



Center For
Health Market Innovations



STANDARDIZING AND IMPROVING PERFORMANCE MEASUREMENT FOR HEALTHCARE ORGANIZATIONS

Recommendations and Reflections from the Health Metrics Working Group

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Introduction

In many low- and middle-income countries there is a vibrant and diverse private health sector that can be leveraged to improve health outcomes for the poor. This realization has given rise to a number of efforts that focus on how to influence private sector health care providers to achieve health system goals like improved access, affordability and quality of care, especially for poor and disadvantaged populations.¹ In parallel, social entrepreneurs² in numerous emerging markets have been launching social enterprises aimed at providing needed health services. Many investors, donors and domestic government funders are engaging these enterprises as a way to scale up key health services to target populations.

Health delivery organizations³ and their investors understand the importance of demonstrating the impact of their services, but struggle to implement a performance measurement framework that is comprehensive and credible, but also feasible and broadly comparable. Some of these organizations have developed proprietary metrics to track performance; others use metrics developed by third-party institutions and initiatives.⁴ However, even with considerable overlap in the approach and focus of these various performance measurement frameworks, the resulting metrics may have limited comparability across organizations. Others have been developed to track systems-level progress, and are therefore not appropriate for measuring the contribution of specific organizations to broader systems goals.

The IRIS initiative of the Global Impact Investing Network and the Center for Health Market Innovations (CHMI) seek to build on this body of knowledge and to harmonize disparate measures into a common set of metrics and definitions suitable for practical application by funder organizations, including investors, donors and domestic government funders, and by the programs they fund. The focus here is on developing common metrics for tracking organizational performance in health care delivery. This is important because a large and growing proportion of impact investments are to health care delivery organizations.

CHMI and IRIS convened an expert working group, composed of practitioners, impact investors, donors, and others with health implementation and metrics design expertise. Experts reviewed best practices in performance measurement used by health service organizations targeting the poor, pulling from sources such as the World Health Organization and the World Bank. Further, experts vetted the metrics through

The **primary audiences** for this paper include: 1) healthcare organizations seeking investment and structured data collection processes to communicate their impact to funders. Organizations that are building performance frameworks for the first time and those with existing frameworks will find this useful; 2) investors and funders interested in or actively placing investment capital in health delivery organizations or directly funding their services for key populations and who are seeking to measure the organization's performance.

This paper will also help health experts (program managers, evaluators, and researchers) understand impact investors' and funders' measures of social performance, and how they relate to other social performance metrics.

For brevity, throughout this paper we will refer to health delivery organizations, investors, funders, and social entrepreneurs, and program managers in health as stakeholders.

¹ World Health Organization, 2005. http://www.who.int/management/working_paper_2_en_opt.pdf

² Social entrepreneurs are those who recognize a social problem and use entrepreneurial principles to organize, create, and manage a venture for social change (The Canadian Social Entrepreneurship Foundation, www.csfe.ca)

³ Many health delivery organizations are small scale; the Working Group took this into account while developing the metrics.

⁴ The Social Franchising Metrics Working Group, in particular, is developing sophisticated common metrics for social franchises to track and compare their performance.

open comment periods, soliciting feedback on the clarity, usability, and feasibility of the catalog of indicators.

The goal of this paper is twofold:

- 1) To provide a rationale and context to help stakeholders use these metrics, including how these metrics connect to other health metric efforts;
- 2) To summarize key points of discussion from the working group, including important issue areas for which no standard metrics were ultimately recommended.

The working group led the metrics development; however, other key stakeholders such as program managers and implementers were involved at key points during the process. The metrics were designed to describe the performance of healthcare delivery⁵, spanning health issue areas (e.g. maternal health, tuberculosis), organization types, (e.g. hospital, network of clinics), and geographic locations. Many of these metrics will be relevant to organizations operating in high-resource settings, but the group focused on organizations that expand access to care to underserved populations, the majority of whom are based in emerging markets. Early in the process, the working group decided which primary dimensions and core areas they should focus on. From there, they developed metrics associated with each core area.

This paper is organized by the same primary dimensions the working group utilized for discussion – *What populations are being served by this organization’s health services? What health services is this organization delivering? How are health services being delivered by this organization?* The working group developed these questions based on core areas of importance to performance measurement (e.g. pro-poor targeting, affordability, etc.), and then developed metrics associated with each core area. In this paper, we describe the importance of each primary dimension in addition to the metrics the working group developed and recommended for each category.

Performance Dimensions Of Healthcare Metrics

1 WHO IS BEING SERVED?	Pro-Poor Targeting What is the population coverage of key interventions? Affordability Is the product or service affordable? Scale What is the scale of the organization’s operations?
2 WHAT IS BEING DELIVERED?	Health Outputs What type of products and services are being delivered?
3 HOW IS IT BEING DELIVERED?	Clinical Quality What is the level of quality of services delivered? User Satisfaction Do patients’ experiences meet expectations? Financial Sustainability Are financials sustainable to maintain operations over the long term?

⁵ Healthcare delivery refers to interventions intended to provide direct preventative or clinical care; it does not include topics such as the provision of medical education, or medical insurance.

HOW TO USE THESE METRICS

IRIS and CHMI offer the following suggestions for healthcare organizations and funders interested in adopting standardized reporting metrics.

- **Choose from within this catalog of metrics.** There is no single combination of metrics that is right for every organization; this set is designed as a catalog that investors and investees can use to select the most appropriate metrics for their work.
- **Adapt metrics to specific healthcare activities.** While the metrics are meant to be generally applicable to organizations delivering healthcare services, they should be tailored to reflect an organization's area of focus. For example, an organization may wish to provide details on the total patients served by their organization and the number of patients served by a specific activity, for instance, attended newborn deliveries.
- **Use the metrics to measure an organization's outputs and evaluate its effectiveness.** Most metrics in the catalog are measures of activities or outputs of a healthcare delivery organization. Outputs serve as a foundation for measuring health outcomes and impacts.
- **Use metrics to help identify successful health organizations.** Comparable indicators of organizational performance can help program managers to demonstrate impact and compare performance to similar organizations. Standardized metrics can also help investors channel funding into solutions that effectively address healthcare challenges.

What populations are being served by this organization's health services?

WHO IS BEING SERVED?

Pro-Poor Targeting What is the population coverage of key interventions?

Affordability Is the product or service affordable?

Scale What is the scale of the organization's operations?

Stakeholders interested in investing in health enterprises seek to support organizations that can work to improve the health and wellbeing of those most in need while remaining financial sustainable. We know that while the poor often have the greatest health needs, they also face the most difficulty accessing needed health products and services, due to financial, geographic and social barriers. To understand whether an organization's health products and services are reaching the poor through commercially sustainable means and improving their client's health, stakeholders need to examine how an organization is targeting the poor, the affordability of its products/services and the scale at which it is operating now and can reach in the future. Together, these create a description of an organization's goals, approaches, and results in providing health products and services to those with the greatest need.

Organizations will choose from these the metrics relevant to them, and supplement those with metrics that are specific to the organization's impact objectives, activities, or disease focus.

Pro-poor Targeting

A standard approach to measuring pro-poor targeting involves determining whether an organization's clients could be classified as poor. There are numerous ways to define and measure poverty, but they include two major types of approaches: relative and absolute.

Relative poverty refers to one's income or assets in relation to others', using the overall distribution of income or consumption in a country. Absolute poverty is a measure of whether an individual or household has sufficient income or assets to provide basic needs, anchored in some absolute standard of what households require to meet basic needs.⁶ Organizations will determine whether their patients are poor by using the method most appropriate for their setting; IRIS does not recommend any particular method, but does provide a list of common approaches in the metrics usage guidance and glossary. The proposed metrics are described below, grouped by indicator category, and summarized in Table 1:

1. **Client Description:** A detailed client description will help investors assess the extent to which an organization targets the poor. The measure of the proportion of clients who are poor (or presumed poor, due to their gender, sociocultural identity, or geographic location) can be used as an indicator of pro-poor targeting. To describe its patients, an organization can indicate who it is targeting by describing its **Target Beneficiary Demographic, Target Beneficiary Setting** (geographic

Users may want to report on both the metric directly as well as indicators that incorporate these metrics such as:

Proportion of Clients who are Poor or Very Poor:

$$\frac{\text{Client Individuals: Poor} + \text{Client Individuals: Very Poor}}{\text{Client Individuals: Total}}$$

⁶ The World Bank describes methods on determining poverty lines and poverty estimators.

<http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPA/0,contentMDK:20242879~menuPK:435055~pagePK:148956~piPK:216618~theSitePK:430367,00.html>

location), and **Target Beneficiary Socioeconomics**. An organization can also indicate how many **Client Individuals** they serve, by demographic, setting and socioeconomic description. These metrics can be reported on in total or as a proportion of **Client Individuals: Total**. Alternatively, an organization can report on the number of **Client Households: Total** it serves. This metric is meant to capture the number of unique households that were recipients of products or services. Organizations that provide goods and services at the individual level might find it more appropriate to report against Client Individuals. To add credibility to its client description, an organization may want to report on **Poverty Assessment**, indicating whether it assesses the poverty level of its clients. The above metrics should be used in combination with affordability, quality and user satisfaction metrics to create a more comprehensive picture of how and how well the organization targets the poor.

Table 1: Summary of IRIS Pro-poor Targeting Metrics

Metric	Definition
Target Beneficiary Demographic/ Setting/ Socioeconomic (3 separate metrics)	<p>Groups of beneficiaries targeted by the organization's operations, by demographic/setting/ socioeconomic. Select all that apply:</p> <ul style="list-style-type: none"> • Very poor • Poor • Low Income • Persons with disabilities • Minorities/Previously Excluded • Older/elderly Adult • Women • Pregnant Women • Rural • Urban • Peri-urban • Other at risk populations • Other target populations • Children and Adolescents (5-17) • Young Children (< 5 years old)
Client Individuals: Total	Total number of unique individuals or households who were clients of the organization during the reporting period.
Client Households: Total	Number of unique households who were clients of the organization during the reporting period.
Client Individuals/ Households (by type) (separate metrics)	<p>Number of unique individuals or households, by category, who were clients of the organization during the reporting period. Choose all that apply:</p> <ul style="list-style-type: none"> • Very poor • Poor • Low Income • Female • Rural • Urban • Peri-urban • Children and Adolescents • Disabled • Minorities/Previously Excluded
Poverty Assessment	Indicate whether the organization assesses the poverty levels of its intended beneficiaries.

Affordability

Affordability is a measure of the ability of particular consumer groups to pay for a given product or service and is central to understanding access to care for underserved populations. Stakeholders are interested in affordability because if products or services are priced beyond the reach of individuals, they are unlikely to be customers and potential health benefits will not be realized. The challenge of measuring affordability is its relativity; what is affordable to a factory worker in Bangladesh may not be affordable to a farmer in Burundi. One alternative to determining affordability based on price is to track who uses an organization's goods or services; if many poor people use them, they are likely affordable. When it is difficult to

determine whether clients are poor through tracking their income or wealth, some organizations track client demographics as a proxy for poverty. The proposed metrics on affordability (summarized in Table 2), which track cost to patients and patient socioeconomics, are as follows, grouped by topic:

1. **Provision of Products or Services without Payment.** When looking at the cost of products and services, it's important to consider the expenditure from the client (patient) and the revenues received by the organization. Where patients receive products and services for no payment there are instances in which the organization will receive no revenues (the product/service is provided for free) and other instances where the organization will receive revenues from third party payers including insurance, government, etc.

The metric, **Client Individuals: Receiving Free Products/Services** is defined as the number of client (patient) individuals who received free products/services from the organization during the reporting period. A related metric is **Units/Volumes Sold: Free**, the amount of the product/service provided by the organization for free during the reporting period. Organizations should report against these metrics in instance where they did not request payment from patients and for which they did not expect reimbursement.

In other instances it may be more appropriate to report against **Client Individuals: No Direct Payment**, the number of client individuals who received products/services during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed. Related to this metric is **Units/Volumes Sold: No Direct Payment**, the amount of the product/service sold during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed.

Average out-of-pocket payment can be calculated as:

$$\frac{\text{Sales Revenue: Collected Directly}}{\text{Client Individuals: Total} - \text{Client Individuals No Direct Payment}}$$

2. **Out-of-Pocket Payments per Client.** How much each patient directly pays for a health product or service is typically referred to as an “Out-of-pocket payment”. This is a measure of affordability because it indicates how much patients have to directly pay, on average, for a health product or service. **Sales Revenue: Collected Directly** is the value of the revenue from sales of the organization's product or service collected from clients directly during the reporting period. Stakeholders could compare average out-of-pocket payments to things like national minimum wage as a proxy for how affordable things are. Organizations may choose to report on out-of-pocket payment per **Client Individuals: Total** or out-of-pocket payment per client paying directly (calculated as **Client Individuals: Total** minus **Client Individuals: Receiving Free Products/Services**). This metric is most meaningful for organizations without a sliding payment scale. For those with a sliding payment scale, they may choose to footnote the details about their sliding scale, possibly divided into varying levels of subsidy.

These metrics ask whether poor patients use the services and how much patients pay for the services. Table 2 summarizes metrics for measuring Affordability. It includes those described above, plus select cross-cutting metrics already described in previous sections.

Table 2: Summary of IRIS Affordability Metrics⁷

Metric	Definition
Client Individuals: Receiving Free Products/Services	Number of client individuals who received free products/services from the organization during the reporting period. This metric includes all clients who received products/services provided by the organization for which it did not request payment and for which it did not expect reimbursement.
Client Individuals: No Direct Payment	Number of client individuals who received products/services during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed.
Units/Volumes Sold: Free	Amount of the product/service provided by the organization for free during the reporting period.
Units/Volumes Sold: No Direct Payment	Amount of the product/service sold during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed.
Sales Revenue: Collected Directly	Value of the revenue from sales of the organization's product or service collected from clients directly during the reporting period.
Client Individuals: Total	Total number of individuals or households who were clients during the reporting period.
Client Individuals (by type) (individual metrics)	Number of individuals or households, by category, who were clients during the reporting period. Select all that apply: <ul style="list-style-type: none"> • Very poor • Poor • Low Income • Disabled • Minority/Previously Excluded • Children and Adolescents • Female • Rural • Urban • Peri-urban

⁷ Some of the IRIS metrics should be reported individually, and others should be reported in combination with others to produce an indicator.

Scale

Achieving 'scale' is a goal for many market-based health enterprises that target the poor. While smaller organizations can provide products and services that benefit the poor, when a Bottom of the Pyramid (BoP) venture reaches scale and sustainability its positive impacts are multiplied. Scale can involve changes in the number of patients, suppliers, geographies, and/or services/products provided – this should be measured over time in order to adequately capture meaningful changes in scale. In the Health sector it is important to not just look at volume of transactions, but whether the organization is delivering valued and needed services and addressing the health needs of a community. The metrics included in IRIS measure an organization's coverage of a given service, product, or population, but should be tracked over time to measure changes in the scale or an enterprise's operations. Additionally, the metrics should be coupled with those that address health outcomes and quality to better understand impact.

A useful measure to understand how well an organization reaches the poor and underserved, addressing those with the greatest need:

Client Individuals (by category)
Client Individuals: Total

When interpreting scale metrics, investors should remember that social enterprises often take longer to reach scale. These metrics provide a snapshot of an organization's current scale, but tracking these metrics over time will provide a better indication of how likely the organization will reach its scale objectives. The proposed metrics to measure scale (summarized in Table 3), are as follows, grouped by topic:

1. **New Clients**. This metric measures how much incremental care an organization is providing. This is an important method of understanding its wider impact and social value. Collecting this data typically requires interviewing clients and asking whether they have used the product or service before and whether they would have significantly delayed or avoided care without access to the product or service. Client interviews can be expensive and time consuming to conduct and their accuracy is questionable. However, this method can measure incremental coverage and benefit. A related and easier to measure metric is **Client Individuals: New**, the number of unique individuals that were first-time clients of the organization during the reporting period. A subset of these may be seeking the type of product or service for the first time because they otherwise did not have access to them. This metric, **Client Individuals: Provided New Access**, is the number of clients who were not able to access the products or services previously. These clients could be new to the organization, or current clients who are now accessing products or services they did not have access to previously.
2. **Clients Served**. This measures an organization's total reach. The metric, **Client Individuals: Total** is defined as the number of individuals or households who were clients during the reporting period. This measures the number of clients, not the number of client transactions. For some organizations, it is difficult to measure the number of clients served (e.g. family planning organizations who sell condoms). In these cases, the number of **Client Transactions**, the number of sales or client transactions during the reporting period. Related to total reach, is **Healthcare Facilities**, the number of health service delivery units/facilities under the organization's

To understand organizational expansion, users may wish to report on **New Clients as a Proportion of Total Clients**:

Client Individuals: New
Client Individuals: Total

management at the end of the reporting period. This metric provides a description of the reach and spread of healthcare facilities, and is a crude measure of scale. For example, if a social franchise expands from two to five locations, this provides an indication of increased scale and reach.

3. **Staffing.** The number of caregivers in an organization can be a measure of scale because the quantity of health provision is influenced by the total number of health providers. In IRIS, there is a distinction between Caregivers and Caregiver Professionals. **Caregivers Employed: Total** is the number of caregivers, with current licenses, certifications, or trainings based on local requirements, employed by the organization as of the end of the reporting period. They are individuals who provide preventive, curative, rehabilitative and promotional health services. A caregiver could be a doctor, nurse, clinician, community health worker, or other health care provider. A subset of this group includes **Caregivers Employed: Professionals**, who provide healthcare based on their training in an extensive body of theoretical and factual knowledge. They are usually trained at a higher educational institution in a health-related field for a period of 3-6 years leading to the award of a first degree or higher education. Caregiver Professionals would include general and specialist medical practitioners, nurses, dentists, paramedics, etc. The number of caregivers *may* impact reach or quality, but organizations need to track caregivers alongside other scale and quality metrics to verify this. In fact, efficient and innovative approaches to healthcare may increase scale and reach while maintaining or decreasing the number of caregivers employed.

The above metrics are important for understanding how an organization is serving the poor (who are most often in need). Clients Provided New Access (and to a lesser extent New Clients) measures the organization’s incremental care provided. Client Individuals, Client Individual Transactions, and Health Services measure total reach. Table 3 summarizes metrics for measuring Scale. It includes those described above, plus selected cross-cutting metrics already described in previous sections.

Table 3: Summary of IRIS Scale Metrics

Metric	Definition
Client Individuals: New	Number of unique individuals that were first-time clients of the organization during the reporting period.
Client Individuals: Provided New Access	Number of client individuals who were served by the organization and provided access, during the reporting period, to products or services they were unable to access prior to the reporting period.
Client Individuals: Total	Number of unique individuals who were clients of the organization during the reporting period.
Client Transactions	Number of sales or client transactions during the reporting period.
Healthcare Facilities	Number of healthcare units/facilities under the organization’s management as of the end of the reporting period.
Caregivers Employed: Total	Number of caregivers, with current licenses, certifications, or trainings based on local requirements, employed by the organization as of the end of the reporting period.
Caregivers Employed: Professionals	Number of caregiver professionals licensed or certified based on local requirements, employed by the organization at the end of the reporting period.

As with all areas of evaluation, there are many areas that stakeholders should consider outside of the metrics provided here when assessing an organization’s ability and progress towards scale. Examples of these include: competitive landscape, consumer awareness, and measures of financial sustainability.

What health services is this organization delivering?

2 WHAT IS BEING DELIVERED?

Health Outputs What type of products and services are being delivered?

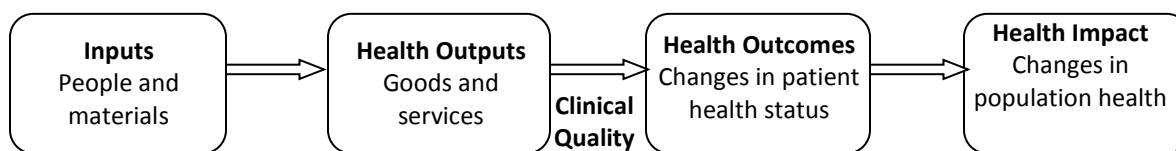
Health enterprises provide a wide range of products and services to meet the needs of the world's most vulnerable groups. Stakeholders need to understand the type and volume of products and services provided (health outputs) and how these influence patient and client health (health outcomes) to evaluate the organization's social value. Health outputs and outcomes also assist stakeholders in determining whether an organization is providing relevant and quality products and services to patients, households, and communities.

Health Outputs

Health outputs are the products of a health service organization. They are the immediate products or results of the activities implemented, such as the number of newborn deliveries conducted, number of child malaria cases treated, or number of contraceptives distributed. Outputs are results that an organization or manager can directly assess.

Stakeholders may be interested in health outputs because they can be a proxy for expected outcomes if the services delivered are known to be closely linked to outcomes. Health outputs are generally simple to track and vital to an organization's basic operations; most organizations will maintain careful record of these metrics. If effective, health outputs can lead to improved health outcomes (Figure 1).

Figure 1: The Value Chain of a Health Organization



The proposed metrics to measure health outputs (summarized in Table 4) are as follows, grouped by topic:

1. **Health Products and Services Delivered.** The number of services provided (e.g. number of HIV treatments) or health products sold (e.g. number of condoms) are measures of direct output. **Units/Volume Sold: Total** is the amount of product or services sold by the organization during the reporting period. In the health context, a "unit sold" refers to a healthcare service or product provided to a patient. In some cases, the "unit" is a bundle of services, such as a complete course of drugs for tuberculosis. In other cases, a "unit" is a discrete service or product, such as a dental extraction or insecticidal net. Organizations can determine what they consider to be each product/service they report against and detail the specifics in free-form text. Some organizations may only report against one product/service and others may report against many. A similar metric is **Client Transactions**, a measure of the total number of sales or client transactions. In conjunction with these metrics, organizations can also report on the **Disease/Condition Addressed**. IRIS contains a list of disease/condition addressed types, which the working group developed using

external sources.⁸ Because health products and services target a range of diseases/conditions, it is important that stakeholders look carefully at both the type of disease/condition addressed as well as the volume and type of products/services sold. Organizations can report on this type of metric in two ways:

- i) At an organization level (i.e. what diseases/ conditions are addressed across the entire organization)
- ii) At a product/service level (i.e. what diseases/conditions are addressed by the specific product or service being reported on)

Organizations can also report on **Product/ Service Detailed Type**, to describe the type of product or service they provide (for example, a service such as a health clinic, or a product such as TB medication). This metric is based off of the International Standard Industrial Classification (ISIC) classifications, a United Nations system for classifying economic data. Organizations can also drill down one level further and report on **Product/Service Description**, a description of the specific products or services provided by the organization. It may not be efficient for organizations to report on all products and services provided; organizations should work with stakeholders and funders to determine tracking and reporting priorities.

2. **Treatment Completion.** This is the percentage of clients, or patients, who successfully complete the full recommended course of a health intervention. Successful completion means that all necessary steps were completed, steps were taken in the appropriate timeframe, and that the treatment adhered to protocols. The metric, **Health Intervention Completion Rate**, is calculated as:

$$\frac{\text{Number of patients who successfully complete the intervention}}{\text{Number of patients who should have completed treatment}}$$

This metric lets stakeholders know how well an organization is providing full-service treatment. This is important because many treatments (such as TB medication, malaria treatment, and diabetes care) are most effective, and sometimes only effective, if all recommended elements are completed. This metric will only be applicable to those organizations that provide services where multiple treatments are recommended.

Inputs, Outputs, Outcomes and Impacts

Health outputs are the direct results of an organization's activities; *health outcomes* are the indirect results of these outputs, and over time can lead to population-level *health impact* such as reduced maternal mortality rates.

Health outputs are easier for social enterprises to measure and can more accurately reflect their contribution to improved outcomes. However, outputs may also drive service provision and not necessarily better health. One method for correcting this is to report on health output metrics alongside health quality indicators to indicate the quantity of good health provided.

Health outcomes (such a longevity, cure rates) can be challenging to measure because they are influenced by more than what an organization contributes (such as nutrition, sanitation, and wider social factors), which can make it difficult to attribute solely to the activities of one organization. This is makes it more resource-intensive to measure and report against.

⁸ The external sources used were the Disease Control Priorities Network <http://www.dcp-3.org/> and the World Health Organization 2004 Global Burden of Disease Report http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/

Table 4 summarizes metrics for measuring Health Outputs. It includes the metrics described above, in addition to select cross-cutting metrics already described in previous sections.

Table 4: Summary of IRIS Health Output Metrics

Metric	Definition
Units/Volume Sold: Total	Amount of the product/service sold by the organization during the reporting period.
Disease/Condition Addressed	Diseases/conditions addressed by the organization's products or services, provided during the reporting period. (Select all that apply) (See Table 5)
Product /Service Detailed Type	Detailed type of product or service provided by the organization. Choose one.
Product/Service Description	Description of the product or service provided by the organization.
Client Individuals: Total	Number of unique individuals who were clients of the organization during the reporting period.
Client Transactions	Number of sales or client transactions during the reporting period.
Health Intervention Completion Rate	Percentage of patients who successfully complete the full recommended course of a health intervention. Successful completion means that all necessary steps were completed and taken in the appropriate timeframe, and that the treatment adhered to protocols. <i>Calculation:</i> (number of patients completing treatment within the clinically recommended timeframe) / (number of patients who started treatment and who were expected to complete treatment)

Table 5: Disease/Conditions Addressed⁹

<ul style="list-style-type: none"> • General: Primary Care • General: Acute or Emergency Care • Specific: Infectious and parasitic diseases • Specific: Infections and parasitic diseases: Tuberculosis • Specific: Infections and parasitic diseases: HIV/AIDS • Specific: Infections and parasitic diseases: Diarrheal diseases • Specific: Infections and parasitic diseases: Childhood cluster diseases • Specific: Infections and parasitic diseases: Malaria • Specific: Infections and parasitic diseases: Tropical-cluster diseases • Specific: Respiratory infections • Specific: Malignant neoplasms (cancer) • Specific: Other neoplasms • Specific: Nutritional deficiencies 	<ul style="list-style-type: none"> • Specific: Diabetes mellitus • Specific: Endocrine disorders • Specific: Neuropsychiatric conditions • Specific: Sense organ diseases • Specific: Cardiovascular diseases • Specific: Respiratory diseases • Specific: Digestive diseases • Specific: Genitourinary diseases • Specific: Skin diseases • Specific: Musculoskeletal diseases • Specific: Congenital anomalies • Specific: Oral conditions • Specific: Unintentional injuries • Specific: Unintentional injuries: Traffic accidents • Specific: Intentional injuries • Specific: Maternal conditions • Specific: Prenatal period
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⁹ Adapted from the World Health Organization 2004 Global Burden of Disease Report http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/

Health Outcomes

Health outcomes are the results of an organization's health outputs and are demonstrated by improvements in patients' health. Health outcomes are important to stakeholders because they measure how an organization is ultimately improving patient health. They are proof that the output activities of an organization are adding value and improving lives. The working group tabled several health outcome metrics, but decided not to include any in the final list of health metrics for the following reasons:

- I. *Measuring health outcomes is challenging and costly.* Measuring health outcomes directly requires tracking clients over time to determine the impact of care, which is very resource-intensive. It can also involve community/population wide assessment, which is resource intensive. To overcome this challenge, health researchers have developed methods of estimating health outcomes based on health outputs. These estimates are difficult to calculate and health intervention- and country-specific.
- II. *Attribution is unclear.* When a patient receives or consumes a health product or service, their health outcomes are linked to the product or service plus a number of other complex factors, such as their underlying health, nutrition, income, vocation, and housing. Even when organizations can measure their patients' outcomes, they may not be able to demonstrate that they are due to their products and services.

The health outcome metrics the working group tabled, but did not include are:

- **Cure Rate** is regularly reported by health clinics and hospitals because it provides a measure of service provision success. It is the proportion of patients treated who are cured of their condition or complaint. However, it was not included in the final set of metrics for feasibility and validity reasons; the working group felt that it is too difficult to accurately track and measure. Determining whether a patient is cured is often not possible because (a) many chronic conditions are never "cured" and (b) when patients are "cured" they often do not return for care and are impossible to track.
- **Case Fatality Rate** was also not included in the final group of metrics for validity concerns. This measures the proportion of patients who die as a result of a condition. While this is widely reported, increasingly programs are moving away from it due to concerns about its validity. It is often not a comparable performance metric because often it's driven by an organization's patient population. For example, the highest performing institutions may see higher risk patients, resulting in higher fatality rates than other facilities. The working group still recognizes it as an important metric for health facilities to track internal performance.
- **Mortality Rate** was not included due to concerns about its validity and feasibility. Population-based mortality rates are sensitive to fluctuations in physical, social, political, and economic environments. It is difficult to attribute changes to a population's mortality rate to a particular health product or service. Moreover, it is extremely challenging for organizations to track and measure local mortality rates.
- **Estimated Number of Disability Adjusted Life Years (DALYs) Averted** measures the number of years of full health that can be attributed to an intervention. This metric was not included due to feasibility issues. For example, country and intervention specific coefficients are needed to estimate the number of DALYs averted. Currently, these coefficients do not exist for all interventions or all countries. Furthermore, the coefficients need to be updated annually, an expensive and technical task. The field of DALY estimation is developing, including efforts to standardize the coefficients. DALYs averted may be useful for tracking progress in the future, once the field has matured. DALYs are most useful when trying to compare the cost-effectiveness of many different types of health outputs. They are also useful for large organizations that are trying to best allocate resources across various potential priorities.

How are health services being delivered by this organization?

3 HOW IS IT BEING DELIVERED?

Clinical Quality What is the level of quality of services delivered?

User Satisfaction Do patients' experiences meet expectations?

Financial Sustainability Are financials sustainable to maintain operations over the long term?

The above metrics tell investors what types of populations organizations are reaching through their products and services. Stakeholders also need data on how an organization operates to learn more about the quality of its products or services, the degree of user satisfaction, and how financially sustainable it is. They provide investors with additional information to evaluate the business model to learn more about how the organization balances addressing health needs with patient experiences, clinical quality, and the financial bottom line.

Clinical Quality

Clinical quality refers to care that is safe and medically appropriate. Improving clinical quality increases the chances of good outcomes and reduces the chances of poor ones. Clinical quality is important to stakeholders for two reasons. First, patients who invest in healthcare services are seeking good quality care at an affordable price. Second, having high quality services increases an organization's chances of attracting return customers and developing a good reputation to attract new ones. Moreover, Clinical Quality measures help ensure that the health system can deliver safe, efficient, patient-centered, equitable and timely care. High Clinical Quality links Health Outputs to better Health Outcomes.

Defining and measuring Clinical Quality is both critical and complex. Many large national and international organizations¹⁰ have developed their own health quality measurement frameworks, each reflecting particular priorities and assumptions. There are three types of quality measures, ranging in level of sophistication and ability to link to outcomes: structure, process and outcome¹¹. The metrics below are structure and process measures. Many of the metrics are binary (yes/no) and do not assess the breadth or depth of the item being measured. They measure whether a particular quality structure or process is in place, not how well it is operating. Health quality outcome measures are very specific, and the working group decided that they did not meet comparability criteria. Investors should be encouraged to review an organization's clinical quality reporting documents if they want further detail and richness. The proposed metrics to measure clinical quality are as follows, grouped by topic:

1. **Quality Assurance Programs.** Quality assurance programs, like audit and feedback programs, checklists and logs, and guidelines and protocols are associated with higher quality and fewer adverse events. Organizations can indicate which of the following **Quality Assurance Mechanisms** they have in place¹²:
 - Peer Review/Supervision
 - Audit and Feedback
 - Checklists and Logs

¹⁰ Such as the Institute of Medicine, National Health Service, World Health Organization, and World Bank.

¹¹ *Structure* refers to the factors that influence the context of health delivery, such as facilities, personnel, etc. *Process* refers to the actions that make up health care, and include what and how care is delivered. *Outcome* refers to the effects of healthcare products and services on patients, including changes to health status. Donabedian, Avedis. 1966. Evaluating the Quality of Medical Care. *The Milbank Memorial Fund Quarterly*, 44(3, Part 2):166-206.

¹² This list was adapted from a systematic review of quality assurance mechanisms conducted by the National Health Services in the UK, <http://evidencecentre.com/Best%20practice%20in%20clinical%20quality%20assurance.pdf>

- Electronic Monitoring Systems
- Communication and Education Strategies
- Guidelines, Protocols, and Registries
- Other (indicate)

Organizations may use any of these mechanisms to track adverse events (e.g. infection rates, error rates) and appropriateness of care (e.g. proportion of diabetic patients receiving preventive care according to guidelines). This information can provide stakeholders with a good sense of the range of clinical quality processes in place, but should be coupled with targeted questions to learn about specific quality outcome data, such as copies of checklists and surveys used and the results tracked. Quality Assurance Programs can also track health outcome data, such as fatality rates. Quality assurance mechanisms are most common in inpatient medical facilities, although a range of organizations can use these mechanisms to track supply and medicine stocks, monitor equipment maintenance, and track client referrals.

2. **Third-Party Certifications.** In order to demonstrate clinical quality, some organizations (typically those that provide direct care) are externally audited by third parties. Such audits may result in a recognized certification or accreditation, which typically also comes with additional suggestions for incremental quality improvement. **Operational Certifications** denote that an organization has been audited for clinical quality by a third party and they have passed the audit. This metric does not indicate the quality of the care provided, but the existence and functioning of processes which are designed to assure quality.
3. **Relevant Staff Training.** Measuring the extent to which staff members are appropriately trained in the services they deliver is one proxy for assessing safe and appropriate medical care. The metric, **Employees Trained: Total**, is the number of employees (full-time, part-time, or temporary) who were trained through programs provided by the organization (both internally and externally) during the reporting period. Appropriate training is not necessarily formal education; some organizations are able to increase their efficiency and reach by training lay workers to perform specific healthcare functions. Organizations should report details of the employee training relevant to their organizational functions. Organizations may also wish to report the **Employee Training Hours: Total**, to quantify the amount of training provided.
4. **Critical Equipment or Facilities.** A commonly used utilization rate among hospitals is *patient bed occupancy rate*. However, the working group modified to the metric to include delivery models beyond inpatient services. Critical equipment or facilities are fixed assets that are necessary for the organization to provide its products and services. If the equipment were destroyed, degraded or compromised, it would make it difficult or impossible for the organization to provide its services/products. Equipment also typically has a maximum utilization that can limit the units produced or services provided. For example, a hospital might cite patient beds, an MRI machine, or sterile surgical rooms as critical equipment/facilities. This metric, **Critical Equipment/Facilities Utilization Rate** is calculated as the:

$$\frac{\text{Number of days/hours the identified critical equipment was utilized}}{\text{Number of days/hours of installed capacity of the identified critical equipment}}$$

Under-utilization of equipment or facilities may imply a quality issue - it could indicate that the equipment or facilities are not available or inoperable. Stakeholders should work with organizations to learn more about what the reported result means in the organizational context.

The above metrics are primarily process metrics, which are relatively feasible to track and report. These metrics are most appropriate for organizations that directly provide health services, such as clinics and hospitals. However, organizations that do not directly provide services can ensure their staff are appropriately trained and institute a relevant quality assurance program. Table 6 summarizes metrics for measuring Clinical Quality. It includes those described above.

Table 6: Summary of IRIS Clinical Quality Metrics

Metric	Definition
Quality Assurance Mechanisms	Does the organization have the following quality assurance mechanisms? Select all that apply: <ul style="list-style-type: none"> • Audit and Feedback • Checklists and Logs • Communication and Education Strategies • Electronic Monitoring Systems • Guidelines, Protocols, and Registries • Peer Review/Supervision • Other (indicate)
Operational Certifications	List the third-party certifications held by the organization that are related to its business processes and practices and that are valid as of the end of the reporting period.
Employees Trained: Total	Number of employees (full-time, part-time, or temporary) who were trained through programs provided by the organization (both internally and externally) during the reporting period.
Employee Training Hours: Total	Number of training hours provided for employees (full-time, part-time, or temporary) during the reporting period.
Critical Equipment/Facilities Utilization Rate	Utilization rate of identified critical equipment/facility during the reporting period. Calculation: (Number of days/hours the identified critical equipment was utilized) / (Number of days/hours of installed capacity of the identified critical equipment)

User Satisfaction

In health, user satisfaction is a measure of whether a patients’ experience met or exceeded their expectations. User satisfaction is both a measure of clinical quality, as it captures the perceived quality of products and services received, and financial sustainability, as it is a predictor of whether clients return to receive additional services or refer others. It can also be used to assess an organization’s ability to reach scale.

Patient experience measures report the experience of care (length of wait time, having unanswered questions after a visit) while user satisfaction measures how respondents rate their experience (“I waited too long”, “I was unsatisfied with how thoroughly things were explained to me”). User satisfaction is dependent on context and demographics (age, gender, socioeconomic status); people with the same experience may have different perceptions of it and different satisfaction levels. Though it is subjective, user satisfaction is a major driver of utilization. There are two types of methods to elicit user satisfaction: direct and indirect. Direct methods explicitly ask about levels of satisfaction with care experience (e.g. how satisfied were you with the care you received from the nurse?). Indirect methods collect measures that infer user satisfaction from questions that assess usage, or repeat usage of services. Our metrics use indirect methods to assess user satisfaction because in some locations, directly questioning clients about satisfaction is inappropriate or unreliable. It is important to consider the context users are being

questioned; sometimes users can be more or less candid when being asked about care at home as compared to at the hospital or clinic.

The proposed metrics to measure user satisfaction (summarized in Table 8), are as follows, grouped by topic:

1. **Returning Clients.** Patients may continue to seek care at a facility because they value its products or services. This metric, **Client Retention Rate**, allows a user to specify what proportion of patients continued to seek care with the organization. It provides a gross measure of user satisfaction because if the patient returns for treatment, an organization may attribute it to satisfaction with the product or service. The business model dictates whether this metric is an applicable measure of user satisfaction. It is not appropriate for types of care where patients may not be expected to continue to seek care during the reporting period (e.g. surgery, immunization). This differs from **Client Intervention Completion Rate** because that metric tracks whether a client completes a specific course of treatment (if they do not this may be as a result of failure on the part of the organization to provide the complete set of treatment, or failure on the part of the patient to return for treatment).
2. **Client Research.** Health organizations often conduct research on patients and potential patients as part of a quality improvement process. Market research can also be a direct method for soliciting client feedback and user satisfaction. **Market Research on Clients** indicates whether the organization conducts market research. Organizations that conduct client surveys can also report on **Client Feedback**, to indicate whether it has a system to collect and address client feedback.
3. **Attracting New Clients.** The number of new patients an organization attracts may indicate that potential patients believe that they will be satisfied by the products and services they will receive (alternatively, it could indicate that the population is sicker or that neighboring facilities have closed). It is partially influenced by current client referral rates, which is an indirect measure of current user satisfaction. The number of **Client Individuals: New**, defined as the number of individuals or households that were first-time clients, is relevant to only a selection of business models and healthcare services. For example, it is relevant in family planning where there is a large population of potential clients/patients, some of whom may already be receiving family planning services elsewhere. Thus, only a proportion of clients that a family planning organization attracts may be first-time clients. It is least relevant in surgical care, where most patients are new, and services may only be needed once. In many cases, it will be difficult for organizations to determine whether clients who are receiving their services for the first time did not receive those services previously because they did not know about them or want them, or because they did not need them. See also **Client Individuals: Provided New Access**, the number of new clients who received products or services to which they had no prior access, which the working group determined was best understood as a measure of scale. This metric can also be reported by household; **Client Households: Provided New Access**.

A common indicator for New Clients reports new clients as a proportion of total clients:

$$\frac{\text{Client Individuals: New}}{\text{Client Individuals: Total}}$$

The above metrics are comprehensive because they encompass structures which measure user satisfaction (**Market Research on Clients**) and output measures (**Client Retention Rate** and **Client Individuals: New**). Table 7 summarizes metrics for measuring User Satisfaction. It includes those described above, plus selected cross-cutting metrics already described in previous sections.

Table 7: Summary of IRIS User Satisfaction Metrics

Metric	Definition
Client Retention Rate	The retention rate of the organization's clients for the reporting period. <i>Calculation:</i> Total number of clients at the end of the reporting period / (Number of new clients during the period + Total number of clients at the beginning of the reporting period).
Market Research on Clients	Indicate whether the organization uses market research to identify the needs of clients and potential clients.
Client Feedback	Indicate whether the organization has a feedback system to solicit client feedback and an established procedure and/or committee to deal with client feedback.
Client Individuals: New	Number of unique individuals that were first-time clients of the organization during the reporting period.
Client Individuals: Provided New Access	Number of clients, individuals or households, who were served by the organization and provided access, during the reporting period, to products or services they were unable to access prior to the reporting period.
Client Households: Provided New Access	Number of unique households who were clients of the organization and provided access, during the reporting period, to products or services they were unable to access prior to the reporting period.

Financial Sustainability

Financial sustainability for health organizations targeting the poor is challenging to achieve, requiring creative business models and efficient operations, particularly in resource-constrained settings. Stakeholders are interested in financial sustainability performance because it may demonstrate an organization's potential longevity and value. Financial sustainability has four major pillars: strategic and financial planning, income diversification, administration and finance, and income generation. These pillars are common across sectors and business models. Metrics which measure administration and finance tend to be structural; metrics which measure strategic and financial planning tend to be process-oriented; metrics which measure income diversification and income generation are often outcome measures. IRIS has numerous financial metrics pulled from 3rd party standards such as the International Financial Reporting Standards (IFRS) that can be used as metrics or combined to create key financial performance indicators essential for monitoring and evaluating any business. The metrics below are a selection from a fuller catalogue of [financial performance](#) and [governance & social policies](#) metrics in IRIS, which are commonly used in the health field.

The proposed metrics for financial sustainability – which focus on structural and outcome measures deemed most relevant to the health sector (summarized in Table 8) - are as follows, grouped by topic:

1. **Governance.** Governance responsibilities should be described in documents such as bylaws or policies and procedures with guidance on how they are to be carried out. **Governance Policies** are written corporate governance policies that have been communicated to stakeholders. The organization can report the number of people on its **Board of Directors: Total** at the end of the reporting period. These individuals are legally responsible to govern the organization and are accountable to shareholders and sometimes other stakeholders. A related metric, **Board of Directors: Independent** is the number of independent members of the Board of Directors. A board which is highly independent will be less likely to have conflicts of interest and other biases, helping it assess financial and operational risks more keenly and effectively. Another structural

measure which can address this is a **Conflict of Interest Policy**, a written policy to monitor and disclose any potential conflicts of interest between the company, board members, owners, or material investors. An important policy for ensuring financial integrity is a **Financial Statement Review**, a policy to produce financial statements that are verified annually by a certified independent auditor. As structural metrics, the above metrics do not tell us whether the policies are followed. However, they provide investors with an understanding of the types of structures in place to support financial sustainability.

2. **Revenue.** Revenue is a critical measure of financial sustainability. For health enterprises, source of revenue can also tell stakeholders something about affordability and ability to target the poor. A major health system goal in many countries is to reduce out-of-pocket spending, especially catastrophic expenditures that can push households into poverty. Some healthcare enterprises, especially those that provide more complex, expensive care like antenatal care and newborn deliveries, will not be able to target the poor unless they rely on revenues beyond direct point of care, out-of-pocket payments from patients. **Total Revenue** is the value of all revenue received by the organization during the reporting period. **Sales Revenue** is the value of the revenue from sales of the organization's product or service during the reporting period. **Revenue from Grants and Donations** is the value of the revenue that is contributed through grants and donations, during the reporting period. **Charitable Donations**, however, is the value of all financial contributions and in-kind donations of goods and services made by the organization to charities, private foundations, non-profits or non-governmental organizations, during the reporting period. In many cases, investors are looking to see not just the total revenue, but also the **Revenue Growth**, the growth in value of an organization's revenue from one reporting period to another. In IRIS, **Sales Revenue** is broken down into revenue from patients in the form of out-of-pocket payments (**Sales Revenue: Collected Directly**) and revenue from non-patients in the form of third-party or contract payments (**Sales Revenue: Collected from Third Party Payers**). The revenue metrics are described in the Figure below. Some organizations will want to split some of the metric categories into subcategories (for example, Revenue: Collected from third Party Payers may be split by funding source).

To understand how dependent an organization is on out-of-pocket payments, it may choose to report on the indicator **Proportion of Sales which are Out of Pocket**:

$$\frac{\text{Sales Revenue: Collected Directly}}{\text{Sales Revenue: Total}}$$

3. **Expenses.** A reliable measure of the costs of an organization is **Cost of Goods Sold**, the value of direct expenditures attributable to the production of the goods sold by the organization during the reporting period. The cost should include all costs of purchase, costs of conversion, and other direct costs incurred in producing and selling the organization's products. Organizations can also report on their **Operating Expenses**, the value of direct expenditures attributable to the production of the goods sold by the organization during the reporting period. In health, salary expenses, or **Personnel Expenses**, can be a significant portion of operating expenses. A significant sub-set of this expense is **Permanent Employee Wages: Total**.

Table 8 summarizes metrics for measuring Financial Sustainability. It includes those described above, plus select cross-cutting metrics already described in previous sections. They are a selection of many financial and governmental metrics available in IRIS.

Table 8: Summary of IRIS Financial Sustainability Metrics

Metric	Definition
Governance Policies	Indicate whether the organization has written corporate governance policies that have been communicated to stakeholders.
Board of Directors: Total	Number of members of the organization's board of directors or other governing body, as of the end of the reporting period.
Board of Directors: Independent	Number of Independent members of the organization's Board of Directors or governing body, as of the end of the reporting period.
Conflict of Interest Policy	Indicate whether the organization has a written policy to monitor and disclose any potential conflicts of interest between the company, board members, owners, or material investors.
Financial Statement Review	Indicate whether it is the organization's policy to produce financial statements that are verified annually by a certified independent auditor.
Total Revenue	Value of all revenue received by the organization during the reporting period.
Sales Revenue	Value of the revenue from sales of the organization's product or service during the reporting period.
Revenue from Grants and Donations	Value of the revenue that is contributed through grants and donations, during the reporting period.
Sales Revenue: Collected Directly	Value of the revenue from sales of the organization's product or service collected from clients directly during the reporting period.
Sales Revenue: Collected from Third Party Payers	Value of the revenue from sales of the organization's product or service collected from public or private payers, during the reporting period.
Revenue Growth	Growth in value of the organization's revenue from one reporting period to another. Calculation: $(\text{Earned Revenue in reporting period 2} - \text{Earned Revenue in reporting period 1}) / \text{Earned Revenue in reporting period 1}$
Charitable Donations	Value of all financial contributions and in-kind donations of goods and services made by the organization to charities, private foundations, non-profits or non-governmental organizations, during the reporting period.
Operating Expenses	Value of direct expenditures attributable to the production of the goods sold by the organization during the reporting period.
Personnel Expenses	Value of expenditures related to personnel, including wages, benefits, trainings, and payroll taxes incurred by the organization, during the reporting period.
Permanent Employee Wages: Total	Value of wages (including bonuses, excluding benefits) paid to all full-time and part-time employees of the organization during the reporting period.
Costs of Goods Sold	Value of direct expenditures attributable to the production of the goods sold by the organization during the reporting period.
Client Individuals: No Direct Payment	Number of client individuals who received products/services during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed.
Units/Volume Sold: No Direct Payment	Amount of the product/service sold during the reporting period where no direct payment was provided to the organization at the time of service but for which the organization expects to be reimbursed.
Critical Equipment/Facilities Utilization Rate	Utilization rate of identified critical equipment/facility during the reporting period. Calculation: $(\text{Number of days/hours the identified critical equipment was utilized}) / (\text{Number of days/hours of installed capacity of the identified critical equipment})$

These financial sustainability metrics include structural metrics, like Governance Policies (which are relatively inexpensive to develop and track) and financial outcome metrics like revenue (which are

essential because investors and funders require them). The list does not contain any process measures, which in finance typically cover financial and strategic planning mechanisms. Investors may want to work directly with organizations to elicit or develop these, as they are often highly complex and contextual.

Metrics tabled but not included

To be included, metrics had to meet the criteria of feasibility, usability and validity.¹³ In certain cases, metrics were not recommended in important areas because practice needs to advance for a common impact measure to be feasible. Some were especially challenging to develop standard definitions; others were onerous for organizations to measure. The working group identified these as areas for further research.

1 WHO IS BEING SERVED?	Pro-Poor Targeting What is the population coverage of key interventions? Affordability Is the product or service affordable? Scale What is the scale of the organization's operations?
2 WHAT IS BEING DELIVERED?	Health Outputs What type of products and services are being delivered?
3 HOW IS IT BEING DELIVERED?	Clinical Quality What is the level of quality of services delivered? User Satisfaction Do patients' experiences meet expectations? Financial Sustainability Are financials sustainable to maintain operations over the long term?

Who is being served?

- **Addressable Market** was not included because it did not meet feasibility or comparability criteria. Addressable market is the maximum number of people or households who could theoretically buy or access the product or service. It was difficult to develop standardized method of estimating the addressable market size. Further, the addressable market size for an organization may vary radically by type of service (e.g. maternal care versus injury prevention).
- **Product or Price Compared to Best Alternative** was not included based on usability and validity criteria. The working group determined that although an important measure of pro-poor targeting, it is challenging to standardize and codify because "best alternative" is difficult to define and possibly difficult for an organization to identify. It ought to be part of an organization's business plan, but does not lend itself to a standardized metric. Providing healthcare at the same quality but at a cheaper price than local alternatives targets the poor through reducing financial barriers. This metric is appropriate for products or services where alternatives are available. An alternative to measuring affordability organizations may consider is total out of pocket payments, **Revenue: Direct Sales**.

¹³ Feasible means that organizations could be expected to collect data to report on the measure within an investment timeframe and within the business activities of a mission-driven organization. Usable means that the metric and resulting data could be used to make decisions and understand performance. Valid means that the measure is related to an important impact area in health and that performance data would accurately assess and represent performance in that area.

What is being delivered?

- **Number of Priority Services Provided** was considered an important metric, but ultimately not included for feasibility reasons. Evidence suggests that certain health outputs (such as a full course of tuberculosis treatment, four or more antenatal visits) have a direct relationship to health outcomes. We know that these so-called “priority interventions” can improve health. Listing priority interventions educates investors about high value interventions with strong evidence behind them. However, given the contextual nature of priority services, such as the population of focus, and the continual shifts in priority service areas based on changes in the disease landscape, the Working Group decided against developing a list of prescriptive priority interventions. Funders and investees should educate themselves about the efficacy of health interventions relevant to the diseases of focus in order to achieve high value and impact, at both the individual patient and health system level. As an alternative, the working group suggests that organizations report on **Disease/Condition Addressed** (above).

How is it being delivered?

- **Client Dropout Rate** was not included because it did not meet usefulness criteria. It is the proportion of clients who enter treatment who drop out. It is the opposite of **Client Retention Rate**, which the working group did include. Thus, the working group felt it was not sufficiently useful. Organizations that are interested in reporting on client conversion or retention should report **Client Retention Rate**.
- **Clinical Error Rate** was not included for feasibility and validity reasons. Tracking clinical errors often requires sophisticated tracking systems or robust client survey systems. In addition, since they are uncommon and unwanted, the rate may fluctuate widely between reporting periods and organizations have an incentive to under report. The working group supports organizations that have the infrastructure and volumes to report this data, but did not recommend it for inclusion in IRIS. Clinical error rates can be tracked through quality assurance mechanisms such as audit and feedback, checklists and logs, computerized monitoring systems, and guidelines and protocols. If an organization indicates that they have any of these quality assurance mechanisms, a stakeholder may ask for further detail regarding clinical error rates.
- **Communicable Disease Case Notification Rate** was not included because it did not meet usability criteria. The working group felt it was not sufficiently widely applicable to include in the metrics list. Organizations, such as those that provide tuberculosis diagnosis and treatment, may choose to report this as a health output under **Units/Volume Sold** and note the type of service provided.
- **Health Facilities Service Readiness Score** was not recommended for usability reasons; the working group could not agree on an appropriately broadly applicable definition. A service readiness score captures whether a facility is able to provide the services that it advertises in a manner that is clean, dignified, appropriate, and consistent; this score is most appropriate for hospitals. This can include whether a facility has basic services like running water and electricity, supplies such as latex gloves, and necessary medicines and equipment such as consultation rooms and sterilization equipment. Some facilities hire third parties to assess whether they have achieved sufficient service readiness. They would report this under **Certifications**. In these cases, investors and funders may choose to ask the organization for their service readiness score.
- **Healthcare Visit Consultation Time** was not recommended because it did not meet validity criteria. According to the working group, it is difficult to assess whether a consultation time is appropriate without considerable contextual information. A very long consultation time may indicate low operational efficiency. A very short consultation time may indicate poor attentiveness of staff and poor quality of care. However, most reported figures would lie between those two extremes. An alternative measure of operational efficiency is **Critical Equipment/Facility Utilization Rate**.

- **Patient to Fixed Asset Ratio** was not included for feasibility reasons. The working group thought it was too complex to ask a small provider to complete. Furthermore, it is not relevant or feasible for many types of organizations. It is the ratio of the number of patients to the number of fixed assets (reported by fixed asset type). A high patient to fixed asset ratio may indicate over use of assets and low quality care. An alternative to this metric is **Critical Equipment/Facility Utilization Rate**.
- **Patient Wait Time for Unscheduled Services** did not meet usability and feasibility criteria. The metric measures the patient experience and can help hospitals benchmark themselves to other facilities to measure whether their organization provides care at a lower opportunity cost for patients. The working group did not recommend this metric because it is not applicable to numerous care models (e.g. mobile care, mHealth, pharmacies) and is most useful in comparison to competitors' wait times, which can be difficult to obtain. An alternative metric is **Client Retention Rate**; if wait times are unreasonably high, an organization may expect a low client retention rate
- **Salary Delay** did not meet validity criteria. The working group felt that this metric was not sufficiently useful for measuring financial sustainability and may not be reported reliably. It is intended to reveal cash flow challenges. Salary delay indicates significant cash flow problems but is not sufficiently sensitive. To demonstrate financial sustainability, organizations may choose to report **Revenue Growth**.
- **Staff to Service Ratio** did not meet feasibility criteria. For an organization that provides numerous types of products and services (as many healthcare organizations do), it is only meaningful to report by product or service. However, reporting staff to service ratio by product or service requires careful auditing and calculations and the working group felt this was not feasible for most organizations. It is a measure of the number of staff required to produce one product or service and a measure of financial efficiency.
- **Unscheduled Readmission Rate** was not adopted by the working group because of its limited usability. Hospitals commonly report 30-day readmission rates, assuming that readmissions within 30 days of hospital discharge are due to gaps in quality of care, but they vary due to patient case-mix and need to be risk-adjusted to be comparable. The group felt that it was not broadly applicable because in addition to difficulty doing risk-adjustment, in poor and unsanitary areas, hospital readmissions may be more of a reflection on poor living conditions and less on the quality of care received.

Conclusion

The above metrics provide a menu from which an organization can select appropriate options. There is no single combination of metrics that is right for everyone; this is why IRIS is designed as a catalog that you can browse to find the most appropriate metrics for your work. IRIS includes metrics tailored to specific sectors, as well as metrics that can be used by companies irrespective of their social or environmental goals and the sector and regions in which they work. This means that IRIS is a useful resource for impact investors working around the world, in different sectors, and with a variety of social and environmental impact objectives. IRIS metrics can also be selected to complement and sit alongside any proprietary impact metrics your organization tracks. Because IRIS is a catalog, you can choose as few or as many metrics as you deem necessary to describe the performance of your investees. Organizations can work with stakeholders to develop a unique set of IRIS and non-IRIS metrics to report on annually to develop a long-term description of its performance and impact.

IRIS and CHMI will jointly publish and disseminate the metrics for use and adoption by funders and their investee programs. [IRIS will disseminate the metrics for use by impact investors](#), to support the development of a performance measurement system across an investor's portfolio. [CHMI will share the metrics for use by its program managers](#) in reporting to its respective funders, and help programs align internal tracking processes with reporting to external bodies. CHMI will incorporate the IRIS health metrics into its program reporting processes, encouraging programs to share results across these dimensions to encourage greater transparency and standardization of how program performance is shared with the global community. Over the long term, CHMI hopes to explore the use of program performance data to support third-party evaluation of programs ripe for formal evaluation, to facilitate the flow of funding to programs that are having impact, and to identify successful models to serve as resources or learning centers for pilot initiatives.

About

Impact Reporting and Investment Standards (IRIS) is the catalog of generally accepted performance metrics that leading impact investors use to measure social, environmental, and financial success, evaluate deals, and grow the credibility of the impact investing industry. IRIS is used by hundreds of investors and thousands of companies to track and communicate performance. It is a free resource available at iris.thegiin.org.

Center for Health Market Innovations (CHMI) promotes programs, policies, and practices that make quality healthcare delivered by private organizations affordable and accessible to the world's poor. Its Reported Results initiative helps to aggregate the performance results of these programs across themes like cost, quality, and sustainability. Details on more than 1,200 innovative health enterprises, nonprofits, public-private partnerships, and policies can be found at HealthMarketInnovations.org.