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THE MEANING OF BALANCED SCORECARDS IN THE HEALTH CARE ORGANISATION

Lars-Göran Aidemark*

INTRODUCTION

Financial problems have threatened Swedish public health care organisations for almost two decades. The general weakness of the economy and central government finances has reduced the tax base and central government grants. The democratically elected county councils (principal providers of health care) have tried to balance income and expenditure by reducing costs. The main tool during the 1990s has been budget control. In many county councils, the ambition to make responsibility accounting actionable gave rise to accounting reforms based on the principles of economic rationality and the workings of the 'free market'.

However, the tension resulting from stronger financial control has lead to demands for new forms of responsibility accounting. Transfer pricing is considered yesterday's management tool in Swedish health care. Of course, activity based costing, process re-engineering, lean production and so on are on the menu, but the meal for today is the balanced scorecard. Managers in health care are inspired at seminars, conferences and courses and by consultants to modernise their management accounting system using the new miraculous treatment of balanced scorecards (BSC).

This paper discusses balance scorecards and the process of governance in health care. The market, hierarchy and clans' perspective developed by Ouchi (1979 and 1980) and Hernes' framework (1978) for analysing power and 'mixed administration', inform the investigation. It focuses particularly on the meaning of balanced scorecards in health care management and how it affects the relation between hierarchy and clan control in the organisation.

Balanced scorecards were originally designed as hierarchical top-down management tools linking long-term financial goals to performance targets and measures within four perspectives (Kaplan and Norton, 1992, 1993, 1996a and 1996b). They facilitate activity accounting and an extension of hierarchical control to activities of operational services. On the other hand, redesigned balanced scorecards mean new possibilities for the medical

* The author is a Senior Lecturer in the School of Management and Economics, Växjö University, Sweden. He gratefully acknowledges the helpful comments of Professor Sten Jönsson, GRI, Göteborg School of Economics and Commercial Law, Göteborg University.

Address for correspondence: Lars-Göran Aidemark, School of Management and Economics, Växjö University, 315 95 Växjö, Sweden.
e-mail: Lars-Goran.Aidemark@ehv.vxu.se

professionals, who claim that the quality of health care service needs rehabilitation. Medical professionals see the possibility of using balanced scorecards to put patients, employees and processes to the fore.

The meaning of balanced scorecards in the health care organisation is ambiguous due to the type of control structure. They are strategic management systems built on measurement. But, a system of governance based on professionalism (based on clan mechanisms in contrast to market or bureaucratic mechanisms, Ouchi, 1979, p.837) is presumed to find measurement repulsive:

> every attempt at systematic performance auditing would be frustrated (Ouchi, 1979, p. 837).

And, in this medical professional context, administrators, controlled by politicians and employed to manage the health care organisation, cannot construct measures of behaviour or output (Ouchi, 1979, p. 843). Balanced scorecards are, however, attractive to the professionals, as a tool to tone down financial measurement and accentuate perspectives preferred by physicians.

These contradictions lead to the following principal issue: what is the meaning of balanced scorecards in a public health care organisation? Here, this issue is discussed based on experiences from Jönköping County Council.[1] The theoretical implications drawn from the study are necessarily somewhat speculative, given the infancy of balanced scorecards in the health care organisation. However, field experiments in progress for more than two years, underpins some hypothetical conclusions.

In this County Council medical professionals looked upon the balanced scorecard as a possibility to replace the financial responsibility accounting system with their view of activities. They wanted to use balanced scorecards as a structure for dialog and communication. The concept 'balanced' was regarded as a balance between four perspectives, implying that patients, employees and processes were just as important as finances. These balanced scorecards, redesigned by professionals, were considered effective control mechanisms in the health care organisation. As elements in a new dialogue on the complex work of professionals they reduce the goal in-congruence between parties and as measurements on four perspectives they have a potential to reduce the ambiguity of performance evaluation.

Furthermore, this study indicates that control mechanisms of different control types (bureaucracy and clan) can be used successfully to compensate for the weaknesses of the other. The mix of control mechanisms addresses both the balancing and optimising judgements in the health care organisation (Vickers, 1965). New forms of control occur, however, containing new problems requiring solutions. This means that change becomes institutionalised. In the following sections I discuss the basic concepts underlying the BSC and its interaction with different mechanisms of control and conclude with presenting the study and its results.

BALANCED SCORECARDS

Conventional management accounting, based on financial measurement, has lost relevance (Johnson and Kaplan, 1987). Balanced scorecards were developed as one solution to this problem (Kaplan and Norton, 1992). This view of what management accounting should be provides a reference point for the public sector (Lapsley and Pettigrew, 1992), especially in Sweden, where existing financial control systems are criticised and the BSC is seen as an appealing new possibility. Isomorphism is shaped through imitation (DiMaggio and Powell, 1983).

Balanced scorecards are based on the idea that three different perspectives, the customer, internal business processes and learning and growth, are of vital importance to a fourth, the financial perspective. Balanced scorecards link customers, internal processes, employees and system performance to long-term financial success. If the first three perspectives are developed in the right direction, then the fourth overarching financial perspective follows suit. The innovation and learning perspective is supposed to strengthen competence among staff members. This will support the development of internal business processes, which in turn will lead to better customer relations. Growth in customer loyalty means financial prosperity. The BSC is, in other words, more of a strategic management system than an information structure and it has its greatest impact when it is used to implement strategy and to drive organisational change (Kaplan and Norton, 1996b).

The relevance of the BSC is taken for granted. In an institutional perspective its popularity among managers is easily explained. New institutional theory in organisation research attributes the accounting system hardly any reform potential in the organisation (Brunsson, 1990a). Accounting is considered to be loosely coupled to the activities of the organisation (Weick, 1976). Accounting could lend legitimacy to the management of the organisation and give the impression of a modern, efficient bureaucracy (Meyer and Rowan, 1977). Bureaucratic control mechanisms, disconnected from action, can survive (Kouzes and Mico, 1979) and be a solution to a legitimacy problem rather than a problem of control (Brunsson, 1990b).

Balanced scorecards, however, combine activity accounting and financial accounting. Developed and used by those who perform activities they have a considerable potential to influence these activities. In the health care organisation, balanced scorecards have a great chance to be more than formal structures loosely coupled to activities. They could be control mechanisms used to underpin the necessity of financing those activities. They could be control mechanisms through which the health care organisation can be managed so that it moves towards its objectives.

THE MECHANISMS OF CONTROL

Ouchi (1979) describes three fundamentally different mechanisms, which can be used by organisations to cope with the problems of evaluating and control: markets, bureaucracies and clans. He claims that:

> the ability to measure either output or behaviour which is relevant to the desired performance is critical to the 'rational' application of market and bureaucratic forms of control (ibid., p. 843).

In other organisations, like hospitals, these measurements are considered impossible. In these organisations clan forms of control are the only alternative. High commitment is necessary to the clan. It relies on selecting the appropriate, educated people that can be expected to share the values of the profession and the organisation. The clan is the least demanding form of control when it comes to measurement, but the most demanding with respect to social underpinning (ibid., p. 838).

Ouchi (1979) also presents a conceptual framework for the design of organisational control mechanisms. The determination of which form of control will be more efficient is a question of balance between trust and measurement. If there is high level of goal congruity, measurement is hardly needed. On the other hand, high levels of goal incongruity can be tolerated only as long as performance can be evaluated with precision:

> The problem of organisational design is to discover that balance of socialisation and measurement which most efficiently permits a particular organisation to achieve co-operation among its members (ibid., p. 846).

Drawing on the classical work by Williamson (1975), Ouchi (1980) developed this reasoning in a market–hierarchy perspective. He claimed that the ambiguity of measurement of individual performance and the congruence of the employee's and employer's goals determine whether market or employment relations are preferable within the organisation. He reformulated the transactional cost problem:

> in order to mediate transactions efficiently, any organisational form must reduce either the ambiguity of performance evaluation or the goal incongruence between parties (Ouchi, 1980, p. 135).

The clan minimises goal incongruity and so it can accept performance ambiguity. Market relations presume measurement that minimises performance ambiguity and can accept the goal incongruity of employees and employers. In between, the bureaucratic form of control is most efficient. In the health care organisation, however, the implementation of measurement, i.e. balanced scorecards, might improve clan control. Perhaps the organisation can be managed so that it moves towards its objectives by clan mechanisms. But, it can be considered as a weakness of this control model that it is difficult for professionals, administrators and politicians to evaluate at what pace the goals of the organisation are reached. It is possible that the

clan model of control can function without measurement, but measurement might reinforce the mechanisms of clan control. The introduction of balanced scorecards, designed by professionals, is an attempt at reinforcing the control mechanisms of health care management. The question is if it is possible to take advantage of bureaucratic measurement without sacrificing the norms of reciprocity, shared values and beliefs of clan control?[2]

Hernes (1978) gave some guidance on how to analyse a mix of control mechanisms. He considered how decisions, made by organisations in markets, politics and in bureaucracy, interplay. He analysed the 'mixed administration' that was formed when market, democracy and bureaucracy acted together in society. This analysis was accomplished in four steps. First, the function of each ideal model was discussed in its 'own' institutional arena. Second, some common problems of each model were presented. Third, each model was considered in its capacity to solve the problems of the others. Each control model might act as a provider against weaknesses in the other models. Fourth, he showed that these new combinations of the ideal models contained new problems. This implies that combinations of ideal control mechanisms can be seen as 'transition forms', and the platforms of new combinations (cp. Brunsson, 1990c).

In hospitals, the clan mechanisms serve as a basis of activity control. But, clan, bureaucratic and market mechanisms overlap as in any organisation (Ouchi, 1979, p. 834). The reforms of the management control system have the objective of changing the status quo. The BSC is a hierarchical control mechanism. In this theoretical perspective, the implementation of balanced scorecards in the hospital management system ought to be opposed by the clan. In spite of this, balanced scorecards turned out to be attractive to both the medical professionals and managers. BSC focuses on 'the golden triangle' of quality work in a hospital, patients, employees and processes, without disregarding the financial perspective. The popularity rests on a reconstructed management tool used in new ways. Balanced scorecards, influenced by context, influence context.

THE STUDY

Background

In Sweden, the County Councils are the main providers of health care. They are under democratic control and allowed to raise a local income tax which in 1997, on average, financed more than 70% of the budgets (benefits averaged around 6% and the remainder came from patient fees and other activity compensations). But even if medical service is the responsibility of elected politicians, professionals control activities. The medical profession has, as a group, a dual status, which combines the characteristics of a self-regulating profession and salaried employees (Coombs, 1987).

In the beginning of the 1990s, County Councils in Sweden had growing financial problems, in some cases implying an acute liquidity problem. During 1988 to 1991 the County Councils accounted for a reduction in their equity of more than eight thousand SEK million (about 8% of equity in 1988, before changes in pension liabilities) and increased debts by more than three thousand SEK million. The financial prognoses were discouraging and the increase in taxation temporarily prohibited by law. Different reforms were introduced to make budget control work. During the 1990s productivity improved, mostly during 1992 and 1993 and particularly for inpatient care. Resources were reallocated from in-patient care to open care and the number of beds was reduced. Even if the total health care costs for society in Sweden only changed marginally and amounted to about 7.7% of GNP in 1995 (Arvidsson and Jönsson, 1997), solidity (the ratio between equity, before changes in pension liabilities, and total capital) in the County Councils as a group went from 64% in 1991 to 73% in 1995. Equity increased by more than eleven thousand SEK million (22% of equity in 1991) and debts were amortised by eight thousand SEK million (both long and short-term loans were paid off). This period of economising represented a move in governance from clan control towards a greater influence over activities by the politicians and the administrative hierarchy. Responsibility accounting dominated the control system. A financial downturn in the Swedish economy and, among other factors, the threat of market discipline (Aidemark, 1998), contributed to a receptive context (Pettigrew, 1992) where strategic financial changes were possible. However, public debate on health care has changed from financial problems to the scarcity of resources. The possibilities to control the development in health care by financial measurement has attenuated. Professionals and mass media, underlining the increasing need for more resources, repeatedly disclosed negative consequences of economising. In this situation balanced scorecards were introduced as a new management tool in health care organisations.

This part of the paper discusses some experiences made from the introduction of balanced scorecards in health care management. First, however, the organisation of the clinic in the hospital must be considered. In Sweden the 'clan' consists of two hierarchies. The head of the clinic is a medical professional with medical, administrative and economic responsibilities. Subordinate to the head, nurses function as the department chiefs, responsible for the scheduling of the nursing staff, among other things. Along with this professional bureaucracy, doctors work relatively independently from their colleagues, with considerable control over their timetables, in close consultation with the clients they serve. The interviews reported have been made with administrators (senior head of the county council, head of hospital and head of quality management) and heads of the professional bureaucracies. According to the latter, the enthusiasm among doctors varies but it is increasing.

The Introduction of Balanced Scorecards

Balanced scorecards became the focus of convergence in the outlook of the head of quality management and the head of the medical clinic at the Högland Hospital (about 1,500 employees, of whom 260 work at the medical clinic) run by Jönköping County Council. The professional and administrative domain in co-operation pursued the introduction of BSC in the health care organisation. The balanced scorecard was redesigned and implemented at the medical clinic. This development started more than five years ago. Balanced scorecards were extremely attractive to the professional head of the medical clinic. It supported him in the dual role as 'advocate' for the particular clinic, and as 'guardian' of resources on behalf of the suppliers of resources (Wildavsky, 1975). Redesigned, balanced scorecards offered a way to combine activity accounting and cost accounting. Supported by the council director experimental work started in 1997 at each of three clinics at three different hospitals. In 1998 one of these hospitals started to use balanced scorecards in the activity and budget planning process involving all clinics of the hospital. Also, the County Council used balanced scorecards in the long-term planning process for the period 1999–2001.

The results from the interviews and analysis of internal documents are discussed under six headings: (1) management and measurement, (2) the reconstruction of links between the four perspectives, (3) the inversion of top-down control, (4) strategic change of clan conditions, (5) the hospital planning process, and (6) the long-term planning of the county council. The first four headings are connected to the experimental work managed and executed by medical professionals within nine clinics (about 40 persons involved). Under the fifth heading the ambition to implement balanced scorecards within all clinics at Värnamo hospital, a process controlled by hospital management, is discussed. The last heading presents the ambition of the County Council Board to introduce a new long-term planning system.

Management and Measurement

Balanced scorecards presuppose measurement:

> If you can't measure it, you can't manage it (Kaplan and Norton, 1996b, p. 21).

But in organisations like health care, measurement with reliability and precision is not considered possible. Ouchi (1979) even suggested that a management based on measurement was likely to reward a narrow range of maladaptive behaviour, leading ultimately to organisational decline.

The question about the possibility to measure health care activities was put forward to the doctor and head of the medical clinic and followed by this answer (my translation):

> Measurement fits very well in this culture of natural science. There are few branches that are as permeated by research work as health care. Medical care is built on natural science. More than 25% of medical doctors in Sweden have also completed a Ph.D. in natural science. These are reliable dissertations built on the measurement of health care and medical activities. Of course, if someone really had induced these professionals to measure what they were doing and the results of their efforts, they would have done so and they would have shown it in figures. But if this measurement does not lead to more resources, if this measurement does not influence anything, then what use is it to measure one's effort? (interview with head of a medical clinic, 1998–11–25).

This quotation must be interpreted in its context. Health care has been left to the honour, professional pride and professionalism of the employees during this period of financial pressure. Of course, patients hold a prominent position in the view of medical professionals. But, according to the head of a medical clinic, financial control mechanisms have been obstacles in the quality improvement processes (my translation):

> You can't develop new ways to work if money is tied to the number of beds and the length of queues (interview with head of a medical clinic, 1998–11–25).

Professionals regard balanced scorecards as a means to present a more compound picture of health care activities. They are considered to give a far more honest view of the complex work of doctors, than the financial statement. In that way, balanced scorecards in health care and business have the same or similar background. Both are replacing overemphasised financial measurement. But in this context measurement has some limitations. Medical professionals considered it impossible to compare costs between clinics, even within the same speciality, as the conditions are widely differing. Furthermore, in several areas it is difficult to define performance targets for key factors and measurement can only be used to compare different periods within the clinic. With restrictions like these, the clan is more than willing to present their results in figures. But of course, the measures are decided and developed by the medical professionals. They are controlled by the clan and not to control the clan.

The Reconstruction of Links Between the Four Perspectives

The series of cause-and-effect relationships on which balanced scorecards are based are not at hand in the health care organisation. There are no price mechanisms within health care in Sweden. The supposed links between the perspective of customers and finance are missing. Instead, emphasis on the perspective of customers appears as a method to increase activity and expenses, especially in connection with a buying and selling system where professionals are paid to expand health treatment. It is not even clear that patients benefit from stressing the wishes of patients. In many respects, professionals are better informed than patients are. 'The customer knows best' is not always true.

The hierarchy between the four perspectives was replaced and the links reconstructed when balanced scorecards were implemented in the health care organisation.

The new links were built on the concept of 'balance'. 'Balance' was given a new significance. It was not referring to the balance between short- and long-term objectives, the balance between financial and non-financial measures, or the balance between lagging and leading indicators or the balance between external and internal performance (Kaplan and Norton, 1996b, p. viii). Instead, the professionals introduced a common meaning of 'well-balanced perspectives'. The four perspectives were not viewed as a hierarchy but as a *network of perspectives in balance*. The professionals did not regard any one perspective as more important than the others. The balanced scorecard is of importance just because it helps the organisation to focus on this interaction between perspectives. The senior executive of the County Council, however, saw the balanced scorecard as a potential long-term planning tool and underlined that the financial perspective formed a restriction to the other three. The financial perspective involved the restriction of the perspectives of internal processes and learning and growth. Those three perspectives determined whether the perspective of customers could be developed. In this view the balanced scorecard was turned upside down (cp. Kaplan and Norton, 1996b, p. 31).

The Inversion of Top-down Control

The balanced scorecard should translate the mission and the strategy of the organisation into objectives and measures. Of course, the financial perspective provides a constraint, not an objective for non-profit organisations. The opportunity for scorecards to improve the management in these organisations depends on the possibilities to translate their long-term goals into primary objectives. But, how do you translate the intention to give all members of the society a good health care on equal terms (the second paragraph of the health care law) into strategic objectives? In Swedish health care the translation from vision to strategy is missing (Culyer et al., 1992). Without that link it is difficult to translate strategy to strategic objectives within the four perspectives.

The professional that introduced the balanced scorecard in the health care organisation did not see it as this top-down management tool. Instead its strength was its possibility to present a bottom-up view of the activities of the operational service of the organisation. Balanced scorecards gave professionals a possibility to *communicate* between clinics and with the administration of the hospital and the county council and show every effort made in order to give patients the best possible care. These measures of the four perspectives presented a new construction of reality to administrators and politicians (cp. Morgan, 1988). Balanced scorecards gave the 'advocate'

ammunition in the budget game where the accountant's view of reality has traditionally carried more weight than other views. The whole work-orientation can change towards a patient-oriented rather than financial focus. Balance was seen as a strategy to maximise patient utility not as the means to achieve financial success. Balanced scorecards were regarded as elements of a conversation or *dialogue* around activities and costs. 'Accounting talk' (Jönsson, 1992; and Jönsson and Solli, 1992) was assigned a quality improvement potential. The head of a medical clinic put it this way (my translation):

> The whole culture has changed (medical professional's attitudes towards responsibility accounting – my comment). This does not depend on hard data and measurement. It depends on how we talk over the model. It is the dialogue that has power. It really has power (interview with head of a medical clinic, 1998–11–25).

Balanced scorecards have importance according to the professionals. They alter the power relations associated with the allocation and control of scarce resources. Financial statements are no longer the 'true and fair view' of reality. Activity accounting has become an element in a dialogue about the allocation of resources. The pros and cons of balanced scorecards were summarised as shown in Table 1 at a follow-up meeting with all the employees involved in the experimental work.

Table 1

The Strengths, Weaknesses, Possibilities and Threats of Balanced Scorecards

Strengths	*Weaknesses*
• Promoting a dialogue • Making discussions about visions and goals necessary • A structure for quality work • A language for communication • Useful on several levels • Understandable/pedagogical	• Mix of measurement without self-evident priorities in health care • Demanding (management, education, IT support) • The name (in Sweden often translated to 'control-card' and associated with financial control)
Possibilities	*Threats*
• Stimulate strategy discussion • Stimulating comparison leading to participation and co-operation • Pedagogic performance measurement for learning • Long-term planning tool	• A mayfly • Unclear ambitions • Top-down control instead of dialogue • Insufficient IT support • Too resource consuming (time and people)

Source: Compiled at a follow-up meeting with professionals working with BSC, 1999–02–02.

Strategic Change of Clan Conditions

Balanced scorecards have changed the control system within the clinic. These new ambitions to measure professional work are in no way repulsive to employees trained in natural science. Balanced scorecards involve new possibilities to plan, present and follow up the daily activities and the development of health and medical services within the clinic. The doctor and head of the medical clinic that started to develop and introduce balanced scorecards in the organisation saw this as a solution to a management problem. As Minzberg (1983, pp. 205–10) declared, the professional bureaucracy is not without problems. It is hard to deal with professionals who tend to overlook the major problems of co-ordination, of discretion and of innovation that arise in the professional bureaucracy. Administrators, 'taking office to announce major reforms', have no solutions to these problems, according to Minzberg (ibid., p. 213). The problems of co-ordination and of discretion are well known, but what about innovations? Undoubtedly, the professionals urge on development. They are the entrepreneurs of the health care organisation (Ham, 1987; and Pettersson et al., 1989). As the senior executive of one hospital put it (my translation):

> The self-interest of doctors is the driving force of the development in this hospital (interview with head of the Växjö Central Hospital, 1994–11–10).

But, the problem of innovation arises, as Minzberg wrote (ibid., p. 213), as major innovations cut across existing specialities and are dependent on co-operation. The solution was presented under declarations like 'From financial control to activity management'. It was characterised by disclosure through measurement and the shaping of a decentralised organisation where professionals were left with room for action. Empowerment and self-government at the departmental level were key concepts in this aspiration. The head of the medical clinic meant that most changes were accomplished close to the patient and he wanted to give the departments possibilities to make all those improvements that could serve the patients. But this decentralisation necessitated objectives, strategies and success factors in common to avoid co-operation problems and sub-optimisation. Within this framework, the department goals and measurements were left up to the departments of the clinic themselves to decide and develop. It was assumed that these were reassessed regularly according to the clinic's objectives, strategies and success factors. The objectives, strategies and success factors of one clinic are presented in Table 2. The success factors developed, constitute the links between the strategies and the goals and measures developed in each department.

Within these frames balanced scorecards are implemented at department level. Here, only one example is presented as to how the process perspective concerning diabetes care is particularised and complemented with performance targets. The experimental work at department level is breathing

Table 2

The Strategic Management System of One Clinic

Objective	*Strategies*
• Our objective is that the clinic will be the centre of competence for care and development of internal medicine • The medical clinic will be an effective link in the chain of care of the patients – hospital, primary care and the municipalities within the Högland District • We will be a precursor when it comes to provide for our patient's and other customer's needs and expectations by means of systematic development of quality	• Emergency temporary treatment and specialised open care • Develop effective chains of care and programmes of care in co-operation with primary care and the municipalities • Training of employees in primary care and the municipalities • Every employee will have the possibility for further development, including shadowing. To create a learning environment • Implementation of balanced quality analysis of our results with computer support

Factors of Success, Some Examples			
Learning and Growth	*Economy*	*Customer/Patient*	*Process/Productivity*
• Work satisfaction • Number of education days • Number of improvement projects, etc.	• Staff costs/budget • Costs of pharmaceuticals • Working costs (lab, X-ray etc.) • Patient fees – income, etc.	• Patient satisfaction index • Accessibility • Time to report to primary care and municipalities • Covering index, etc.	• Quality of care index • Utilisation of possible number of occupied beds • Diabetes care (HbA1c) • Stroke (survival) • Costs of care staff /DRG

Source: Documentation at the medical clinic, Högland hospital.

Table 3

Example of Performance Targets in the Balanced Quality Analysis on Department Level

Diabetes HbAIC for patients born between 1973–1978	The target is 100% goal fulfilment concerning three different variables HbA1c < 7.5% for the whole group HbA1c < 6.5% for 50% of patients in the group Reducing median value by 1 % in the whole group under the year

Source: Documentation from meeting 1999–02–02.

guarded optimism. But there are reservations:

> if the willingness is not present from the management (on hospital and county council level to improve communication) we from our side kindly ask not to have to participate (in the development and implementation of BSC) (Documentation from follow-up meeting with professionals working with BSC, 1999-02-02).

The financial constraints that constituted the dominant basis of accountability during the 1990s are complemented. Action is not evaluated by financial measures only, but also by activity and quality accounting. Balanced scorecards constructed from the bottom-up are used to communicate the activities of operational services to hospital and county council management. This activity accounting is an element in the dialogue around health care services and money. The monitoring process differs between the clinics involved in the experimental work. The most advanced clinic, in this respect, arranges follow-up meetings every second month where about forty performances targets on the four perspectives are evaluated. However, there are still many problems to solve in the monitoring process, e.g. insufficient IT-support, incomplete data-basis and diagrams easy to misunderstand.

The Hospital Planning Process

During 1997, Värnamo Hospital (about 1,200 employees) within Jönköping County Council developed its activity and budget-planning process for 1998 based on balanced scorecards. All seventeen clinics were involved, but they have had different degrees of success in carrying out this reform. This renewal of the planning process is regarded as a continuation of a quality improvement project, 'quality-development-leadership', that has been going on for several years. Hospital management regards balanced scorecards as tools that in the future will link the hospital vision and strategy to the goals of the clinics. A vision built on co-operation, satisfied patients and committed staff members. At the hospital level, success factors are formulated on four perspectives, including information about the key-factors to measure them.

- Economy: keep budgets, effective use of resources.
- Customer: satisfaction: availability, information, reception, security, covering.
- Processes: good medical results, effective chains of care, guarantee for care.
- Learning: training, leadership, work satisfaction.

Every clinic was given the assignment to make a balanced scorecard of its own, complementing its activity plan with goals, strategies, success factors and measurable key factors, if possible. The activity plan is built on the needs of the patient-groups for which the clinics have commitment and responsibility. One fragmentary example from the perspective of customers might show these links of the activity plan. The example comes from the Geriatric Clinic. The patient-groups considered are patients with stroke, orthopaedic patients, patients with suspected dementia, patients with Parkinson's and patients with osteoporosis.

Hospital management attached great importance to balanced scorecards as the new planning tools of the clinics, but there were some reservations. Balanced scorecards are dependent on the ability and willingness of professionals to co-operate and can only partly be used as a top-down management tool. They have great impact on the relations between hospital management and the clinics as they make possible an extended communication on activities of operational services. So far, politicians and hospital management has mostly dominated the quantitative, economic side of the health care organisation. Balanced scorecards might contribute to a deeper dialogue about activities between professionals and health care management. But the new planning technique is not unobjectionable. As the

Table 4

The Balanced Scorecard on Clinic Level

Strategic Goal	*Success-factor*	*Key-factor*	*Measurement*
The demands of patients are governing our activities. Patients have the right to feel secure and participate in care and treatment.	High accessibility and short time of waiting (one of seven factors within the perspective of customers)	• time of waiting before consultation • time of waiting in consultation rooms • time of waiting during treatment • accessibility by phone	In 1998 all these factors scored over 9 out of 10 (10 are *quite acceptable* in the patient inquiry. Approx. 1,000 inquiries were made in 1998, at least 40 in every consultation room.

Source: Activity planning 1999 at the Geriatric Clinic, Värnamo hospital.

head of one clinic put it (my translation):

> We may have these measurements transferred into management goals one day, but the risk is worth taking. The new dialogue is about health care activities and not only about money. Anyhow, from now on it will be difficult to get extended resources if you do not argue on the basis of the four perspectives of balanced scorecards.

The balanced scorecard is an interest common to hospital management and the professional management of the clinic. This does not mean that all doctors are enthusiastic. According to my interviews some of them still persist: 'why measure at all'.

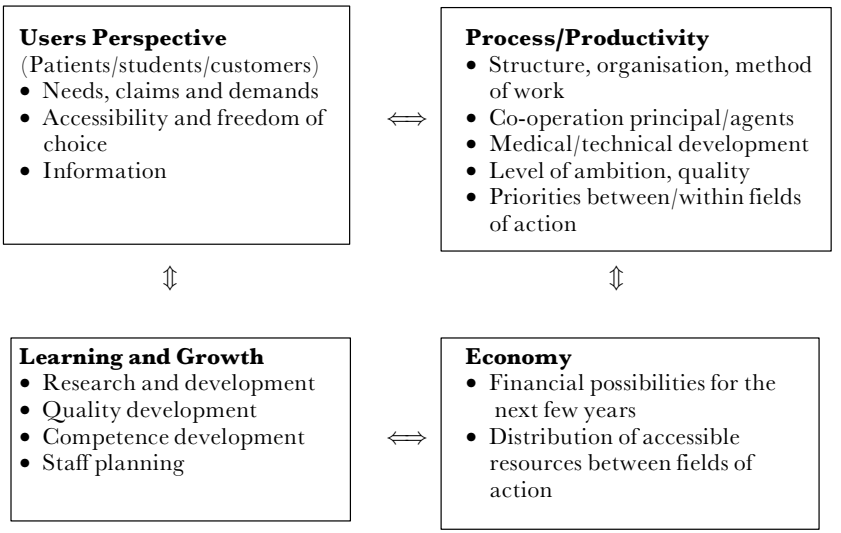
The Long-term Planning of the County Council

Balanced scorecards have reduced goal-uncertainty at the county council level and they are assigned the potential to reduce the gap between the political, administrative and professional domains in the organisation.

During the 1990s, financial accounting has had an impact on action as departments have been forced to adapt to diminishing resources. This emphasis on financial measurement has become a problem to the organisation. Many important aspects of health care management have been neglected. The council director and the council's senior decision-making political body decided to use balanced scorecards, introduced by

Figure 1

Balanced Scorecards in Long-term Planning at County Council Level



Source: Long-term planning at Jönköping County Council 1999–2001.

professionals, in the long-term planning. They inspired the experimental work mentioned earlier and looked forward to a deeper dialogue between professionals, administrators and politicians with the help of balanced scorecards. Measurement, in common, is attractive to management, and measurement according to the four perspectives of balanced scorecards, in particular, was regarded almost as specially made for the health care organisation. Claims for more compensation, efficiency improvements and enlargements can now be discussed systematically with the help of the four perspectives of balanced scorecards. It is even possible to stress a different focus according to current political trends.

In the long-term planning for 1999–2001, the balanced scorecard is called 'Balanced Quality Analysis', and it is used to systematise strategic objectives in a total quality perspective. For the first four months of the year 2000 all clinics at the three hospitals at Jönköping County Council have to report to the County Council Director how they score on the same four measures, one on each of the four perspectives of the balanced scorecard. Furthermore, all clinics are requested to report on another ten measures. This may seem as a quite inoffensive demand. However, the intention is clear, balanced scorecards, based on visions and strategies of the organisation, will be used to measure and evaluate activities at all levels.

CONCLUSIONS

During the 1990s, financial measurement has been the dominant mechanism of control in health care. The intention has been to 'maintain those relations between inflow and outflow of resources on which every dynamic system depends' (Vickers, 1965, p. 220). Emphasis on financial control, however, led to the negligence of other important aspects of health care management. In this context, the appreciation of balanced scorecards in Swedish health care organisations is comprehensible. Everyone interviewed in this study considered balanced scorecards as appropriate control mechanisms, almost as designed for health care organisations. They were regarded as a mix of control mechanisms through which the organisation could be managed so that it moved towards its objectives. Balanced scorecards replaced the one-sided financial measurement with control mechanisms that not only focused on the balancing judgements of the organisation but also on the optimising judgements. They reduced goal uncertainty, communicated the complex work of professionals to management and politicians and stimulated a new dialogue about vision and strategy. The four perspectives of balanced scorecards formed the frames for discussion and co-operation both within the clinic and in the organisation as a whole.

It is no paradox that the measurement on the four perspectives appears attractive to the clan, even if it reduces the ambiguity of performance evaluation (cp. Ouchi, 1980, p. 135). These measures promote the

reinstallation of clan control in the health care organisation. Balanced scorecards give emphasis to patients, health care processes and professional staff learning. As professionals define the measures used, they control what is important. Perhaps, the clan does not need measurement to function, but it can use measurement to underpin a mixed administration, in this case implying a move from bureaucracy towards clan control. Measures are powerful tools and in the health care organisation, the clan can measure and it can use that measurement in the new construction of reality.

However, this mix of control mechanisms is in no way stable. It is a transitional form of control that contains contradictions. Future research is needed as the use of balanced scorecards in the health care organisation develops. The introduction gives new possibilities for bureaucratic top-down control, once measures are constructed. Gradually, balanced scorecards are being used at county council and hospital level and among politicians to reduce goal-uncertainty. In the future, developed performance targets can be used to express detailed goals of the political and administrative domain. The confrontation of top-down administrative control and medical professional bottom-up intention to communicate activities under clan control remains to be studied. Future research will show if and how the political and administrative domain try to use balanced scorecards. The question will be if balanced scorecards too, used in a top-down process to control professional work, will end up as 'a story of failure' (Lapsley, 1993, p. 387). Or if balanced scorecards will mean a new dialogue about patients, processes, employees and finances reconciling differences between politicians, administrators and professionals in the public health care organisation.

NOTES

1 Jönköping County Council has 3 hospitals, 31 health centres and 35 public dental service clinics. It has over 9,000 employees and prepares an annual budget of 5 SEK Billion.

The implementation of balanced scorecards has also started in other county councils. Stockholm County Council, responsible for heath care in the whole county of Stockholm with its 1.7 million people, announced that in 1999 all emergency treatment could start to use the balanced scorecard as a responsibility accounting system (http://www.sll.se/fakta/ls/ls0217.htm).

2 Here a problem of definition occurs. Is clan control defined from professionalism, the presence of its norms of reciprocity: legitimate authority, shared values, beliefs, or by the absence of measurement? I assume that the presence of attributes is more important than the absence of measurement and continue using the term clan for the medical profession within the hospital even if measurement is introduced.

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