whereas their application at the “meso level” is associated with performance improvement and quality-based funding; their use at the “macro level” remains limited.

DATA QUALITY AND GOVERNANCE

Evidence highlights the importance of data for informed decision-making. Therefore, data collection and management are fundamental. Measuring, analyzing, and interpreting data make it possible not only to understand the current state of the healthcare system but also to anticipate needs, correct deviations, and promote continuous improvement.

However, the availability of large volumes of information does not, in itself, ensure valid comparisons. Data used for benchmarking must be sufficiently complete, accurate, consistent, timely, relevant, and comparable, with clearly established operational definitions and calculation rules (e.g., consistent inclusion and exclusion criteria, equivalent observation periods, and sufficiently standardized processes to ensure that observed differences can be attributed to performance

rather than to differences in how care is documented or delivered). A recent systematic review identified multiple dimensions of data quality in health information systems, including accuracy, completeness, consistency, timeliness, reliability, accessibility, and security, highlighting the considerable heterogeneity in how these dimensions are defined and assessed.²⁷

In this context, data governance complements data quality assessment. It is not limited to technical aspects but also involves defining what information will be collected, for what purpose, from which sources, using which definitions, and under which validation procedures. It also requires establishing mechanisms to detect errors, missing data, changes in documentation processes, and modifications to information systems.²⁸

Measurement therefore requires a systematic and standardized process that ensures data validity (whether the data actually measure what they are intended to measure: *Are we measuring the right thing?*), reliability (whether the data are consistent and stable when measured repeatedly: *Do we obtain the same result each time we measure it?*), and comparability (whether the data can be compared across different settings, time periods, or groups: *Can we compare these data with other data in a meaningful way?*). This process involves four fundamental steps:

Clear definition of indicators: data source, calculation method, measurement frequency, and expected thresholds. For example, mortality among adults on

the liver transplant waiting list can be estimated by treating transplantation as a competing risk, reported annually, and compared with data from the same year from the United Network for Organ Sharing (UNOS). A more realistic approach requires more than a simple Kaplan–Meier analysis, because such an analysis could overestimate or underestimate the risk of death by failing to account for the fact that some patients undergo transplantation before they die.

Integrated information systems: electronic health records, administrative databases, and specific registries.

Use of digital technologies: visualization tools that enable large volumes of information to be processed in real time, such as dashboards.⁵

Staff training: all stakeholders involved should understand the importance of accurately recording data and using them ethically.²⁹

The “5-P Framework” for indicator selection (Fig. 1) comprises five domains:³⁰ Purpose (objective through an operational process or scope through a strategic plan), Policy (governance or steering committee), Preparation (literature review and end-user input), Procedure (recognized consensus-building method), and Pilot (pilot testing for quality and training).

WHAT DOES COMPARISON MEAN IN HEALTHCARE?

It involves much more than having indicators and identifying differences between two or more organizations, services, or healthcare units. Comparison

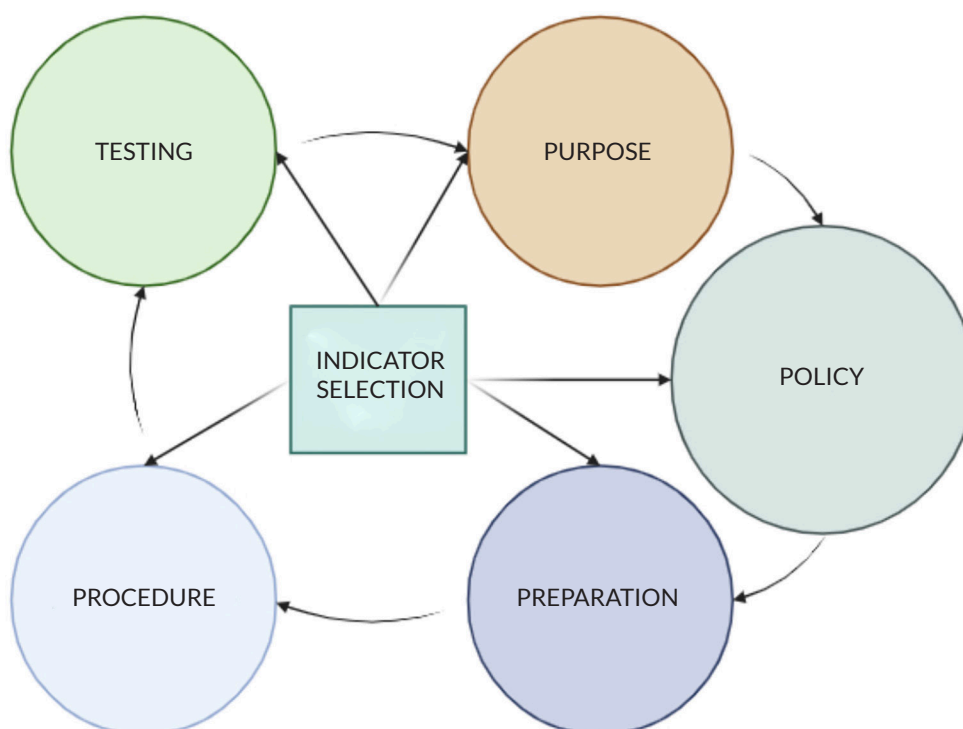


Figure 1. The Five Domains (“5 Ps”) of the Indicator Selection Process. Source: Authors’ own elaboration, created with BioRender.com®.

helps identify performance variations and raise questions about their magnitude, consistency, and potential relevance. However, an observed difference does not necessarily represent a difference in quality. It may reflect differences in the characteristics of the populations served, case complexity, resource availability, organizational structure, models of care, information systems, or socioeconomic context. These differences are particularly relevant in Latin America, where fragmented and heterogeneous healthcare systems coexist, with substantial variations in coverage, access, resource availability, and information system capacity across countries and, in some cases, within the same country. Therefore, interpreting a comparison requires consideration of both the characteristics of the units being compared and the conditions under which outcomes are generated.

This aspect is particularly relevant in healthcare, where heterogeneity among institutions and populations is substantial. Comparing rates of mortality, readmissions, complications, waiting times, resource utilization, or patient experience can provide valuable information; however, interpretation requires determining whether observed differences are expected, attributable to baseline population risk, the result of differences in care processes, or potentially avoidable. Consequently, identifying a gap represents the starting point for further investigation rather than necessarily a conclusion about performance. A learning-oriented comparison seeks to move toward deeper questions: Why do these differences exist? What processes, practices, or conditions might explain them? What can we learn from those achieving better outcomes? Which elements could we adapt to our own context? At this point, comparison becomes a meaningful component of benchmarking.

In comparative assessment, indicators may not be directly comparable across institutions because of differences in operational definitions, the populations served, care processes, and organizational context. Byrne and Haut described this challenge as “*comparing apples to oranges*”.¹⁴ Particularly in Latin America and Argentina, heterogeneity among institutions, models of care, resource availability, and information systems may limit direct comparability. Even risk-adjustment models used to generate benchmarking reports may not fully capture differences in patient characteristics across hospitals, potentially leading to unfair comparisons.

Interpreting healthcare comparisons requires integrating epidemiological, statistical, and economic considerations, since populations and healthcare settings are rarely identical. For example, if a hospital emergency department had an average waiting time of two hours while the benchmark was one hour, interpreting this difference would require consideration of the “context” and the methodology used to calculate the indicator. Similarly, Van Vliet et al. compared three ophthalmology hospitals in the United Kingdom, the United States, and the Netherlands.³¹ Although these were major international tertiary care and ophthalmology training

centers, the authors had to account for contextual factors influencing cataract procedures and therefore provide details on the organizations’ location, type, teaching status, and surgical volume.

Similarly, Byrne et al. cited a surgical example involving high-complexity hospitals, some of which receive referrals of severe trauma cases (e.g., gunshot wounds), thereby increasing their baseline mortality risk.⁴ In such cases, excluding this subpopulation has been suggested to allow more equitable and fair comparisons with hospitals that do not receive such referrals.

COMPARABILITY AND INTERPRETATION OF DIFFERENCES (Table 3)

As early as 2006, Arah et al. proposed a methodological framework for measuring and comparing system performance, particularly healthcare quality indicators, across countries in the Organization for Economic Co-operation and Development (OECD).³² The authors’ starting point is particularly relevant: before selecting indicators, we should ask, “Whose performance are we measuring, and for what purpose?” They distinguish primarily between two types of frameworks: a health performance framework, which takes a broader societal or public health perspective on the determinants of health, and a healthcare performance framework, which takes a narrower, primarily clinical or technical perspective on healthcare in relation to health needs. The authors argue that benchmarking should not simply begin by selecting indicators and comparing numbers within a microsystem; rather, it should go beyond measurement and promote learning from processes.

In 2018, Kruk et al.³³ noted that healthcare systems have historically emphasized on coverage, access, and utilization while paying relatively less attention to quality of care. This creates a paradoxical situation: expanding coverage of low-quality services may yield little benefit and may even cause harm. Accordingly, they proposed viewing quality as a feature that should be embedded throughout the health system rather than merely a characteristic of an individual healthcare service.

Thus, their contribution is broader: it provides a conceptual rationale for measuring and comparing quality, identifying gaps, and using this information to guide improvement. The article uses comparative data and shows substantial variation in quality-of-care indicators, even among countries with similar levels of development or resources. Comparison highlights a fundamental issue: differences in performance across organizations create an opportunity to examine what those achieving better outcomes are doing differently, with an emphasis on turning comparison into organizational learning.

Indicators can identify this gap; benchmarking seeks to understand it and learn from those achieving better outcomes. The conceptual framework of Value-Based Healthcare (VBHC)³⁴ helps address key complementary questions: What do we mean by value? What outcomes matter? What does “better performance” in healthcare actually mean?

Table 3. From Defining Outcomes to Comparing Performance: Key Concepts and Tools

Concept	What is it used for?
Benchmarking	Enables performance comparisons and learning from differences
VBHC	Helps define which outcomes matter
ICHOM	Provides an example of standardization regarding what and how to measure, allowing outcomes to be compared
PROMs/PREMs	
Help measure outcomes and experiences from the patient perspective	
VBHC: Value-Based Healthcare	
ICHOM: International Consortium for Health Outcomes Measurement	
PROMs: Patient-Reported Outcome Measures. PREMs: Patient-Reported Experience Measures	

FROM BENCHMARKING TO CONTINUOUS IMPROVEMENT

A 2022 systematic review included 17 studies that showed a positive association between the implementation of benchmarking and improvements in quality of care: 10 studies reported improvements in processes, 13 in outcomes, and 7 in both types of indicators.³⁵ Willmington et al. reported that most studies (12 of 17) combined benchmarking with at least one complementary intervention (e.g., meetings among key stakeholders, audit and feedback, improvement plans, and/or financial incentives), and 10 studies used multiple strategies simultaneously.³⁵ This makes it difficult to determine the effect attributable specifically to benchmarking and underscores that its effectiveness appears to increase when accompanied by additional interventions. Another limitation is that many studies had short follow-up periods (e.g., six months to two years), raising questions about the sustainability of the observed effect, as initial improvements may reflect the immediate post-implementation effect of the project rather than lasting long-term organizational and cultural change.³⁶ In this regard, benchmarking should be considered part of quality management programs rather than a substitute for them.³⁶

DISCUSSION

Organizational changes that could improve patient health are often difficult to implement in practice, even when supported by robust evidence; they require interdisciplinary teams and a collaborative culture.³⁷ “Implementation science” is the study of methods and strategies to promote the adoption and integration of proven clinical treatments, practices, and organizational and/or management interventions into routine clinical practice, thereby improving health.³⁸ It bridges the gap “from theory to practice” by examining how evidence-based interventions or practices are implemented in real-world settings and by identifying the barriers that hinder their implementation.³⁸ In particular, several tools can be used before, during, or after the comparison process to translate benchmarking findings into improvement

actions: (a) Lean, which helps identify waste, variability, and non-value-adding activities;³⁹ (b) Six Sigma, which provides tools to reduce variability and defects and improve process capability;⁴⁰ and (c) PDSA (plan-do-study-act) cycles, a complementary approach that provides an iterative mechanism for testing and refining changes.⁴¹

It is the crucial final step in bringing potentially transferable “best practices” in care to many patients.⁴² However, the sheer volume and complexity of real-world data also require the development of more appropriate, sophisticated, and innovative data processing and analytical techniques, while maintaining the scientific rigor of research findings and addressing data ethics to harness their potential fully.⁴³

Many organizations still fail to recognize that placing patients at the center is the primary purpose of healthcare (e.g., because of skepticism or concerns about potential punitive uses), which entails actively engaging patients in system improvement. This approach still faces resistance from some leaders and healthcare professionals.³ An ongoing process of evaluation and communication can help foster a culture of transparency, trust, and learning.

The ultimate goal of measuring quality of care is to provide new insights into how performance can be improved— that is, what changes can be made to existing structures or processes to improve patient outcomes. Comparative performance assessment has been widely incorporated into strategies to evaluate and improve healthcare quality.⁴ However, its usefulness depends not only on the availability of comparable indicators but also on data quality, the validity of the measures, appropriate consideration of differences in risk and in the context of the populations being evaluated, clear governance, transparency, and a nonpunitive culture of improvement.

CONCLUSIONS

Benchmarking can be a highly valuable tool for healthcare management by transforming performance measurement into actionable information for improvement. Its value lies in identifying gaps,

understanding observed differences, and fostering learning and the adoption of evidence-based practices while accounting for clinical, institutional, and population contexts.

However, its ability to generate value depends on methodologically valid comparisons supported by high-quality data, comparable indicators, and appropriate adjustments.

When integrated into quality improvement strategies and organizations that foster transparency, trust, and learning, benchmarking can help translate findings into improvement actions. Conversely, incomplete data, noncomparable indicators, or inadequate adjustments may lead to misinterpretations or unfair comparisons. Incorporating the patient experience can help orient these assessments toward outcomes that matter to patients.

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