

# The EFQM Excellence Model. German experiences with the EFQM approach in health care

JOHANNES MOELLER

The School of Public Health, University of Bielefeld, Germany

---

## Abstract

**Objective.** To expand on previous reports by illustrating experiences German health services organizations made in their assessment against the European Foundation for Quality Management (EFQM) Excellence Model. To provide an evaluation of the EFQM method compared to peer auditing and accreditation concepts within health care.

**Design.** To indicate the EFQM method and scoring system and draft the process of self-assessment in health services organizations. To refer to the experiences of German health care pioneers during their early assessments.

**Results.** Using the EFQM approach, an organization can earn up to 1,000 points. More than 50% of German hospitals scored 200–300 points and not a single organization achieved over 450 points. To make a comparison, the best score obtained in an industrial setting was between 650–750 points. In addition to the numbers, this report describes success factors and best practices of self-assessments, as well as limitations, barriers and lessons learned during the implementation phase.

**Conclusion.** The Excellence Model is a systematic quality management approach to gain competitive advantage. It is non-governmental, non-financier driven, and generic enough to address health care issues. Having its foundation in industry, however, it is not specific enough to cover all areas relevant to health care. Integrating the management-smart method of self-assessment with clinical standards as delivered by peer auditing and accreditation systems generates the potential to deliver excellence in health care.

**Keywords:** EFQM excellence model, evaluation, health, self-assessment, total quality management, German

---

Around the world, health care is receiving increasing attention, not only for its tremendous impact on the economic resources available to a population, but also for its elementary value to that specific population. In many countries today, regardless of their size or wealth, the health of the population and how health care is provided is a major concern. Those who manage health care delivery strive to achieve the highest quality of care possible with the resources available. Evaluation of health services is, therefore, required.

A study of the German Federal Ministry of Health [1] and a European Union project [2] researched the scope, mechanisms and use of peer review techniques in international health care systems. They specified the Excellence Model generated by the European Foundation for Quality Management (EFQM) as a guiding quality management development perspective in health care. In the meantime, health care improvements on the basis of the EFQM approach have been seen in nearly every European country [3–9]. An official

forum for sharing best clinical practice in using the model is the International EFQM Health Sector Group [10].

## Methods

### Design of the Excellence Model

The EFQM was founded in 1988 with the endorsement of the European Commission. It is a membership based, not-for-profit organization. The present membership is in excess of 800 organizations from most European countries and branches of inclusive health care. The EFQM has developed a quality-management-approach, termed the 'Excellence Model', and has introduced the principle of self-assessment to apply the model. Criteria one to five of the Excellence Model are grouped as 'enabler criteria'. They are concerned both with the things that are used to make a health organization

Address reprint requests to Johannes Moeller, The School of Public Health, WHO Collaborating Center, University of Bielefeld, PO Box 100 131, D 33501, Bielefeld, Germany. E-mail: johannes.moeller@uni-bielefeld.de

function (e.g. leadership, policy and strategy, people, partnerships and resources and health care market knowledge) and also with the processes in a health organization (e.g. diagnosis and therapy activities that generate care, service and management procedures). Criteria six to nine of the model are grouped as ‘result criteria’. They are concerned with the outcomes (e.g. key performance results, customer results, people results and society results) of what is done in a health organization [11]. The nine criteria are broken down into 32 sub-criteria (see appendix) with each sub-criterion being complemented by a list of examples (so-called ‘areas to address’) [10].

### The RADAR measurement system

Next to the Excellence Model lies the measurement system known as RADAR. It consists of four elements: **R**esults, **A**pproach, **D**eployment, **A**ssessment and **R**eview. The Result criteria are scored for trends, performance against targets and benchmarks, scope, and whether or not they are caused by approach. The enabler criteria are rated on Approach, Deployment, Assessment and Review. The five step rating scale (0% – 25% – 50% – 75% – 100%) is used similarly for both enabler and result criteria [7]. Further details about the EFQM approach and its relevance to health care can be found in the literature [7].

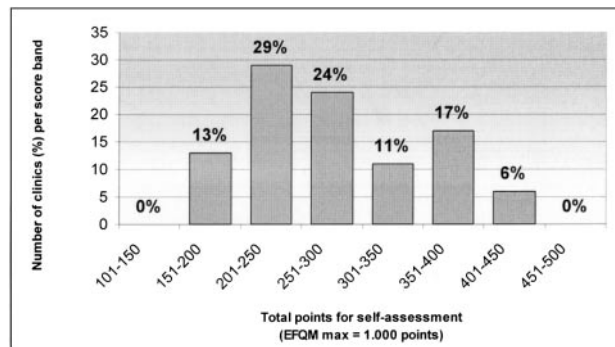
## Results

### The German case

German health organizations are obliged to participate in total quality management (Code of Social Law V, Chapter 9, Article 137). Following that commitment they can use the Excellence Model in different ways. It may be used as a frame of reference for their quality management documentation and development. Secondly, it may be used as a tool for self-assessment and thirdly, the criteria can be used to apply for both the German national quality award (‘Ludwig Erhard Preis’) and the European Quality Award.

The first health organizations in Germany to begin using the EFQM approach in 1996 were: the German Heart Centre Munich (specialized care) [12], the Heidelberg University Hospital/ Hygiene-Institute (acute care) [13], the Rehabilitation Clinic Triberg (rehabilitation services) [14] and Dr. Scheibe of the Urologische Facharztpraxis (out-patient GP specializing in urology) [15]. They started to apply the model by doing a self-assessment to identify their strengths and weaknesses for each criterion. This led them to the first feedback report that is still referred to today. Out of the feedback report, they generated a list of areas for improvement, which they implemented and evaluated. Subsequent feedbacks had provided evidence of continuous quality improvements with a high degree of accuracy and consistency – and an entry into the quality award process is being considered.

Other EFQM initiatives include a network of WHO Health Promoting Hospitals [16], a network of general practitioners



**Figure 1** The range of total points for self-assessment ( $n=17$  health care organizations). The Excellence Model serves as a barometer where organizations can earn up to 1,000 points. The 1,000 points are distributed among the nine criteria for excellence. Figure 1 shows the range of total points that a sample of the 17 pioneering hospitals in Germany achieved in their first assessment. Nine hospitals (53%) arrived at 201–300 points and another five enrollees (28%) made between 301–400 points. Two hospitals (13%) scored less than 200 points and only one remainder (6%) earned in excess of 400 points.

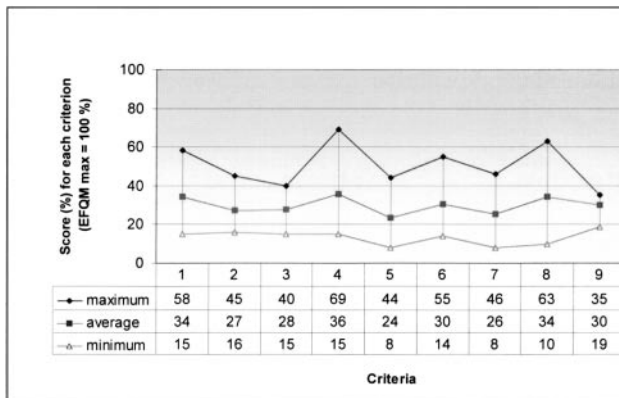
[17], and a network of municipal hospitals in the state of Hamburg [18]. Other examples include privately held hospital federations [19], networks of church-held hospitals [20], an association of centres of psychiatry [21] as well as services specializing in addiction treatment, dermatology [22,23], ear nose and throat treatment [24], pharmacies and medical laboratories [25], social medicine, geriatrics and care for the elderly [26] and many others. Federal health insurance funds and pharmaceutical companies, likewise, use the EFQM approach to evaluate their strategic direction and development [27].

In 1998, the German Federal Ministry of Health started a 3-year pilot project called ‘Quality Management in Hospitals’ [28]. The progress of both the 44 study hospitals and the 80 control group hospitals is evaluated with regard to their progress against the EFQM Excellence Model.

Since 1997, a nationwide EFQM Health Sector Group, co-ordinated at the Universities of Heidelberg (Medical School) and Bielefeld (School of Public Health) has held annual quality conferences, where case reports of EFQM projects are presented. This group also performed a study to compare health service performance against industry’s best and to share learning experiences from early assessments in health care [29]. The results of the study are displayed in Figures 1 and 2.

To make an international comparison, a Dutch treatment centre for addiction in Amsterdam, The Jellinek Centre, scored above 500 points [7] and winners of the European Quality Award reached 650–750 points.

Figure 2 shows the scoring range (in percent) that the sample of 17 pioneering hospitals in Germany achieved in their assessment per each criterion. Small variations in key performance results [criterion 9 (max value/min value) < 2]



**Figure 2** The scoring range of points per each criterion ( $n = 17$  health care organizations). The 1,000 points an organization can achieve with the Excellence Model are distributed among the nine criteria for excellence: criterion 1 = leadership (max. 100 points), 2 = policy and strategy (80), 3 = people (90), 4 = partnerships and resources (90), 5 = processes (140), 6 = customer results (200), 7 = people results (90), 8 = society results (60) and 9 = key performance results (150). By adopting those weightings, health care organizations can benchmark scoring profiles with peers and they can compare themselves against other industries. Figure 2 shows the range of percentage per criterion – minimum, average, maximum – that the pioneering German hospital sample earned in their first assessment.

are contrasted by large intervals within process management and people results [criteria 5 and 7 (max value/min value) > 5].

Whilst excellent organizations typify an equable scoring profile [(max value of all criteria / min value of all criteria) < 1.4] three health care organizations out of the sample realized a quotient of [max value of all criteria / min value of all criteria] > 3.4. To give an idea, here is a collation from authentic consensus report statements delivered during that study.

### Strengths (selection)

There is evidence that the scope and intensity of any patient assessment (e.g. nutritional, functional) are based on the patient's diagnosis, the care setting, the patient's desire for care, and the patient's response to any previous care. Before anesthesia, any patient is determined to be an appropriate candidate. In addition, any patient for whom anesthesia is contemplated receives a pre-anesthesia assessment. A registered nurse assesses the patient's need for nursing care in all settings where nursing care is provided.

### Areas of improvement (selection)

It remains unclear to what extent patients asked to participate in a research project are given a description of the expected benefits, discomforts and risks as well as a description of alternative technologies that may also be advantageous to them.

The rationale behind permanently providing prompt in-house performance of adequate examinations in pathology,

microbiology, immunohaematology, serology, virology, and nuclear medicine remains partly unclear. It is also unclear to what extent patients who have special needs due to age (infant, child, adolescent), disability (treatment for emotional or behavioural disorders), or condition (alcoholism, drug dependencies) are assessed and re-assessed to include information specific to their situation.

### Site visit issues (selection)

The aim of a site visit is to clarify the degree to which the hospital demonstrates respect for patient needs such as confidentiality, privacy, security, resolution of complaints, pastoral counselling, and communication. Furthermore, it should verify that the hospital operates according to a code of behaviour which suitably addresses the relationship of the hospital and its staff members to patients, relatives, other health care providers, educational and funding institutions. Finally, it must verify that the hospital has defined patient assessment activities in writing.

Today, the total number of hospitals using the EFQM approach in Germany is estimated to be between 200–300, representing 10–15% of the national total.

## Discussion

### Lessons learnt in early assessments

#### Barriers

Achieving successful EFQM assessments was not without difficulty. Clinicians repeatedly described problems such as lack of time and lack of dedicated staff. The conflict between allocating time for treating patients and doing self-assessments remained partly unsolved. Problems also arose when there was a lack of good quality information systems and information specialists to help health professionals. In addition, logistical problems of finding appropriate and mutually convenient places for meetings were also mentioned. These difficulties were sometimes aggravated by a lack of adequately trained support staff contracted on a short-term basis, and a failure to renew contracts or recruit staff due to insufficient funding [30].

Dysfunctional group membership or ineffective group dynamics may also have impeded the success of self-assessments. Poor relations between and within assessment teams resulting from frequent interruptions (e.g. telephones, beepers and members coming and going), lack of commitment, concerns about confidentiality, fluctuating membership of the group and reluctance to change practice were all found to influence the success of self-assessments. Clashes between clinicians (e.g. 'the outcome of self-assessments may not allow us to influence medical practice') and managers (e.g. 'we don't make changes on the grounds of cost') were also identified as a cause of failure.

Because the model has its foundation in industry, terminology was identified as another barrier. Moreover, trying to implement too much at one time imposed barriers and caused disappointment. Other pitfalls lay with management

teams who were less personally involved, preferring to delegate most of the work. If 'cosmetic' aspects are over-emphasized, the self-assessment approach runs the risk of becoming an exercise in creative writing rather than a useful activity to identify areas requiring improvement.

### Success factors

Despite many obstacles, the pilot studies identified several factors which facilitated successful self-assessments. These included dedicated staff, a supportive organizational environment, sound leadership, regular meetings with colleagues, information on the aims of the program and protected time to release health professionals from their clinical workload. Furthermore, it was shown that successful self-assessments occurred when leaders thought carefully about the range of skills needed by the facilitator and when the duties of the assessment staff were not solely clerical. Treating support staff as valuable members of the team and providing training when required were also important factors for a successful outcome. Providing reassurance to people that 'something would be done' was another success factor as was commitment from management. It is recommended, therefore, that organizations start with 'champions' areas where people will be able to see rapid numeric evidence of success.

### Conclusion

This article describes the method and scoring system of the EFQM approach for the evaluation of excellence in health care. It provides background information about the assessment process and the diffusion of the Excellence Model. It also describes German experiences in health care which provide evidence that self-assessment is a systematic quality management approach to gaining competitive advantage. The underlying model has a high level of face validity and it is not governmental nor financier driven but it can be linked to existing clinical review mechanisms as appropriate. The approach is sufficiently generic to avoid interference from dilemmas between physicians, nurses, and administrators and it does not affect domains of professional autonomy or clinical excellence. Finally, the EFQM approach provides an indicator (e.g. total score) of the level of success and an outcome from the assessment (e.g. report).

The EFQM feedback report, however, provides no evaluation from the assessment that would equal an accreditation status in the form of a 'pass' or 'fail', or a scaled grading which denotes compliance with standards. Moreover, there is no document of goal attainment (e.g. accreditation decision grid or certificate), nor is there a penalty mechanism if assessment findings do not result in appropriate action. Having its foundation in industry, the approach is not specific enough to cover all areas relevant to health care and EFQM terminology can cause a barrier [31]. Despite these cautions, a combination of the management-smart method of EFQM assessment with clinical standards as developed by peer

auditing and accreditation systems generates the potential to deliver excellence in health care [32].

### Acknowledgements

The author would like to thank the following for their contribution: Sue Jackson, Udo Nabitz and the members of the International EFQM Health Sector Group; Bernhard Guentert, Hans Sonntag and the members of a German EFQM Health Sector Group.

### References

1. Swertz P, Möller J, Butthoff W, Viethen G. *Accreditation and Certification of Hospitals* (in German). German Federal Ministry of Health, Vol. 108. Baden-Baden: Nomos Press, 1998.
2. Shaw CD. External quality mechanisms for health care: summary of the EXPERT project. *Int J Qual Health Care* 2000; **3**: 169–175.
3. Arcelay A, Sanchez E, Hernandez L. Self-assessment of all the health centers of a public health service through the European Model of Total Quality Management. *Int J Health Qual Assurance* 1999; **2**: 54–58.
4. Jackson S. Excellence model right tool for management. *Br J Health Care Man* 1999; **12**: 506–510.
5. Harr J. *Total Quality Management in Dentistry*. Basel: Harr-Print, 1998.
6. Holma T. *A Method of Self-assessment and Quality Management in a Work Unit*. Helsinki: The Association of Finnish Local and Regional Authorities, 1998.
7. Nabitz U, Klazinga N, Walburg J. The EFQM Excellence Model: European and Dutch Experiences with the EFQM approach in health care. *Int J Qual Health Care* 2000; **3**: 191–201.
8. Oydvin T. *Using the EFQM Model for Self-assessment of Hospital Wards* (in Norwegian). Tromsø: Acute Care Hospital, 1998.
9. Pitt D. Improving Performance through self-assessment. *Int J Health Qual Assurance* 1999; **2**: 45–53.
10. European Foundation for Quality Management. *The EFQM Health Care Working Group*. Tilburg: Pabo Prestige Press, 2000.
11. European Foundation for Quality Management. *The EFQM Excellence Model 1999*. Tilburg: Pabo Prestige Press, 1999.
12. Vogt W, Moeller J, Schroeder J-P, Friedl I, Paeger A. Early acute care assessments in the German health care system (in German). *The Hospital* 1997; **12**: 734–738.
13. Moeller J, Sonntag HG. Systematic analysis and controlling of health care organisations lead to numerical health care improvements. *Health Manpower Manage* 1998; **5**: 178–182.
14. Paeger A, Moeller J. Early rehabilitation care assessments in the German health care system (in German). *Managing Hospitals* 1997; **3**: 242–245.
15. Moeller J, Scheibe H. Early out-patient care assessments in the German health care system (in German). *J Qual Manage Med* 1998; **6**: 443–446.

16. Schmidt W, Brandt E. Implementation of the EFQM approach in WHO Health Promoting Hospitals (in German). *Hospital Survey* 1999; **9**: 48–52.
  17. Scheibe H. Implementation of the EFQM approach in an outpatient setting. In Moeller J, Bach A, Sonntag HG. *Total Quality Management, Quo Vadis?* (in German) Heidelberg: Heidelberg University Press, 1999: pp. 167–174.
  18. Muendemann-Hahn A. Implementation of the EFQM approach in the municipal hospitals of the state of Hamburg. In Moeller J, Bach A, Sonntag HG. *Total Quality Management, Quo Vadis?* (in German) Heidelberg: Heidelberg University Press, 1999: pp. 159–165.
  19. Wagner O, Meier S. EFQM as a framework for quality management in a privately held hospital chain (in German). *Hospital Survey* 1999; **9**: 27–30.
  20. Merschbaecher G, Stolz KH, Quast W. Implementation of the EFQM approach in ecclesiastical hospitals (in German). *Hospital Survey* 1999; **9**: 21–26.
  21. Jung N. Implementation of the EFQM approach in psychiatric hospitals (in German). *Hospital Survey* 1999; **9**: 34–37.
  22. Disch R, Simon D, Walker A. Implementation of the EFQM approach in dermatology (in German). *Qual Med* 1998; **5**: 41–45.
  23. Amon U, Bangha E. Implementation of the EFQM approach in dermatology (in German). *Dermatology* 1999; **5**: 273–276.
  24. Wallner F, Moeller J. Implementation of the EFQM approach in an ear, nose and throat setting. In Moeller J, Bach A, Sonntag HG. *Total Quality Management, Quo Vadis?* (in German) Heidelberg: Heidelberg University Press, 1999: pp. 187–196.
  25. Vogt W, Braun S. EFQM assessments in medical laboratories (in German). *Quality Newsletter* 1999; **3**: 8–11.
  26. Moeller J, Breinlinger O'Reilly J, Elser J. Quality Management in German Health Care – The EFQM Excellence Model. *Int J Health Care Qual Assur* 2000; **6**: 254–258.
  27. Kunkel K, Breucker G. EFQM and Health Promotion (in German). *Momentum Newsletter* 1999; **25**: 1–2.
  28. Jannsen S. Network for the future (in German). *Quality Newsletter* 2000; **1**: 42–45.
  29. Swertz P, Moeller J. Excellence in Health Care (in German). *Hospital Survey* 1999; **6**: 396–399.
  30. Robinson S. Audit in the therapy professions: some constraints on progress. *Qual Health Care* 1999; **5**: 206–214.
  31. Jennings K, Westfall F. A survey-based benchmarking approach for health care using the Baldrige quality criteria. *Jt Comm J Qual Improv* 1994; **20**: 500–509.
  32. Caspe Research London, UK: www.expert-caspe.demon.co.uk/news.htm Note: website address correct at time of printing.
- 1b Leaders are personally involved in ensuring the organization's management system is developed, implemented and continuously improved
  - 1c Leaders are involved with customers, partners and representatives of society
  - 1d Leaders motivate, support and recognize the organization's people
- ## 2 Policy and strategy
- 2a Policy and strategy are based on the present and future needs and expectations of stakeholders
  - 2b Policy and strategy are based on information from performance measurement, research, learning and creativity related activities
  - 2c Policy and strategy are developed, reviewed and updated
  - 2d Policy and strategy are deployed through a framework of key processes
  - 2e Policy and strategy are communicated and implemented
- ## 3 People
- 3a People resources are planned, managed and improved
  - 3b People's knowledge and competencies are identified, developed and sustained
  - 3c People are involved and empowered
  - 3d People and the organization have a dialogue
  - 3e People are rewarded, recognized and cared for
- ## 4 Partnerships and resources
- 4a External partnerships are managed
  - 4b Finances are managed
  - 4c Buildings, equipment and materials are managed
  - 4d Technology is managed
  - 4e Information and knowledge are managed
- ## 5 Processes
- 5a Processes are systematically designed and managed
  - 5b All processes are improved, as needed, using innovation in order to fully satisfy and generate increasing value for customers and other stakeholders
  - 5c Products and Services are designed and developed based on customer needs and expectations
  - 5d Products and Services are produced, delivered and serviced
  - 5e Customer relationships are managed and enhanced
- ## 6 Customer results
- 6a Perception Measures
  - 6b Performance Indicators
- ## 7 People results
- 7a Perception Measures
  - 7b Performance Indicators
- ## 8 Society results
- 8a Perception Measures
  - 8b Performance Indicators
- ## 9 Key performance results
- 9a Key Performance Outcomes
  - 9b Key Performance Indicators

## Appendix

### Criteria and criterion parts for excellence

#### I Leadership

- 1a Leaders develop the mission, vision and values and a role model of a culture of excellence

Accepted for publication 27 September 2000