

The EFQM excellence model: European and Dutch experiences with the EFQM approach in health care

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Abstract

One way to meet the challenges in creating a high performance organization in health care is the approach of the European Foundation for Quality Management (EFQM). The Foundation is in the tradition of the American Malcolm Baldrige Award and was initiated by the European Commission and 14 European multi-national organizations in 1988. The essence of the approach is the EFQM Model, which can be used as a self-assessment instrument on all levels of a health care organization and as an auditing instrument for the Quality Award. In 1999 the EFQM Model was revised but its principles remained the same.

In The Netherlands many health care organizations apply the EFQM Model. In addition to improvement projects, peer review of professional practices, accreditation and certification, the EFQM Approach is used mainly as a framework for quality management and as a conceptualization for organizational excellence. The Dutch National Institute for Quality, the Instituut Nederlandse Kwaliteit, delivers training and supports self-assessment and runs the Dutch quality award programme. Two specific guidelines for health care organizations, 'Positioning and Improving' and 'Self-Assessment', have been developed and are used frequently. To illustrate the EFQM approach in The Netherlands, the improvement project of the Jellinek Centre is described. The Jellinek Centre conducted internal and external assessments and received in 1996, as the first health care organization, the Dutch Quality Prize.

Keywords: Jellinek Centre, quality improvement, quality prizes and awards, total quality management

Some of today's primary discussion topics in health care are cost management, empowerment of patients, deregulation and competition between health care providers. Simultaneously, the terms 'evidence based practice', 'professionalism' and 'quality of care' have acquired new meaning. Casparie [1] and Berwick [2] point out that within this context a new paradigm has emerged: quality management in health care. What is the meaning and the development of the emerging paradigm? What does it mean for providers, organizations and institutions?

One answer to the questions is given by the approach of The European Foundation for Quality Management (EFQM) that has developed a model to structure and review the quality management of an organization. Self-assessment, benchmarking, external review and quality awards are essential elements. The EFQM approach is an integral approach and was originally developed by multi-national corporations. During the last years many not-for-profit organizations also

recognized the value of the EFQM Model and used it to structure their own quality management. The ExPeRT Project [3], a European research project supported by the European Commission, identified four quality approaches of health care in western Europe. They are the ISO approach, health care-specific accreditation, *visitatie*, which is a Dutch form of external peer review, and the EFQM Approach. The Expert working group concluded that the EFQM Approach is the most generic approach of the four. The EFQM approach covers quality management as an integral part of all professional and management functions on all levels of the institution. Furthermore, it focuses on organizational development and continuous improvement [4], which ISO and accreditation typically do not emphasize as much.

In this article we describe the background and the principles of the EFQM Approach. The first part of the article closes with the results of the first major revision of the EFQM Approach in 1999. In the second part we summarize some

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experiences in Europe and in The Netherlands. The Dutch EFQM Approach for health care organizations is laid out and we give the example of the Dutch prize-winner. The article ends with our reflections on the further dissemination and use of the EFQM Approach.

The EFQM approach

In 1988 14 representatives of European multi-national companies such as British Telecom, Volkswagen and Philips initiated EFQM. The European Commission and the European Organization for Quality supported the initiative. The founding members developed a multi-dimensional quality management model, called the EFQM Model and introduced the principle of self-assessment and the European Quality Award Program. According to the Foundation, quality management should focus on all activities, on all levels in an organization and should be a continuous process to improve performance. The essence of the approach is that the performance has to meet the expectations, needs and demands of the stakeholders. This description of quality management is directly related to the philosophy of total quality management and organizational excellence and is further explained in the fundamental concepts of the EFQM Model [5].

Comparisons and model development

The EFQM Model shows many parallels with the assessment model of the American Malcolm Baldrige Award [6,7], the Australian, the South African Quality Award and Deming Award in Japan. The Baldrige Award was introduced by the American Congress as a part of the Quality Improvement Act, and consists of a very detailed framework of criteria and procedures for assessing the quality of an organization. The Baldrige Award has seven assessment dimensions, called 'The Seven Pillars' whereas the EFQM Model is characterized by nine dimensions. In 1995 the Baldrige Pilot Criteria for health care organizations were introduced and used by some health care organizations [8]. The Baldrige criteria are reviewed every year and major changes have been made in 1995 and 1997.

Since the introduction of the EFQM Model in 1993 there has been an annual review procedure. In 1997 the Steering Group for model development was installed to develop a proposal for an Improved EFQM Model. As a first step a broad collection of suggestions for improvements was carried out and analysed with the method of Concept Mapping [9]. In a second research phase the improved model was tested and reviewed by more than 500 model users in Europe. The final draft for the improved model was named the EFQM Excellence Model. The EFQM Excellence Model was presented in the spring of 1999 at the EFQM representatives meeting in Geneva and was accepted as the approach for the next years. Comparison of the old EFQM Model of 1997 and the new EFQM Excellence Model of 1999 shows some differences [10]: the number of criteria, the basic structure and the fundamental concepts remain the same but the

meaning of the 32 subcriteria are modified in the new model. In short, the EFQM Approaches of 1999 is more focused on results and performance and on customers and stakeholders.

EFQM and health care quality

Health care in Europe has a long tradition of developing methods and models to assess the quality of the work. Well known are the professional standards, inspection procedures, visitation committees, peer reviews, certification and accreditation procedures [11–13]. In several publications the EFQM Approach is mentioned as a new and promising overall conceptual framework [14–17]. Many organizations do experiments and carry out pilot projects to use the approach in practice. However, until now there are only a few publications concerning the EFQM Approach in the academic literature. There are attempts to compare and integrate the different approaches and models, but a formal proposal is has not yet been developed [18,19]. In general the conclusion is that the EFQM Approach provides a broader and more generic framework than most traditional health care approaches. Being generic it does not go into specific standards and norms for health care as the European Accreditation Systems such as the King's Fund [20] and PACE [21] or the Joint Commission for Accreditation of Healthcare Organizations in North America [22]. The EFQM Approach is general and aligns conceptually with the ideas that are formulated by Donabedian [23]. Donabedian looked at the health care service as a whole and distinguished between structure, process and outcome quality. The dimensions structure, process and outcome fit well with the dimensions of the EFQM Model.

The EFQM Excellence Model

The EFQM Excellence Model [24] is a generic model for quality management, which is used in all types of organizations, regardless of sector, size, structure or maturity. The essence of the approach is the model with nine dimensions, which are called criteria. Although this is somewhat contradictory to the definition of criteria in the quality literature in health care we decided to use the term criteria for the nine dimensions as this is consistent with the general terminology on the EFQM approach. The nine criteria are: leadership, people, policy and strategy, partnership and resources, processes, people results, customer results, society results and key performance results. Next to the model there are eight fundamental concepts and a measuring system. The nine criteria are grouped in 'enabler' and 'result' criteria. The enablers cover the process, the structure and the means of an organization. The result criteria cover the aspects of performance in a broad way. The EFQM Model is based on the premise that enablers direct and drive the results. Simplified, it means that an organization with well-developed enablers will have excellent results. The most important result criteria are customer results and the key performance results.

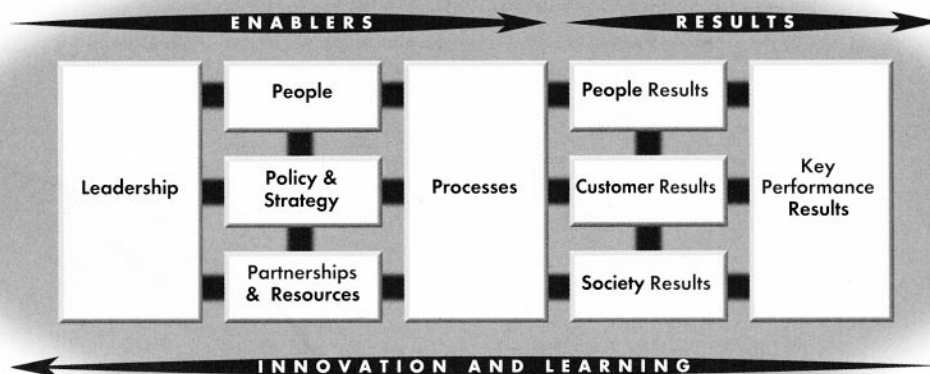


Figure 1 The EFQM Excellence Model.

The most important enablers are processes and leadership. An illustration of the model is given in Figure 1.

The EFQM Model is not based on a definition of quality. The model is not prescriptive and rather soft. The following definition of quality, which is closely related to the EFQM Model can be given: customer results, people results and society results are achieved through leadership driving policy and strategy, people, partnership and resources and processes, which leads ultimately to excellence key performance results.

Each criterion of the EFQM model includes a number of subcriteria, the total number of subcriteria is 32. The enablers are broken down into 24 subcriteria, which are used to assess the approach, the deployment and the evaluation. The four result dimensions are broken down into eight subcriteria, which require objective measures, data and facts, allowing comparison of performances with other organizations. The subcriteria are illustrated with 172 examples, which are called areas to address and measurements. The areas to address and the measurements make the subcriteria and the dimensions understandable and clear; an overview is given in Table 1.

The Measurement System RADAR

The assessment of the quality of an organization is based, on the one side, on the EFQM Model with the nine criteria and the 32 subcriteria; on the other side it is based on a measuring instrument called RADAR. RADAR is an abbreviation for Results, Approach, Deploy, Assess and Review. The five steps of the RADAR are a modification of the Plan-Do-Check-Act cycle of Deming. The measurement system is fundamental to the EFQM Approach; in practice it is applied to the assessment of each subcriterion. The resulting subcriteria are scored for trends, targets, benchmark, cause and scope on a 5-point scale (0–25–50–75–100%). Each subcriterion of the enablers has to be rated on approach, deployment, assessment and review with a similar 5-point rating scale as used for the enablers. The RADAR measuring

Table 1 Overview of subcriteria and areas to address of the EFQM Excellence Model

Criteria	Subcriteria	Areas to address and measurements
1. Leadership	4	24
2. Policy and strategy	5	28
3. People	5	30
4. Partnerships and resources	5	33
5. Processes	5	29
6. Customer results	2	8
7. People results	2	5
8. Society results	2	8
9. Key performance results	2	8
Total	32	173

system, which is illustrated in Figure 2 is a hard and prescriptive part of the EFQM Excellence Approach.

Application of the EFQM approach

The EFQM Approach is applied in three ways. First it is used as a frame of reference for the quality management of an organization, second it is as self-assessment tool and third the criteria of the model are used for the national or European Quality Awards.

Many businesses, institutions or organizations have chosen the EFQM Model as a frame of reference for their quality policy. In most of the cases the chief executive officer, the president, the senior management or the directorate takes the decision to use the EFQM Approach. Some organizations go through a thorough investigation and a decision making process; others decide on the bases of their mission or on

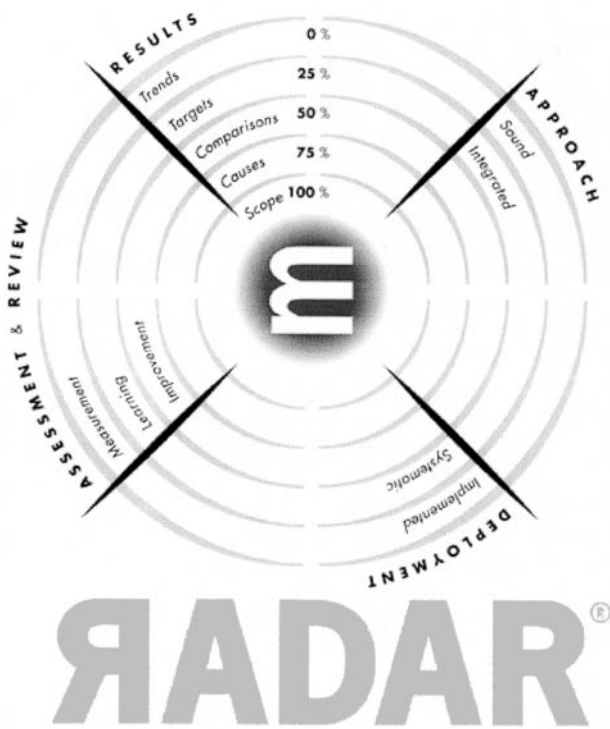


Figure 2 The RADAR Measurement System of the EFQM approach.

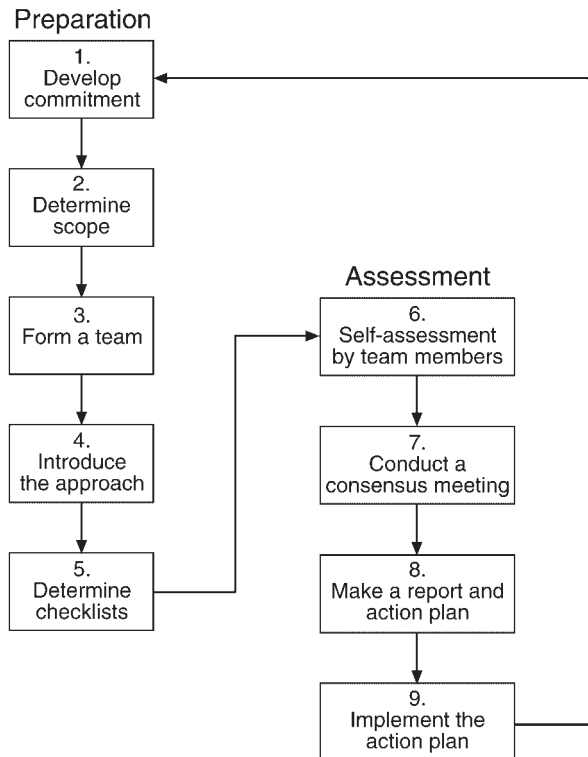


Figure 3 The process of self-assessment in nine steps.

the fact that they operate in a competitive market. After the decision is taken by the leaders, in most cases a broad training programme follows to introduce the EFQM way of thinking to the people in the organization. Eventually, the overall quality policy and the specific quality improvement projects are aligned to the nine criteria of the EFQM Model and benchmarking and assessments are carried out.

Other organizations start to apply the EFQM Model by doing a self-assessment. Frequent self-assessment is a powerful improvement tool. There are six different methods of carrying out self-assessment [25]. The steps to conduct a self-assessment are illustrated in Figure 3. In most cases a facilitator or an internal or external consultant prepares and conducts the self-assessment together with the management. The nine criteria and the measuring system are used as the tool to identify the strong and weak points of the quality management of the organization.

Organizations with a mature form of quality management are challenged by the EFQM Model to apply for the national or European Quality Award. In that case a team of experienced quality managers or consultants collects the information and writes a report which is admitted and scored by EFQM assessors. The assessors use a rating scale from 0 to 1000 points. If the assessors rate the application report higher than 500 points a site visit is carried out. If the assessors come to a rating higher than 550 points after the site visit the applicant is a finalist. If the rating is about 620 points the organization is a prize-winner. The jury of the European Quality Award chooses among all prize-winners the best for

the EFQM award in five classes. In 1999 the Award winners for the five categories have been Yellow Pages from United Kingdom, Volvo Cars Gent in Belgium, Danish International Continuing Education and Service Network Services in France. In the public sector category no award winner was chosen.

EFQM approach in European health care

In almost all European countries the EFQM Approach is used by health care organizations for self-assessment. Inpatient and outpatient services, acute care and rehabilitation clinics, specialized services and primary care offices have used the approach. However only in the UK and The Netherlands is a national institute formally supporting the practical work. The British Quality Foundation has published and adapted the EFQM criteria for healthcare [26] and the Dutch quality institute has developed specific Guidelines for Healthcare which are supported by the minister of health [27]. Other European countries also have quality awards but in most cases they are not directly related to the EFQM Approach. For example, in Sweden the Institute för Kvalitetsutveckling has an approach closely related to the Malcolm Baldrige Award with seven criteria [28]. Often larger health care services develop their own instrument, tune it to the EFQM criteria and subcriteria and experiment and implement their own approach directly in the field. That way of working is in conformance with the non-prescriptive philosophy of

EFQM. The emphasis is on improvement and organizational excellence and not on measuring and standardization. Many organizations and their managers are attracted by this practical approach. This pragmatic view implies, however, that many quality projects of health care organizations are not formally documented and published in the scientific English literature. We tried to collect examples through literature searches, conference proceedings and the EFQM Healthcare Working Group. The publications that we found do not cover the whole field and therefore the short descriptions below are more anecdotal.

In the UK there are several trusts and health care organizations which use the EFQM Approach as a framework or for self-assessment. The following list is not comprehensive but illustrative. The Salford Royal Hospitals in Manchester [29] supported by the University of Salford uses the EFQM approach as a framework for quality management and training; Lifecare Trust in Surrey [30], a health care service for people with learning disabilities, uses the EFQM model to integrate and align its improvement projects; the Royal Bolton Hospitals [31] did an assessment with the questionnaire method and identified projects to improve efficiency and performance; the Community Health NHS Trust of Wakefield [32] conducted with a self-assessment team an overall assessment and used the results for the business planning.

In Scandinavia there are two projects that should be mentioned. The Hospital of Tromsø [33] in Norway conducted about 60 self-assessments with the teams of the hospital and moved on to redesign the processes; they also won the Norwegian National Quality Award. The Finnish Association of Local and Regional Authorities [34] developed a short questionnaire for units and small groups which is used in 200 services; the method proved to be simple, rapid and inexpensive. The experience is positive because all employees are engaged and motivated for quality management.

In Germany the first health care organizations that used the EFQM Model were the Deutsche Herz Zentrum in München and the Asklepios Klinik in Triberg [35]. During recent years the University Hospital of Heidelberg [36] and the Healthcare Services of Asklepios [37] have held annual quality conferences at which they present cases of the use of the EFQM Model in acute hospitals, laboratories and rehabilitation services. It is of interest also that a network of private practices [38] uses the EFQM approach to assess and improve quality. Several specialized services for addiction treatment in Hamburg, Frankfurt and in Nordrhein-Westfalen [39] use the self-assessment tool to develop a quality policy and identify improvement projects. In Berlin a large home for elderly, the Max Burger Zentrum [40], introduced the EFQM Approach and conducted a self-assessment with the 24 senior staff members. In Switzerland and Austria several health care services are in the phase of orientation or reorientation of their quality policy and consider the EFQM Approach as a framework. Two examples are: a dentistry in Basel [41] that uses self-assessment to improve performance and excellence, and a

regional mental health care service in Innsbruck [42] that is aligning its quality management along the nine EFQM criteria.

In France the orientation is mainly on the national accreditation programme of the Agence Nationale d'Accréditation et d'Évaluation en Santé, but there are some specialized units which consider an organizational excellence approach [43]. In southern Europe a large pilot project in the Basque Country Public Health service illustrates how the EFQM Approach can be used on a regional scale [44]. Twelve hospitals and 12 regional health care centres with a total of 22 000 employees conduct self-assessments in order to introduce quality management on a large scale. The Basque health services are supported by the Basque Foundation for Quality Promotion. This regional project shows well that on all levels in a health care setting the generic model for quality management can be applied. In Italy and Portugal there are first initiatives to introduce the EFQM model in health care [45,46].

We wish to emphasize again that the cases and projects reported do not constitute a comprehensive list. However, it shows that many institutions take their own responsibility for quality management, use the generic EFQM Model, and adapt the subcriteria to their own needs. This is completely in line with the fundamental principles of EFQM—the work is not directed or structured by an European agency but it is an evolving process. In that process the EFQM Health Care Working Group, initiated in 1998 by University of Heidelberg, has a facilitating role. To date there are around 50 EFQM users participating in the health care working group, they meet twice a year and exchange experiences and ideas [47].

The EFQM approach in The Netherlands

The Netherlands has a special relationship with EFQM. In 1988, C. J. van der Klugt, President of Philips in Eindhoven took the initiative to invite the secretary general of the European Commission and 14 presidents of well-known European companies for the founding conference. At that conference a letter of intent to improve quality in Europe was signed by all presidents. During the first years the work of EFQM was co-ordinated from the representative office in Eindhoven; later the office moved to Brussels. The Netherlands was also one of the first nations to found a national quality institute the Instituut Nederlandse Kwaliteit, which promoted the EFQM approach and initiated the Dutch national award programme. The institute translated the EFQM guidelines and materials and started teaching programmes in which, from the very beginning, self-assessment was emphasized. That is why the Dutch quality model based on EFQM often is called the Self-Assessment Model. The official name of the model in Dutch is the model of the Instituut Nederlandse Kwaliteit, usually abbreviated as the INK Model or INK/

EFQM Model. In addition to the translation of the model and the introduction of the teaching programme, the Dutch Quality Institute improved the measuring system by introducing the idea of linking it to organizational development and the Profile and Quality-web.

From the beginning, health care authorities and organizations in The Netherlands were very interested in the EFQM Approach. The Netherlands has a rich tradition concerning quality in health care [48]. For years there have been programmes for professionals focusing on audit, guidelines, registries and external peer review procedures called *visitatie* [49]. In the past decade quality systems in health care institutions and quality management have become mandatory, backed up by a national health care policy. Hospitals participate in an accreditation programme, and institutions for mental health, sheltered living and homes for elderly have developed quality systems based on ISO. In the last few years there also have been several initiatives to harmonize the different certification schemes [50]. In this context the EFQM Approach was very attractive because it is generic, has a certain 'face validity', and is easy to use by management, staff and others.

In the early 1990s two National Conferences on 'Policy on Quality Care' played an important role in developing The Netherlands' approach to health care quality. These conferences were initiated by the Dutch health authorities, the financiers, the health care organizations and patient representatives as a reaction to the introduction of market elements in the Dutch health care system described in the report by Dekker *et al.* [51]. The result of the first conference in 1989 was an outline for a quality policy, which stated that all health care organizations should develop a quality system [52]; the Dutch Parliament enforced this intention by passing legislation in 1996. The quality law is not specific and focuses on patient orientation and the improvement of efficiency and effectiveness of care. Managers and directors of health care organization had to act and became interested in a broad view of quality. The broad approach of the EFQM Model was attractive to them, because quality and management, customer focus and efficiency and effectiveness are integrated. Directors and managers were soon convinced that the EFQM approach would work in health care organizations because there was enough evidence from companies in other sectors. By then many businesses throughout the whole of Europe were using the self-assessment tool successfully [53].

A national committee, installed in 1990 at the National Conference, supervised the implementation of quality systems in Dutch health care institutions. In 1995 a survey was conducted among all the health care institutions to measure implementation progress [54]. The survey was conducted for all subsectors of health care such as primary care, care for the handicapped, mental health care, care for the elderly, hospital care and pharmacies. It did not include general practices and other private practices. A postal questionnaire was sent to 1594 institutions; it was structured along the criteria of the EFQM Model. Specific

questions such as protocols and guidelines were added. The response on survey was 74% and results showed that after 5 years 13% of the institutions surveyed had a coherent integral quality system in place. These organizations reported, among other effects, an increase in staff effort and job satisfaction despite the increased workload. Fifty-nine per cent of the institutions had implemented parts of a quality system. In 1998 a short survey among the 20 best hospitals was conducted and showed that 13 of the 20 hospitals use the EFQM as a framework for their quality management system [55].

The Dutch EFQM – a model for health care organizations

In 1997 the Dutch Instituut Nederlandse Kwaliteit published two guidelines for health care organizations: 'Positioning and Improvement' and 'Self-Assessment'. The Dutch Minister of Health endorsed the approach by writing the introduction to the Guidelines [56]. The first set of guidelines, 'Positioning and Improving', helps the management of health care organizations to conduct a quick scan of their quality management on the basis of the nine criteria and the subcriteria. To do this matrices for the assessment of the enablers and checklist for the results are available. With the help of these matrices (which include several items for each subcriterion) and the checklists, in which the indicators are represented, the management can conduct an initial assessment without external support. This approach provides an easy way for an organization to determine its position.

The second sets of guidelines, 'Self-Assessment', is used by organizations that have already carried out a self-assessment. These guidelines are more difficult to apply and more expertise is required. The measuring system in the 'Self-Assessment Guidelines' is a 5-point rating scale from 0 to 100% into which the ideas and principles of quality management are incorporated.

In the guidelines 'Positioning and Improvement', the Instituut Nederlandse Kwaliteit has added some features to the EFQM Approach, namely the five phases of organizational development. The idea of developmental phases originates from the generation model for quality management of Hardjono and Hes [57]. The five phases have proved to be very helpful for organizations working with the EFQM Model. The Product-Oriented Phase of an organization represents the bottom level or the first phase, followed by the Process-Oriented, the System-Oriented and the Chain-Oriented Phase. The fifth and top phase is called 'Total Quality'. The five different phases can be seen as onion skins. Phase one is covered by phase two, phase three covers phase two and one and so on. This distinction in phases supports the self-assessment and helps to give an interpretation of the assessment results.

Another minor but practical addition in the Dutch EFQM Approach is the two graphical representations of the self-assessment results: the Profile and the Quality-web. The Profile illustrates clearly the 32 scores on the subcriteria and the Quality-web shows the scores on the level of the nine

ENABLER CRITERIA, SUB-CRITERIA AND PHASES						
CRITERIA	SUB-CRITERIA	PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
		20%	40%	60%	80%	
1. LEADERSHIP (49%) [60%]	1A Involvement of managem. (53%) [60%]					
	1B Quality Cultuur (58%) [70%]					
	1C Recognition, appreciation (45%) [50%]					
	1D Support (40%) [60%]					
2. POLICY & STRATEGY (57%) [62%]	2A Quality management (65%) [70%]					
	2B Information (65%) [80%]					
	2C Business plans (55%) [60%]					
	2D Communication (60%) [50%]					
	2E Testing (40%) [50%]					
3. PEOPLE MANAGEMENT (34%) [55%]	3A Staff policy (35%) [50%]					
	3B Expertise (25%) [50%]					
	3C Attaining goals (58%) [60%]					
	3D Involvement for improve. (20%) [60%]					
4. RESOURCE MANAGEMENT (44%) [45%]	4A Finances (43%) [60%]					
	4B Information support (65%) [50%]					
	4C Suppliers (25%) [40%]					
	4D Technology (45%) [30%]					
5. PROCESSES MANAGEMENT (25%) [50%]	5A Identification of processes (38%) [50%]					
	5B Control processes (30%) [50%]					
	5C Review and improve proc. (20%) [50%]					
	5D Stimulate innovation (23%) [50%]					
	5E Process change (15%) [50%]					

RESULT CRITERIA, SUB-CRITERIA AND LEVELS					
CRITERIA	LEVEL I	LEVEL II	LEVEL III	LEVEL IV	LEVEL V
	20%	40%	60%	80%	
6. CUSTOMER SATISFACTION (25%) [44%]					
7. PEOPLE SATISFACTION (28%)[49%]					
8. IMPACT ON SOCIETY (65%)[62%]					
9. END RESULTS (50%) [47%]					

Figure 4 The profile of the pre- and post-assessments of the assessor teams.

criteria. These two graphs are the final product of the consensus meeting of a self-assessment; they reduce the assessment ratings to the essence, help to decide on priorities for quality projects and enhance comparison of the assessments.

Dutch quality award and prize

Many health care organizations and institutions in The Netherlands currently use the EFQM manual and undertake the self-assessment. Some organizations write a detailed application report and ask for a site visit by the audit team from Dutch Quality. So far six hospitals have conducted formal external assessments; however, only the Jellinek Centre in Amsterdam has gone through the entire process of internal and external assessment. We give a short description of the award process of the Jellinek Centre to illustrate how it

works. The process for the Dutch Award is very similar to the European Quality Award process. Hardjono and Hes give a detailed plan of action for the award application [58].

The Jellinek Centre is a treatment centre for addiction in Amsterdam. There are approximately 5000 clients treated by a staff of 500 people in 24 different programmes such as consultation, case management, intake, detoxification, inpatient treatment, aftercare and specialized services. In 1988 the Jellinek Centre started its first quality improvement project and decided in 1993 to use the Dutch EFQM approach. The management team also decided to start an improvement plan with a pre- and post-assessment. First they performed a self-assessment, wrote an application report and asked for an external audit from Dutch Quality for the pre-assessment.

In The Netherlands the external EFQM audits are coordinated by the Instituut Nederlandse Kwaliteit. A team of three assessors reviewed the application report and visited

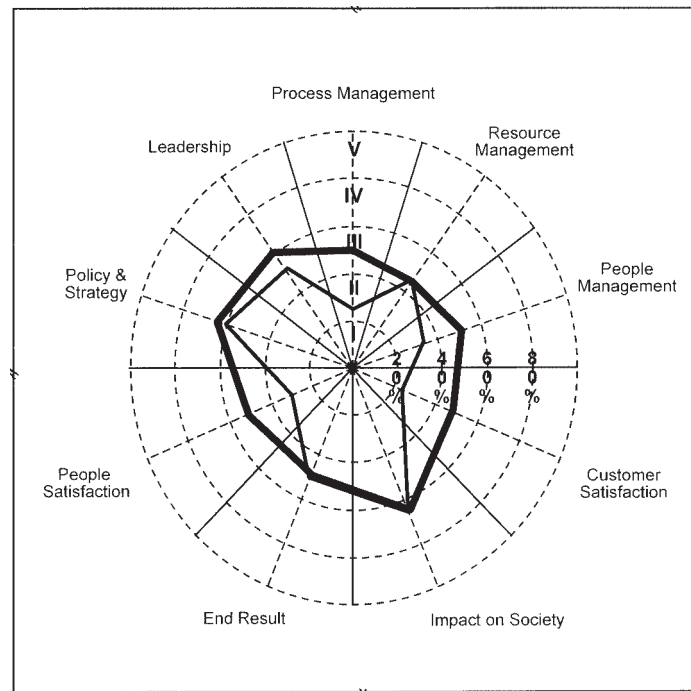


Figure 5 The Quality-web of the pre- and post-assessments of the assessor teams.

the Jellinek in fall of 1994. Their conclusion was ‘The Jellinek Centre operates between level two and three (20% to 60%)’. The organization was in the stage of process orientation with strengths in policy and strategy, leadership, resource management, performance results and society results. The weaknesses lie in the fact that the measuring systems were not established. There was only little data available for people and customer satisfaction. Also the management of the processes was weak. The quality level of the Jellinek Centre was translated in a point score of 350. The Profile and the Quality-web, which the assessment team made is represented as the thin line in Figures 4 and 5. The feedback report of the assessors also covered more than 100 suggestions for improvement. The management of the Jellinek Centre used the report to develop a quality improvement plan. For each subcriterion the suggestions of the audit team were summarized and actions were identified and assigned to the different members of the management team. This document was presented to everybody in the organization as the Quality Improvement Plan 1995–1996. The emphases in the plan were to implement quality thinking throughout the organization, to improve the processes by starting an ISO certification project, and to measure customer satisfaction and people satisfaction.

After 2 years of working on this Quality Improvement Plan, a second application report was written and submitted to the Instituut Nederlandse Kwaliteit. An assessor team of six people reviewed the application report [59] and came for a site visit during autumn 1996 for the post-assessment. They analysed the situation of the Jellinek Centre thoroughly and drew a new Profile and a Quality-web, shown by the thick lines in Figures 4 and 5.

Table 2 Post assessment of the Jellinek Centre: weights, percentages and points

Criteria	Weight	Percentage	Points
1. Leadership	1.0	55	55
2. Policy and strategy	0.8	60	48
3. People	0.9	40	36
4. Partnerships and resources	0.9	55	40
5. Process management	1.4	50	70
6. Customer results	2.0	50	100
7. People results	0.9	45	41
8. Society results	0.6	70	42
9. Key performance results	1.5	45	68
Total	–	–	510

The Profile clearly shows that the quality level of the Jellinek Centre improved over the past 2 years on almost all subcriteria. The Quality-web also shows that the irregularity was reduced and that the web was more balanced than before. Processes and result criteria were rated higher, and the other criteria remained the same or improved slightly. This new Quality-web represents an organization on level three and implies that the Jellinek Centre has passed the organizational development stage of process improvement and is now in the phase of system improvement.

After allocating the weights to each subcriterion and criteria as shown in Table 2 the assessment scores were converted into an overall score of 510 on a scale ranging from 0 to 1000. Whenever the points are between 450 and 650 the

organization is proposed to the jury for consideration for the Dutch Prize. The jury decided positively and the Jellinek Centre received the 1996 quality prize awarded by the Dutch Minister of Finances during the annual quality days.

Discussion and conclusion

This article describes and illustrates the philosophy, method and application of the EFQM approach. Background information is given, the EFQM Excellence Model and the scoring system is explained. We also illustrate the use of the approach by European health care organizations and give insight into the award process of the Jellinek Centre in Amsterdam. In the discussion we want to touch on some topics that are essential in a broader context. First it is remarkable how this approach has gained popularity in health care in a relative short period of time. Following the innovation–diffusion theory of Rogers [60] we propose some explanations. Next we discuss the EFQM approach in the developing marketplace of health care institutions and conclude with some limitations and suggestions for further research.

Innovation

The EFQM Model is both generic and concise, with a high level of face validity for users that are used to conceptualizing organizations in terms of structure, processes and outcome. Furthermore it is related to theories on organizational change and knowledge management and innovation, rather than theories on engineering and structuring of organizations. For health care institutions that have to start with the development of quality systems and quality management, it can be related easily with existing practice and is not as complex as detailed certification schemes. The approach is also attractive because the self-assessment is new and offers an easy start. The management of an institution can try it without making major investments, and if positive results are achieved the leaders can decide whether to continue using it. Compared with other models, such as ISO or accreditation, the self-assessment and the face validity are clear advantages for the EFQM approach and strongly support its dissemination.

Being voluntary, a decision to apply the model is not forced upon an organization but can be undertaken when it is considered to be appropriate. Thus timing is under the control of the health care institution and an ‘external review’ can be planned at a moment where it seems supportive to internal developments.

Our prediction is that as long as the EFQM model can maintain its credibility, based on its concept and construct validity and the credibility of its authors, it will continue to diffuse amongst health care organizations.

Health care organizations in a changing context

Given the policy context of market oriented health care reforms and its consequences for quality of care initiatives, as demonstrated by Thomson [61], the EFQM model has

some attractive characteristics. It is associated with quality management of the manufacture and service industry and notably with some ‘role model’ organizations. That is attractive for health care managers. They can position their institution in the context of service organizations with excellent reputations. To be associated with Rank Xerox or TNT gives market advantages, status, and opens new ideas and perspectives.

Furthermore, because it is generic, the model does not interfere with the dilemma between profession and management that is typical of health care organizations. The subcriteria of the EFQM model do not really go into domains of professional autonomy or clinical excellence; although they are hidden behind some of the general formulations, the subcriteria are less explicit about the control functions in professional bureaucracies. The norms of ISO or hospital accreditation schemes touch those topics directly. The avoidance of those dilemmas can be an advantage when the aim of management is to introduce the general concepts of quality management in the organization.

The EFQM approach does not represent a governmental initiative or an initiative from financiers. This positions the approach, in many European countries, with a kind of ‘outsider’ status that can be beneficial when, as part of the market oriented reforms, power relations between government, financiers and providers are changing. It is a new opportunity for health care institutions which have to move forward with quality management but do not want to submit to direct external review and control from the government. Despite the reputation of the European Commission that endorsed the approach, the relative neutrality of EFQM makes it a credible approach in the highly politicized arena of accountability mechanisms in health care.

Limitations and further research

The characteristics described above that explain the popularity of the EFQM model for health care organizations in western Europe are, at the same time, its weak points. Although the approach is beneficial in starting quality management initiatives and offering ground for comparison of health care organizations with other sectors in society, it is and will not be specific enough to address all areas relevant to health care. We are convinced that it will never replace the health care-specific approaches of hospitals and professionals that assure the quality of the clinical content of health care. However, if used correctly, the EFQM can provide an overarching conceptual framework for quality management initiatives that is acceptable for the different groups in health care organizations, including the professional, management and growing number of technical and facilitating staff. The convergence between the four main models used in Europe as described in the results of the Expert Project [3] emphasizes this point.

It seems, however, necessary that the EFQM approach in health care is evaluated in a more systematic and rigorous way than has been done so far. The exploratory data collected should be supplemented by systematically collected empirical

data through evaluation research and, when possible, results of experimental research. Only then will we be able to establish whether the popularity of the EFQM approach in health care is not only judgement based but also evidence based.

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