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The NHS performance assessment framework as a balanced scorecard approach

Limitations and implications

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Abstract

Purpose – The use of the balanced scorecard has been subject to increasing scrutiny and criticism in academic literature. The purpose of this paper is to explore the limitations of, and implications for, the Performance Assessment Framework (PAF) as a balanced scorecard approach in the NHS. Although Kaplan and Norton suggested that the balanced scorecard can be adapted for strategic performance management purposes in the public sector, this study aims to argue that such claims fail to give sufficient weight to the political context in which a public sector organization operates.

Design/methodology/approach – Semi-structured interviews were employed to investigate the perceptions about the PAF of local managers and whether and how they incorporated central government's performance targets into their local operations within two health authorities. Furthermore, in order to examine these two health authorities' performance measurement practices, documents relating to their internal performance reports and local delivery plans were analysed.

Findings – Empirical findings drawn from local health authorities indicate that the use of the PAF was primarily for legitimacy seeking purposes rather than for rational performance improvement. For central government, the PAF was used to make the performance of the NHS visible to the public so that the public would receive the signal that central government has attempted to deliver government mandates. For local health authority managers, in order to seek legitimacy from central government, imposed performance indicators were incorporated into their local performance measurement practice. However, the use of the PAF was symbolic and ceremonial and had little impact on improving performance valued by local managers in NHS.

Originality/value – This study agrees with institutional theorists' argument that the use of performance measurement systems should take into account politics and power faced by an organization. In the NHS, performance measurement might be used by local NHS organizations primarily as a ceremonial means of demonstrating their symbolic commitment for legitimacy seeking purposes.

Keywords Performance appraisal, Balanced scorecard, National Health Service, United Kingdom

Paper type Research paper

Introduction

In the public sector, the trend of "new public management" has seen the use of performance measurement (PM) to drive a more efficient, effective and accountable public sector (Hood, 1995; Lapsley, 1999). However, in the 1980s the use of PMs primarily focused on economy and efficiency for cost saving and operational control purposes was unable to support organisational objectives (Pollitt, 1985, 1986; Ghobadian and Ashworth, 1994; Guthrie and English, 1997). Some have thus suggested the use of multi-dimensional PM (Jackson, 1993; Kloot and Martin, 2000). Indeed, in a recent survey of accounting practice in Scotland, Jackson and Lapsley (2003) found that some public

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sector organizations have attempted to adopt Key Performance Indicators and Balanced Scorecard.

In the NHS, the government has attempted to apply the concept of the balanced scorecard to benchmark local NHS organizations' performance (Department of Health, 2001a). One of the key developments is the use of the Performance Assessment Framework to enhance local NHS organisations' accountability in delivering central government's targets (Department of Health, 2000, 2001b). As noted in a consultation document:

> The Performance Assessment Framework ... is based on the balanced scorecard approach. The use of the balanced scorecard allows organisations to get a more rounded view of performance by identifying different key elements of performance and understanding how changes in them may have implications for others (Department of Health, 2001a, p. 2).

The balanced scorecard was first introduced to address the limitations of single dimensional PM and was claimed to be a comprehensive strategic management mechanism for linking an organization's long-term objectives and local operations (Kaplan and Norton, 1992, 1996, 2001). As reflected in the quotation above, central government attempted to adopt the PAF as a balanced scorecard approach to improve local NHS organizations' performance in delivering its long-term objectives. Increasingly there have been some increasing criticisms of the architecture, however, and key concepts of this framework (see Neely *et al.*, 1995, Otley, 1999, Norreklit, 2000 and Norreklit, 2003, Malmi, 2001 and Brignall, 2002). For example, Neely *et al.*(1995) and Otley (1999) argued that the four dimensions of the balanced scorecard are rather simplistic and do not take into account some key stakeholders' interests (e.g. competitors) into account. Ittner *et al.*(1997) also argued that the balanced scorecard is problematic in linking an organisation's objectives and local operations. Furthermore, Brignall and Modell (2000) argued that the use of a balanced scorecard approach as a rational strategic management mechanism may ignore power and conflicts faced by a local unit within the public sector. In order to demonstrate its commitment to external pressures, the public sector may use PM for legitimacy seeking purposes.

This study provides empirical evidence drawn from interviews with local health authority managers to investigate whether and, if so, to what extent the perceived limitations in the balanced scorecard approach carry over into the PAF and thereby into the NHS. Specifically, this study examines whether the design of the PAF is comprehensive enough in measuring and improving local NHS organisations' performance and linking their operations with central government's long-term targets. This is achieved by analysing local managers' perceptions of the application of the PAF and its impact on performance measurement practice within local health authorities. By doing so, this study intends to draw out the implications for whether the PAF was used for legitimacy seeking purposes rather than for rational strategic management.

The structure of the remaining parts of this paper is as follows. The section immediately following summarizes some criticisms of the balanced scorecard. Section three describes the NHS PAF. Section four presents research methods employed. This paper then provides in section five some empirical evidence to indicate whether the perceived limitations of the balanced scorecard that encountered by the implementation of the PAF in the NHS. This is followed by concluding discussions in section six.

The balanced scorecard and its criticisms

The balanced scorecard was first introduced to address the limitations of single dimensional PM (Kaplan and Norton, 1992). This performance measurement system includes financial measures and drivers for future financial outcomes, which are customer, internal process and learning and growth. It is a framework that considers both outcome and process, and internal and external perspectives of different stakeholders' interests. Kaplan and Norton (1996, 2001) have recently introduced the concept of "strategy map" indicating that the balanced scorecard should be used as a strategic measurement system and integrated into an organization's strategic management process. To maximize the utility as a strategic measurement and management mechanism, Kaplan and Norton (1996) suggested that different dimensions of performance measurement should be linked together in a causal manner to enhance the linkage between an organisation's outcome targets and its local operations.

Criticisms of the balanced scorecard

After its introduction in the early 1990s, the balanced scorecard has attracted much attention in the literature. As mentioned earlier, the balanced scorecard was originally introduced as a multi-dimensional and multi-stakeholder approach for performance measurement purposes. However, in order to compete with other performance measurement systems (e.g. EVA), Otley (1999) argued that Kaplan and Norton have attempted to promote the balanced scorecard as a strategic management mechanism for maximizing shareholders' value. This development, however, has attracted increasing criticisms. For example, some have attempted to analyse its key concepts; Kaplan and Norton (1996, 2001) (see Brignall, 2002; Brignall and Modell, 2000; Neely *et al.*, 1995; Norrekilt, 2000, 2003; Otley, 1999). Others have examined the application of this performance measurement system in both private and public sectors (see Aidemark, 2001; Chow *et al.*, 1998; Ittner *et al.*, 1997; Lipe and Salterio, 2000; Malmi, 2001). Based on the literature reviewed, several key criticisms of the balanced scorecard are identified and are set out below.

First, the balanced scorecard has conceptual limitations in serving as a strategic management mechanism. Norreklit (2000) argued that to be applied as an effective strategic management mechanism, the scorecard should be rooted in the management practice of an organization. However, the implementation procedure of the scorecard does not always have this feature. It may be difficult for an organization to implement the scorecard effectively, since its four perspectives may be different from the strategic model in terms of which the management prefers. In order to address this criticism, Kaplan and Norton (2001) have recently suggested that the application of the balanced scorecard should be adapted to organizational context. However, Malmi (2001) found that the scorecard was rather used either as an information system or based on the concept of management by objective (MBO), which did not consider the linkage between performance measures and strategies. Furthermore, one key benefit of the balanced scorecard is that it enhances strategic linkage between central and local units. Ittner *et al.* (1997), however, found no evidence that the balanced scorecard serves as a strategic management for communicating business goals and objectives to branch managers. Lipe and Salterio's (200) study of clothing industries also shows that local units' managers were reluctant to adopt performance measures that would drive an

organisation's long-term outcome objectives. In a study of the use of multi-dimensional PM in the UK's public sector, Neely and Micheli (2005) found that the alignment between central government's performance targets and local units' performance improvement practice is often not consistent. Findings of these studies indicate that the balanced scorecard might be problematic in promoting strategic dialogue between centre and local units to link local operations and long-term objectives.

Furthermore, Kaplan and Norton (2001) emphasized the importance of linking process and outcome measures in a causal manner for strategic management purposes. Norreklit (2000), however, argued that this assumption is problematic. For example, the time lag required by the causal relationship is not considered within the balanced scorecard, since outcome and process measures are reported within the same framework. It may thus be difficult for senior managers to observe whether progress made in process perspectives has contributed to outcome targets. It is also likely that the relationship between perspectives is interdependent, rather than causal. The hypothesis of causal relationships made by Kaplan and Norton are based on the rationale that an organization faces one primary long-term objective (e.g. maximizing shareholders' wealth in a profit-motivated organization). However, an organization especially a public sector one may have to deliver multiple objectives. Within such a complex organization, it may be difficult to incorporate clear causal relationships between multiple objectives and process indicators within a simplified balanced scorecard framework.

As a multi-stakeholder approach, the balanced scorecard was criticized for not being comprehensive enough. It does not consider the interests of other key stakeholders such as competitors, suppliers, community and regulators (Neely *et al.*, 1995). Brignall and Modell (2000) further argued that the integration of the needs of different stakeholders within one performance measurement system does not take the effect of power relationships and conflicts into consideration. From an institutional theory perspective, they argued that pressures from different stakeholders may be inconsistent and contradictory, especially in the public sector. The use of a particular aspect of PM within a public sector organization might depend on the power relationship between its stakeholders and itself. A specific aspect of PM may thus be used by managers to seek simultaneous legitimacy from a coercive stakeholder rather than to deliver organizational long-term objectives. Indeed, Modell (2001) found that when facing a more coercive central government, local managers have attempted to diffuse central government's performance targets into their local operations although such targets are not consistent with their organizational objectives. In order to seek stability between stakeholders, he also found that local managers acted proactively to decouple the financial performance targets required by central government from those of other local stakeholders. Local managers' conforming behaviour might be due to the fact that their survival is very much dependant on their fulfillment of mandatory requirements imposed by and financial support from central government (DiMaggio and Powell, 1983).

In another study of the US government's attempt to apply multi-dimensional PM for accountability purposes, Cavalluzzo and Ittner (2004, p. 265) found that implementation of externally-mandated PM was to meet legal requirements, which "is likely to be symbolic with little influence on internal operations". It is thus very likely that PM information might be used by central government as a means of gaining

support from the public (Edelman, 1977). Although Chow *et al.* (1998) and Aidemark (2001) have demonstrated how the balanced scorecard has been transformed to be adapted to a healthcare organization, these studies adopt an instrumentalism perspective, which might ignore those issues argued by institutional theorists, e.g. Brignall and Modell (2000).

Although the balanced scorecard was initially designed for profit-motivated organizations, Kaplan and Norton (1996, 2001) noted its potential application in public sector contexts as well. When it is to be applied in not-for-profit organizations, they suggested that the four specific dimensions could be rearranged or some other perspectives could be considered to suit the public sector context. However, Kaplan and Norton's claim might have ignored the organizational and political context and institutional pressures faced by public sector organizations. This study argues that a public sector organization often has to deliver multiple objectives, which might not be easily measured within a simplified scorecard framework. Causal relationships between performance measures might also be difficult to incorporate to link local operations and central government's objectives for strategic management purposes. In addition, a public sector organization often faces more pressure to conform to social norms and legal requirements than a profit motivated company (Van Peursem *et al.*, 1995). A local unit may also face a relatively coercive central government, which may force its managers to acquiesce in central government's performance targets (Oliver, 1991). Thus, it is very likely that the use of a balanced scorecard approach in the public sector may not serve principally as a tool for rational performance improvement but rather as a "ceremonial means for symbolically demonstrating an organization's commitment to a rational course of action" (Covaleski *et al.*, 1996, p. 11). In the NHS, the government has attempted to adopt the PAF as a balanced scorecard approach. The PAF and how central government adopted this framework to benchmark local health authorities' performance are reviewed next.

The NHS performance assessment framework

In order to address the perceived problems of the internal market-based NHS (see Le Grand *et al.*, 1998), central government has recently developed the NHS Plan (Department of Health, 2000), which sets out long-term objectives and incorporates performance measurement for the future development of the NHS (Department of Health, 2001b). Health authorities were given the pivotal role of leading their health communities in the delivery of the government's policy for the NHS. They were required to develop local health improvement programs which should incorporate central government's long-term objectives, targets and national standards (NHS Executive, 1999a). In order to enhance health authorities' accountability, the PAF was used to benchmark their performance in delivering central government's long-term objectives (DoH, 2001a)[1].

There are six dimensions within the PAF (see list overleaf), which were intended to support the long-term objectives of the NHS Plan. These six dimensions show that the government not only intended to measure the NHS performance in terms of how efficiently financial resources are to be spent (efficiency), but also clinical outputs (effective delivery, health outcomes of NHS care), reducing health inequality (fair access) and improving service users' satisfaction (patient/carer experience), which were believed would contribute to the public's health (health improvement) (NHS Executive,

1999b). In other words, the government did not only seek to improve the NHS performance in terms of inputs and processes of service delivery, but, more importantly, clinical effectiveness and long-term health.

(1) *Health improvement*:
- deaths from all causes (ages 15-64);
- death from all causes (ages 65-74);
- deaths from cancer;
- deaths from all circulatory diseases;
- suicide rates;
- deaths from accidents; and
- serious injury from accidents.

(2) *Fair access*:
- inpatient waiting list;
- adult dental registrations;
- early detection of cancer;
- cancer waiting times;
- number of GPs;
- GP practice availability;
- elective surgery rates; and
- surgery rates – coronary heart disease.

(3) *Effective delivery of appropriate health care*:
- childhood immunisations;
- inappropriately used surgery;
- acute care management;
- chronic care management;
- mental health in primary care;
- cost effective prescribing;
- returning home following treatment for a stroke; and
- returning home following treatment for a fractured hip.

(4) *Efficiency*:
- day case rate;
- length of stay;
- maternity unit costs;
- mental health unit costs; and
- generic prescribing.

(5) *Patient/carer experience of the NHS*:
- patients who wait less than 2 hours for emergency admission (through A&E);

- cancelled operations;
- delayed discharge;
- first outpatient appointments for which patients did not attend;
- outpatients seen within 13 weeks of GP referral;
- per cent of those on waiting lists waiting 18 months or more; and
- patient satisfaction.

(6) *Health outcomes of NHS health care*:

- conceptions below age 18;
- decayed, missing or filled teeth in five year old children;
- readmission to hospital following discharge;
- emergency admissions of older people;
- emergency psychiatric re-admissions;
- stillbirths and infant deaths;
- breast cancer survival;
- cervical cancer survival;
- lung cancer survival;
- colon cancer survival;
- deaths in hospital following surgery (emergency admissions);
- deaths in hospital following surgery (non-emergency admissions);
- deaths in hospital following a heart attack (ages 35-74); and
- deaths in hospital following a fractured hip (NHS Executive, 2000).

In supporting the six dimensions, a set of performance indicators was developed, called the High Level Performance Indicators (HLPIs) (NHS Executive, 1998). Indicators for each dimension were chosen for delivering long-term objectives and targets. For example, in order to improve long-term health, seven indicators were selected to reflect national targets for this objective, which are deaths from all causes (ages 15-64), deaths from all causes (ages 65-74), deaths from cancer, deaths from circulatory diseases, deaths due to accidents, suicide rates, and serious injury from accidents (see list above). The other five dimensions, each incorporating several specified performance indicators, were then proposed as the key drivers of identified outcome measures. As was stated in a government document:

> . . .we need to ensure that everyone with health care needs (*Fair Access*) receives appropriate and effective health care (*Effective Delivery*) offering good value for money for services (*Efficiency*), as sensitively and conveniently as possible (*User/Carer Experience*), so that good clinical outcomes are achieved (*Health Outcome of NHS Care*) to maximise the contribution to improved health (back to *Health Improvement*) (emphasis added) (NHS Executive, 1999b, p. 7-8).

The above statement makes clear the government's assumption that, to achieve overall health improvement, it is crucial that the NHS should focus on and improve the five areas of NHS care performance reflected in the process and output related indicators. In

other words, by measuring the identified processes and outputs performance of local health organizations, long-term outcomes (i.e. reducing death rates) will be delivered.

The HLPIs were intended to raise questions and also aimed at supporting the local NHS organizations in meeting the national targets and objectives set out in the NHS Plan (Department of Health, 2000). To hold health authorities accountable for the utilization of allocated public funding, the HLPIs were used to benchmark their performance in terms of delivering central government's long-term objectives. League tables for each indicator have been published annually since 1999 to compare the performance of all health authorities in England (see NHS Executive, 1999b, 2000 and Department of Health, 2002). For those under-performing organizations, more pressure would be given from central government (via NHS Executive regional offices). By publishing the league tables, the government also intended to inform the public about the performance of local NHS organizations. The public would then be able to know (or judge), for example, whether their local heath service was more or less efficient/effective in terms of reducing waiting lists than the rest of the country.

According to documents published by the Department of Health (see Department of Health, 2001a, 2001b), the government seemed to believe that the adoption of the PAF as a "balanced scorecard" approach would ensure the delivery of its performance targets. However, the principal use to which PAF has been put in practice is arguably somewhat different. The formulation of strategies and measures of performance for the NHS is a highly political act. It involved political issues, such as how to structure the relationship between the centre and local organizations, and public accountability (Le Grand *et al.*, 1998). Performance indicators within the PAF might be chosen by central government to reflect its mandatory targets and used as a control mechanism to ensure that those targets are delivered by local NHS organization. When facing a coercive central government, local managers might have to conform to performance targets imposed upon them. In order to demonstrate their commitment to central government's performance targets, local managers might attempt to incorporate the HLPIs into their local performance measurement practice for legitimacy seeking purposes.

The purpose of this study is to draw out some implications with regard to the application of multi-dimensional PM in the NHS by analyzing the limitations of the PAF as a balanced scorecard approach. This study intends to achieve this by examining the perceptions of local health authorities' managers on the effectiveness of PAF in linking local operations and central government's long-term targets. Furthermore, this study intends to investigate how local health authorities' managers cope with central government's performance targets when implementing their performance measurement practice for their health improvement program.

Research methods

Semi-structured interviews were employed to investigate the perceptions of local health authorities' managers on the PAF and HLPIs and whether and how they incorporated central government's performance targets into their local operations. Managers within two health authorities were interviewed to understand their perceptions of the accountability mechanism imposed by central government and its influence on local performance improvement. Research access to the first health authority, located in Merseyside, was agreed with a senior manager of the NHS Executive Northwest regional office after communicating the research objective with

him. Introductory meetings were first held with the manager of each department individually – eight in all, to explain how the fieldwork would be conducted within this organization. These initial meetings also gave the researcher an opportunity to understand how the organization operated and the role of each manager. After gaining some background knowledge of this organization, several interviews were arranged with managers involving discussion of the development of performance measurement and management. The local managers interviewed included a chief executive, a public health director, a finance director, a deputy finance director, one performance management manager, and one information manager. The first three interviewees are senior level managers. The last two interviewees are middle level managers. For some operational issues, lower level officers were interviewed during the fieldwork.

Interviews with the managers within the second health authority were undertaken at a later stage of the fieldwork. Again, this health authority, located in Derbyshire, was suggested by a performance management manager within the NHS Executive Trent regional office. Managers and officers with same roles to the interviewees within the first health authority were interviewed. The purpose of interviewing managers within a different organization was to reinforce or to clarify opinions expressed by managers within the first health authority and to canvass views on a wider basis. To fulfill this purpose, similar phrases of questions were used to conducted interviews. In general, managers and officers within these two health authorities expressed a similar view that the delivery of performance measures imposed by central government was for accountability purposes. There were 22 interviewees and, in total, 31 interviews were undertaken. Most interviews lasted for one hour. They were all tape recorded and later transcribed. Furthermore, in order to examine these two health authorities' performance measurement practice, documents related to their internal performance reports and local delivery plans were analysed.

Empirical findings: some potential limitations

Disconnection between the PAF and local operations

One issue arising concerns the capability of the HLPIs to co-ordinate central government's objectives and local NHS organizations' operations. As was argued by the chief executive of the Merseyside health authority:

> the Performance Assessment Framework is an assessment, but it is not a performance framework that you can use to drive improvement in care… Its major deficiency is that it does not describe the organizational framework which we have to work within the NHS and the development of that.

Indeed, in order to reduce deaths from heart disease (one of the long-term targets measured within the aspect of Health Improvement), this health authority had attempted to implement those clinical evidence based standards suggested by the National Service Framework for Coronary Heart Disease (see Department of Health, 1999). Public health manager identified several initiatives within the health authority's health improvement program to indicate how resources should be invested to deliver those clinical standards. One of the key examples was the recruitment of a specialized nurse to shorten thrombolysis response time. However, very few of these inputs and processes were measured by the HLPIs. As mentioned earlier, the government's official document (NHS Executive, 1999b, pp. 7-8) seems to suggest that the improvement of

process dimensions would contribute to long-term outcome (i.e. reducing death rates). However, the process indicators chosen were unable to reflect a local health authority's attempt to improve those clinical standards that are believed to effective for reducing death rates from heart diseases by local managers. In other words, the HLPIs might not integrate comprehensively all key aspects of NHS performance. The PAF and HLPIs might thus be problematic in linking central government's long-term targets and local health authorities' operations. This evidence supports arguments of Ittner *et al.* (1997) and Lipe and Salterio (2000) that a balanced scorecard approach is problematic for strategic management within a decentralized organizational context.

Furthermore, the effectiveness of the HLPIs for performance improvement can also be hindered by the use of general death rates for benchmarking health authorities' performance. Although the outcome perspective of the PAF is to improve health, those process and output measures are all about improving health service standards. While there is no doubt that improving health service standards will contribute to patients' health, other social factors, such as employment, education and social policies, are believed to be equally critical in improving long-term public health (Appleby and Mulligan, 2000). Therefore, if death rates cannot be totally controlled by the NHS organizations, the use of death rates without appropriate adjustments is inappropriate given that one of the purposes of using the HLPIs is to benchmark local health authorities' performance.

Performance improvement or legitimacy seeking?

The above finding seems to suggest that the HLPIs might not genuinely reflect a health authority's performance. Local managers might perceive the HLPIs were not consistent with their local health improvement. This study, however, found that local managers within health authorities studied had attempted to deliver targets required by central government. One of the typical examples is the target for shortening patients' waiting lists/times. As stated by an information officer within the Derbyshire health authority:

> The way we did it was that we did a lot of easy operations. So you reduce the number of people on the waiting list, but it was not necessarily in the right priority order health wise. So you got a lot of people with tiny problems who were treated. But people with big operations, such as hip replacement or other joint replacement, may have to wait longer than they would have done. Now we hit the target and that is what we have to do.

Reducing the number of patients on the waiting lists was an important policy agenda within the current government's general election manifestos in 1997 and 2001. Those health organizations unable to meet the government's targets were often labeled as "failing" organizations by ministers in the media. The attempt to deliver better performance for those targets imposed might be a consequence of political pressure imposed by central government. According to the performance management manger within the Merseyside health authority:

> The issue of reducing waiting times has become an important political agenda and the political consequences are potentially very high, because automatically it could mean that chief executives lose their jobs.

Although the waiting list target was perceived by local managers to make little contribution to health improvement, central government attempted to force them to deliver this target by linking this requirement with local managers' own interests (i.e. job

security). Closer monitoring and more pressure were imposed by central government on local health authorities' managers to ensure performance targets were delivered (see Le Grand *et al.*, 1998). It was the local managers who had to face the inevitable consequences if the requisite targets were not met. Furthermore, by publishing the HLPIs league table, the reputation of local managers was exposed to their peers and the public. Naming and shaming exercises to identify failing organizations were often witnessed. From the perspective of central government, it was able to send a signal to the public about the performance of the NHS in delivering its mandatory targets. In other words, central government might have attempted to use performance information generated by the HLPIs league tables to shift the perception of responsibility for any failure to deliver government's targets to the NHS. On the other hand, in order to deliver better performance for the targets imposed, local managers had attempted to prioritize central government's targets even at the price of skewing the clinical priorities. Local managers' conforming behaviour might reflect their pressures to acquiesce to what was deemed to be acceptable by the society and seek legitimacy from central government to secure their own interests (Covaleski *et al.*, 1996).

Decoupling or integrating?

Modell (2001) argued that when facing multiple stakeholders' pressures, managers tend to decouple performance indicators required by a more coercive stakeholder from those of others rather than integrate the performance indicators within a multi-dimensional framework. The above finding indicated that local managers had attempted to diffuse central government's performance targets into their local operations for legitimacy seeking purposes. However, how would such pressure affect performance measurement practice within local health authorities? This study found that local managers had attempted to adopt a balanced scorecard approach to integrate various stakeholders' interests. As indicated by the chief executive of the Merseyside health authority, different stakeholders usually work in isolation and that each group prioritizes its own interests within the health community. He argued that:

> [t]he clinicians think they actually should run the services. The managers think they are running it. And the interesting thing is that, separate from the manager are the group who are the finance people, they think they are running it... Sometimes people can walk into their own tribe and just look at their own interests. So, you can get situation where financial balance comes above doing the right things for the right patient.

The above argument seems to suggest that the key stakeholders whom performance managers had to deal with might have inconsistent interests. In order to deliver their patients' needs, the chief executive believed that it is essential that key stakeholders should work cooperatively. He further stated that:

> [t]he whole idea was to enable people to come together where their perspectives, their values were respected, but they were able to see the large picture. And hopefully, everyone put on the top the patient's interest, which is the outcome, access, and choices.

A balanced scorecard approach was then developed for the health authority's health improvement program. In order to gain support from the health authority's key stakeholders, the chief executive defined performance or success in terms of their interests. An example of a balanced scorecard for coronary heart disease is shown in Figure 1. For the patient and the public, it is important to include outcome measures

Effectiveness
% patients with MI discharged live from hospital
No. patients prescribed aspirin
No. patients prescribed statins
% patients with chest pain, door to needle <1 hour (thrombolytic therapy)
% patients with CVD (cardiovascular disease) reviewed in primary care who smoke
Ambulance response times
Life threatening calls reached in 8 minutes
Life threatening calls reached in 14 minutes
Non-life threatening calls reached in 8 minutes
Non-life threatening calls reached in 14 minutes
Patient expectations
% residents waiting > 12 months for revascularisation from date of decision to admit
% residents waiting > 3 months for catheters from date of decision to admit
Severity score system applied to waiting list revascularisation
SMR (standardized mortality rate) IHD males < 65 yrs
SMR IHD males 65-74 years
SMR IHD females < 65 years
SMR IHD females 65-74 years
SMR CVD males all ages
SMR CVD females all ages
SMR CVD persons all ages
CVD death rate/100k population < 65 years
CVD death rate/100k population 65 to 74 years
Efficiency
Statin spend as % of total drug expenditure
% of patients with angina re-admitted within 3 months
% of patients with angina re-admitted within 6 months
Bed days for CVD as % of medical
No. revascularizations
No. of catheters
% catheters on day case basis
Organisational development
% practices with pro-active secondary prevention programme
No. patients reviewed by CVD nurses
Providers with structured acute care pathway

Figure 1.
The Merseyside Health Authority balanced scorecard for coronary heart disease

from the patient's point of view, such as death rate. With regard to the finance people's interest, performance is defined as efficiency, which includes indicators related to activity and throughput level. For health care professionals, it aims at shifting the system towards evidence-based practice in order to deliver effective services for

patients. The effectiveness perspective includes indicators derived from work on evidence-based medicine such as the percentage of patients with angina receiving prescriptions for aspirin. Furthermore, the senior manager also identified the organizational development dimension. This perspective intends to contain qualitative information and indicators to provide information on whether his organization is actively developing staff and services, such as integrating education, research and development and decision support systems. Therefore, by presenting different stakeholders' interests together within this balanced scorecard framework, the chief executive believed that:

> there would be a deeper understanding for each other's perspective and each other's contributions. The financial director, for instance, might take a little bit more note that the clinicians are trying to do the right things to the right people.

This finding indicates that although facing multiple stakeholders with potential conflicting interests, a balanced scorecard approach was adopted to integrate their interests. As shown in Figure 1, the Merseyside health authority's balanced scorecard does not only incorporate performance targets required by central government (e.g. waiting list and death rates) but also performance indicators reflecting other local stakeholders' interests. The evidence shows that the behaviour of decoupling performance measures suggested by Modell (2001) did not happen to local health authority managers interviewed when they faced multiple stakeholders.

For the Merseyside health authority, the implementation of the balanced scorecard approach was primarily used to provide key performance information reflecting interests of its key stakeholders. Managers responsible for various health improvement programs (e.g. coronary heart disease and cancers) rarely used their balanced scorecard approach for managing their local performance. One manager responsible for Old People health improvement program even complained that the concept of the balanced scorecard is "difficult to understand" and was reluctant to use it. It was actually the duty of information officers to collect data for the health authority's performance report. Monthly meeting was held among managers to review the progress of the performance of targets for its local health community and those required by central government. No intention was made to link various perspectives in a causal manner as were suggested by Kaplan and Norton (1996) for strategic management purposes. The use of the balanced scorecard has thus become a ceremonial means of providing information to demonstrate its commitments in fulfilling its stakeholders' interests.

Concluding discussions

Multi-dimensional performance measurement has increased in popularity in the public sector since 1990s. Since it came to power in 1997, the government has attempted to adopt a balanced scorecard approach to enhance local NHS organisations' performance in delivering its long-term targets. Although the balanced scorecard has been claimed to be an effective strategic performance mechanism, several studies have shown its limitations and problems in this regard. This study argues that the use of a balanced scorecard approach in the NHS should not be disassociated from its political context. Evidence from this study indicates that the application of the PAF in the NHS might

have been skewed to serve central government's political interests and might be used for legitimacy seeking rather than performance improvement purposes.

This study found that performance indicators within the Performance Assessment Framework were unable to link local operations with central government's long-term targets and were not comprehensive either. The set of performance indicators studied was too "high level" and did not fully reflect clinical evidence-based standards (e.g. national service frameworks) that heath authorities attempted to delivered locally. Local health authorities' managers might perceive that the imposed performance indicators were inconsistent with their local operations and had little impact on their local performance improvement. However, delivering those targets is part of the political agenda. In order to secure their own interests, local managers have deliberately diffused central government's requirements into local health communities. A typical example is the use of waiting list measures as an indication of the management of service delivery within the health communities studied. Indeed, a local unit is often exposed to mandatory targets imposed by central government, and known to the public. The consequence of failing to conform to these targets is more tangible to the public and sometimes punitive (Oliver, 1991). In order to conform to social norms, local managers attempted to deliver central government's targets within their local health community. By publishing the high level performance indicators league table, central government was also able to make local NHS organisations' performance visible so that the public would receive the signal that government targets promised in the election campaign are delivered. In other words, in order to secure its support from the public, central government had attempted to use the PAF as a control mechanism to ensure that its targets are delivered by local NHS organizations.

In addition to analyzing the central government's attempt to use the PAF as a balanced scorecard approach, this study also provides evidence to show the impact of central government's imposition of this framework on performance practice within local health authority. As was argued by Modell (2001), local managers tend to decouple performance measures required by a more coercive stakeholder from those of other stakeholders rather than integrate them into a multi-dimensional performance measurement system in the public sector. However, evidence from this study does not support such argument. This study found that a balanced scorecard approach had been adopted to resolve potential conflicts and promote cooperative working between various stakeholders within the health communities studied. Evidence shows that performance measures had been identified to fulfill local stakeholders' interests as well as central government's performance targets. For those managers interviewed, they did not only recognize the pressures imposed by central government, but they also believed their responsibility in meeting other local stakeholders' needs. A balanced scorecard was thus used by the senior managers to integrate various stakeholders' interests. However, the balance scorecard approach was not intended to be used as a strategic management mechanism. This system was primarily used to generate performance information to gain support from the key stakeholders of the health authority studied. In other words, the balanced scorecard approach was used as an information system rather than a strategic performance management mechanism (Malmi, 2001).

Kaplan and Norton (2001) suggested that the balanced scorecard can be transformed to serve as a strategic performance management mechanism in the

public sector. This study argues that such claim is based on rational instrumentalism and does not consider the political context that a public sector organization faces (Brignall and Modell, 2000). As argued by Le Grand *et al.* (1998), the reform of the NHS carried out by the current government was intended to create an arm's length accountability relationship between central government and local health organizations. Performance targets were identified very specifically. Closer monitoring processes of local health organizations were constantly carried out by the NHS Executive regional offices. Through this chain of control, central government was able to impose more pressure on managers within local health authorities. For central government, the PAF was used to seek support for the delivery of government mandates from the public. On the other hand, in order to seek legitimacy from central government, local managers had attempted to incorporated performance indicators imposed into their performance measurement practice even when they perceived those indicators were inconsistent with their local health performance improvement. This study agrees with institutional theorists' argument that the use of performance measurement systems should take into account the political context in which a public sector organization operates. In the NHS, performance measurement might be used by local NHS organizations primarily as a means of demonstrating their symbolic commitment to central government pressures for legitimacy seeking purposes.

Note

1. The PAF was used between 1999 and 2002 to benchmark health authorities' performance. Due to the change in NHS structure taken place in 2002, health authorities where then ceased to function. Most of their responsibilities were devolved to primary care trusts.

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