External peer review in Europe: an overview from the ExPeRT Project

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Abstract

Objective. This paper aims to evaluate the use and development of external peer review models and to identify where the main models are used in European Union member states and countries with reciprocal research agreements with the European Union.

Design. The ExPeRT (external peer review techniques) project research team conducted a series of fact-finding missions to all participating European nations.

Study participants. I. Blomberg, Sweden; L. Bohigas, Spain; S. Cucic, The Netherlands; P. Morosini, Italy. The Project is led by C. Shaw, UK and is managed by C. Heaton, CASPE Research.

Results. We identified four main external peer review models aimed at measuring the quality of service management and delivery: health care accreditation, the International Organization for Standardization ISO 9000 standards, the European Foundation for Quality Management Excellence Model and visitatie, which is Dutch for ‘visitation’ or peer review-based schemes.

Discussion. ExPeRT has demonstrated that in principle, convergence of the four main models in order to gain from each model’s key strengths is feasible. Whether convergence is practical, depends upon the willingness of governments, health service providers, health care quality professionals and organizations to come together and adopt the recommendations of the ExPeRT project.

Keywords: accreditation, ISO 9000, European Foundation for Quality Management, ExPeRT, external peer review, visitatie

The focus of quality in health care has only recently turned from simply considering the content of care, to addressing the delivery and management of service provision. This emphasis is particularly evident in Europe [1], brought about by rising quality consciousness, changes in the way health services are financed, and consumers’ growing expectations of better health care. In order to meet increasing demands for accountability from consumers and health care financiers, external peer review systems have been employed to bring a measure of comparability to service standards. In some countries health care accreditation has led the way; other countries have looked to internationally recognized standards such as ISO 9000, or have taken up the European Excellence model (formerly Business Excellence). Elsewhere, the impetus has come from clinicians who have implemented visitatie (peer review)-based systems.

With European Commission funding, the ExPeRT project (external peer review techniques – contract PL951128) was established to evaluate the use and development of external peer review in the European Union and countries associated to the European Union through reciprocal research agreements. The ExPeRT team (I. Blomberg, Sweden; L. Bohigas, Spain; S. Cucic, The Netherlands; P. Morosini, Italy; led by C. Shaw, UK; managed by C. Heaton, CASPE Research, UK) conducted a series of fact-finding missions to all participating European nations. We identified four main external peer review models aimed at measuring the quality of service management and delivery: health care accreditation, the International Organization for Standardization’s ISO 9000 standards, the European Foundation for Quality Management (EFQM) Excellence Model, and visitatie, which is Dutch for ‘visitation’ or peer review-based schemes. Working with a network of health care professionals, representing their countries in the ExPeRT project, we proceeded to catalogue the distinctive ways in which these models have been used and adapted by organizations and governments across Europe.

Origins of the Four Main Models

Although accreditation, ISO, EFQM and visitatie are now the four main external review systems for Europe’s health services, the four models have very different roots and consequently, quite distinct purposes (see Table 1).
Table 1 Origins and growth of the four main approaches to external peer review

<table>
<thead>
<tr>
<th>Origins</th>
<th>Growth</th>
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<tbody>
<tr>
<td>Accreditation</td>
<td>Used world-wide; model operational or being</td>
</tr>
<tr>
<td>USA 1917, Hospital Standardization Program set up by American College of Surgeons</td>
<td>developed in more than 80% of the nations participating in ExPeRT</td>
</tr>
<tr>
<td>ISO</td>
<td>11 000 international standards in use; 230 000 ISO 9000 certificates awarded; health sector use in 88% of participating nations</td>
</tr>
<tr>
<td>UK 1947, standards designed for defence engineering and manufacturing industries</td>
<td>ISO 9000 certificates awarded; health sector use in 88% of participating nations</td>
</tr>
<tr>
<td>EFQM</td>
<td>600 member organizations throughout Europe; used by health care organizations in around 65% of participating nations</td>
</tr>
<tr>
<td>Europe 1988, introduced by presidents of 14 major European companies, with EC endorsement</td>
<td>Widespread use in The Netherlands; interest or implementation of model in 30% of participating nations</td>
</tr>
<tr>
<td>Visitatie</td>
<td>The Netherlands 1992, implemented by medical associations as a peer review for re-registration of members</td>
</tr>
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Health care accreditation originated in America, with the founding of the Hospital Standardization Program in 1918, instituted to award proper recognition to facilities with high standards and to stimulate improvement in those with inferior equipment and standards [2]. First implemented by the American College of Surgeons, accreditation is firmly rooted in the health care profession, recognizing the importance of good organizational processes underpinning clinical practice. Interest in the model spread first to Australia in 1926, then to Canada in 1953 when the Canadian health service became independent from the USA. Though slow to follow (Europe's first accreditation programme was established in the Catalan region of Spain nearly 20 years ago), most European Union member states now have either fully operational programmes or an interest in developing accreditation (see Figure 1).

The ISO 9000 series of standards developed by the International Organization for Standardization (ISO) began in UK as the British Standard for quality management systems (BS5750). The latest revision encompasses the series within one standard, ISO 9001. Rooted in defence engineering and manufacturing industries, ISO 9000's appropriateness for the health care sector is not universally accepted. In January 1996, a number of German medical associations and insurers issued a joint press statement that 'certification of hospitals by ISO standards is not the right way', because ISO 9000 does not give due attention to the population impact of health services, clinical outcomes or staff orientation. Despite this, the model has become popular in many parts of Europe and is used in departments, laboratories or hospitals in virtually all European Union member states (Figure 1). Enthusiasm for an internationally recognized health care quality standard has led to a proliferation of guidelines and interpretations of ISO 9000 being developed for the health care sector by organizations throughout Europe, affiliated with ISO, by independent bodies and by individual ISO consultants [3].

The visitatie approach originated and developed in The Netherlands. Firmly grounded in the medical profession and based on explicit standards, it shares some common ground with accreditation, but aims to improve the quality of patient care by focusing on the quality of individuals’
Overview from the ExPeRT Project

... clinical teams’ professional performance and does not award a certificate of achievement. Although it is currently the least widespread of the four models, visitatie-based systems have spread to UK, Sweden and Finland where programmes, launched by medical societies, royal colleges and by reciprocal arrangement between clinics, are in various stages of development. It has been speculated that some form of visitatie or external peer review will soon be compulsory in the UK to ensure doctors effectively regulate the quality of their own professional performance.

The roots of accreditation, ISO and visitatie can be traced to an individual country. The Business Excellence Model (re-launched in 1999 as the Excellence Model) has pan-European origins. EFQM was founded in 1988 by the presidents of 14 major European companies, with the endorsement of the European Commission. Present membership is in excess of 600 organizations, ranging from major multinational and national companies to small university research units. The model has wider influence, as it has also been adapted in several countries to form the basis of national quality awards. The Excellence Model provides a graphic conceptual framework, which is used both as a self-assessment tool and by facilities applying for external review in order to achieve the European Quality Award or national quality awards. Inspired by the Malcolm Baldrige Award in the USA, EFQM follows the Donabedian Award structure: process, outcome, and emphasizes organizational development through self-assessment before an application for the European Quality Award can be considered on the results of an external assessment.

Use of the four models in Europe

The ExPeRT team found examples of the four main approaches to external peer review throughout Europe. Figure 1 shows which of the models have been implemented in participating European nations; where there are fully operational programmes (dark grey), initial introduction, development and piloting of the models (mid grey) or some evidence of practical interest, including proposals to develop one of more of the models (light grey). We found that ISO 9000 had been used in the most countries (though within each country use of the model is not necessarily widespread), followed closely by accreditation, then EFQM and visitatie.

The popularity of ISO may be due to its international recognition and to its suitability for individual departments and quality systems, particularly laboratories and radiology units. Although it is used in many countries, few entire hospitals have applied ISO 9000 standards. The applicability of the model may change as the revised ISO 9000 embraces a process, rather than system-based approach. Accreditation, designed primarily for whole organizations with some specialty-specific exceptions – for example the UK programmes for the Accreditation and Development of health Records, accreditation for autism services and Clinical Pathology Accreditation (CPA UK) – has significant uptake in those countries where programmes are fully operational. For example, in the UK more than 30% of National Health Service (NHS) trusts and more than 80% of clinical pathology laboratories use accreditation. This compares with around 20% of NHS trusts achieving ISO certification for some function of health care provision, with only a fraction of a percentage implementing ISO standards throughout the organization. The other two models are also used in UK, around 4% of NHS trusts have implemented the EFQM model, and visitatie-based peer review programmes, developed and promoted by the royal medical colleges, are gradually gaining popularity.

The impact of legislation on the use of peer review models

The perceived appropriateness of each of the four main models for the health care sector is only one element influencing the prevalence of one approach over another. Legislation also affects the use and development of external peer review.

In almost half of the countries participating in the ExPeRT study, there is no legal requirement for health care facilities to meet specific organizational standards in order to practice. Nations with little government direction on organizational health service standards, include Greece, the Republic of Ireland, Luxembourg, Portugal and the UK. The reasons for lack of legislation differ from country to country. For example, in Luxembourg the government is concerned to give maximum autonomy to its physicians. Instead of legislating on the use of external peer review, there have been efforts to make clinicians aware of quality issues and problems, with the hope that this will increase the level of quality. Although there is some use of external quality assurance initiatives, for example ISO 9000 audits in radiology departments, many physicians retain a more passive attitude towards external review. In Portugal, because of continuing debate over the potential problems of accrediting public hospitals by a public body and the consequences of identifying inferior health service provision, there has been an expression of interest in accreditation but, until recently, no implementation. The government has now commissioned the UK-based Health Quality Service (HQS) to develop an organizational development programme, leading to accreditation in the future.

The lack of endorsement of external peer review techniques by governments appears to have led in some countries to a proliferation of external evaluation programmes being developed and in others to very little action. In the UK, for example, a succession of white papers over the past decade have raised the profile of quality in health care, and emphasized the need for frameworks to monitor service delivery. Over this same period of time accreditation programmes have become...
Characteristics of European external peer review programmes

National variants of the EFQM and ISO models trace directly to the parent models. For example, the Swedish Quality Award is a localized version of EFQM’s European Quality Award, and the Swiss H-9001/2 [7] is a direct health care specific translation of ISO 9000. The SANTE Coordination of the law on hospitals’, passed 7 August 1987, in Germany, hospitals are required to implement systems for assuring quality of organization, performance and outcomes, including a mechanism for comparison with similar organizations, facilitated by the Arbeitsgemeinschaft zur Förderung der Qualitätssicherung in Medizin. The French government requires that “in order to ensure the continued improvement of quality and the safety of care, all health organizations, public and private, should participate in an external procedure of evaluation called accreditation’ [5]. In addition to explicit endorsement of the accreditation approach, the government has contracted the Agence Nationale d’Accréditation et Evaluation en Santé [6] to provide accreditation services throughout the country.

We found that in many instances, where a single model (usually accreditation) is made mandatory, opportunities for competition and collaboration with other external peer review models and motivation to continually improve programmes, are diminished. This is evident in France, where the uptake of ISO 9000 has been affected, and in Belgium (see Figure 1) where no other model is fully operational. However, in Italy, where institutional accreditation co-exists with voluntary accreditation, there has been a strong, although not unopposed, movement for the application of ISO 9000 standards. The uptake of ISO 9000 has been affected, and in Belgium (see Figure 1) where no other model is fully operational. However, in Italy, where institutional accreditation co-exists with voluntary accreditation, there has been a strong, although not unopposed, movement for the application of ISO 9000 standards. The Irish use of ISO 9000 standards and EFQM’s Business Excellence model has a more convoluted history. ‘Excellence Ireland’ was originally established as the Irish Quality Association to promote quality development within industry in Ireland. Its primary catalyst in this was the development of the ‘Q mark’ award. The standard was based loosely on the ISO 9002 model. Upon its metamorphosis in 1997, ‘Excellence Ireland’ undertook to review the ‘Q Mark’ criteria and develop the Irish Business Excellence Model, based on the EFQM model. The ‘Q Mark’ is the most publicly recognized symbol of quality in Ireland. Under the old standard criteria a few health care facilities (e.g. Portugal) and where there has been little evaluation of health service quality, with a country where health care is entirely insurance funded (e.g. The Netherlands) where there is full national integration of external quality measurement mechanisms into the health care system. However, in Italy and the UK, where public provision of health services is still prevalent, external peer review models are used widely. This suggests a growing culture of continuous quality improvement and exchange of ideas throughout most of Europe, regardless of individual nation’s funding arrangements.

As accreditation programmes are not centrally organized, the relationships between them are heterogeneous. It is also not clear what association there is between visitatie-based initiatives in different countries beyond some practical exchange of information initiated by the ExPeRT staff exchange programme [4], as the approach has emerged outside The Netherlands only recently.

Accreditation was first adapted for a European context by Spain, with the Catalan Hospital Accreditation Programme, developed by Fundacio Avedis Donabedian following the traditional model. Although the programme was launched several years before other major European
accreditation programmes were established, most European players have continued to look to the North American and Australian models for guidance. As a result, French accreditation has its roots in the Canadian system; Iceland’s interest in accreditation has embraced aspects of several other approaches, primarily the American (Joint Commission on Accreditation of Health Care Organizations; JCAHO) standards; Italy has taken elements of the Australian (The Australian Council on Healthcare Standards; ACHS) and Canadian (The Canadian Council on Health Services Accreditation; CCHSA) programmes; and accreditation in the UK has taken its inspiration from Australia, where the health service context most resembled the British system.

The UK’s first hospital accreditation programme, HAP, began working with small community hospitals (fewer than 150 beds) in the early 1990s. Since then numerous programmes have developed with multiple influences, covering whole organizations and specialties. Some programmes are now in competition, for example: the HQS, the Trent Accreditation Scheme, and HAP all compete for a share in the UK community hospital market. The Royal College of General Practitioners and HQS both offer primary care accreditation, and there are several initiatives for hospice care, including the Trent Hospice Audit Group, Yorkshire Peer Review and HQS. In Ireland too, although accreditation is in its infancy, several programmes are being developed concurrently: the Independent Hospital Association, working with the Joint Commission; the five main teaching hospitals within the Dublin area; and the Irish Society for Quality in Healthcare are all developing accreditation-based initiatives.

Although most programmes have taken a lead directly from the original North American model, Finland and Sweden chose the UK-based King’s Fund Organizational Audit (KFOA, now HQS) as the prototype for the Swedish SPRI Organizational Audit and the Finnish OA programme, developed by Health Services Research (SF – Suomen Terveystutkimus Oy). Sweden analysed all internationally applied programmes and systems for internal self-assessment and external audit, including JCAHO; CCHSA; ACHS. Their manuals and standards were piloted in different health care facilities before it was decided to base the approach on the King’s Fund OA Programme. The revised Canadian system is now an equally important source of inspiration. The SPRI programme bears many of the marks of traditional accreditation, including health care specific standards and a peer review survey using a team of health care professionals, but does not offer certification or an accreditation award.

A few countries, instead of developing national versions of the traditional accreditation model, are working with the UK-based HQS and USA-based Joint Commission International (linked with the JCAHO) who offer organizational development consultancy and/or accreditation in Europe. HQS appoints consultants, based within the country, to develop standards appropriate to the national context. With assistance from accreditation bodies throughout the world, Joint Commission International have developed a set of international core standards, which were launched in Barcelona in July 1999. Intended for international applicability, these standards are now beginning to be applied in a number of European nations, including Denmark and Ireland.

Moving towards collaboration and convergence of the four main models

With increasing interest in external peer review throughout Europe, it is encouraging to see former suspicion between models giving way to mutual respect and collaboration. Although a single system to external peer review has not developed in Europe, many organizations and individuals now recognize the benefits of each of the models and have sought to incorporate the strengths of each approach as programmes develop.

In a number of countries, including Austria and Sweden, the same people have contributed to the development both of ISO 9000 and EFQM’s Excellence Model for the health care sector. The influence, particularly of EFQM on ISO is evident in the way the ISO 9000 standards have been revised, bringing the models closer together.

Accreditation-based systems have been influenced by the call for international transparency and the popularity of ISO. This is evident in the way programmes have sought to include ISO standards into accreditation manuals. Recent revisions of the HAP standards have informally incorporated most aspects of the ISO 9000 series, as have the Finnish organizational audit standards, which now cover the full spectrum of health care and social services and include all key elements of the ISO 9000 standards and EFQM. The National University Hospital in Iceland has used accreditation and ISO side-by-side; ISO for designing and maintaining quality systems and JCAHO standards for self-assessment and internal evaluation. In Italy the Regional Health Agency of Regione Emilia-Romagna, located in Bologna, is seeking to develop regional standards which blend together ISO 9000 standards with the traditional accreditation model, particularly the Canadian and Australian programmes. The most complete integration of ISO and accreditation has been undertaken by HQS, who in 1998 gained United Kingdom Accreditation Service accredited status and offer facilities the option of health care specific ISO 9000 assessment as part of their accreditation process or as an alternative. Future developments promise more emphasis on results, influenced by the EFQM Excellence Model and a more in-depth focus on the delivery of specific clinical services, in line with the visitatie approach.

Until recently there has been little co-ordination of external peer review efforts within individual countries, let alone across Europe. Some degree of collaboration between external peer review programmes is being facilitated in UK, by the United Kingdom Accreditation Forum, established in 1998, bringing together around 30 initiatives. However, the most comprehensive national initiative can be found in the Dutch health care system, which demonstrates how
accreditation and ISO-based certification can be absorbed and adapted in a way that is consistent with a nation's structure and culture. An insurance-based system with a high level of solidarity; private (not-for-profit) ownership of the majority of the health care facilities; strong professional bodies; and a consensus culture for decision making, provide the backdrop for the way in which accreditation, visitatie, EFQM and ISO certification have been absorbed by the health care system [9]. The Dutch Foundation for the Harmonization of Quality Assessment in Health Care (Stichting Harmonisatie Kwaliteitsbeoordeling Zorgsector; HKZ) was set up in 1994 by various corporate organizations of providers, patients and insurers, and financed by the Ministry of Health to co-ordinate external peer review activities. HKZ developed a health care-specific ‘harmonization model’ in 1996, inspired by EFQM and fully compatible, but with a broader scope than the ISO 9002.4 standard. The competence of external peer review organizations to operate within the health care sector and specific subsectors is assessed against the harmonization model. As a result accreditation schemes developed in accordance with HKZ’s model meet the approval of patient organizations and insurers as well as the industrial council for accreditation. Private companies, wanting to certify health services have to use the schemes approved by HKZ and thus by the health care sector itself.

The inauguration of a pan-European body representing a significant proportion of health care quality professionals, European Societies for Quality in Health Care may contribute to the co-ordination of efforts across Europe. However, as yet this body has not put external peer review high on the agenda. The only truly international activity has been lead by the International Society for Quality in Health Care through the ALPHA programme, which will offer endorsement and bring a level of comparability to accreditation operations world-wide. What this initiative does not offer is a mechanism for approving health care assessment using the other three approaches, nor has it evaluated the benefits of convergence between the four main models.

Conclusions

The ExPeRT project has begun the work of exchanging information and gaining an understanding of external peer review in Europe. We have introduced, in this paper, some of the key themes: where the four main models came from; where they are being used; what political and health service contexts favour which systems; what characteristics can be seen in European programmes and how the cultural context influences programme development. These issues and the potential for convergence will be addressed in more depth in subsequent articles in this edition of the journal.

The ExPeRT project has chartered the development of the models from four very different origins to a place where systems are being modified to encompass the strengths of more than one model. With accreditation systems embracing ISO 9000 standards and EFQM being used as a framework to structure use of the other three models [10], external peer review models are gradually converging. How this process continues will depend upon the way in which the concept of a convergent model is embraced. ExPeRT has demonstrated that, in principle, convergence is feasible. Whether convergence is practical, depends upon the willingness of governments, health service providers, health care quality professionals and organizations to come together and adopt the recommendations of the ExPeRT project.

Acknowledgements

I would like to acknowledge the contribution of the ExPeRT team and all those involved in producing ExPeRT’s Baseline Summary Report, as well as delegates whose valuable participation in seminars and conferences, added to the ExPeRT knowledge base.

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Accepted for publication 13 March 2000