IFC Healthcare Benchmarking

Key Insights from the Round of 2025

April 2026

In partnership with the Government of Japan

IFC International Finance Corporation
WORLD BANK GROUP

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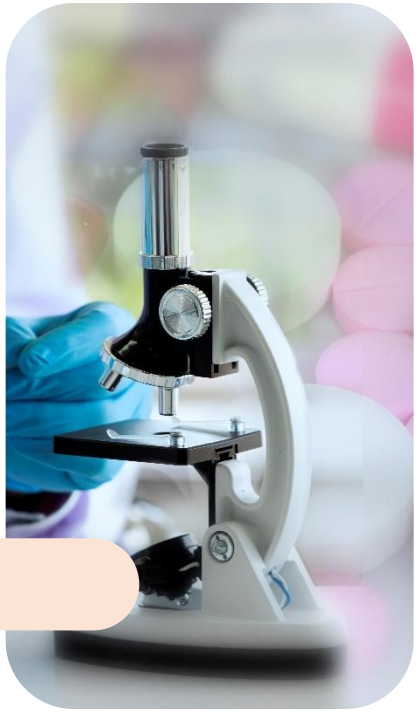


Executive Summary

Executive Summary (1/5)

Introduction

- This report describes the IFC Healthcare Benchmarking Program and some of the **key findings** that emerged from the 2025 round.
- The analysis covered **53 participating companies**, including **182 entities** (mostly hospitals) operating across **30 countries**. We complemented this extensive "data pool" with subscriber data from >150 other healthcare organizations worldwide. In total, we analyzed **>40,000 data points.**
- Some of the findings point to **significant potential gains** in **efficiency and quality.**

International Context – Why Benchmarking?

In countries around the world, governments are aiming to provide **Universal Health Coverage** (UHC). To achieve this goal there are three distinct facets of the healthcare system that must be measured, understood, and improved.

- Increasing overall **access** to care
- Increasing the **efficiency** of funding used to provide care
- Increasing the **quality** of care delivered to patients.

In other words, the **capital donated or invested must be spent wisely** to ensure increased access and improved patient outcomes. Otherwise, that money may never achieve its intended goal of improving lives, because simply increasing expenditure on healthcare may not yield the expected health outcomes, especially if the efficiency of this spending is low.

Due to limited fiscal space (e.g. as many governments reduce donor funds), policymakers are turning their attention to health spending **efficiency.**

This benchmarking analysis, conducted with private providers, highlights the importance of performance improvement that can support efficiency and deliver greater value (better services delivered at a lower cost, with maintained or improved quality). There are lessons to be shared from this exercise for both public and private care providers.

Executive Summary (2/5)

International Context (cont'd)

- In March 2022, the **IMF** outlined this issue in a report*:
- *"**The scope for efficiency gains is the largest among low-income developing countries and emerging markets**...that can translate into years of life lost (up to 10 years in Sub-Saharan countries) and between 1 and 2 percent of GDP on wasted resources... This study serves as an analysis of the "macro-efficiency" of healthcare spending, and there remains **a need for analyses of "micro efficiency" that looks into specific aspects of health systems, such as hospitals...to produce more actionable interventions**."*
- This is not just a public sector consideration. The private health services sector is being challenged equally to provide quality aligned care but with more value offered to payors. This requires them to understand the fundamentals of operational efficiency, performance improvement, quality focus and business model design.
- The IFC Healthcare Benchmarking Program seeks to address this need by analyzing "micro-efficiency" at the hospital level across different geographies.

Why did IFC launch the international Healthcare Benchmarking Program?

- IFC launched the Healthcare Benchmarking Program **in response to requests from health sector client companies seeking comparative data from peer healthcare organizations internationally. The goal? To identify opportunities for performance improvement**.
- The Program was initially developed in partnership with 18 companies and **piloted in 2021**. Specifically, these companies collaborated with IFC to develop a chart of relevant comparative metrics, definitions and outputs based on their needs. In 2023, he first full round was then launched, followed by the second round in 2025. Client retention is high; each year more than half of the participating companies from the previous round have re-enrolled.
- In 2025, a record of **53 companies**, including **182 entities** (hospitals, consolidated groups, and clinic companies) from **30 countries** participated.

* www.imf.org/en/publications/wp/issues/2022/03/04/patterns-and-drivers-of-health-spending-efficiency-513694

Executive Summary (3/5)

What motivates healthcare organizations to join the IFC Healthcare Benchmarking Program?

Participating organizations invested time and energy to provide detailed data, much of which is sensitive and highly confidential.

Motivations for healthcare organizations in emerging markets to join the Benchmarking Program include:

- **Geographic isolation**: Little contact with peers to share relevant comparable information.
- **Lack of access to relevant information**: Inability to compare performance with national and international peers, including in more mature markets.
- **Low-trust environments**: Reluctance to share sensitive data locally.
- **Lack of understanding** of approaches to performance improvement, including relevant performance measurement metrics.
- Pressures relating to **resource planning and optimization** including staffing and asset utilization.
- Desire to learn **performance improvement techniques** across financial, operational and clinical domains.

Importantly, regarding the above, IFC is perceived as an expert and confidential **honest broker**.

IFC's Motivations

Specifically, IFC aims to:

- Address the need for **"micro-level analysis" of hospital efficiency**, as called for by the IMF in 2022.
- **Promote performance measurement** as a practical tool and a first step to improve performance.
- **Encourage knowledge sharing** of challenges and best practices.
- **Encourage innovation** and the use of productive business processes and technologies.

Executive Summary (4/5)

IFC's Motivations (cont'd)

- Promote international practices of **Quality Improvement** including Patient Safety.
- **Identify common themes** and bottlenecks affecting performance.
- **Leverage detailed sector data** to better understand trends, nuances and common performance challenges.
- Demonstrate the different types of private sector **business models** and how cross-country learning can support enhancement. For example, how to: operate with Social Health Insurance, maximize utilization of operating theaters, or increase the use of day case surgery.
- Help determine how private sector business models can support governments in overall **health system strengthening**.

Observations

Based on the findings of the IFC Healthcare Benchmarking Program in 2025 (and previous rounds), key observations include:

- There are **wide variations in performance** across the Benchmarking participants. Market nuances, business model maturity, service type, access to health professionals, financial protection (ability to pay) all impact performance variations. These issues impact overall performance and specific asset utilization.
- **Regional variations** in performance were generally lower than expected.
- There are consistent **high levels of interest in Healthcare Benchmarking**, and 2025 was a record year for the Program. There was also a high retention rate: 66% of participants in 2023 rejoined in 2025.

Executive Summary (5/5)

Observations (cont'd)

- Overall, on average participating companies **perform similarly financially** to international publicly listed healthcare companies.
- **Day-Case Surgery** appears to be highly underdeveloped in emerging markets.
- Reporting of key **Quality indicators** appears to be established in some areas, but there are concerns about under-reporting.
- There is **strong evidence** that the IFC Benchmarking Program (and relating Quality improvement support) is increasing the levels of Quality Measurement.
- Measurement of **Maternity Outcomes** appears to be under-developed.
- There is **scope to treat significantly more patients** within existing resources.

Finally

We hope that this report will be interesting to healthcare planners and policymakers. We believe that some of the findings are transferable to other geographies and to the public sector.

We want to thank the Government of Japan for their support of the IFC Healthcare Benchmarking program.

Profile of Participants

2025: A Record Year for the Benchmarking Program

66% of companies participating in 2023 re-enrolled in 2025

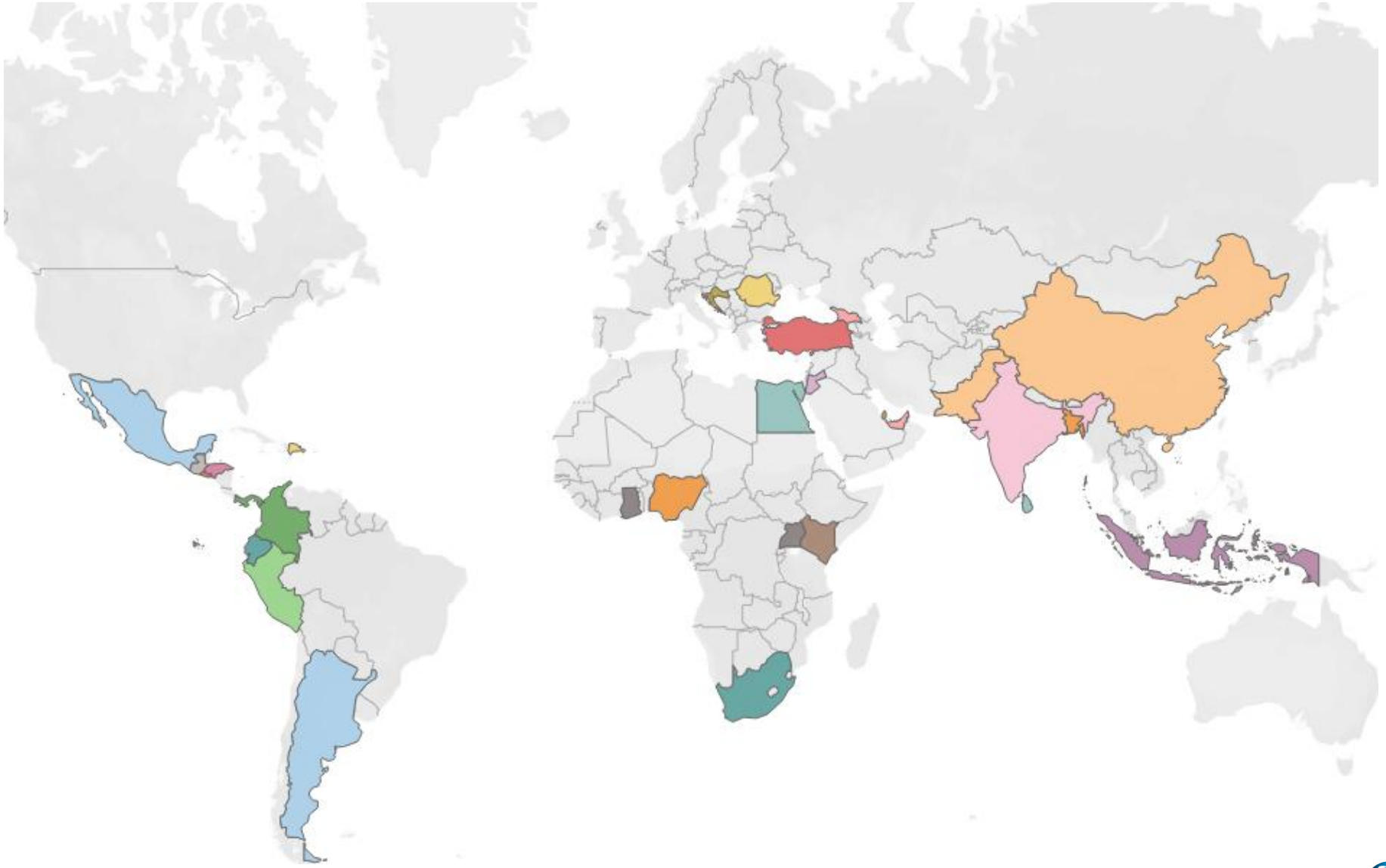
53	182	30	➢ 40,000
Companies participating	**Entities**	**Countries**	**Data Points analyzed**

- **18,000** Hospital Beds
- **1.2 million** Inpatient Admissions (**58%** Female)
- **561,000** OR Procedures
- **65,000** Maternal Deliveries
- **419,000** Day-case Procedures
- **21 million** Outpatient Attendances
- **89,000** Staff employed (**60%** Female)

Notes:
- Most entities are **hospitals** (either individual facilities or groups). Others include outpatient and specialist (eg eye-care) clinics/companies.
- 87 entities (48% of participants) participate in **Social Health insurance** programs.
- See **Annex** for further profile information, including No of Hospitals per organization, No of Beds, and Accreditations.

Geographic Profile

Participating Companies Operate Across 30 Countries



IFC's Approach

Framework for Healthcare Benchmarking

Superior and improved performance can be achieved across all four key dimensions in the Quest for Excellence

- Cost structure
- Revenue profile
- Profitability
- Pricing

- Bed utilization
- Key Asset utilization
- Human Resources
- Payor mix

- Mortality rates (risk-adjusted where possible)
- Hospital-acquired infection rates
- Adverse event reporting
- Preventable patient harm indicators

- Day-case rates
- Maternity Outcomes

See **Annex** for the full list of 148 comparative indicators used.

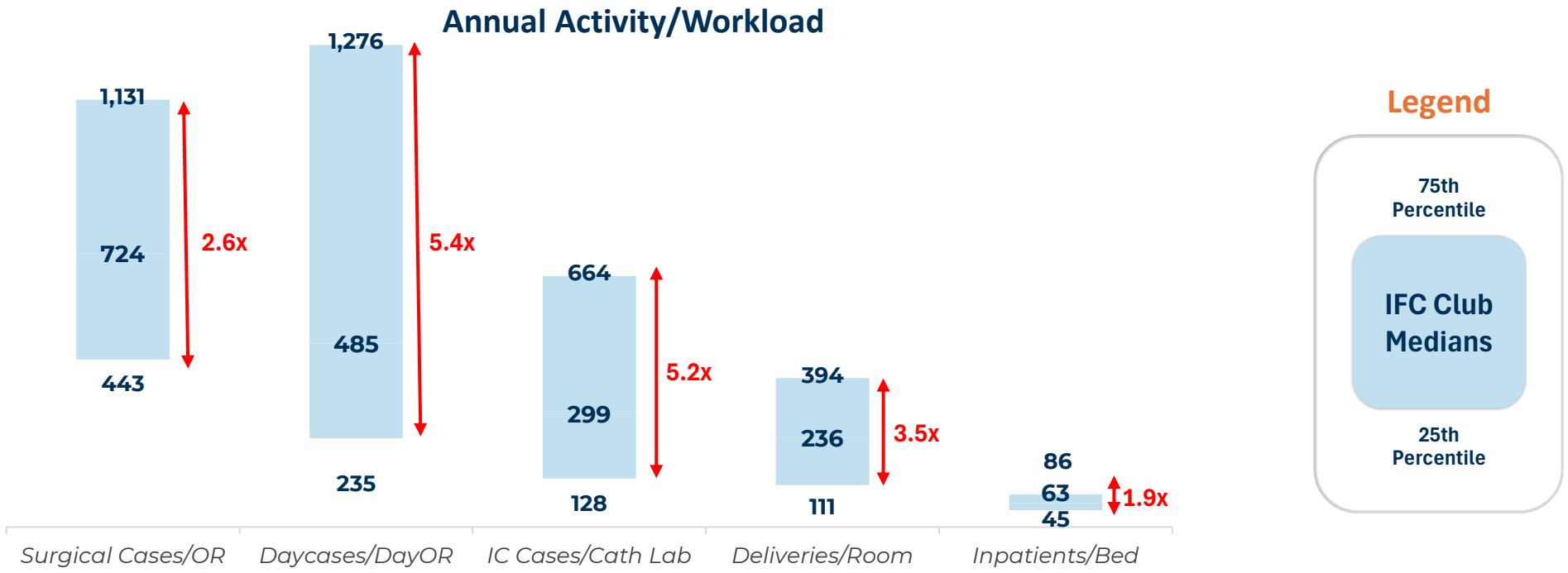
Selected Findings

Notes:

- Benchmarking variations may be caused by multiple reasons including: different definitions, stage of development, case-mix, and business model -- as well as variations in performance.
- Some statistical outliers were removed from the analysis in order to improve clarity.

Utilization of Key Healthcare Facilities Varies By Factor Of 2-5x

By increasing productivity, many healthcare facilities could serve more patients within the same infrastructure

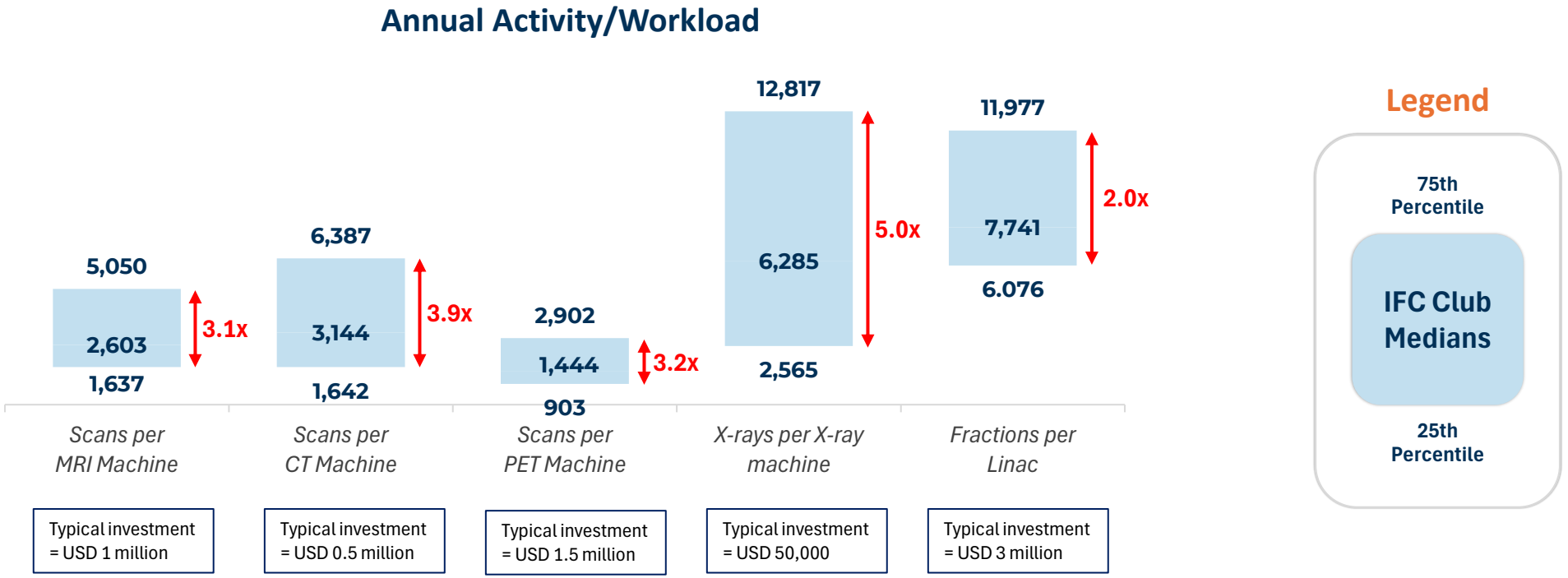


Commentary

- Our analysis shows that there are **very wide variations** in utilization of "core" high-cost hospital facilities – with typically **2-5 times variation** between the highest and lowest quartiles of utilization.
- Some variations are explained due to factors including: stage of business maturity/years of operation, local market, and business model –- but many variations indicate **potential for performance improvement**.

There are wide variations in utilization of high-cost equipment

Wide variations in the utilization of key equipment indicate potential for improvement



Commentary

- Our analysis of radiology and imaging (incl radiation therapy) equipment shows that there are **very wide variations** in utilization of high-cost healthcare equipment.
- Some variations are explained due to factors such as: stage of business maturity/years of operation, access to maintenance and spare parts, local market factors, and clinical model – but **many variations are unexplained**.

Years in operation is an important determinant of performance

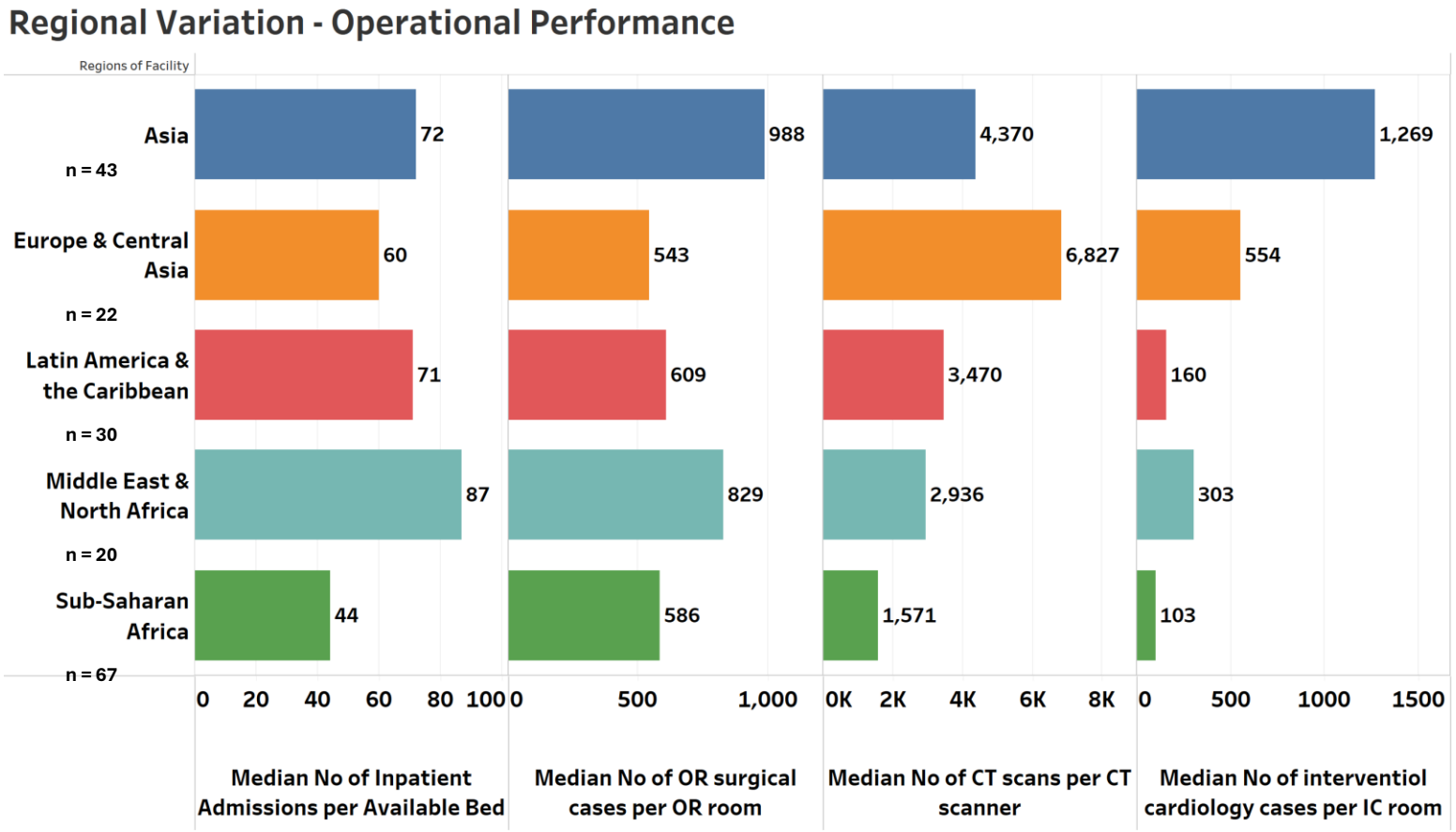
More mature facilities have significantly higher productivity

	Operational Performance		
	<5 Years	*>5 Years*	
Inpatient Admissions per Inpatient Bed	47	65	↑
ICU Admissions per ICU Bed	19	40	↑
Outpatient Consultations per Consultation Room	2,004	3,429	↑
Surgical Procedures per Operating Room	450	820	↑
Number of X-rays per X-ray machine	5,645	6,417	↑

Commentary

- **Business longevity** is a key determinant of performance. Our analysis shows that healthcare facilities operating for 5 years or more have significantly higher productivity compared with younger facilities.
- Reasons include time required to: gain the trust of local people, including health professionals; recruit large numbers of staff who can then work together in teams; gain an understanding of local market dynamics; and develop systems of performance management.
- In IFC's experience it usually takes **at least 3-4 years** (in some cases even longer) for a new greenfield hospital to achieve financial (EBITDA) breakeven. Underestimating this (as well as the scope for project cost overruns) is one of the most common reasons for financial distress and **investment failure**.

Analysis of regional variations shows a "mixed picture"

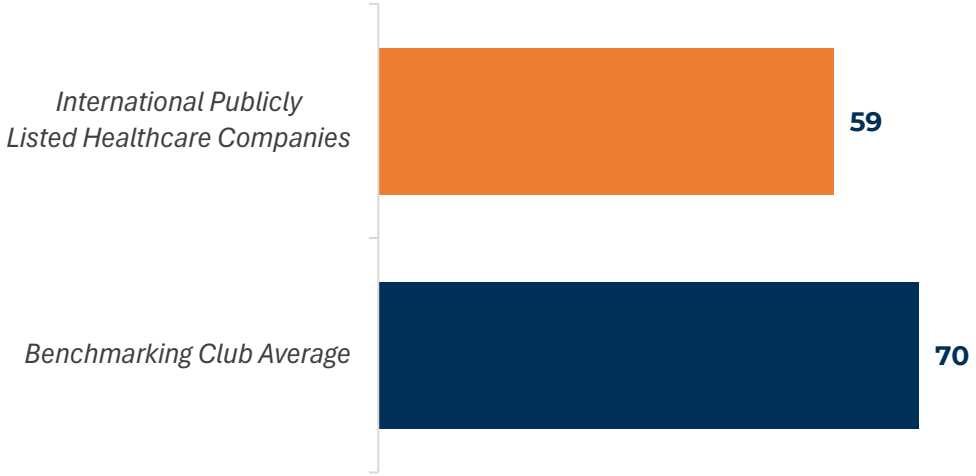


Commentary

- Overall, participating facilities in **Asia and MENA** showed the highest levels of productivity.
- Hospitals in **Sub-Saharan Africa** appear to have generally lower productivity levels, particularly regarding **high-cost assets**. But they compare similarly regarding OR efficiency.
- However, overall, we observed greater variations **within regions** (and countries) than between them.
- Analysis of financial performance (e.g. profitability and Return of Assets) showed a similarly mixed picture.

Healthcare companies in emerging markets have greater liquidity needs

Average Receivable Days
IFC Club members, Hospitals Only, vs International Companies



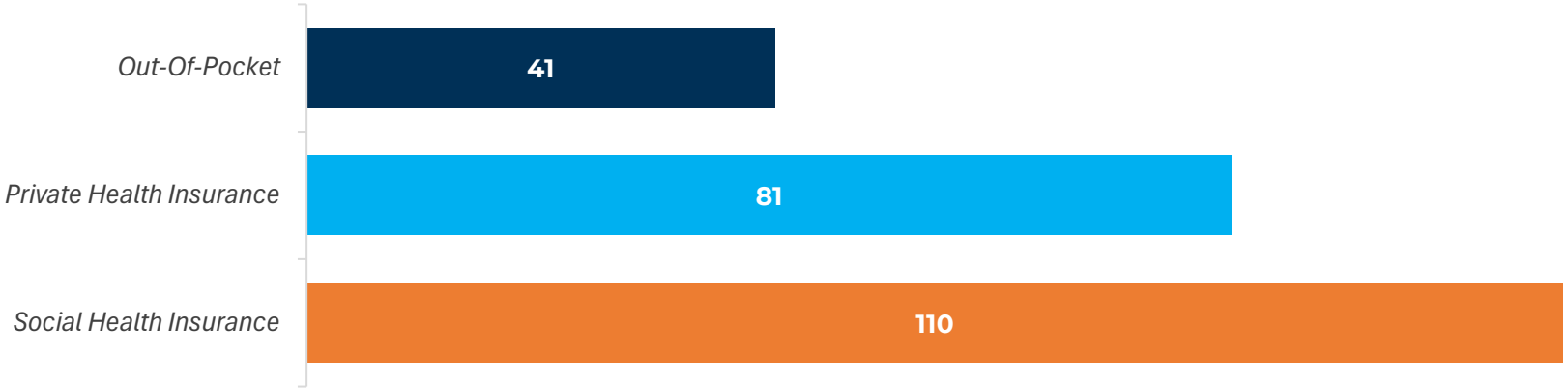
Commentary

- Although our analysis shows that the financial profitability and returns achieved by IFC Club members compare well with internationally publicly listed companies, the picture is different regarding **liquidity metrics**.
- As the chart shows, Receivables Days across the Club are **significantly higher** than those of international publicly listed healthcare companies.
- This issue raises many important related business challenges including ability to pay staff and suppliers, to leverage procurement discounts, and to generate sufficient funds to **invest for growth**.
- Ratios are similarly higher for other related measures of liquidity including **Payable Days** and **Inventory Days**

Payor Profile significantly impacts Financial Liquidity

Receivable Days vary significantly, depending on the type of dominant payor

Average Receivable Days
IFC Club members by largest Payor Type,

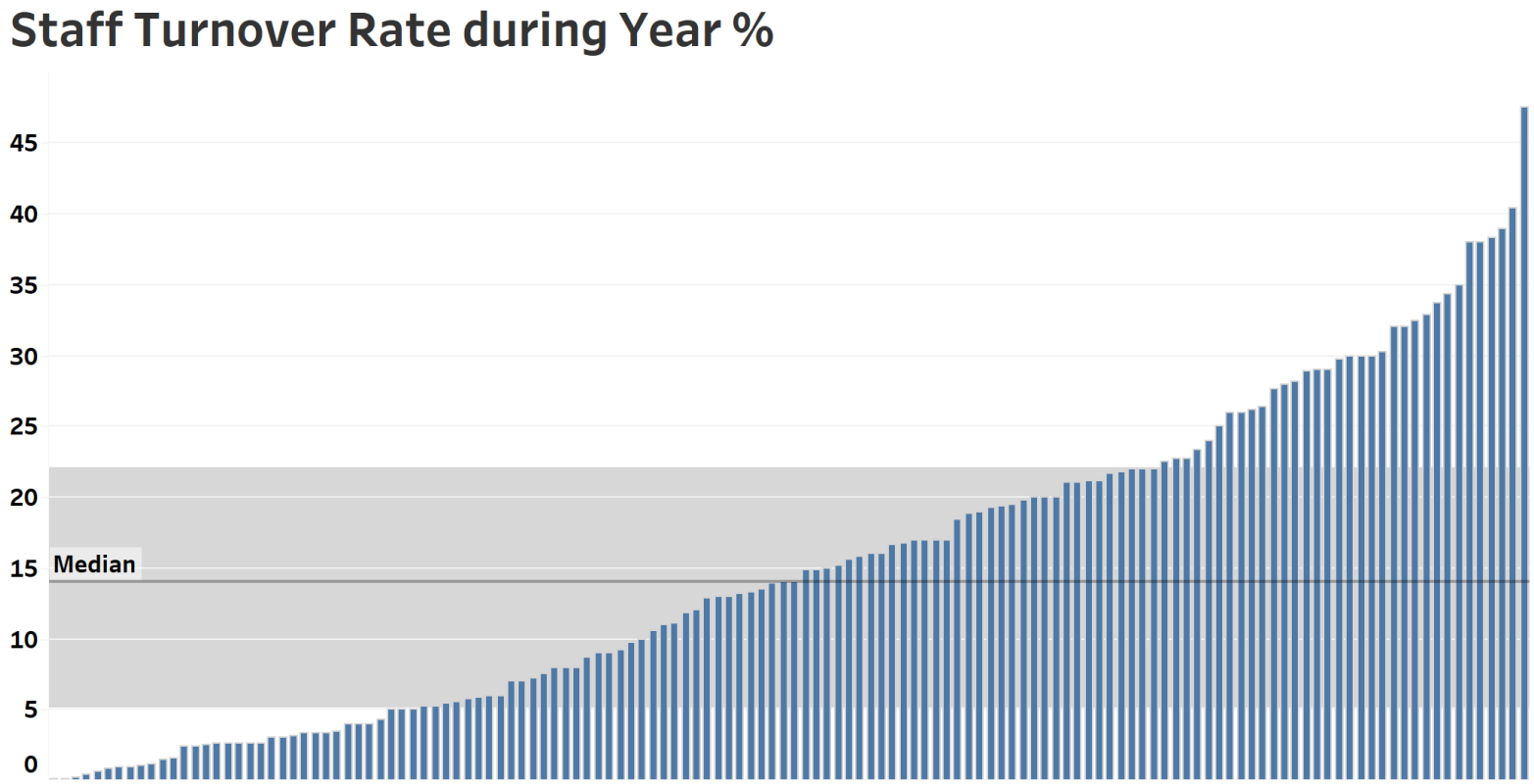


Commentary

- As the chart above shows, companies oriented towards **Social Health Insurance** have **significantly higher** Receivable Days compared with other payor profiles.
- This factor may **deter** companies from participating in such programs, unless working capital financing solutions are available in the local market.
- Not surprisingly, companies oriented towards cash/out-of-pocket payment have the lowest number of Receivables Days.

Staff turnover rates vary significantly across participants

Top performers were able to contain staff turnover below 5%.



Commentary

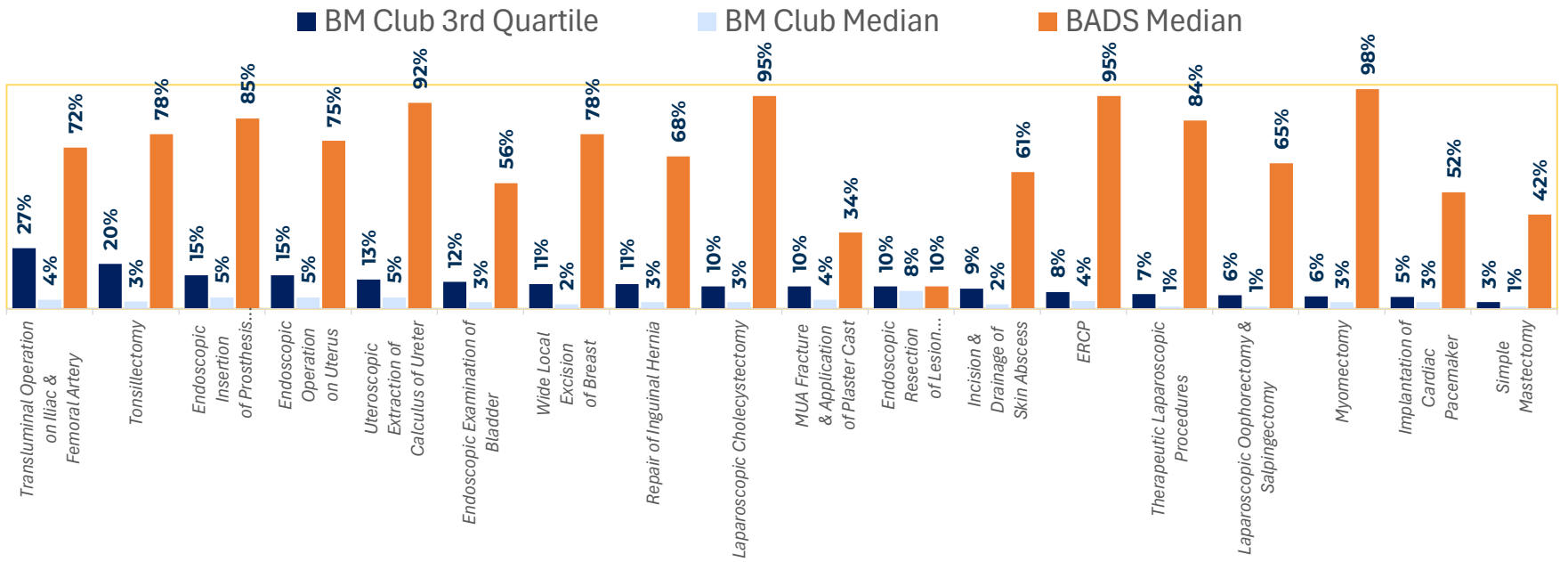
The WHO estimates a projected **shortfall of 11 million health workers** by 2030, mostly in low and lower-middle income countries. High staff turnover can be costly and impact on the quality of care.

Strategies to reduce staff turnover include:

- **Leadership and Culture**: Compassionate leadership that values staff, celebrates achievements, and involves them in decision-making improves retention.
- **Professional Development**: Investing in training, skills, and career development.
- **Flexible Working**: Offering flexible schedules that help staff achieve a better work-life balance.
- **Onboarding**: Providing robust, supportive, and peer-supported induction reduces early turnover.

Day-case surgery remains under-developed in emerging markets

Day-case rates for common procedures significantly lag international rates (based on British Association of Day Surgery)



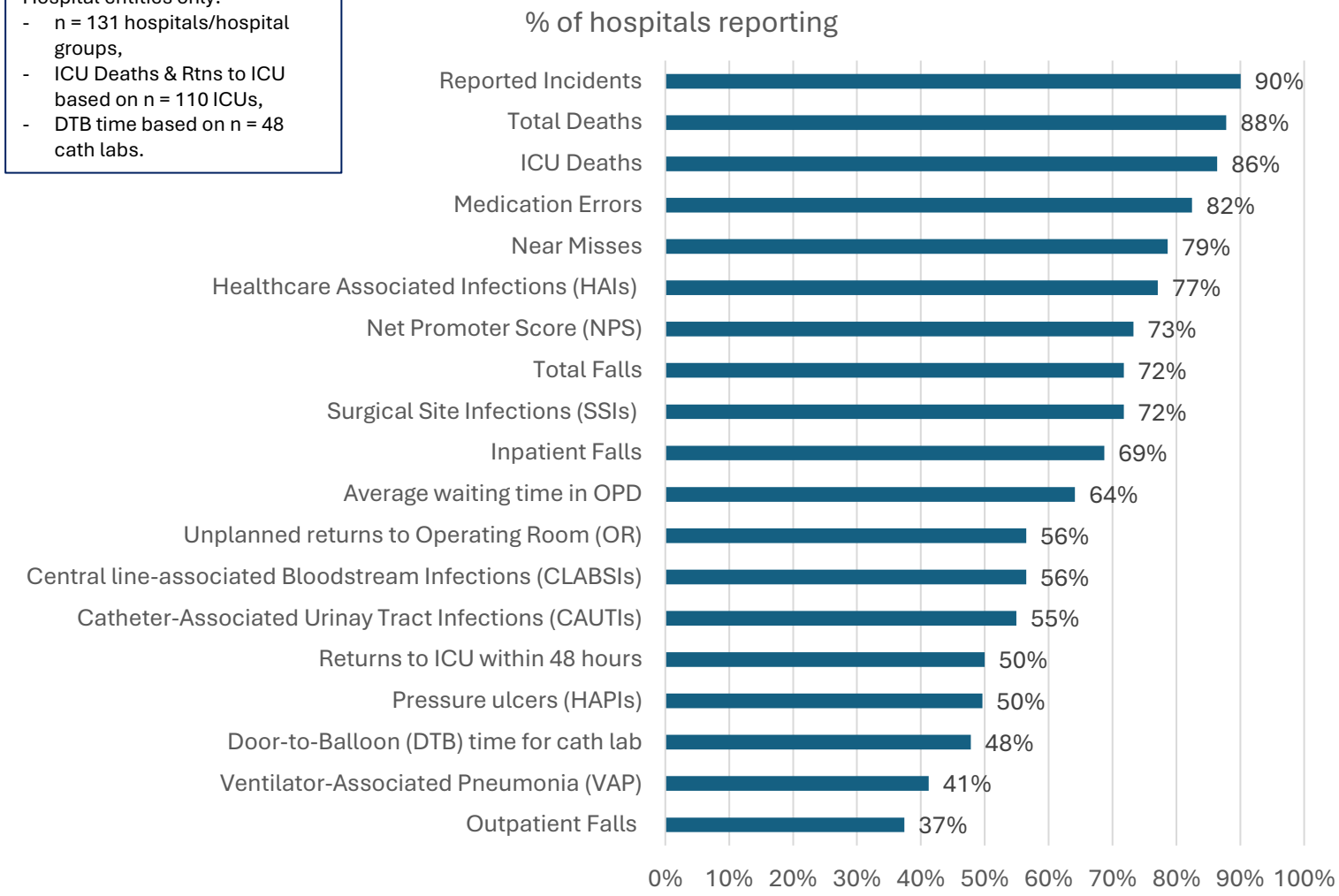
Commentary

- Definition: A day-case is a patient who is **electively admitted and discharged on the same day**, so does not require an overnight stay in hospital.
- Studies consistently show that procedures carried out as day-cases **cost significantly less compared with inpatient admissions**.
- However, our analysis shows that **day-case surgery is highly under-developed** among healthcare companies operating in emerging markets.
- Common reasons given include: lack of relevant skills and equipment, patients' preferences, "conservative" clinical practices, and payor reimbursement systems (i.e. that encourage overnight stays).
- There is also **evidence that keeping patients in hospital for longer increases the chances of harm,** e.g. from infections, adverse drug reactions and pressure ulcers.
- See **IFC webinar**: https://www.youtube.com/watch?v=SyFNsFEHCQE

Quality Measurement has been established in some areas

However, some measures of avoidable harm (e.g. unplanned returns to OR/ICU, pressure ulcers and outpatient falls) are measured less frequently

Hospital entities only:
- n = 131 hospitals/hospital groups,
- ICU Deaths & Rtns to ICU based on n = 110 ICUs,
- DTB time based on n = 48 cath labs.



Commentary

- **Context:** In the US about **one in 10 patients** is harmed while receiving hospital care. The WHO considers that the situation is much worse in low- and middle-income countries, which it estimates account for 66% of the global burden of adverse events from unsafe healthcare. It considers patient safety to be a **serious global public health issue**, and the 14th leading cause of the global disease burden – - about the same as TB and malaria.
- **Findings:** The rate of completeness of quality metrics surveyed is **low in many important areas**. More than half of the respondents were unable to report core metrics including unplanned returns to ICU, pressure ulcers, door-to-balloon times, ventilator-associated pneumonia, and outpatient falls.
- **Implications:** **International investors** are also increasingly concerned about quality and patient safety, not least due to **risk management** and **reputational concerns**. Therefore, developing robust QA systems is not only good for patients and staff, but also represents an important opportunity for organizations seeking differentiation and value improvement.

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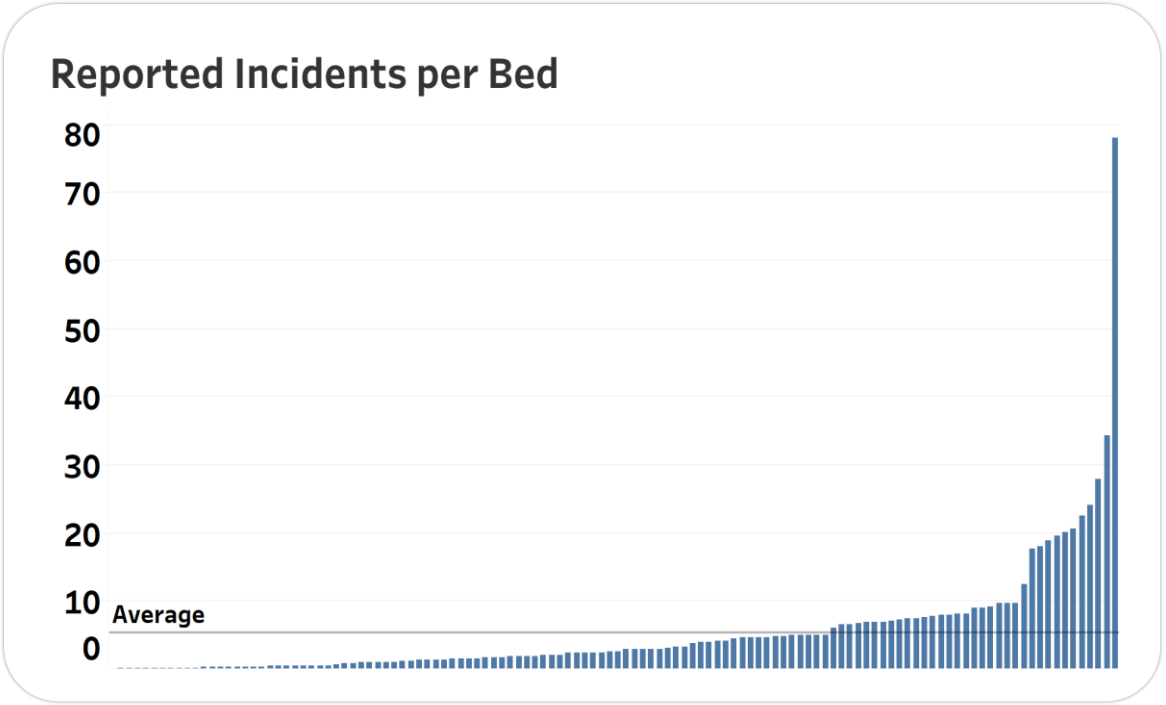
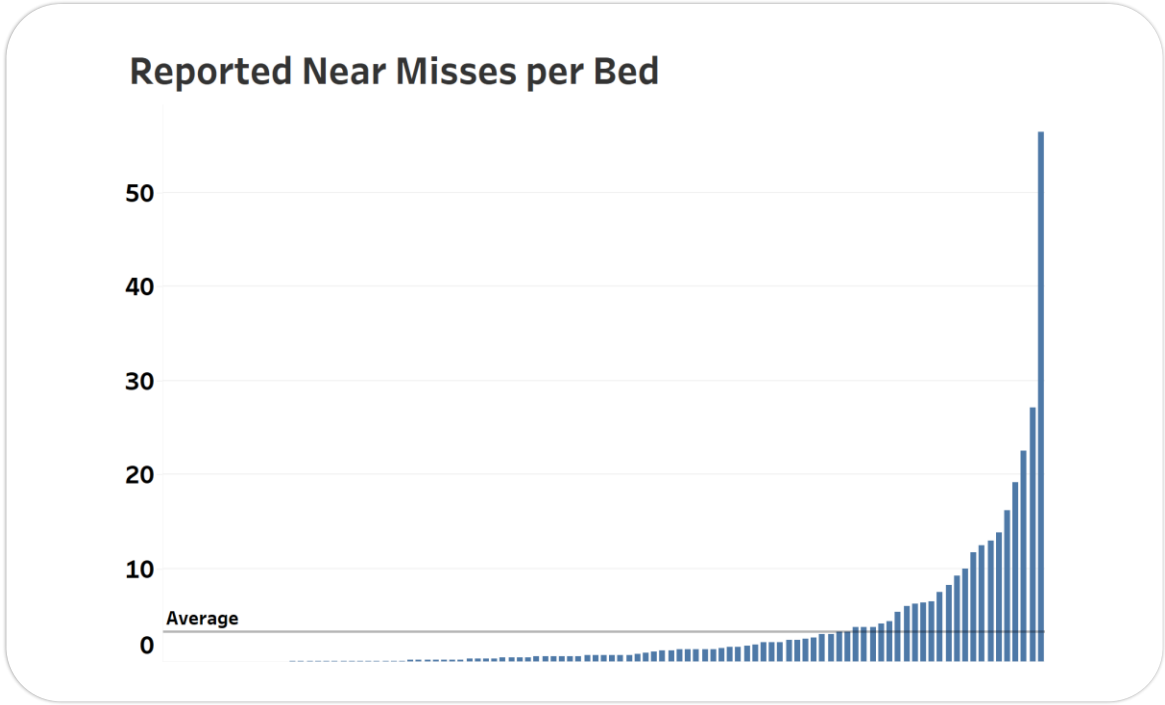
However, important quality metrics appear to be under-reported

More than half of participants reported Zero or near-Zero Incidents and Near-Misses



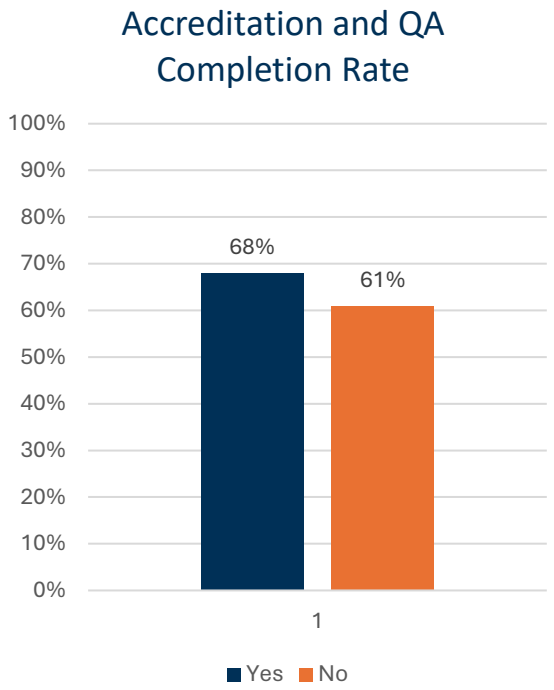


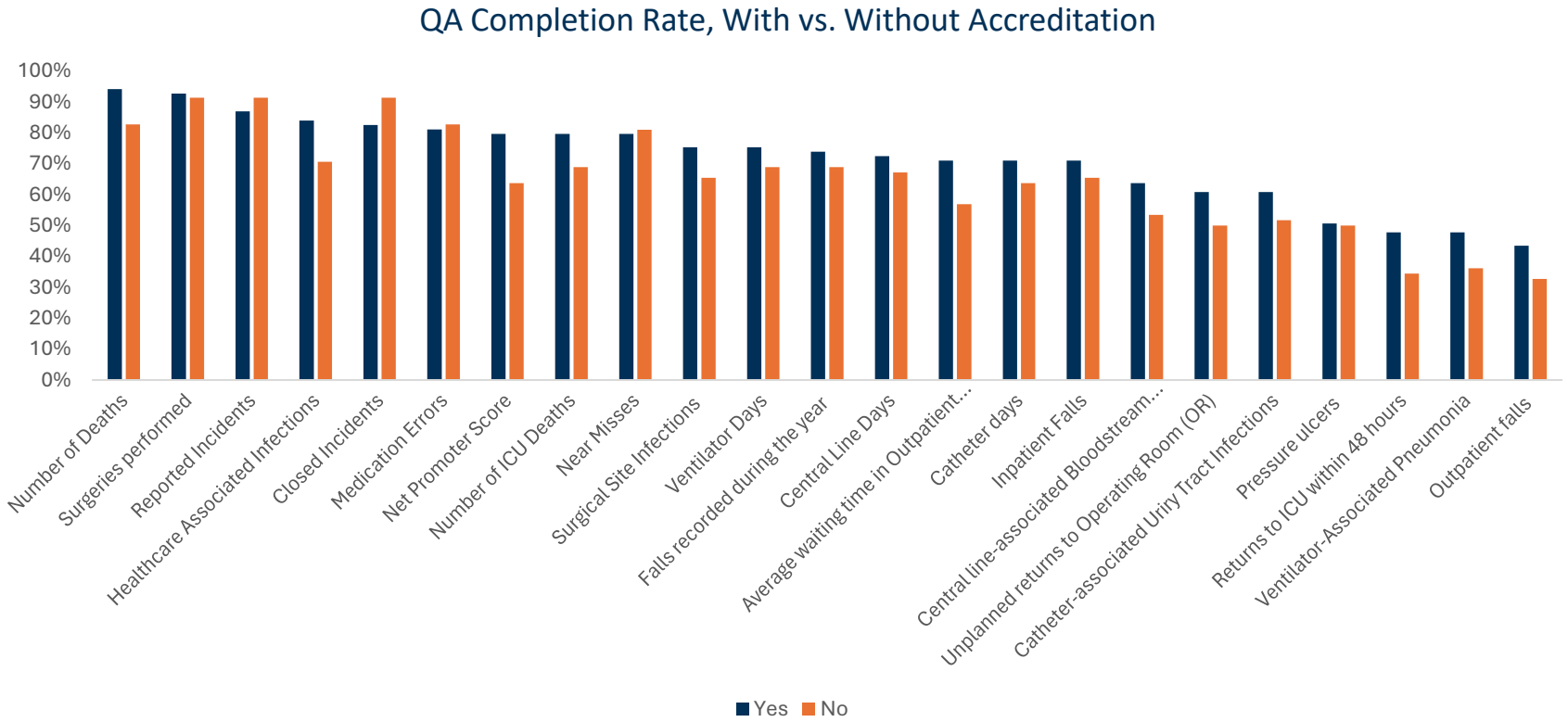
Commentary

- Considering the highest quartile of reporting, a “rule of thumb” would be to expect around 10-15 Incidents per bed annually, and 5-10 near misses per bed.
- Lower numbers may indicate under-reporting.
- We observed similar patterns for other measures of preventable harm including infections and medication errors.

Formal Accreditation appears to impact levels of completion of Quality metrics

Overall, hospitals with formal healthcare accreditations have higher reporting rates for Quality metrics



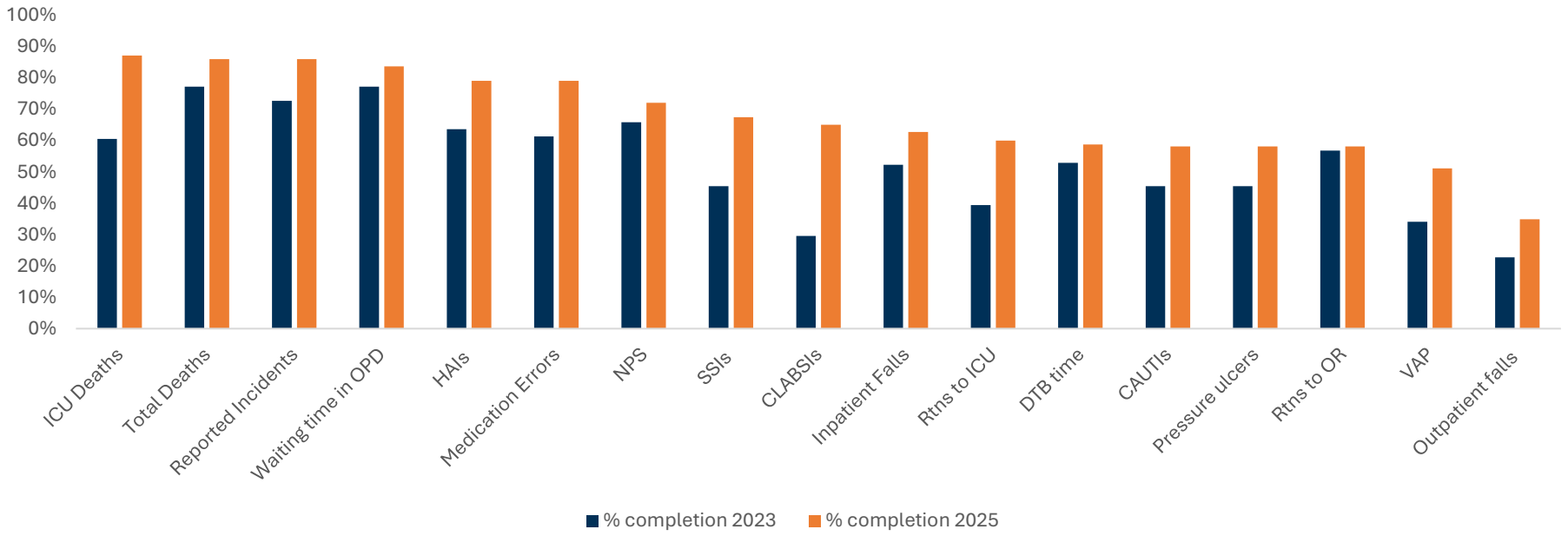


Commentary

- Overall, hospitals with formal healthcare accreditations (national or international) have higher reporting rates for quality metrics.
- Accredited companies have a higher rate of reporting for 21 of the 25 quality metrics surveyed in 2025.

Significant improvement in quality measurement is possible

Repeat participants were able to able to improve measurement across all 17 indicators



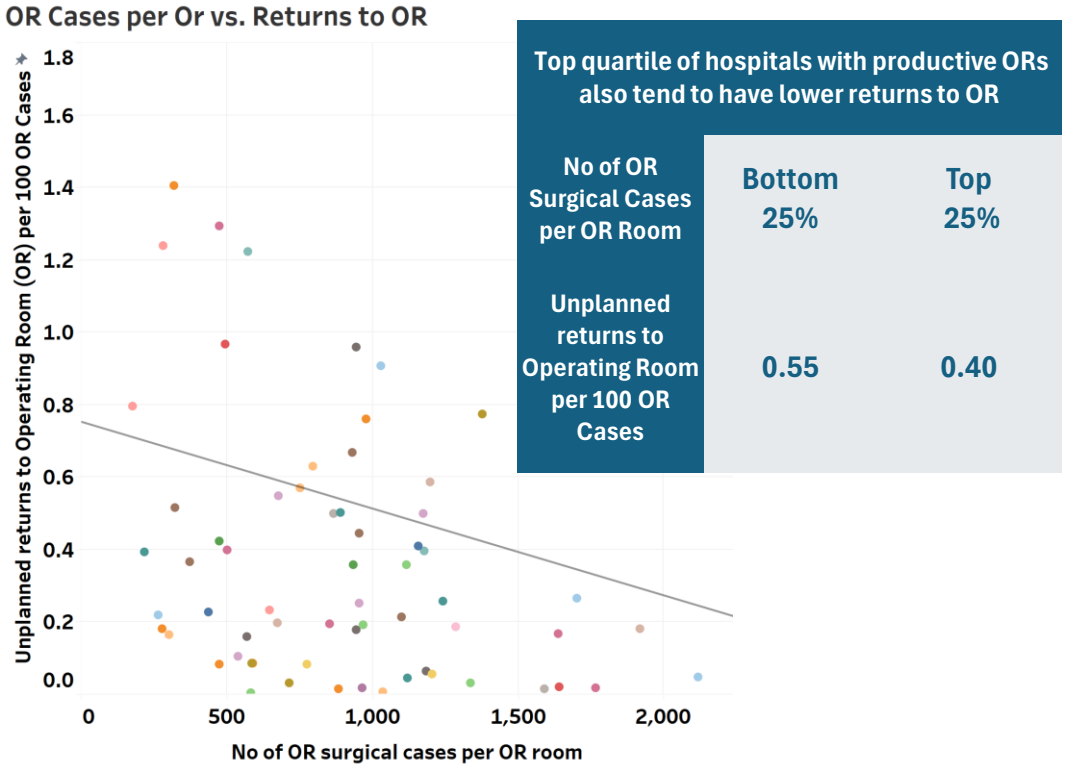
Hospital entities only:
- n = 44 hospitals/hospital groups,
- ICU Deaths & Rtns to ICU based on n = 38 ICUs,
- DTB based on n = 17 cath labs.

Commentary

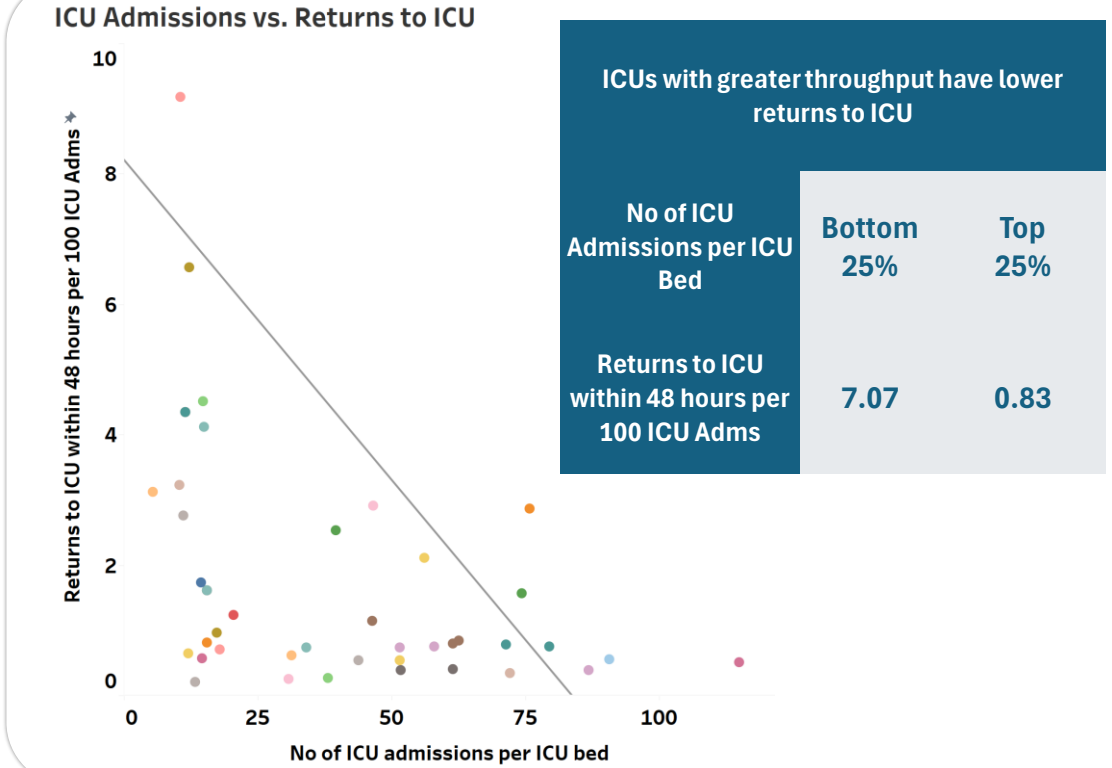
- We surveyed the 44 hospital entities that participated in **both** 2023 and 2025 Benchmarking rounds, across the 17 QA metric surveyed in both years.
- The **rate of completeness** of Quality metrics reported **improved significantly** across **all 17 QA metrics surveyed**.
- This **consistent and significant improvement** is evidence that the Benchmarking Program is having a **significant positive impact on Quality Measurement**.
- The most significant improvements (rates of reporting completeness) related to: **ICU Mortality**, **Surgical Site Infections** (SSIs), **Central Line-Associated Bloodstream Infections** (CLABSIs), **Outpatient Falls**, and **Unplanned Returns to ICU**.

No evidence that higher productivity reduces quality

Higher productivity appears to be correlated with fewer unplanned returns in OR and ICU.



Top quartile of hospitals with productive ORs also tend to have lower returns to OR		
No of OR Surgical Cases per OR Room	Bottom 25%	Top 25%
Unplanned returns to Operating Room per 100 OR Cases	0.55	0.40



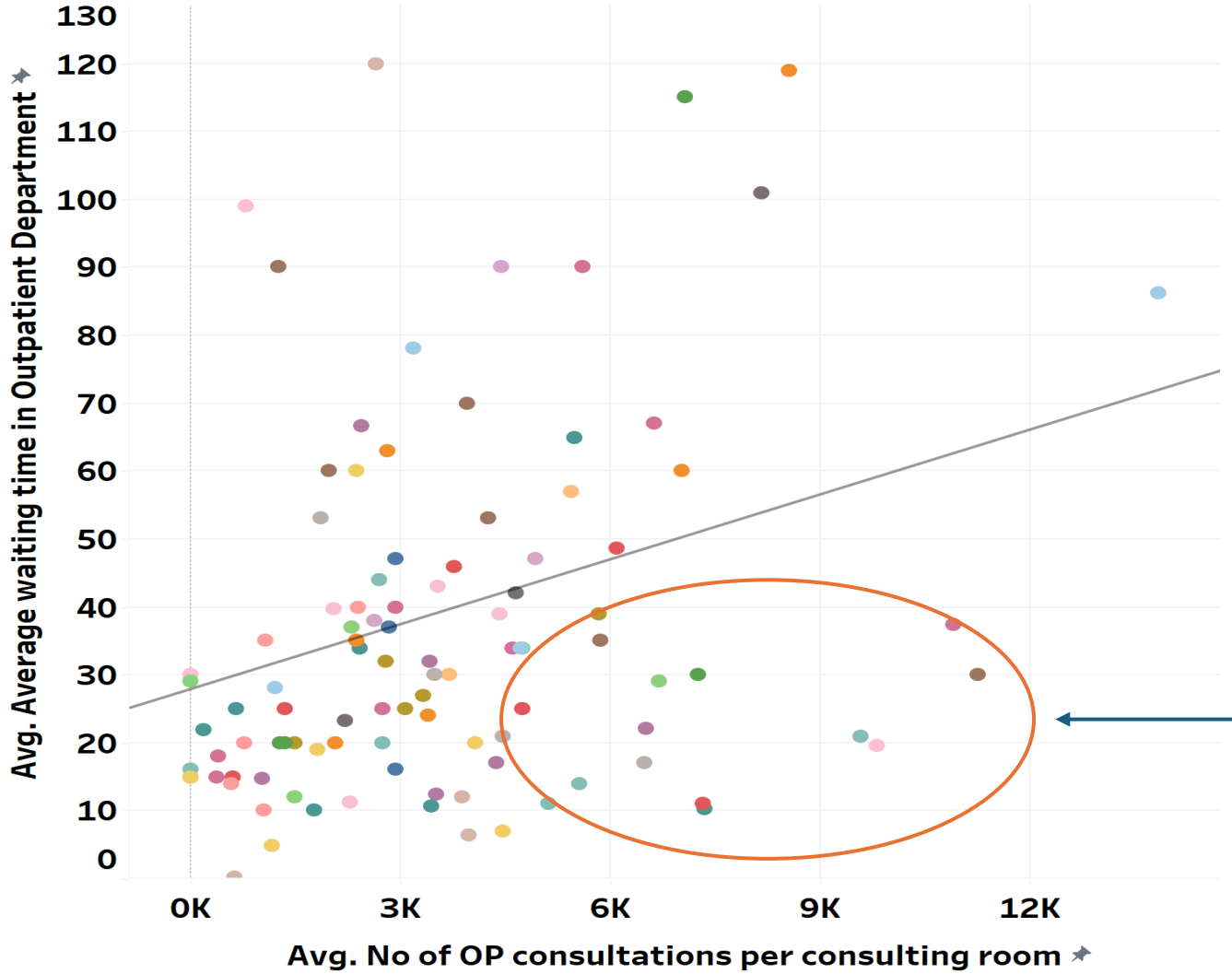
ICUs with greater throughput have lower returns to ICU		
No of ICU Admissions per ICU Bed	Bottom 25%	Top 25%
Returns to ICU within 48 hours per 100 ICU Adms	7.07	0.83

Commentary

- Operating Rooms (ORs) and ICU with **higher productivity levels** appear to have **fewer unplanned returns**. This **may** imply that higher productivity and well-organized processes are correlated with higher quality.
- Interestingly we did not find any similar correlation between high **overall volumes** and fewer returns.

However, busy outpatient departments appear to have longer waiting times

Higher utilization of outpatient consultation rooms appear to be correlated with longer waiting times.



With increased productivity waiting time increases			
No of OP consultations per consulting room	Bottom 25% (<1599)	Medium (1599-5439)	Top 25% (>5439)
Average waiting time in outpatient department (mins)	24	46	57

Some organizations were able to achieve high OPD utilization <u>and</u> low waiting times

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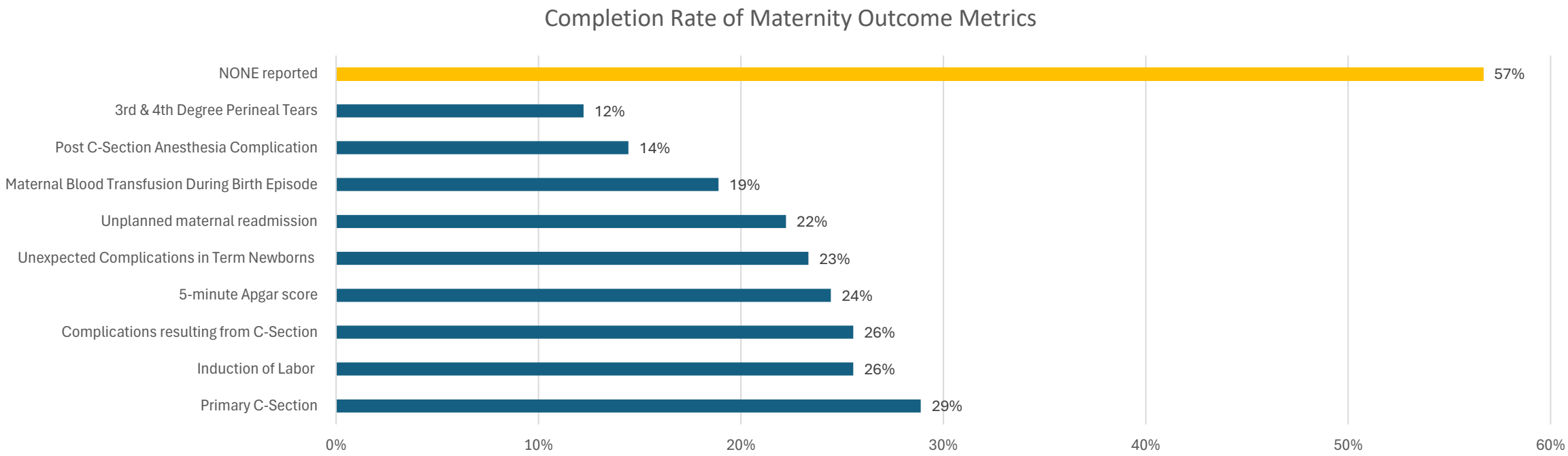
Maternity outcomes measurement appears to be under-developed

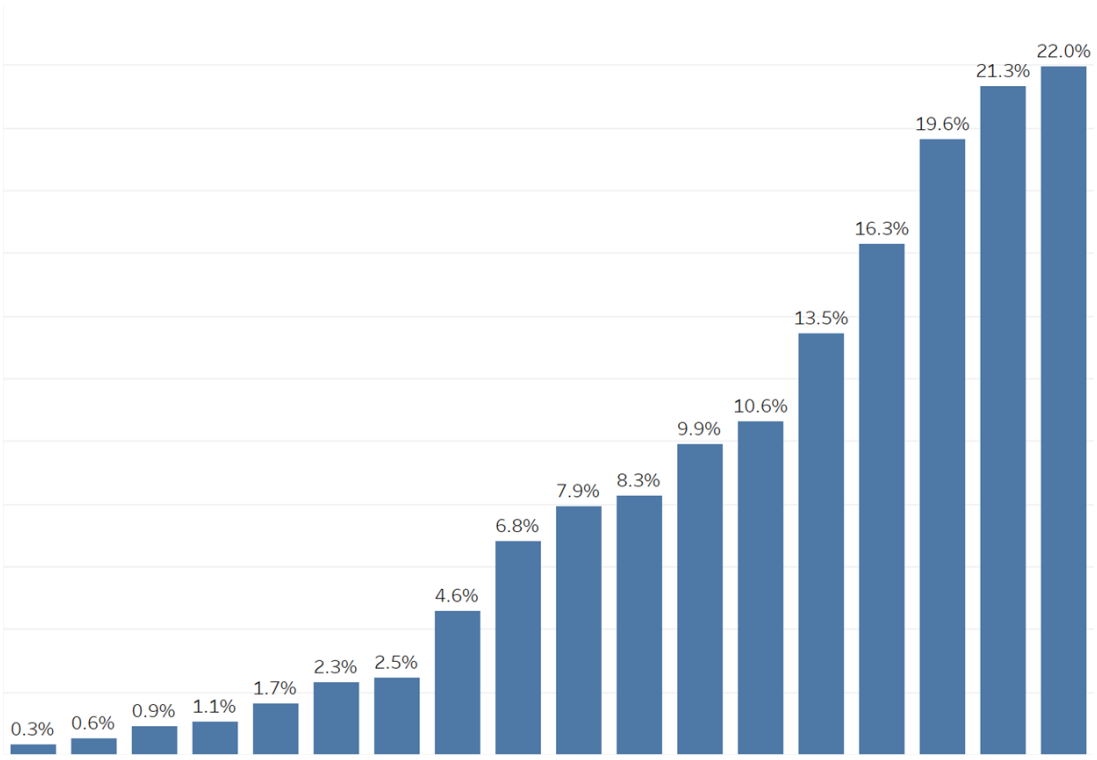
Most hospitals providing maternity services reported no outcomes data



Commentary

- This **pilot initiative** of the Benchmarking Program surveyed 9 x maternity outcome metrics.
- According to WHO, about **260,000 women** (>700 per day) died during and following pregnancy and childbirth in 2023. Approximately 92% of these occurred in low and lower-middle-income countries, and **most could have been prevented**.
- Improving maternal health is crucial for long-term development, affecting not just the mothers but the survival and well-being of their children and families.
- Overall, the benchmarking participants provide *c.***65,000 deliveries**, and 95 (around half of all participants) reported >100 deliveries per year.
- However, most participants (51) reported **none** of the outcome metrics surveyed (or zero). Only four reported **all** nine metrics.

Lowest quartiles and lowest reported values for Maternity Outcomes indicate achievable performance



Metric name	Lowest Record	Lowest Quartile
Primary C-section Rate (n=22)	4%	37%
Induction of Labor Rate (n=7)	4%	12%
Unplanned Maternity Readmission (Post-Partum or Post-Delivery) Rate (n=28)	0.1%	0.3%
Unexpected Complications in Term Newborns Rate (n=18)	0.3%	1.8%
Apgar Score Less than 7 at 5 mins Rate (n =29)	0.2%	0.7%
Severe Perineal Tear Rate (n = 9)	0.2%	0.7%
Maternal Blood Transfusion Associated with Delivery Rate (n=27)	0.1%	0.8%
Post-Cesarean Surgical Site Infections Rate (n=35)	0.1%	0.2%
Post-Cesarean Anesthesia Complication Rate (n=28)	0.1%	0.8%

Note: *Only includes entities with >100 deliveries per year*

Observations (1/3)

Based on the findings of the IFC Healthcare Benchmarking Program in 2025 (and previous rounds), key observations include:

There is a need for facility-level international healthcare benchmarking.

- The scope for efficiency gains is largest among low-income developing countries and emerging markets.
- To reach the goal of Universal Health Coverage (UHC), it is essential to increase the efficiency of spending on healthcare and quality of care, especially as donor governments reduce funds.
- Healthcare organizations in emerging markets are increasingly requesting comparative data as they seek to improve their performance

There are wide variations in performance across healthcare organizations, many of which are unexplained.

- These include variations in core healthcare facilities (e.g. inpatient beds and operating theatres) and high-cost equipment (e.g. CT and MRI) – with typical 2-5 times variation between the highest and lowest quartiles of efficiency.
- Number of years in operation is an important factor relating to efficiency, with more mature facilities achieving higher efficiency levels.

Observations (2/3)

These wide variations indicate scope to treat significantly more patients within the same resources.

- If all hospitals participating in the benchmarking program were as efficient as the highest quartile, then 358,000 more people (i.e. 29% more) could access inpatient care within the existing bed capacity.
- Similarly, regarding outpatient care, if all participants were as efficient as the highest quartile, then 9.1 million more people (i.e. 43% more) could access outpatient care (incl. ER) within existing room capacity.

Regional variations in performance were generally inconclusive.

- Overall, participants in Asia and MENA showed the highest levels of productivity.
- Hospitals in Sub-Saharan Africa appear to have generally lower productivity levels, particularly regarding high-cost assets. But they compare similarly regarding OR efficiency.
- However, overall, we observed greater variations within regions (and countries) than between them.

There were several interesting observations regarding financial performance.

- Participating companies perform similarly financially compared with international publicly listed healthcare companies. This would appear to strengthen the case for investing in emerging markets healthcare.
- However, an important constraint on business performance for companies in emerging markets relates to liquidity, e.g. considering the higher receivable days of participants compared with listed companies.
- Companies oriented toward social health insurance have the highest number of receivable days, and therefore likely the highest liquidity challenges.

Observations (3/3)

Day-Case surgery appears to be highly underdeveloped in emerging markets.

- Reported rate of Day-Case surgery for the common procedures surveyed are typically ten times lower than international practice (based on the median rates of the British Association of Day Surgery).
- Increasing these rates could have a significant impact on raising efficiency and lowering costs.

Quality Measurement appears to be established in some areas.

- However, some important measures of avoidable harm are measured less frequently.
- We also observed many zero and near-zero measures reported, which may indicate under-reporting of quality indicators.
- We found no evidence that higher productivity reduces quality.

There is strong evidence that significant improvements in quality measurement are possible

- We observed consistent and significant improvement in the reporting of Quality metrics among the organizations participating in both the 2023 and 2025 Benchmarking rounds.

Measurement of maternity outcomes appears to be underdeveloped

- Most participants providing Maternity services reported none of the Maternity Outcome metrics surveyed (or Zero). Only 4% reported all nine metrics.

Participant Feedback

What we're hearing

Debriefs held with benchmarking participants identified a number of themes where they indicated a need for support, as well as areas where they would be open to contributing to knowledge-sharing events with other benchmarking participants, organized by the IFC Team:

- **Operating Theatre Workflow Management:** Improving operating theatre efficiency through better scheduling, patient flow, and coordination to maximize utilization and reduce delays.
- **Specialist Doctor Engagement Models:** Exploring effective models for engaging specialists (e.g., full-time, visiting, or incentive-based) to ensure access to expertise while maintaining sustainability.
- **Quality Improvement Techniques:** Including what to measure and how, and how to use quality metrics to deliver meaningful improvements.
- **HR Planning / Optimal Staffing Levels:** Strengthening workforce planning to align staffing levels and skill mix with service demand.
- **Staff Retention:** Identifying strategies to retain skilled health workers through incentives, career development, and supportive workplace environments.

Based on this feedback IFC is organizing a series of learning events including webinars featuring international experts.

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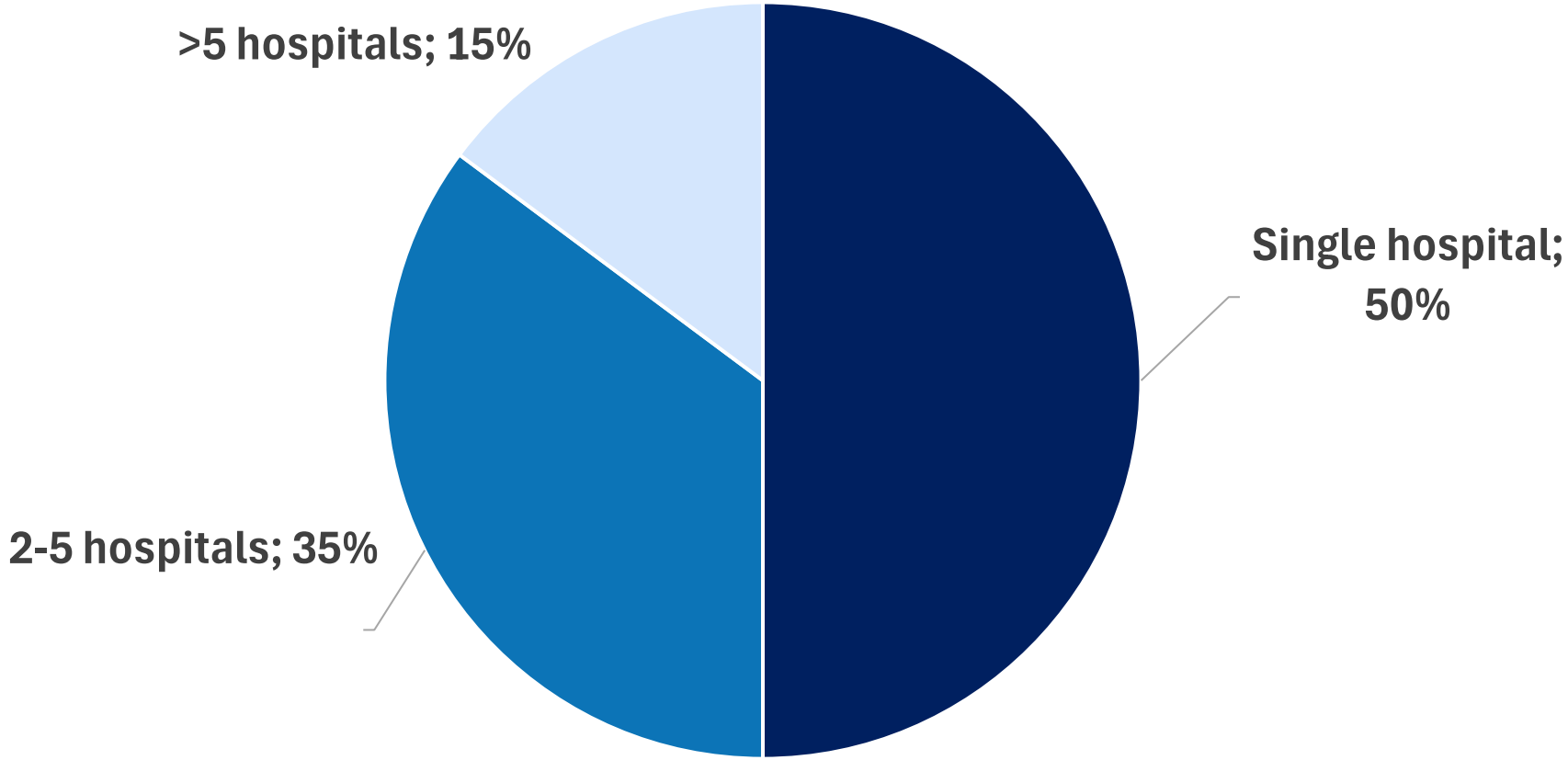
If you are interested in participating in the next IFC Healthcare Benchmarking round, please send an email to Jenny Zhao: **czhao5@ifc.org**

Annexes

Participant Profile

Number of hospitals per company

Most companies operate 1-5 hospitals

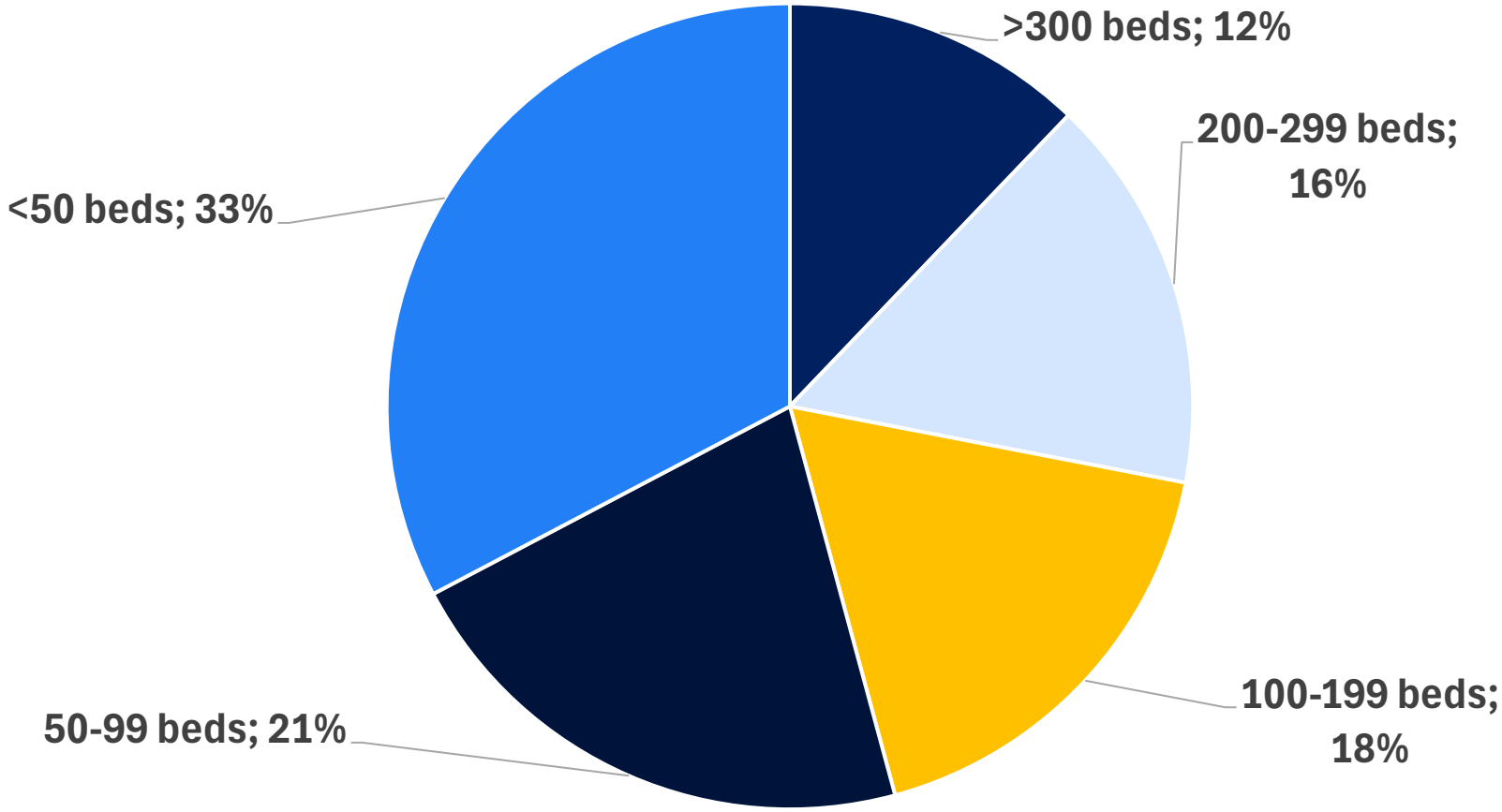


Numbers include hospitals only, exclude outpatient and other non-hospital facilities

Participant Profile

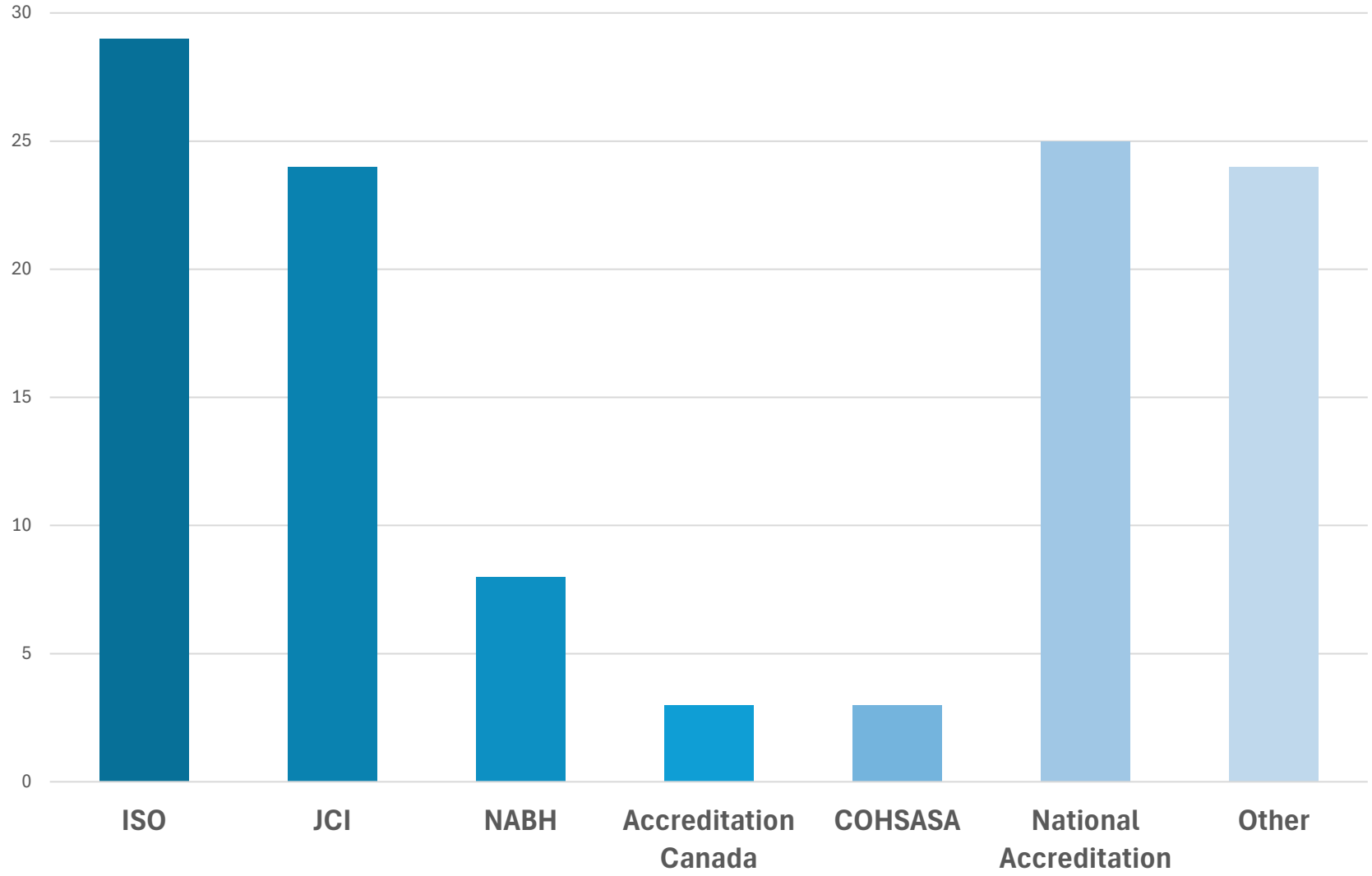
Number of beds per hospital facility

Most hospitals have up to 300 beds



Some participants have local and /or international quality accreditations

Member Profile



IFC International Finance Corporation WORLD BANK GROUP

Process Map

All participant receive 3 practical deliverables in Microsoft Excel, PowerPoint, and Tableau

CONSULTATION & RECRUITMENT

- Discuss with potential members data they could provide and desired outputs
- Sign up members of the Benchmarking Club

METRICS

- Develop and iterate list of KPIs given consultative feedback

SOFTWARE & DATA

- Develop database to house and analyze all of the member submitted KPI data
- Collect all member and external benchmark data

VALIDATION & QUALIFICATION

- Validate the submitted data to ensure it is correct
- Qualify the data across KPIs to ensure proper comparison

ANALYSIS

- Conduct statistical analysis on the data to draw conclusions

INSIGHT

- Combine the analysis with IFC's expertise to provide narrative insights

TRENDS

- Using cross-cutting data analysis to identify trends amongst the entire dataset that provide unique perspectives to club members

Process: Participant's anonymized data is complemented with international data

53x Participating Companies

- 182 entities (consolidated and facility-level)
- 30 countries

CapIQ, S&P

- Data acquired by IFC covering >150 publicly listed healthcare companies around the world.

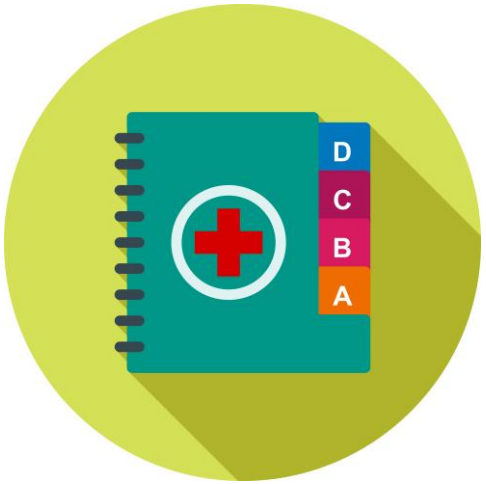
British Association of Day Surgery

- Data acquired by IFC covering 19 common procedures aggregated across 145 UK hospitals.

>40,000 data points!

Process: Benchmarking Deliverables

All participant receive 3 practical deliverables in Microsoft Excel, PowerPoint, and Tableau



Bespoke report

Unique insights

- An individualized report showing graphically how the company compares against others across key metrics.
- A commentary of the findings, highlighting areas for attention, and drawing on IFC's international experience in the sector.

Organized, extractable data

designed for analysts

- Easy-to-use xls database that allows for importation into more advanced statistical software such as R, Stata, Tableau, Minitab, etc.
- Easily readable by those with a moderate degree of data analytics skills.

Interactive, in-depth business tool

"Build Your Own" Charts

- A fully interactive "chart builder" with hovering capabilities, DIY chart capabilities, and custom highlighting that carries across multiple charts

Financial Metrics

Revenue Profile

- Revenue from companies and private insurance as % of Total Revenue
- Revenue from self-pay/cash as % of Total Revenue
- Revenue from government/SHI as % of Total Revenue
- Revenue from Other Sources as % of Total Revenue
- Revenue to Asset Ratio
- % split of total revenue across IP/OP services
- Medical travel: Revenue from Foreign patients as % of all revenue

Profitability

- EBITDA Margin (%)
- Net Income Margin (%)
- EV / EBITDA
- Total Debt / EBITDA
- Total Debt / Equity
- Current Ratio
- Return on Assets %
- Return on Equity %
- Receivable Days
- Inventory Days
- Payable Days

Sample Prices

- Average price of Normal Delivery package
- Average price of C-Section Delivery package
- Average price of Abdominal Hernia
- Average price of Hip Replacement (unilateral, non-trauma)
- Average price of Cholecystectomy
- Average price for medical outpatient consultation
- Average price of CT scan
- Average price of MRI scan
- Average nightly room rates
- Average total revenue (or check size) per inpatient admission
- Average total revenue (or check size) per outpatient visit

Expenditure / Cost Profile

- Staff costs as % of Total Revenue
- Drugs costs as % of Total Revenue
- Supplies cost as % of Total Revenue
- Total expenditure on capex (replacement) as % of Total Revenue

Operational Metrics

Bed Capacity & Utilization

- No of Inpatient Admissions per Available Bed
- Medical Admissions as % of all Inpatient Admissions
- Surgical Admissions as % of all Inpatient Admissions
- O&G Admissions as % of all Inpatient Admissions
- Paediatric Admissions as % of all Inpatient Admissions
- Other Admissions as % of all Inpatient Admissions
- Day cases as % of All Admissions (DC & IPs)
- Average Revenue per Occupied Bed-day (ARPOB)
- Average Bed Occupancy Rate (BOR)
- Average Length of Stay (AvLOS)
- Emergency Admissions as % of all Inpatient Admissions
- Medical Travel: Foreign patients as % of all Inpatient Admissions
- % Female Inpatient/Hospitalizations

Intensive Care Unit

- Total Number of Available ICU Beds
- Total number of Inpatient ICU Admissions
- No of ICU admissions per ICU bed
- Average ICU Bed Occupancy Rate (BOR)
- Average Length of Stay (AvLOS) in ICU

Inpatient Payer Profile

- % of all inpatients funded by private medical insurance (PMI) or corporate payor
- % of all inpatients funded by self/cash
- % of all inpatients funded by government (eg social/obligatory health insurance schemes)
- % of all inpatients funded by other sources (eg charitable, free).

Dialysis & Chemotherapy

Dialysis

- No of dialysis sessions per machine

Chemotherapy

- No of Chemotherapy sessions per Chemotherapy couch

Outpatient Care

- No of Outpatient consultations per consulting room
- No of ER visits per ER room
- IP/OP "conversion" ratio %
- % Female Outpatient Consultations

Operational Metrics (cont'd)

Surgical & Interventional

General Surgical
- No of OR surgical cases per OR room
- Elective OR utilization % (based on open hours)
- No of Surgical Day-cases per Day-Case theatre

Interventional Cardiology
- No of interventional cardiology cases per IC room

Maternity
- Total no of deliveries per labor/delivery room
- % C-section rate

Endoscopy
- No of procedures per Endoscopy Room.

Diagnostic Services

- No of MRI scans per MRI scanner
- MRI scanner utilization rate %
- No of CT scans per CT scanner
- CT scanner utilization rate %
- No of PET scans per PET scanner
- PET scanner utilization rate %
- No of X-rays per X-ray machine
- No of lab tests per Available Bed
- No of lab tests per Patient (total IPs + OPs)

Radiotherapy

- No of radiotherapy fractions delivered per RT Machine
- Linear accelerator utilization rate %

Human Resources & Staffing

Total Staff Employed
- Total Staff Headcount per Available Bed
- Total staff FTEs per Available Bed
- % of female staff
- % of foreign staff
- Staff vacancy rate %
- Staff turnover rate during year
- Staff sickness/absence rate
- % of all staff vaccinated for Covid 19
- % non-clinical staff - NEW

Medical Staff
- No. of full-time doctors per available bed
- No. of part-time doctors per available bed
- No. of Clinical Officers per available bed

Nursing Staff
- Total qualified FTE per nurses per available bed
- All FTE nursing staff per available bed
- Nurse/bed ratio in adult general wards
- Nurse/bed ratio in ICU
- % of female registered nursing staff

Other Staff
- Total Paramedical and Scientific Staff per Available Bed
- Total Technical and Engineering Staff per Available Bed
- Total no. of mgmt. and admin staff per Available Bed

Quality Assurance Metrics

Mortality

- Gross mortality rate
- ICU mortality rate

Infection

- Healthcare Associated Infection (HAI) rate
- Surgical Site Infection (SSI) rate
- Catheter-associated Urinary Tract Infection (CAUTI) rate (adults)
- Central line-associated Bloodstream Infection (CLABSI) rate.
- Ventilator-associated Pneumonia (VAP)

Other Preventable Harm

- No of reported incidents per Available Bed
- % of Incidents closed
- Near misses
- Pressure ulcer (HAP) rate
- No of inpatient falls per Inpatient Admission
- No of outpatient falls per Outpatient & ER attendance
- Unplanned return to OR as % of Total OR cases
- Return to ICU within 48 hours as % of Total ICU Admissions
- Medication error rate

Patient Experience/Other

- Net promoter score (NPS)
- Average waiting time in Outpatient Dept
- Average Door-to-Needle time (DNT) for stroke patients
- Door-to-Balloon (DTB) time for cath lab

Day-Case Metrics

General Surgery

- Laparoscopic cholecystectomy
- Primary repair of inguinal hernia

Gynaecology

- Myomectomy (incl laparoscopically)
- Therapeutic endoscopic operations on uterus (incl endometrial ablation)
- Laparoscopic oophorectomy and salpingectomy (incl bilateral)
- Therapeutic laparoscopic procedures incl laser, diathermy, and destruction (e.g., endometriosis, adhesiolysis, tubal surgery)
- Posterior colporrhaphy

Urology

- Uteroscopic extraction of calculus of ureter
- Endoscopic insertion of prosthesis into ureter
- Endoscopic resection/destruction of lesion of the bladder
- Diagnostic endoscopic examination of bladder (incl any biopsy)

Pediatric Surgery

- Tonsillectomy

Vascular Surgery

- Transluminal operations on iliac and femoral artery

Medical

- ERCP
- Implantation of cardiac pacemaker

Emergency

- MUA fracture and application of plaster cast
- Incision and drainage of skin abscess

Breast Surgery

- Wide local excision of breast, including wire guided
- Simple mastectomy (without axillary surgery)

Maternity Outcomes Metrics

Clinical Indicators

- Primary caesarian section
- Induction of Labor
- Maternal mortality
- Unplanned maternal readmission
- Unexpected Complications in Term Newborns
- Five-minute Apgar score
- 3rd and 4th degree perineal tears
- Maternal blood transfusion maternal blood transfusion during the birth episode of care
- Post-caesarean surgical site infections, including endometritis
- Post-caesarean anesthesia complication