Lives in the balance: an analysis of the balanced scorecard (BSC) in healthcare organizations

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Abstract
Purpose – The purpose of this paper is to show how the balanced scorecard (BSC) has been a prominent innovation in strategic performance measurement systems. The health care sector has started to adopt this approach.

Design/methodology/approach – There are many case studies of BSC applications and this paper reviews this literature to analyse the application of the BSC across this sector. In particular, it is argued that the current applications do not tend to show the health of patients as being central in the development of the BSC; the balance is tilted towards the financial not the health outcomes. BSCs are still in an evolutionary stage in health care settings and strategy mapping is not yet common.

Findings – The paper has drawn together and analysed the published cases of BSC in health care. It is possible that some excellent examples of BSC in health care are not yet published or have been missed by this research approach. This analysis was limited by using information from papers which sometimes were very limited. A future research project could investigate the characteristics of unsuccessful implementations – ineffective and short-lived. It is suggested that a more comprehensive view would come from a cross-national survey of best practice use of the BSC in health care; an interesting project for future research.

Originality/value – In reviewing the past applications, the paper shows a way forward for future developments of the scorecard in health settings.

Keywords Balanced scorecard, Health services

Paper type Conceptual paper

Introduction
In healthcare, the balanced scorecard is the current “meal for today”, with consultants advocating this “miraculous treatment” (Aidemark, 2001, p. 23). The healthcare industry has a long tradition of extensive and detailed performance measurement (Pieper, 2005). It seem clichéd to focus on increased competitive pressures; but these are very apparent in health care in many countries – ageing populations increasing demand, improved treatments which are wanted by more people, shortage of skilled health care workers, and governments seeking to reduce their financial involvement. In this context, performance measurement is seen as having a key role: “When dramatic changes are inevitable, developing a strategic focus and examining the business and
quality of the health care in a measurable and repeatable manner becomes each organisation’s opportunity” (Meliones et al., 2001, p. 28).

The Healthcare organizations have had to meet some unique challenges in adapting the BSC to their environment. Since 1994, when the first refereed article was published on the BSC in health care settings, numerous articles have appeared in the health services and management literature, as the BSC appears to have gone into a growth phase (Zelman et al., 2003). According to Zelman et al.’s (2003), study the BSC has been adopted by a broad range of health care organisations, including hospital systems, hospitals, psychiatric centres, and national health care organisations.

Although the BSC has been applied successfully many times as a strategic management tool; there is also evidence of many failures. Neely and Bourne (2000) claim a failure rate of 70 percent. Identifying features of successful implementations is therefore important. In heath care, much of the literature relates to how to apply BSC successfully (for example, Chow et al., 1998; Stewart and Bestor, 2000; Pink et al. 2001; Oliveira, 2001; Fitzpatrick, 2002; Shutt, 2003; Tarantino, 2003; Radnor and Lovell, 2003a, b). Less common are surveys about applying BSC in health care. However, Chan and Ho (2000) conducted a survey of the BSC in Canadian hospitals in 2000 and Inamdar and Kaplan (2002) surveyed executives in nine provider organizations in the USA. There is insufficient information about the overall pattern and success of BSC implementation in health care. This paper integrates all of the case studies to seek for common patterns and contrasts.

The paper is arranged as follows. The next section uses the research literature to develop three research questions. This is followed by a short methodology section and then the findings. The discussion section precedes the final conclusion.

Prior literature
We have explored these cases using three research questions. Our first question is: What are the perspectives used? The earliest BSC papers (Kaplan and Norton, 1992) advocated the use of the four perspectives – financial, customer, internal business process and learning and growth. Subsequent developments brought about the inclusion of other perspectives such as sustainability (Brignall, 2002). In the development of the literature Kaplan and Norton (2001) developed a perspective labelled “Mission” for not-for-profit organisations. The choice of perspectives remains one of the most important decisions in BSC design – how many perspectives will there be and what will they be? It was anticipated that the focus of these scorecards, especially those in the not-for-profit sector, would have been on patient health – on the change to the lives of the people who these healthcare institutions are trying to help.

The second question is: Which specific performance measures are used within the scorecard? Most health organizations have a range of measures already in place. Pieper (2005, p. 9) notes:

Hospitals have been using metrics for a long time, longer than most other organizations. . . Technology has enabled hospital leadership to collect and distribute vast amounts of data; benchmarking processes that allow healthcare organizations to measure their performance against industry averages have been in place since the late 1970s.

The BSC is supposed to assist in identifying the most critical measures for monitoring and developing strategy. The selection of measures should demonstrate the creativity
in seeking measures which support strategic direction. In particular, we were interested in the learning and growth perspective which Marr and Adams (2004) argue is the BSC’s weakest link. Frigo and Krumwiede (1999) reported that the majority of BSC users rate the effectiveness of the innovation perspective as “less than adequate to poor”. Speckbacher et al. (2003) concluded that over 30 percent of the BSC users in their study had no learning and growth perspective; not, presumably, through any lack of knowledge of this perspective, but the very difficulty of finding measures. Kaplan and Norton (1996, p. 144) admit that “this gap is disappointing since one of the most important goals for adopting the scorecard measurement and management framework is to promote the growth of individual and organisational capabilities”.

The third question is: Which generation of scorecards are used? At least three different definitions of the stages of the evolution of BSC exist in the literature (Morisawa, 2002; Miyake, 2002; Lawrie and Cobbold, 2004; Speckbacher et al., 2003). All authors agree that the first generation BSC combines financial and non-financial indicators with the four perspectives (financial, customer, internal business process and learning and growth). At this stage, “measurement systems without cause-and-effect logic may also qualify as Balanced Scorecards” (Malmi, 2001, p. 216). Speckbacher et al. (2003) and Lawrie and Cobbold (2004) argue that the second generation BSC emphasised the cause-and-effect relationships between measures and strategic objectives. It became a strategic management tool, usually utilising a strategy map to illustrate the linkage between measures and strategies. In contrast there is a view in the literature (Morisawa, 2002; Miyake, 2002) that the key contribution of second-generation BSC was the formal linkage of strategic management with performance management. According to Lawrie and Cobbold (2004), the third generation BSC is about developing strategic control systems by incorporating destination statements and optionally two perspective strategic linkage models. They used “activity” and “outcome” perspectives to instead of the traditional four perspectives (Lawrie and Cobbold, 2004). Speckbacher et al. (2003) suggested that the third generation BSC was the second generation but adding action plans/targets and linked to incentives. A third view (e.g. Morisawa, 2002; Miyake, 2002) is that the concept of the strategy-focused organization (Kaplan and Norton, 2001) reflected the third-generation application of the BSC. As Speckbacher et al.’s (2003) view appears to be dominant in the literature, it has been accepted here.

Research method

The ideal research method to answer these questions would be to conduct in-depth analysis of multiple BSC cases by collecting primary data; or at least conduct surveys in several countries. This remains a desirable approach, although very research intensive. As a first step, this paper uses secondary data and analyses the published research in the area by identifying as many BSC cases in the health sector. There is a clear bias with this method; as implementations viewed as unsuccessful are not likely to be written up. Nevertheless, this secondary data is an invaluable resource to compare and contrast approaches to the BSC in the sector.

The first step was to identify as many published papers as possible. The initial search was conducted in early 2005 and extended to cover all papers until the end of 2005. Google and Google Scholar were used to non-refereed papers, professional presentations and conference papers. In addition, two academic data bases were used...
Findings
We found 22 case studies in the literature: ten were from the USA, three from the UK and Sweden respectively, two from Australia and New Zealand, and one each from Canada and Taiwan. The 22 case studies were all not-for-profit organizations. A summary of the cases is found in Table I.

Perspectives
Kaplan and Norton (2001) have argued that organizations should develop the best set of dimensions that reflect their strategy. For not-for-profits they recommend that it can place their customers or constituents – not the financials – at the top of its BSC. The perspectives used in the cases are shown in Table II.

Most used the financial and internal business process perspectives. We have treated terms such as economy, cost, and financial resources as synonyms for the financial perspective[1]. There are three examples without a financial perspective in the scorecard, but they had measures at a corporate level or outside of the scorecard. Within their BSC, only 77 percent had a customer or patient perspective. This seems to be a problem with these scorecards; health outcomes for patients, in these cases, are not the central focus. Chan and Ho (2000) found that in Canada the financial and customer perspectives were weighted equally. A total of 50 percent used a learning and growth (or innovation and learning) perspective, which is relatively low but consistent with problems of implementing this perspective (Hoque and James, 2000). Only three cases used the traditional BSC with the standard four perspectives; but rather they changed it to meet their specific strategies. In the 22 cases, 15 had four perspectives, three had five, two had three perspectives and one had eight perspectives. Some of the major variations in perspectives are shown in Table III. One case did not use perspectives but instead had 12 non-financial measures and one financial measure. Kaplan and Norton’s approach appears to be the template for implementations in health care, no matter how they were modified in practice.

Selection of performance measures
In practice, how many indicators should be involved in a BSC top level is a difficult problem faced in every organization applying the BSC. We found a wide number of measures – from 13 to 44. The upper bounds of these numbers seem to be well above the recommended levels in the literature (Kaplan and Norton, 1996), and beyond the ability of managers to focus on them.

The financial perspective in a for-profit setting would show the results of the organization’s strategy from the other perspectives. In a not-for-profit and public sector setting it would show that the organization achieves its results in an efficient manner that minimizes cost (Olve et al., 2000). We found two groups of measures in this perspective – revenue growth indicators and productivity indicators (see Table IV).
<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Organization</th>
<th>Approximate date</th>
<th>Stage of BSC</th>
<th>Strategic or performance management tool</th>
<th>Number of perspectives</th>
<th>Top perspective</th>
<th>Number of indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital system</td>
<td>Mayo Clinic, USA</td>
<td>2000</td>
<td>II</td>
<td>Strategy</td>
<td>8</td>
<td>Unclear</td>
<td>13</td>
<td>Curtwright et al. (2000)</td>
</tr>
<tr>
<td></td>
<td>Cambridge Health Alliance, USA</td>
<td>2000</td>
<td>I</td>
<td>Performance</td>
<td>4</td>
<td>Unclear</td>
<td>44</td>
<td>Hermann et al. (2000)</td>
</tr>
<tr>
<td></td>
<td>St Mary’s/Duluth Clinic Health System, USA</td>
<td>2002</td>
<td>II</td>
<td>Strategy</td>
<td>5</td>
<td>Financial</td>
<td>25</td>
<td>Balanced Scorecard Collaborative Inc. (2002)</td>
</tr>
<tr>
<td>Hospital</td>
<td>Duke Children’s Hospital, USA</td>
<td>1999</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Customer and financial</td>
<td>22</td>
<td>VA web site (1900)</td>
</tr>
<tr>
<td></td>
<td>Falls Memorial Hospital, International Falls, USA</td>
<td>2004</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Quality and safety, staff and clinicians</td>
<td>37</td>
<td>Mohan (2004)</td>
</tr>
<tr>
<td></td>
<td>Bridgeport Hospital, USA</td>
<td>2002</td>
<td>II</td>
<td>Strategy</td>
<td>5</td>
<td>Unclear</td>
<td>18</td>
<td>Gumbus et al. (2002)</td>
</tr>
<tr>
<td></td>
<td>Royal Ottawa Hospital, Canada</td>
<td>2005</td>
<td>II</td>
<td>Strategy</td>
<td>5</td>
<td>Innovation and growth, care and service</td>
<td>32</td>
<td>Royal Ottawa Hospital (n.d.)</td>
</tr>
<tr>
<td></td>
<td>Community Memorial Hospital(CMH), USA</td>
<td>2000</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Unclear</td>
<td>13</td>
<td>Stewart and Bestor (2000)</td>
</tr>
<tr>
<td></td>
<td>Royal Brisbane and Women’s Hospital, AU</td>
<td>2005</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Patients, clients and staff, process</td>
<td>26</td>
<td>Royal Brisbane &amp; Women’s Hospital Service District (2005)</td>
</tr>
<tr>
<td></td>
<td>Silver Cross Hospital, USA</td>
<td>2005</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Quality and financial performance</td>
<td>27</td>
<td>Pieper (2005)</td>
</tr>
</tbody>
</table>

(continued)
<table>
<thead>
<tr>
<th>Type of organization</th>
<th>Organization</th>
<th>Approximate date</th>
<th>Stage of BSC</th>
<th>Strategic or performance management tool</th>
<th>Number of perspectives</th>
<th>Top perspective</th>
<th>Number of indicators</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital department</td>
<td>A department of Swedish Hospital</td>
<td>2004</td>
<td>II &lt;sup&gt;a&lt;/sup&gt;</td>
<td>Strategy</td>
<td>4</td>
<td>Unclear</td>
<td>21</td>
<td>Kollberg and Elg (2004)</td>
</tr>
<tr>
<td></td>
<td>A hospice unit’s of St Elswhere Hospital, USA</td>
<td>2001</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Financial</td>
<td>11</td>
<td>Kershaw and Kershaw (2001)</td>
</tr>
<tr>
<td></td>
<td>One clinic of Hogland Hospital, Sweden</td>
<td>2001</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Unclear</td>
<td>16</td>
<td>Aidemark (2001)</td>
</tr>
<tr>
<td></td>
<td>Emergency department in a hospital, Taiwan</td>
<td>2004</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Unclear</td>
<td>9</td>
<td>Huang &lt;i&gt;et al.&lt;/i&gt; (2004)</td>
</tr>
<tr>
<td>National health-care system</td>
<td>Hospital Monitoring Directorate, NZ</td>
<td>2004</td>
<td>I &lt;sup&gt;a&lt;/sup&gt;</td>
<td>Performance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4</td>
<td>Unclear</td>
<td>16</td>
<td>Hospitals Monitoring Directorate (2000)</td>
</tr>
<tr>
<td></td>
<td>Mental Health Trusts and Providers of Mental Health Services, Healthcare Commission, UK</td>
<td>2004</td>
<td>I &lt;sup&gt;a&lt;/sup&gt;</td>
<td>Performance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3</td>
<td>Unclear</td>
<td>35</td>
<td>Healthcare Commission (2004)</td>
</tr>
<tr>
<td>Local government</td>
<td>Nursing of Queensland Health, AU</td>
<td>2002</td>
<td>I&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Performance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>3</td>
<td>Unclear</td>
<td>26</td>
<td>Queensland Health (2002)</td>
</tr>
<tr>
<td></td>
<td>Long-term planning at Jonkoping County Council, Sweden</td>
<td>2001</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>User and process/productivity</td>
<td>14</td>
<td>Aidemark (2001)</td>
</tr>
<tr>
<td></td>
<td>Bradford PCT, UK</td>
<td>2003</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Client and internal process</td>
<td>30</td>
<td>Radnor and Lovell (2003a)</td>
</tr>
<tr>
<td></td>
<td>Bradford HIMP, UK</td>
<td>2003</td>
<td>II</td>
<td>Strategy</td>
<td>4</td>
<td>Client and internal process</td>
<td>29</td>
<td>Radnor and Lovell (2003b)</td>
</tr>
<tr>
<td></td>
<td>South Canterbury District Health Board, NZ</td>
<td>2003</td>
<td>I &lt;sup&gt;a&lt;/sup&gt;</td>
<td>Performance&lt;sup&gt;a&lt;/sup&gt;</td>
<td>4</td>
<td>Unclear</td>
<td>16</td>
<td>South Canterbury District Health Board (2003)</td>
</tr>
</tbody>
</table>

Note: <sup>a</sup> Insufficient information to be definitive
It is noticeable that some indicators relate to long-term dimensions in this perspective; such as competitive position, market share, payer mix (percentage commercial), dollars raised from community, and research grants. Market share, especially for targeted customer segments, reveals how well a health facility is penetrating a desired market. The measure of market share with targeted customers would balance a pure financial signal (sales) to indicate whether an intended strategy is yielding expected results (Kaplan and Norton, 1996), linking the BSC to strategy.

The customer perspective describes “the ways in which differentiated, sustainable value is to be created for targeted customer segments, how customer demand for this value is to be satisfied, and why the customer will be willing to pay for it” (Olve et al., 2000, p. 61). These examples show some important factors, such as patient retention, patient acquisition, and patient satisfaction. Staff measures were sometimes listed under this perspective because of their critical importance to patient satisfaction (see Table V).

Hospital food was identified as an important indicator of influencing patient satisfaction by the UK Healthcare Commission (Mental Health Trusts and Providers of Mental Health Services) and some hospitals directors in USA (Chow et al., 1998). The indicators which relate to image and reputation are important for the operation of healthcare organizations.

In relation to internal business processes, an organization can accomplish two vital components of its strategy: producing and delivering the value proposition for customers and improving processes and reducing costs for the productivity component in the financial perspective (Kaplan and Norton, 2004). These are seen in Table VI. Those indicators of operations may in fact be measures of patient satisfaction as well as drivers of customer satisfaction.

These BSCs incorporate innovation processes into to the internal business perspective. This is a difference between the BSC and a traditional performance system which focuses on the processes of delivering services to present customers (Kaplan and Norton, 1996).

The learning and growth perspective enables the organization to ensure its capacity for the long-term run. It describes the organization’s intangible assets and their role in strategy, and organizes intangible assets into three categories (Kaplan and Norton, 2004) which we have followed: Human capital, information capital and organization capital. All three forms of capital are found in the case studies as shown in Table VII.

Workplace injuries, incidents also appear in this perspective, which are a form of reducing human capital.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Number of cases</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial (and synonyms)</td>
<td>19</td>
<td>86</td>
</tr>
<tr>
<td>Customer (and synonyms)</td>
<td>17</td>
<td>77</td>
</tr>
<tr>
<td>Internal business process (and synonyms)</td>
<td>20</td>
<td>91</td>
</tr>
<tr>
<td>Learning and growth or innovation and learning (and synonyms)</td>
<td>11</td>
<td>50</td>
</tr>
<tr>
<td>Other perspectives</td>
<td>14</td>
<td>64</td>
</tr>
</tbody>
</table>

Table II.
<table>
<thead>
<tr>
<th>Example</th>
<th>Modified perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duke Children's Hospital Balanced Scorecard, USA</td>
<td>Research, education and teaching&lt;br&gt;Staff and clinicians&lt;br&gt;Quality&lt;br&gt;Patients and Community&lt;br&gt;Business and development</td>
</tr>
<tr>
<td>Falls Memorial Hospital, International Falls, USA</td>
<td></td>
</tr>
<tr>
<td>Bridgeport Hospital, USA</td>
<td>Volume and market share growth&lt;br&gt;Quality improvement&lt;br&gt;Process improvement&lt;br&gt;Organizational health</td>
</tr>
<tr>
<td>Royal Ottawa Hospital, USA</td>
<td>Innovation and growth&lt;br&gt;Research&lt;br&gt;Care and service&lt;br&gt;Systems integration</td>
</tr>
<tr>
<td>Hospital Monitoring Directorate, NZ</td>
<td>Organization healthcare and learning&lt;br&gt;Process and efficiency&lt;br&gt;Patient and quality</td>
</tr>
<tr>
<td>Nursing Balanced Scorecard, Queensland Health, AU</td>
<td>Patient/client indicators&lt;br&gt;Staff indicators&lt;br&gt;Organization indicators</td>
</tr>
<tr>
<td>Mayo Clinic, USA</td>
<td>Clinical productivity and efficiency&lt;br&gt;Mutual respect and diversity&lt;br&gt;Social commitment&lt;br&gt;External environmental assessment&lt;br&gt;Patient characteristics</td>
</tr>
<tr>
<td>South Canterbury District Health Board, NZ</td>
<td>Quality and patient satisfaction&lt;br&gt;Process and efficiency&lt;br&gt;Organizational health</td>
</tr>
<tr>
<td>Cambridge Health Alliance Behavioral Health Services, USA</td>
<td>Satisfaction&lt;br&gt;Clinical&lt;br&gt;Access/continuity&lt;br&gt;Cost/utilization</td>
</tr>
<tr>
<td>St Mary’s/Duluth Clinic Health System, USA</td>
<td>Operational&lt;br&gt;People&lt;br&gt;Technical</td>
</tr>
<tr>
<td>Mental Health Trusts and Providers of Mental Health Services, UK</td>
<td>Clinical focus&lt;br&gt;Patient focus&lt;br&gt;Capacity and capability</td>
</tr>
<tr>
<td>Royal Brisbane &amp; Women’s Hospital, AU</td>
<td>Patient, clients and staff&lt;br&gt;Learning/innovation&lt;br&gt;Customer/patient&lt;br&gt;Process/productivity</td>
</tr>
<tr>
<td>A department of a Swedish Hospital</td>
<td></td>
</tr>
<tr>
<td>Clinic of Hogland Hospital, Sweden</td>
<td>Economy&lt;br&gt;User perspective</td>
</tr>
<tr>
<td>Long-term planning at Jonköping County Council, Sweden</td>
<td></td>
</tr>
<tr>
<td>Silver Cross Hospital, USA</td>
<td>Quality&lt;br&gt;Operational effectiveness&lt;br&gt;Workplace excellence&lt;br&gt;Client perspective (government and user)&lt;br&gt;Cost perspective</td>
</tr>
<tr>
<td>Bradford PCT and Bradford HIMP, UK</td>
<td></td>
</tr>
</tbody>
</table>

**Table III.** Modified balanced scorecard perspectives used
We found (Table I) that more than 70 percent of the examples emphasise cause-and-effect relationships or the links between strategy and its elements (using BSC as a strategic management tool). This suggests that most examples were second or third generation BSC. We cannot be certain that they are using full strategy maps.

We did anticipate that not-for-profit and government hospitals might place their patients at the top of their scorecards. For half of the examples where we could recognize hierarchical relationships among the perspectives, there was no customer (or...
Discussion

**Perspectives**

So in relation to our first question, we found that few of the scorecards were typical BSCs with the traditional four perspectives; most of them modified the four perspectives according to their institution’s current conditions and different understanding. For example, one institution had the perspectives as client, cost,
learning and growth, and internal process perspective; another one had financial, innovation and growth, care and service, systems integration, and research.

Edenius and Hasselbladh (2002, p. 259) cite the view of an implementer, a project manager:

I don't think it is important what we call the different perspectives, it's more important to capture all the critical success factors. To cover these in the card is more important than what you call them.

The BSC is a conceptual tool (Sasse, 2005), and the four perspectives were never considered as a “strait-jacket” (Kaplan and Norton, 1996). Its adaptability is part of its attraction.

So BSC in healthcare organizations presents a different picture to other industries in relation to the range of perspectives. For example, most health cases used other perspectives in their BSCs whereas a survey in German-speaking countries found that only 17 percent of the companies used other perspectives (Speckbacher et al., 2003). The use of the learning and growth perspective was similar, but there was less use of the customer perspective. Our findings are consistent with Voelker et al. (2001). In healthcare, the BSC scorecard appears more diverse than in other sectors.

One different perspective is “People”. In health care, all efforts to achieve balanced accountability for cost, quality and care are critically dependent on physician attitudes, beliefs, and behaviours (Atchison and Bujak, 2001); as well as the attitudes of nursing and other professionals. In particular, the autonomous culture of physicians and the importance of long-term outcomes are aspects of health care that have few analogies in other industries (Zelman et al., 2003). So, as the role of professionals is important to the role of hospitals, in some examples, “People” or “Staff” became an independent perspective. We concur that when human resources are so critical to strategy implementation they should be another perspective.

Another different perspective is “Community”. In health care the focus may be on the patient as customer, and serving their needs for achieving the mission (Niven, 2003). However, this appears insufficient; they have to achieve a balance between community and patient. For example, in many public health programs, it is difficult to define the clients who are in need, of or who benefits from a service because they target the entire community (Woodward et al., 2004). Some services such as quarantine are mandated and must be provided regardless of the view of the public (Woodward et al., 2004). “Consumers” of public health services sometimes have difficulty in judging services because their preventive and long-term nature may not reflect the entire population at risk (Blendon et al., 2001; Woodward et al., 2004). At the same time, the health care system has to strive for an equitable distribution of services based on health needs. Usually those with the lowest health needs are the most dissatisfied and have the highest expectations; and seeking to solve their concerns could result in new inequities and gaps in health outcomes (Woodward et al., 2004). As a result, some systems rated by experts as high quality can be much more poorly rated by consumers (Blendon et al., 2001). For these reasons, experts claimed that the emphasis for public health should be changed from “client or patient satisfaction” to “community engagement” (Woodward et al., 2004); the “community”, consisting of citizens, high-risk groups, health care providers, government policy makers, and health
department staff. Hence the appearance of “Community” as an independent perspective in health care organization’s BSC is not surprising.

An improvement in efficiency is a limited perspective in the healthcare industry because in practice they have to balance efficiency and fairness, and balance between cost, quality, access, and consumer choice (Inamdar and Kaplan, 2002). This is a significant difference between healthcare and other industries.

Performance measures
Kaplan and Norton (1996) suggested a BSC should not exceed four or five indicators for each perspective; for a total of 20-25 indicators to be tracked closely. The problem of the number of indicators includes the costs or resources tied up in the measurement process, for collecting and analysing the data, reporting the indicators, and interpreting them so as to decipher signals from noise.

Through these samples, we found diverse forms of the BSC. Some of the measures occurred in different perspectives. One measure can be related to multiple goals. For example, patient satisfaction as an overall indicator can be used in the customer perspective or the internal process perspective. It also can be partially explained by waiting time, call centre response time, or weekly patient complaints.

The experience of Bridgeport BSC perhaps reflects a general picture about the indicator problem:

Initially the card focused 12 critical success factors that were created by 56 metrics in FY 2000. In FY 2001, the five critical success factors were created and their metrics will be reduced to 35 this year. Further enhancements for FY 2002 include reducing the number of critical success factors from five to four by combining Quality and Process Improvement” (Gumbus et al., 2002, p. 50).

Generation of scorecards
Our third question related to the generation of BSC used. In particular, had they at least advanced to developing cause-and-effect relationships? Emphasizing cause-and-effect is a watershed between the first and second generation BSC. These examples demonstrate considerable flexibility in applying the BSC. However, Table I demonstrates that all BSCs in the healthcare field appear to be at stage 1 or 2. This may be because implementations are relatively new. It is possible that stage 2 is sufficient for strategic implementation in healthcare.

Finally, we return to the focus of healthcare services – patients. Although all the examples included patients in some parts, there was not a single example where the patient or customer perspective was at the top of the BSC. Why not?

Conclusion
The reflections on the present level of practise of the BSC are useful for both academics and practitioners. The paper has drawn together and analysed the published cases of BSC in health care. It is possible that some excellent examples of BSC in health care are not yet published or have been missed by our research approach. Our analysis was limited by using information from papers which sometimes were very limited. A future research project could investigate the characteristics of unsuccessful implementations – ineffective and short-lived. We suggest that a more comprehensive view would come...
from a cross-national survey of best practice use of the BSC in healthcare; an interesting project for future research.

Although this research has limitations, our findings provide some important insights into the current state of the use of BSC in healthcare. The examples show the diversity of BSCs in health care organizations. Few organizations are treating Kaplan and Norton or other formulas as a strait jacket. This is an encouraging sign for the sector which has taken up the basic tool of the BSC and applied it in rich and diverse ways. The lack of consistency does not enable benchmarking; but in the early application of the BSC there has been some rich experimentation which might lead to more consistent approaches in the longer term. If the BSC is to be a strategic implementation tool, as Kaplan and Norton (2001) have argued, then there will always be some differences due to the different strategic orientations of health care organisations. We encourage health care organisations to work in groups of like organisations to produce scorecards which are both comparable but meet their own strategic needs.

Outside of the health sector there has been a gradual evolution of the BSC. While academics and practitioners claim we are in the third generation; there may be more evolution to continue. However, whatever the number of generations ahead, they are likely to be developed based on a single (and original) set of macro principles developed by Kaplan and Norton. In health care practices, the second generation BSC of a strategic management tool appears to be the mainstream. Although the Lawrie and Cobbold two perspectives’ BSC approach has been introduced and applied, Kaplan and Norton’s four perspectives still has important impact on the practices in healthcare organizations.

We return to our central contention of the lives of healthcare recipients. A core principle of BSC remains balance. We can foresee that the future BSC will not have fixed form other than balance. In the process of applying BSC, organizations seek for balance and harmony between long-term and short-term, financial and non-financial, individual and organizational, internal and external factors, cause-and effects, and efficiency and fairness, particularly in the healthcare industry. Our concern is that the needs of patients have not reached the centre of the BSC in healthcare. Lives are difficult to balance and most countries are struggling to contain health costs. We do not underestimate the importance of the other perspectives but we argue that, especially for not-for-profit and government providers, patient needs must be more central to the BSC.

Note
1. For example, a business and development perspective contained only financial measures. In an example, the business and development perspective is also classified as financial perspective.

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Further reading


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