Exploring the Use of Balanced Scorecards in a Swedish Health Care Organization

Beata Kollberg
ABSTRACT

Due to an extensive decentralization in the County Council of Östergötland during the 1980s, the demands on follow-up reports have increased on the production units. In order to support the units in following up their organizations, the board of the County Council decided to implement Total Quality Management in the beginning of the 1990s. As a part of the program, the QUL concept was introduced to provide the County Council with a comprehensive description of the production units’ activities. In 2001 the County Council decided to implement the Balanced Scorecard (BSC) as a new way of following up the units’ results. The BSC implementation has led to that all production units write their follow-up reports according to the perspectives suggested in the BSC framework. The head of the production units are responsible for the dissemination and implementation of the BSC in their own units.

The present research is conducted on commission from the Federation of Swedish County Councils. The purpose of the thesis is to increase the understanding of the use of the BSC in an organization in the Swedish health care and medical services. Two research questions derive from the purpose: (1) How is the BSC designed, implemented and used in the organization? (2) What factors enable or constrain the use of the BSC in the organization?

Findings from the case study show that the BSC is used in the annual planning, in reporting measures to superiors and in following up the activities in the health care organization. The BSC is also used in discussions between employees, to disseminate information within and outside the organization, to create orderliness and understanding of the annual activities, and in developmental activities. The findings indicate that the BSC has been adapted to the current conditions of the organization with regard to the existing terminology and organizational structures. The BSC is not primarily used as a strategic management system, but rather as an information system that aims to communicate measurable information within and outside the organization.

Several categories of factors that enable or constrain the use of the BSC in a health care organization are identified. The autonomy of the department and units enables people to develop their own scorecards without considerable influence from superiors. The emphasis on employees’ participation is also identified as an important aspect in making people accept the new concept. The way the introduction of the BSC was dealt with and the department’s prior experiences with the Swedish Quality Award have influenced the acceptance and use of the BSC. In addition, the case shows that change agents play a major role in how the BSC is used in the organization today. Several adaptations have been made to current conditions, that both enable and constrain the use of the BSC in the health care organization.
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1 INTRODUCTION

In this chapter the background to the present research is described. An introduction to the Balanced Scorecard (BSC) in the County Council of Östergötland is presented followed by a discussion of previous research concerning performance measurements and the BSC. Moreover, the author’s prior experience from the BSC is discussed. The chapter presents the purpose and the research questions of the thesis. Finally, an outline of the thesis is presented.

1.1 BACKGROUND

The emergence of the quality movement in the closing decades of the twentieth century has implied increased requirements on organizations’ competitiveness. Organizations do not gain a sustainable competitive advantage by merely deploying new technology into physical assets, or by focusing on excellent management of financial assets and liabilities. Process orientation, customer focus, supplier partnership, continuous improvement, and employee knowledge are some of the improvement initiatives that are related to having a competitive advantage within contemporary organizations. However, in order to adapt to these demands, organizations have changed focus from their physical assets to the intangible resources represented by e.g. process orientation, customer satisfaction, and employee knowledge.

According to Johanson et al. (2001), the variety of definitions and classifications of what is meant by “intangibles” has increased during the last decade. The authors propose a model by Haanes and Lowendahl (1997), which categories intangibles into competence and relational resources. Competence resources involve knowledge skills and talents related to the individual, and databases, technology, routines etc. related to the organization. Relational resources are referred to as customer loyalty and reputation. A central issue in contemporary management studies has been to develop technologies for managing these intangible assets, somewhat in the same manner as physical assets historically have been dealt with. Accordingly, a problem related to this development lies in how the intangible assets are measured (Dahlgaard and Dahlgaard 2002).

In 1992 Kaplan and Norton introduced the Balanced Scorecard (BSC) concept as a new system for organizing both financial and non-financial performance measurements. In the beginning of their article they discuss the well-known device these days, “what you measure is what you get”, which points out the authors’ view on the role of performance measurements in managerial work (Kaplan and Norton 1992). The wide range of financial and non-financial measurements, which the scorecard
offers, provides managers with a comprehensive framework representation of both the organization’s tangible and intangible assets. In 1996 Kaplan and Norton evolve the concept further to become a strategic management system, which they argue supports four managerial processes, namely (1) clarify and translate vision and strategy, (2) communicate and link strategic objectives and measures, (3) plan, set targets, and align strategic initiatives, and (4) enhance strategic feedback and learning (Kaplan and Norton 1996a).

As the interest in the Balanced Scorecard has increased over the last decade several authors have questioned its contributions both in theory and practice. For instance, Johnsen (2001) who makes a comparison between the BSC and Management By Objectives (MBO) introduced by Drucker in 1954, claims that the basic elements in the BSC are consistent with the elements in MBO. In fact, Johnsen (2001) argues that the BSC is an extension of the MBO, since it emphasizes feedback on results with its formal performance measurements. Further examination of the BSC and the MBO respectively indicates that both models emphasize the need to focus on both tangible and intangible assets and to balance the different efforts in order to achieve management control (Drucker 1955; Kaplan and Norton 1996b). While the MBO is presented as a tool especially designed to make lower managers heard (Drucker 1955, p. 112), the BSC is argued to be a system for organizing managerial work at all levels in an organization (Kaplan and Norton 1996, p. ix). A major difference between the BSC and MBO may be found in the division of measures into ‘perspectives’ in the BSC. However, the idea of perspectives may also be derived from the MBO since Drucker claims that every manager should “spell out his contribution to the attainment of company goals in all areas of the business.” (Drucker 1955, p. 109)

In addition to Johnsen (2001), Liukkonen (2000), claims that the ideas in this “new” philosophy are consistent with old management control theories regarding how to implement visions and strategies. She describes the BSC as one of today’s management control philosophies and claims that the new is seldom purely new, but rather a classic theory in a new package. Liukkonen (2000) also argues that there is a lack of theoretical foundation and empirical evidence of the practical application of these new philosophies, which make them difficult to understand and use in practice (Liukkonen 2000). Johanson et al (2001) and Otley (1999) also criticize the lack of empirical evidence, and advocate the need for investigations in organizations using performance measurement systems. Otley (1999) advocates a case study approach in single organizations in order to receive an in-depth knowledge of how performance measurement systems are used.
1.1.1 The BSC in the County Council of Östergötland

Due to an extensive decentralization in the County Council of Östergötland during the 1980s, the demands on follow-up reports have increased on the production units\(^1\), which are directly subordinate to the board of the County Council. The decentralization included greater economic responsibility for the production units implying that every unit is autonomous on the basis of its own income statement and balance sheet. In order to support the production units in following up their organizations, the board of the County Council decided to implement Total Quality Management (TQM) in the beginning of the 1990s. According to an interview with the County Director of Finance, the TQM initiative foremost focused on the leadership of the units by introducing management tools, which aimed at supporting management control from different angles. As a part of the program, the QUL concept\(^2\) was introduced to provide the County Council with a comprehensive description of the production units’ activities through a systematic way of working with improvement activities.

Although the introduction of a systematic way of working with quality improvements through quality awards has led to successful outcomes in the 1990s\(^3\), the board of the County Council decided not to require all the production units to work with the QUL concept. The criticism against the QUL concept mainly concerned the difficulties in understanding the basic principles and the large amount of information required. Instead, the management team of the County Council including the County Director of Finance and managers of the production units started looking for a more easily available and logical tool for quality management.

In 2001 the County Council decided to implement the BSC in all production units in Östergötland. The BSC was perceived as an easier way of appraising the units since the BSC perspectives made managers attentive to the whole organization and not only to the financial results. The implementation of the BSC in all production units has led to that all the follow-up reports have to be written according to the perspectives in the BSC. CQ\(^4\) is expected to provide all units with training in how to implement and use the BSC in the health care and medical services. The head of the production units are

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\(^1\) The County Council of Östergötland comprises 90 production units.

\(^2\) The QUL (sw. Qvalitet, Utveckling, Ledarskap) concept is the health care and medical service’s equivalent of the Swedish Quality Award (sw. USK - Utmärkelsen Svensk Kvalitet) (SIQ)

\(^3\) For instance, the Department of Pulmonary Medicine received the Swedish Quality Award in 1996. In 1997 the Women’s Health Clinic in Motala received the QUL award.

\(^4\) CQ (sw. Centrum för verksamhetsutveckling) is a unit in the County Council of Östergötland, which aims to support systematic improvement initiatives and appraisal throughout the County Council.
responsible for the dissemination and implementation of the BSC concept in their own units.

The present research is being conducted on commission from the Federation of Swedish County Councils in a project called “Performance Measurement Systems in Health Care and Medical Services”. At present, several County Councils in Sweden are implementing the BSC with differing results. In order to increase the understanding of BSC implications the commission aims to disseminate knowledge from three case studies to all Swedish County Councils. This thesis is based on one of these case studies. The other case studies are conducted at the Heart and Lung Center in Lund, County Council of Skåne, and at the Department of Internal medicine in Eksjö, Hospital of Hoegland, County Council of Jönköping. The results from the case studies are presented in a report that will be published by the Federation of the County Councils in Autumn 2003.

1.1.2 Previous research

Although the empirical findings of the application of performance measurement systems are few in number, there are some researchers investigating how such systems are used in the field. Malmi (2001), for instance, shows in a study of 17 Finnish organizations, that the reasons for adopting the BSC vary radically between organizations. Firstly, the companies seemed to have difficulties in linking strategy work and operations. Secondly, quality programs and primarily different kinds of quality awards were identified as a reason for introducing the BSC. One interviewee claims, “the BSC is a tool for quality management”. Thirdly, companies seemed to be implementing the scorecard due to other organizational changes, such as implementation of process management and merging of companies. Fourthly, motives related to management fads and fashions were shown as important in the implementation of BSC. Fifthly, some companies had abandoned the traditional way of budgeting, and needed a complement.

A survey conducted by Kald and Nilsson (2000) in 236 Nordic companies shows that the foremost use of performance measurement is for decision support at the top-management level and the operating level. Moreover, the study shows that the main contribution of performance measurement is to provide a better understanding of how the business works. Shortcomings that the survey brings out are that the performance measurements are overly focused on the past and on the short term. The dominant focus on financial performance and overflow of information are also mentioned as problems in the use of performance measurement. However, Kald and Nilsson (2000) stress that the results from the survey should only be used as rough indicators since the interpretations of concepts such as the BSC vary in practice.
Kennerley and Neely (2002) investigate factors affecting the evolution of performance measurement systems. Their research is based on a multiple case study involving semi-structured interviews with 25 managers from seven private organizations. The case study identifies barriers and facilitators of evolution, which are categorized into process, people, systems and culture. The findings show that the existence of a process for reviewing, modifying and deploying measures, and the availability of skills required to use, reflect on, modify and deploy measures are crucial triggers in the evolution process. In addition, the existence of a flexible system that enables the collection, analysis and reporting of appropriate data is presented as important. Finally, they argue that it is crucial to have a measurement culture in which the value of measurement is appreciated.

1.1.3 The author’s prior experience

In 2000, I was involved in a project in the municipality of Hässleholm in Sweden, aimed at designing an over-all BSC for their child-care and elementary school services. The project was conducted as a master thesis in the program of Industrial Engineering and Management. The designing of a BSC was included in a larger quality program initiative aimed at improving the follow-up and reporting process of the child-care units and schools in the municipality. The study was based on semi-structured interviews partly aimed at examining how the BSC could be adapted to the prevailing situation of the organization. The following discussion partly constituted the background to the investigation in Hässleholm:

“Despite the success of the BSC in the private sector, one may question with respect to the obvious differences between private and public organizations, whether the BSC really is useful in a municipality. When designing a BSC it is important to take the conditions of the existing organization as a starting point in order to adapt the tool to the specific context” (Kollberg and Parneborg 2001, p. 3)

Thus, the study was based on the fact that the BSC should be adapted to the actual organizational context. However, later on in the thesis we discussed the need to change the work design at the different autonomous units in order to succeed with the BSC implementation.

“In order to use the BSC in the most appropriate way, all units need to measure the same things, use the same concepts, and evaluate situations similarly. The decentralization has implied that the autonomous units to a large extent have their own interpretation of goals and made their own evaluations. In order to achieve high effectiveness with the BSC, the work designs partly need to be defined and coordinated.” (Kollberg and Parneborg 2001, p. 98)
Hence, the implementation of the BSC at the child-care and elementary school in Hässleholm involved adaptation of the BSC to the current conditions of the organization as well as changes in the current organizational structure. The study resulted in a conceptual design of a BSC and instructions of how the municipality should continue with the implementation of the BSC.

The results from the study points to some difficulties involved in the implementation of the BSC. Although the BSC should be adapted to the specific context, the organization needs to change in order to succeed with the implementation. We argued in the thesis that the autonomy of the units constitutes a barrier to the BSC since the units interpret goals and measures in different ways, which prevent the achievement of a common and unified vision. However, since the autonomous of the units in the municipality is based on a political decision to decentralize the decision-making, one may question the practicability in changing the organizational structure so that all units share the same vision. My experience from the study in Hässleholm made me interested in how the problems involved in the implementation were dealt with in practice. Hence, I became interested in how the BSC could be integrated in the organization and used in work practice.

### 1.2 PURPOSE AND RESEARCH QUESTIONS

The purpose of this study is...

...to increase the understanding of how the Balanced Scorecard is used in an organization in the Swedish health care and medical services.

Understanding the use of the Balanced Scorecard (BSC) involves how the BSC is designed, and being implemented in the organization. One way of describing the distinction between the design, implementation and use dimensions is to view them from David Marr’s Levels of Description (Marr 1982). Marr’s framework was developed as a way to understand an information-processing system, and focused on cognitive processes that take place inside individuals. However, the framework may be applied to other information systems as well (Hutchins 1995). Elg (2001), for instance, has used the levels in understanding the usage of performance measurements in managerial work, and Hutchins (1995) understands navigation activity on a military transport ship on the basis of the same levels.

The framework encompasses three levels that are important to consider in an information system. Firstly, the computational theory of the task that the system performs is taken into account. This level focuses on what the system does, and why it does it. Secondly, the choice of representation and the transformation by which the information is propagated through the system is focused. How the information is
transformed in the system is thus considered in this level. Thirdly, the details of how the system is physically realized in the organization are considered.

In this study, the design of the BSC corresponds to the first level of description and investigates what the system does and why. The design includes the description of the contents of the BSC in the organization, what the BSC emphasizes and why the BSC points to the things it does. For instance, the perspectives in the BSC and why these perspectives were chosen in the organization are illuminated.

The implementation of the BSC reflects the second level of description and focuses on how the BSC was transformed and evolved in the organization. The choices of BSC representations are illuminated through describing how the BSC was built, deployed and disseminated throughout the organization. The study of the implementation reflects a historical aspect of an organization, and is a useful consideration in understanding how the BSC is used today. The focus is on how the BSC is transformed from the initial introduction to the fully integration into the organization.

The use of the BSC focuses on the physical realization of the system in the organization and thus represents the third level of description. The use dimension explores activities, such as documentation of measurements, reconstruction of strategy, reporting of results and communication within units, dissemination of information, and strategic planning all related to the BSC realization. Thus, the use dimension focuses on how people make use of the BSC in their day-to-day practices.

Based on the previous discussion, the first research question in this thesis aims to describe the design, implementation and use of the BSC in the organization:

(1) How is the BSC designed, implemented and used in the organization?

There are many choices available at each level of description presented by Marr, and the choices made at one level may constrain what will work at other levels (Hutchins 1995). Thus, there is a close interrelation between the levels of description. A basic assumption in the present study is that the design, implementation and use of the BSC are strongly interrelated. In other words, what the BSC emphasizes, why these choices are made, and how the BSC was transformed and developed in the organization influence how people use the BSC in practice. In order to understand the use of the BSC it is thus important to investigate how the BSC was implemented and designed in the organization.

The second research question aims to explain the use of the BSC through investigating factors that encourage and constrain the use of the BSC.

(2) What factors enable or constrain the use of the BSC in the organization?
Many scholars in the field of Quality Management focus on design and implementation of quality management tools. Most research in this field is devoted to the development of methods for implementation in organizations (see e.g. Ekdahl 1999; Ekros 2000; Kammerlind 2000; Schütte 2002; Arvidsson 2003). Kaplan and Norton mainly focus on the design of the BSC, what the BSC does and why. They also describe how the BSC is transformed in organizations.

In this study I focus on the use of the BSC, that is how it is actually realized in an organization. In order to understand the explanatory factor to the use, I study the design and implementation of the BSC. The purpose of the study is not to develop prescriptive models in the way they are presented in most management literature. My aim is to place emphasis to the contextual elements surrounding the BSC by illuminating the activities involving the BSC in work practices, and taking the design and the implementation of the BSC in a specific organization into account. Thereby, I hope to contribute to an in-depth knowledge of the practical implications of the BSC in a health care organization that is useful for other health care organizations in their implementation of the BSC as well as for further research within this area.

1.3 EXPECTED CONTRIBUTIONS

This thesis aims to increase the understanding of the use of the BSC in a health care organization. The primary target group of the findings is health care organizations in Sweden that are planning to implement or are implementing the BSC in their organizations. The thesis aims to contribute to an understanding that hopefully will trigger off reflections among health care organizations of how they can improve and develop BSC in their context.

In addition, the thesis aims to contribute to theoretical assumptions that may be investigated in further research. The thesis aims to investigate the design and implementation process of the BSC in a health care context and how these influence the use of the tool. Some questions that this thesis aims to illuminate are: Is the implementation of the BSC following a planned model? How is the BSC design corresponding the framework proposed by the advocates of the BSC? What is important in the implementation and design to get people to use the BSC? Are these factors different from what is proposed in literature? From a Quality Management perspective, the thesis contributes to illuminate how people use a tool that is perceived as a “quality tool”.

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1.4 OUTLINE OF THE THESIS

The introducing chapter of this thesis presents the theoretical framework used to analyze the findings from the research study (Chapter 2). The framework encompasses a review in three theoretical fields, namely Quality Management, Balanced Scorecard, and Organizational Change. Thereafter the methods used in the research study of the BSC are described. Research strategy, collection and analysis of evidence, and the quality of research are some topics that are presented and discussed (Chapter 3).

Next, a short background to the BSC in the case organization is presented followed by a case description (Chapter 4). The case is described by taking three organizational levels as a starting point: the center, department and unit level. Within each level, the BSC is described with respect to how it is designed, implemented and used in the organization.

The results from the case study are presented by discussing how the BSC on each organizational level are linked to each other (Chapter 5). Similarities and differences are discussed with respect to the design, implementation and use of the BSC in the organization.

A discussion of factors that enable and constrain the use of the BSC is then presented (Chapter 6). Finally, the findings are synthesized and the research process is critically discussed (Chapter 7). Questions for further research are also proposed in the final chapter.
2 THEORETICAL FRAMEWORK

The following chapter presents the theoretical frame of reference used in the present research. The research conducted focuses on the BSC in a health care organization. Since the organization studied has a prior experience from TQM and implemented the BSC as a quality management tool, the field of Quality Management is reviewed and discussed. The chapter then discusses the BSC with respect to its advocates and recent empirical findings. In order to understand the implementation of the BSC and the changes involved a review of literature concerning Organizational Change is presented.

2.1 QUALITY MANAGEMENT

As the interest in Quality Management has evolved over the last decade, the frameworks to enhance the understanding of the field have greatly increased in number. The different frameworks analyze different aspects of the quality movement, by dividing it into different schools of thought (see e.g. Giroux and Landry 1998; Kroslid et al. 1999), change principles (see e.g. Hackman and Wageman 1995), practices and techniques (see e.g. Dean and Bowen 1994). The differences in emphasis can be traced back to the founders’ writings about Quality Management. Deming, for instance, emphasizes the importance of leadership, the systematic nature of organizations and the reduction of variation in organizational processes (Deming 1986; Dean and Bowen 1994). In addition, Juran emphasizes the importance of leadership commitment in improvement activities, but advocates the use of statistical tools in managerial work practice (Juran 1951). Giroux and Landry (1998) argue that the confusion about the field originates not only from different approaches of the advocates, but also in the lack of interest from researchers. In an attempt to elucidate the ambiguous features of the Quality Management era, the following sections present three frameworks that analyze the field of Quality Management from different aspects. Firstly, the framework of Giroux and Landry (1998) including two schools of thoughts in the evolution of quality management is presented. Next, Hackman and Wageman’s (1995) analysis of TQM is dealt with. Finally, the comparative framework between TQM and management theory and practice by Grant et al (1994) is discussed.

2.1.1 Two schools of thought

Giroux and Landry (1998) propose a classification of different schools of thought and critiques in Quality Management. They divide the thoughts of quality management into two schools, namely a rational school and a normative school. The common goal of the schools is customer satisfaction. However, the difference lies in their proposals to achieve this goal.
The guiding principles in the *rational school* are based on the importance of systems and process thinking, and belong to the traditional and oldest school of thought in Quality Management. Advocates such as Shewhart, Deming, Juran, Feigenbaum and Ishikawa are all included in this rational school of thought (Giroux and Landry 1998). Statistical tools are viewed as a fundamental ingredient in Quality Management in the context of large-scale production, and should be used properly by management without looking for a scapegoat. In addition, Deming’s 14 points, which emphasizes the need of changing management practice into increased responsibility for quality and process stability, belongs to the rational school (see Deming 1986). Juran (1951) also emphasizes the need of viewing management as responsible for the whole system. The rational school assumes that people in the organization want to do a good job, which is reflected in the way quality is improved. Improvements in quality are achieved by a systematic, critical examination of existing systems and by developing tools for documenting and analyzing data about the quality (Giroux and Landry 1998).

The *normative school* focuses the individual responsibility of employees in quality improvement activities. Instead of changing systems and processes, the normative school stresses the need to correct behavioral flaws in order to increase quality. Crosby, Peters and Waterman are names to be included in this normative school (Giroux and Landry 1998). The statement “to do it right the first time” coined by Crosby characterizes the normative school. Measures of quality are identified as the price of non-conformance, which constitutes the result of the lack of prevention. In the 1980s the interest in attaining quality excellence increased and the belief in achieving “zero-defect” products and processes emerged. In contrast to the rational school, the normative school advocates the development and dissemination of flawless arguments to make individuals take responsibility for attaining quality. The focus is thus on motivating individuals to act in accordance with the goal in the day-to-day work practices.

Kroslid et al. (1999) make a similar classification of the quality movement into two schools of thought. However, instead of focusing on collective or individual aspects of Quality Management, they propose a classification based on the appreciation of variation. The authors identify a *deterministic school*, which has evolved around a deterministic view of reality believing that there is only one best way to achieve quality. This school is based on the belief in quality assurance activities and quality inspections in order to reach “zero-defect” results. The *continuous improvement school* of thought is based on the awareness of improvement potential in every part of the work, which reflects the view of reality as full of variations. Deming, Juran and Ishikawa are mentioned as contributors to this school of thought.
2.1.2 Change principles of TQM

Hackman and Wageman (1995) take a critical approach to Total Quality Management, when discussing whether there really is such a thing as TQM. Based on investigations of studies into TQM activities and outcomes, they evaluate the current state of TQM in practice and theory. In their evaluations they make use of the writings of the movement’s founders, namely Deming, Juran and Ishikawa, who may be placed in the rational school of thought (Giroux and Landry 1998).

According to Hackman and Wageman (1995) the TQM philosophy is based on four interlocking assumptions related to quality, people, organizations, and the role of senior management. In TQM it is assumed that organizations committed to the production of high-quality goods will do better in terms of traditional measures such as profitability than will organizations that lower their costs by compromising on quality. It is thus essential for an organization to focus on quality in order to gain competitive advantages. Moreover, TQM has a positive view on people, which means that employees care about the quality of the work they do and will take initiatives to make improvements. Perceiving organizations as systems of interdependent parts is also a basic assumption in TQM in addition to the responsibility and commitment of senior management.

Based on these assumptions, Hackman and Wageman (1995) present four guiding principles that should be followed in organizational interventions intended to improve quality. First, the organization should focus on work processes. It is essential to focus on the process where products or services are developed and produced instead of focusing on the final product.

The second principle, analysis of variability, deals with uncontrolled variation in processes or outcomes. The root causes of the variation must be analyzed and controlled in order to take actions to improve. Deming states the following: “The central problem in management [...] is to understand better the meaning of variation, and to extract the information contained in variation” (Deming 1986, p. 20; Hackman and Wageman 1995).

The third principle presented by Hackman and Wageman (1995) is management by facts. TQM emphasizes the need of collecting and documenting data in all problem-solving situations. Analytical tools based on statistical methods are used in determining high-priority areas of improvements, analyzing causes and selecting and testing solutions.

Finally, the fourth principle, learning and continuous improvement, deals with the long-term approach to quality. Quality should be treated as a never-ending
phenomenon providing opportunities to develop and learn new and better procedures for working.

Hackman and Wageman (1995) question the existence of a pure TQM philosophy that can be distinguished from other movements. They investigate the *convergent validity* and the *discriminant validity* of TQM in their investigation. Convergent validity refers to the degree to which the versions of TQM share a common set of assumptions and prescriptions. Discriminant validity refers to the degree TQM can be distinguished from other strategies for organizational improvement. The authors conclude that the TQM versions can be unified and thus pass the convergent validity test. However, discriminant validity is more doubtful, due to the ambiguity of TQM in contemporary organizational practices. Many practitioners talk about TQM as synonymous with involvement and empowerment interventions, which may be questioned from a theoretical perspective (Hackman and Wageman 1995).

Another important issue in TQM that is emphasized in recent publications is everyone’s participation in quality change initiatives (Dahlgaard et al. 1998; Eklund 2000; Bergman and Klefsjö 2001). According to Eklund (2000) the TQM philosophy contains several normative assumptions, concepts, techniques and tools. One such assumption is to let everyone participate in improvement and development activities. Eklund (2000) claims that participation in problem solving situations creates a situation, which supports learning on a higher level. The learning is supported through reflection, analytical thinking and comparison with earlier experience (Eklund 2000).

### 2.1.3 TQM and Management Theory

Many authors seem to describe the TQM philosophy by focusing on the unifying and contrasting factors within the philosophy. However, there are also researchers trying to describe the TQM concept by comparisons between other managerial philosophies. Grant et al. (1994) chose to describe TQM by using four distinctive features that stand out in relation to other management methods. Based on this description the authors argue that TQM and the economic model based on the principle of maximizing shareholders value are inherently incompatible. Firstly, the theoretical basis of TQM is statistics, while modern management theory is mainly based on social sciences. Secondly, whereas the main part of new management ideas originate from universities and academia, pioneers of TQM primarily originates from practice. Thirdly, TQM represents a global technique, which has evolved in different countries. Most concepts in financial management, marketing, strategic management, and organizational design have been developed in the United States and thereafter diffused internationally. Fourthly, many management theories are disseminated as a top-down hierarchical
process in large companies, while TQM has evolved from smaller companies with an emphasis on employees’ involvement in quality improvement activities.

Grant et al. (1994) further discuss the implications of TQM for management practice. Since TQM extends quality improvement methods to all functions and management levels in the company they mean that the role of the management increases. They argue that management becomes focused on coaching employees and the organizational structure becomes more flattened and vertically specialized.

In addition, the authors claim that the most significant effect of TQM on organizational effectiveness is the coordination and integration of productive activity. They perceive Juran as one of the main contributors to this area, which involves three organizational changes. Firstly, achieving customer satisfaction is viewed as the main objective in a company, and gives the company an external goal that all departments and units can support. Secondly, the fact that the entire company focuses on the customer leads to increased requirements on the entire chain from the supplier to the customer. The goal of each step in the chain is to fulfill the demands of the subsequent step. Thirdly, perceiving TQM as a philosophy means that the management of the entire company is integrated in enhancing quality.

Grant et al. (1994) argue that Juran’s approach to Quality Management links quality improvement and control with quality planning, which extends the philosophy from merely including operational activities to integrating activities in strategic planning (Grant et al. 1994). Thus, Quality Management is company wide and is the responsibility of top management. In his book “Managerial Breakthrough” from 1964, Juran elucidates two management modes, namely control and breakthrough respectively. While control originates from traditional management models, breakthrough involves “change, a dynamic, decisive movement to new higher levels of performance” (Juran 1964, p. 2) and is essential for the company’s long-term survival.

Juran’s approach to improving management performance emphasizes a central difference between conventional management theory and TQM, which Grant et al. (1994) denote as the difference in the principles of work design (see Table 2.1). Other differences can be found in the role of information. Whereas the conventional economic model views the manager’s access to information as critical to control, TQM emphasizes the need for providing employees with sufficient information and feedback to enable them to improve their behavior. Differences are also identified in organizational and individual goals, time orientation, coordination and control, and firm boundaries. These distinctions between TQM and the economic model of the firm are depicted in Table 2.1 (Grant et al. 1994, p. 33).
Table 2.1: Differences between TQM and the Economic Model of the Firm
(Source: Grant et al. 1994, p. 33)

<table>
<thead>
<tr>
<th></th>
<th><strong>TQM</strong></th>
<th><strong>Economic model of firm</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational goals</td>
<td>Serving customer needs by supplying goods and services of the highest possible quality.</td>
<td>Maximizing profit</td>
</tr>
<tr>
<td>Individual goals</td>
<td>Individuals motivated by economic, social, and psychological goals relating to personal fulfillment and social acceptance.</td>
<td>Individuals motivated only by economic goals: maximization of income and minimization of effort</td>
</tr>
<tr>
<td>Time orientation</td>
<td>Dynamic: innovation and continual improvement.</td>
<td>Static optimization: maximizing the present value of net cash flow by maximizing revenue and minimizing cost</td>
</tr>
<tr>
<td>Coordination and Control</td>
<td>Employees are trustworthy and are experts in their jobs – hence emphasis on self-management. Employees are capable of coordinating on a voluntary basis.</td>
<td>Managers have the expertise to coordinate and direct subordinates. Agency problems necessitate monitoring of subordinates and applying incentives to align objectives.</td>
</tr>
<tr>
<td>Role of Information</td>
<td>Open and timely information flows are critical to self-management, horizontal coordination, and quest for CI.</td>
<td>Information system matches hierarchical structure: key functions are to support managers’ decision making and monitor subordinates.</td>
</tr>
<tr>
<td>Firm Boundaries</td>
<td>Issues of supplier-customer relations, information flow, and dynamic coordination common to transaction within and between firms.</td>
<td>Clear distinction between markets and firms as governance mechanisms. Firm boundaries determined by transaction costs.</td>
</tr>
</tbody>
</table>

2.2 The Balanced Scorecard

In 1992 Robert S. Kaplan and David P. Norton introduced the Balanced Scorecard (BSC) in order to provide organizations with the opportunity to expand their financial performance measurements with non-financial performance measurements (Kaplan and Norton 1992). In addition, the BSC is intended to provide executives with a comprehensive framework that translates the company’s vision and strategy into a coherent set of performance measurements (Kaplan and Norton 1993; Kaplan and Norton 1996b). Thus, the objectives and measures on a BSC should be derived from the organization’s vision and strategy to become a new tool for managing strategy (Kaplan and Norton 2001).

Despite Kaplan and Norton’s definition of the BSC, there seems to be some ambiguity among researchers on what the BSC really is. In order to further elucidate the BSC a
literature search was conducted in databases related to research in management, economics and accounting (Emerald, IDEAL, ScienceDirect). The selection of databases is based on an inquiry among researchers focusing on management systems such as the BSC.

The results from the search showed that the main part of the research about the BSC originates from the accounting research area. The findings also confirm the ambiguity on how to define the BSC. For example, Nørreklit (2000) describes the BSC both as a strategic measurement system and a strategic control system, while Lawton (2002) suggests the BSC to be a management decision tool.

2.2.1 Contents of a BSC

According to Kaplan and Norton (1993), the BSC is designed to support and fulfill the company’s overall vision and strategies. Their version of the BSC presented in 1992 contains four different perspectives: the financial, the customer, the internal business process, and the learning and growth perspective. These perspectives represent how the company is viewed by its most important stakeholders – shareholders, management, customers and employees. In recent years several companies have started to use the term focuses instead of perspectives in order to emphasize the company’s view on its stakeholders (Olve et al. 1997). Within each perspective, critical success factors are developed. Performance measurements are chosen in order to support the critical success factors. The factors constitute the bridge between the vision, strategy, perspectives and the performance measurements, and are critical to the company’s future success. Finally, the BSC includes action plans, which describe how the company should act to achieve its vision.

Anthony and Govindarajan (2001) describe the BSC as a performance measurement system, which “fosters a balance among different strategic measures in an effort to achieve goal congruence, thus encouraging employees to act in the organization’s best interest”. A performance measurement system is a system that supports strategy implementation (Anthony and Govindarajan 2001). In building such a system, management selects measures that best represent the organization’s strategy. Thus, the focus of such a system is the performance measurements, which is reflected in the early descriptions of the BSC. Kaplan and Norton (1992) primarily discuss the elements of the BSC including perspectives, critical success factors and measures.

Although Anthony and Govindarajan (2001) deal with managerial problems that may occur when implementing the BSC, the focus is still on the measurements and the design of the BSC. They describe the performance measurement system as a dashboard with a series of measures, which provide the driver with information about
operations of many different processes. The driver, or in this case the manager, receives information from the measures describing both what has happened and what is happening. In addition to their description, Kaplan and Norton (1992) illustrate the scorecard as an airplane cockpit providing the pilot with detailed information about several aspects of the flight.

**Building strategy maps**

After the analysis of hundreds of strategy scorecards built in organizations, Kaplan and Norton (2001) propose a new BSC framework, which they call a strategy map. The strategy map for a BSC makes explicit the companies’ strategies by presenting every measure in the BSC in a chain of cause-and-effect logic that links the desired outcomes from the strategy with the performance drivers that will attain the strategic outcomes. “The strategy map describes the process for transforming intangible assets into tangible customer and financial outcomes” (Kaplan and Norton 2001, p. 69).

The European Quality Award5 is based on a model that makes a similar distinction between measures into drivers and outcomes. The EFQM Excellence Model is used as a framework to assess applications to the European Quality Award and divides the assessment criteria into ‘enablers’ and ‘results’. The criteria of leadership, people, policy and strategy, partnership and resources, and processes are enablers. The result criteria are identified as people results, customer results, society results and key performance results.

Kaplan and Norton (2001) claim that the strategy maps support the organizations to see their strategies in a cohesive, integrated, and systematic way, which provides the foundation for the management system for implementing strategy effectively and rapidly (Kaplan and Norton 2001, p. 69). The authors describe the strategy map as a way of designing the BSC and communicating the strategy throughout the company.

According to Olve et al. (2003), the BSC is used as a tool for illustrating strategy in the organization. They claim that the strategy map fulfils the following purposes (Olve et al. 2003, p. 126):

- Enabling discussion about cause-effect relationships when facing strategic decisions, and about possible strategic actions.
- They assist in finding and selecting metrics to monitor activities.
- The completed map can be used to communicate strategies and their inherent logic.

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5 The European Quality Award is Europe’s award for organizational excellence arranged by EFQM.
The strategy map is based on two main questions: How does this organization intend to succeed? and How can we recognize whether this organization is succeeding? (Olve et al. 2003). Kaplan and Norton (2001) suggest strategic themes that the strategy map should be built upon. The themes reflect the managers’ view of what must be done internally to achieve strategic outcomes. The strategy can then be divided into several categories, namely (1) build the franchise, (2) increase customer value, (3) achieve operational excellence and (4) be a good corporate citizen. Kaplan and Norton present architecture of a strategy map (see Figure 2.1). The idea is that each strategic theme contains its own cause-and–effect relationships between hypothetical strategies. Critical success factors, metrics, targets and action plans are then developed within each perspective based on the strategies identified through the strategy map (Olve et al. 2003)

![Figure 2.1: Architecture of a Strategy Map](Source: Kaplan and Norton 2001, p. 79)

### 2.2.2 Building and implementing a BSC

In their article from 1993, Kaplan and Norton further suggest how the BSC should be built and implemented in organizations. Although they argue that each organization is unique and follows its own process in developing a BSC, they present a general development plan in building a balanced measurement system. The plan includes eight steps aiming at creating the BSC and encourages commitment among senior and mid-
level managers (Kaplan and Norton 1993; Kaplan and Norton 1996b). The steps are depicted below:

1. Preparation
2. Interviews: First round
3. Executive workshop: First round
4. Interviews: Second Round
5. Executive workshop: Second round
6. Executive workshop: Third round
7. Implementation
8. Periodic reviews

In the preparation step, the authors argue that the organization needs to define the business unit for which a top-level scorecard is appropriate. The scorecard is, according to Kaplan and Norton, primarily appropriate for units that have their own customers, distribution channels, production facilities and financial performance measures. The interviews aim at identifying strategic objectives and give input to the critical measurements, which should be built into the scorecard. A “balanced scorecard facilitator” identified as an external consultant, or an executive is recommended to organize the interviews and facilitate the implementation process. Before the interviews, the senior managers of the unit receive material of the BSC and descriptions of the over-all vision, mission and strategy. In the next step, executive workshop, the top management team is brought together to build a scorecard. The mission and strategy is then debated and key success factors are defined. Within each perspective, operational measures are defined, which are based on the strategic objectives. The second round of interviews focuses on the output from the tentative scorecard and on receiving input about how to implement it. The following executive workshop step involves all mid-level managers and aims at reflecting upon the proposed scorecard. In addition, targets for each measure are set. The third round of executive workshop includes the top management team again and aims at reaching consensus on the total scorecard. The team should also agree upon the implementation program.

The implementation of the BSC is led by a team, which has planned how to integrate the scorecard with databases and information systems, how to communicate the scorecard throughout the organization and how to promote the development of scorecards for decentralized units. Thereafter, periodic reviews should be performed in each quarter or each month by top management in order to discuss matters with
managers from other decentralized units. Kaplan and Norton (1993) suggest that the measures should be revisited annually as part of the strategic planning, goals setting and resource allocation process.

**A change process**

In their book “The Strategy-Focused Organization” from 2001, Kaplan and Norton develop the *implementation* phase presented in 1993. They argue that a successful BSC program starts with the recognition that it is a change project and not a “metrics” project. They describe the change process through three phases, which they claim can evolve over two to three years. The phases are (1) mobilization, (2) governance, and (3) strategic management system. The first phase, *mobilization*, makes clear to the organization why change is needed. The executive leadership identifies and communicates that there is a need for change in the organization. The second phase, *governance*, starts when the change process has been launched. This phase includes reinforcement and definition of new values through open communications, town hall meetings and strategy teams. Kaplan and Norton (2001) argue that strategy should be everyone’s everyday job, which requires that everyone take part in the strategy discussion. They emphasize the importance of making all employees understand the strategy and conduct their work in a way that contributes to the success of that strategy. However, they claim it is not a top-down direction of implementation with a low level of involvement of employees; it is rather a top-down communication (Kaplan and Norton 2001, p. 12).

The third phase of the change process includes linking traditional processes, such as formal planning, budget, and compensation to the BSC in order to create a strategic management system. *“The scorecard described the strategy while the management system wired every part of the organization to the strategy scorecard”* (Kaplan and Norton 2001, p. 17)

**Design issues in introducing and using BSC**

Olve et al. (2003) present several design issues that scorecard projects need to address. The issues are relevant in both introducing and using scorecards. The authors advocate that the issues should be addressed in a certain order:

1. Strategy maps
2. Dialogues
3. Roles
4. Interfaces
5. Incentives
6. IT support

The authors suggest that the project starts in building strategy maps in order to illustrate the strategy and linkages between objectives and measures (1). The authors further argue that the scorecard should be communicated throughout the organization (2). They claim that the scorecard “has often been welcomed when similar metrics are perceived as part of a living dialogues about what is worth doing and how performance relates to organizational progress” (Olve et al. 2003, p. 35). They argue that this dialogue requires that management is able to engage people in the dialogue and to have enough knowledge about the organization’s possible future. Compared to Kaplan and Norton (2001), the authors emphasize the need of creating a dialogue of the future statement instead of a “top-down” communication in which employees have a minor role in the discussions.

Olve et al. (2003) further advocate the need of assigning responsibility in a BSC project (3). The design of the BSC technology, training and promoting are some areas that need to be assigned to different people in the organization. The authors argue that the company then should deal with how the different scorecards should be related (4). Should the measures be the same throughout the organization, or should each unit determine their own measures? Next, incentives for making the scorecard work and ensuring that measures are competitive need to be considered (5). The authors discard the idea that incentives or rewards are generic success factors in a BSC project and point out that incentives, and mainly financial incentives, need to be implemented with great care. Although the authors do not advocate incentives as a way to stimulate a “BSC behavior” among employees, they argue that incentives should be linked to the BSC since it will demonstrate the management’s belief in the BSC. Finally, the authors present the issue of implementing an IT support for the BSC (6). They claim that most organizations benefit from having a BSC on the intranet since measures become easily accessible to the organization.

2.2.3 Benefits and outcome of implementing a BSC

In 1996 Kaplan and Norton argued that the BSC acts like as a new strategic management system. The system is expected to link an organization’s long-term strategy with its short-term actions (Kaplan and Norton 1996a). The BSC is discussed with respect to four critical management processes, namely (1) clarify and translate vision and strategy, (2) communicate and link strategic objectives and measures, (3) plan, set targets, and align strategic initiatives, and (4) enhance strategic feedback and learning.
Mooraj et al. (1999) agree with Kaplan and Norton that the BSC may serve as a strategic management system in an organization, and advocate further that the BSC in practice is a system, which primarily *encourages* managers at all levels to make strategic decisions based on the company’s common strategies.

In developing the BSC concept further, Kaplan and Norton (1996a), present out the benefits from using the BSC in organizations. They argue that the BSC can be used to:

- Clarify and gain consensus about strategy
- Communicate strategy throughout the organization
- Align departmental and personal goals to the strategy
- Link strategic objectives to long-term targets and annual budgets
- Identify and align strategic initiatives
- Perform periodic and systematic strategic reviews
- Obtain feedback to learn about and improve strategy

Anthony and Govindarajan’s (2001) definition of management control may be related to these statements. They describe management control as “*the process by which managers influence other members of the organization to implement the organization’s strategies*”. They place management control in between strategy formulation and task control, see Figure 2.2. While strategy formulation focuses on long-term planning, task control includes short-term activities with a focus on current accurate data. According to Anthony and Govindarajan (2001), the BSC is a performance measurement system, which aims at implementing strategies. The latter version of the BSC introduced by Kaplan and Norton (1996a) primarily aims at supporting management control. Thus, the definition has broadened to include both the nature of the end product and the activity of management control. However, one may reflect upon the long-term and short-term control of the BSC. Although Kaplan and Norton (1996a) do not describe how to put forth vision and long-term strategies, they argue that the organization should work with vision and strategies. One interpretation from their writing may be that an organization that wants to adopt the BSC must have reached a certain degree of maturity before it can be fully implemented. There must be a clear vision and explicit strategies before the BSC can be adopted.
2.2.4 Balanced Scorecards in practice

Although the empirical findings of practical implications of the BSC are few (Otley 1999; Liukkonen 2000; Johanson et al. 2001), there are researchers that in recent years have tried to elucidate the concept in work practices. Some of them were mentioned in the introduction of this thesis. For instance, Malmi (2001), who investigates scorecards in 27 Finnish organizations, shows that the reasons for implementing scorecards vary from organization to organization. In addition, he argues that the BSC is primarily used in two ways, namely as a new information system that helps managers to focus and as a strategic management system based on the criteria presented by Kaplan and Norton (1996a; 1996b).

Findings from a survey conducted by Kald and Nilsson (2000) in 236 business units of Nordic corporations indicate that performance measurement systems, such as the BSC, are primarily used in decision-making at top-management level. The study further shows that the foremost benefit of performance measurement is its contribution to a better understanding of how the business works. The foremost shortcoming is that the measurements often are overly focused on the past. Kald and Nilsson (2000) stress that the results from the survey should be interpreted as rough indicators of the present status, since concepts such as BSC are interpreted in different ways and have no clear definition.
Barriers to and facilitators of evolution

Kennerley and Neely (2002) present a framework of factors affecting the evolution of performance measurement systems. They argue that little consideration has been given to the way measures develop and evolve after they have been implemented. The criterion of the evolution is that it should be dynamic so that measures remain relevant and continue to reflect the important aspects of the organization. The question they aim to explore is what shapes the evolution of an organization’s measurement system.

Based on a multiple case study approach involving semi-structured interviews with 25 managers in seven organizations, factors that encourage and inhibit the introduction of new measures, modification of existing measures and deletion of obsolete measures were identified. The factors are divided in four categories, namely (1) process, (2) people, (3) systems and (4) culture.

Firstly, the absence of an effective process of reviewing measurements is a commonly encountered barrier to the evolution. Secondly, the study identifies the lack of necessary skills and human resources as a barrier to the evolution. A third barrier was identified as inflexible systems for collecting and reporting data. Fourth, the acceptance of measurements throughout the organization was identified as an important condition to the evolution of performance measurements. This is established through creating a culture, in which performance measurements are viewed as essential in managing the business.

Success factors for BSC implementation in a National Health Service multi-agency setting

A recently published article by Radnor and Lovell (2003) presents potential benefits of BSC implementation in a National Health Service multi-agency setting. The article is based on outcomes of eight focus groups including 46 people from the Bradford health sector that either provided or commissioned health care and personal social services. The groups included people from different professional categories (Radnor and Lovell 2003, p. 101). The main findings from the focus groups show that the benefits of BSC implementation brought out by the focus groups strongly corresponded with the benefits presented by Kaplan and Norton (1996a; 1996b).

In addition, despite the organization’s recognition of the BSC potentials, the implementation of BSC involved several difficulties. These inhibiting factors are related to (1) existing performance measurement systems (e.g. existing system is being improved, existing system is flexible etc.), (2) alternative performance measurement systems (e.g. competition with the ‘Value compass’, ‘European Excellence Model’ etc.), (3) the underlying need for a BSC is questioned (e.g. just a package framework, the organization does not have the ability to eliminate imbalances), (4) ability of BSC...
to deliver performance improvement is doubted (e.g. still focus on financial measures, doubtful if the BSC can deliver evidence-based benefits and keep up with changes in the NHS), (5) other practical factors such as the organizational structure cannot mirror the BSC structure, obtaining voluntary support from all partner organizations is unrealistic etc.

Radnor and Lovell (2003) further identify factors related to pre-conditions and design issues as well as implementation issues required for the successful implementation of the BSC. They argue that it is important to establish pre-conditions such as creating a performance development culture for succeeding with BSC implementations. It is also important to have a BSC design that for instance includes measures and targets that are used in everyday work and that the BSC involves a “bottom up” communication process. In addition, the BSC is also successful if it is applied to all levels within the organization and replaces existing performance measurement systems. Top management support is also crucial just like IT support. Implementation issues related to resource allocation and training are identified as important factors. Finally, Radnor and Lovell argue that it is essential to have infrastructure that support changes, and to identify the patient benefits from using the BSC. Relationships with remaining systems also need to be identified. The authors moreover emphasize the need for considering past experiences related to the BSC, performance measurements, external consultants etc. when implementing scorecards in a health care context.

2.2.5 Dimensions of analysis in Balanced Scorecard research

Literature about the BSC that have evolved over the last decade may be divided into three dimensions of analysis, namely the design, the implementation, and the use dimension (see Table 2.1).

The design dimension of the BSC deals with the content of the BSC. Kaplan and Norton (1992) suggest that the BSC framework should include four perspectives, which encompasses financial and non-financial measures and targets. The measures should be aligned to the company’s vision and strategy (Kaplan and Norton 1993). In practice, the content of the BSC is being adopted to the specific organization. For instance, in Swedish organizations it is popular to include a fifth perspective – employee perspective – as a complement to the model presented by Kaplan and Norton (1992) (see e.g. Olve et al. 1997).
The *implementation dimension* of the BSC deals with the building and introduction of the BSC. Kaplan and Norton (1993) propose an eight-step model for implementing the BSC although they argue that each organization is unique and should follow its own path for building a BSC. However, empirical findings show that there are several difficulties in implementing a BSC, which are not highlighted by its advocates (Radnor and Lovell 2003).

The *use dimension* of the BSC deals with the outcome of implementing the concept in terms of organizational effectiveness. Malmi (2001) argues that the BSC is primarily used in two ways, namely as a new information system that helps managers to focus and as a strategic management system based on the criteria presented by Kaplan and Norton (1996a). Kald and Nilsson (2001) show that performance measurement systems are primarily used in decision-making at top-management level. Kennerley and Neely (2002) present a framework of factors affecting the evolution of performance measurement systems. All these studies deal with the period after the implementation when the BSC becomes an integrated part in the organization’s day-to-day work.

The relation between these dimensions can be understood by using a framework for understanding strategic change by Pettigrew et al. (1991). Their model is based on the basic assumption that strategic change should be considered as a continuous process, which is contextually dependent. The authors argue that there are three interrelated dimensions that need to be considered in order to understand strategic change. Firstly, the content of the strategy including goals, markets and products constitute the area in which the change takes place. Secondly, the process dimension deals with the change process and is concerned with how the change was implemented. In this dimension, the content is being realized and formed. Thirdly, the context dimension deals with the surroundings in which the change takes place. These three dimensions are related in the sense that the context needs to be considered in order to understand the content and process dimensions and vice versa. According to Carlsson (2000) the model can be used in studying changes other than only strategic changes, since the model highlights the complexity in general change initiatives.

Using the model on the analytical dimensions of BSC above shows that the content corresponds to the *design dimension* since it deals with the elements included in the BSC. The process corresponds to the *implementation dimension*. In the implementation phase the BSC design is formed and integrated in the organization. The context dimension is primarily considered in the *use dimension*. This dimension deals with how the BSC design is being applied in work practice with respect to the existing structures, systems and processes in the organization. The use of the BSC
depends very much on the implementation dimension, since the use reflects the outcome of the implementation of the BSC.

**Table 2.2: Different dimensions of analysis of the BSC based on a literature review**

<table>
<thead>
<tr>
<th>Focus</th>
<th>Design</th>
<th>Implementation</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus</td>
<td>Contents of a BSC</td>
<td>Building and introducing a BSC</td>
<td>Use of the BSC in daily activities</td>
</tr>
<tr>
<td>Examples of authors</td>
<td>“The balanced scorecard includes financial measures that tell the results of actions already taken. And it complements the financial measures with operational measures on customer satisfaction, internal processes, and the organization’s innovation and improvement activities […]” (Kaplan and Norton 1992, p. 71)</td>
<td>“Each organization is unique and so follows its own path for building a balanced scorecard […] Companies […] can follow a systematic development plan to create the balanced scorecard and encourage commitment to the scorecard among senior and mid-level managers.” (Kaplan and Norton 1993, p. 138)</td>
<td>“For some companies, the BSC seems to be no more than a new information system […] For other companies, BSC s seem to be more […] This type of use comes close to the latter presentation of the BSC as a strategic management system” (Malmi 2001, p. 216)</td>
</tr>
<tr>
<td></td>
<td>“The balanced scorecard is not a template that can be applied to businesses in general or even industry-wide. Different market situations, product strategies, and competitive environments require different scorecards” (Kaplan and Norton 1993, p. 135)</td>
<td>“…if the BSC is to be successfully implemented, it will need to be implemented at a number of levels within an organization because if it simply stays at the highest “strategic level” it will probably never be implemented in practice” (Radnor and Lovell, 2003 p. 105)</td>
<td>“The principal use of performance measurement is for decision support at the top-management level.” (Kald and Nilsson 2000, p. 120). “…for measurement systems to evolve effectively there are key capabilities that an organization must have in place (i.e. effective processes; appropriate skills and human resources; appropriate culture; and flexible systems)” (Kennerley and Neely 2002, p. 1243)</td>
</tr>
</tbody>
</table>
2.3 ORGANIZATIONAL CHANGE

The interest in understanding organizational changes has increased in both research and practice over the last decade. The demands of an ever-changing business environment raise questions related to how to effectively manage changes, efficiently and rapidly. Many companies have experienced failures in implementing change and improvement programs, which further increases the demand for knowledge in the management of organizational changes. As the companies’ need for knowledge regarding these issues increases, researchers have started focusing on understanding changes in organizations. However, the research does not give a unified and integrated framework for dealing with changes.

2.3.1 Two approaches to organizational change

Beer and Nohria (2000) present two approaches to organizational change, which aim to outline the differences of the views on organizational change. The approaches, which are called Theory E and Theory O, differ dramatically in their basic assumptions about the purpose and means for change.

Theory E is based on the assumption that the purpose of change is the achievement of economic value. The changes are focused mainly on the formal structure and system of the organization, and are driven from the top management level and have a high involvement of consultants. Whereas the change is planned and programmatic in the Theory E, the emergence of changes is focused on in Theory O. The purpose is the development of organizations’ human capability and to learn from actions taken about the effectiveness of the changes. Theory O further focuses on high level of involvement of employees and creating a high-commitment culture. Table 2.3 shows the two approaches and their focuses.

Table 2.3: Two approaches to organizational change (Source: Beer and Nohria 2000)

<table>
<thead>
<tr>
<th>Purpose and means</th>
<th>Theory E</th>
<th>Theory O</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Maximize economic value</td>
<td>Develop organizational capabilities</td>
</tr>
<tr>
<td>Leadership</td>
<td>Top-down</td>
<td>Participative</td>
</tr>
<tr>
<td>Focus</td>
<td>Structure and systems</td>
<td>Culture</td>
</tr>
<tr>
<td>Planning</td>
<td>Programmatic</td>
<td>Emergent</td>
</tr>
<tr>
<td>Motivation</td>
<td>Incentives lead</td>
<td>Incentives lag</td>
</tr>
<tr>
<td>Consultants</td>
<td>Large/knowledge-driven</td>
<td>Small/process-driven</td>
</tr>
</tbody>
</table>
According to Beer and Nohria (2000) there is a tension between these two approaches to organizational change. They argue that managers need a clarification in the trade-off between the two approaches in order to succeed in today’s business environment. Combining the two approaches is “to get rapid improvements in economic values while also building sustainable advantage inherent in building organizational capability” (ibid, p. 20).

**Linking the approaches to BSC and TQM literature**

The Balanced Scorecard literature with Kaplan and Norton as the prominent authors primarily originates from the Theory E approach to organizational change. The main purpose of an organization is to maximize economic value, although the BSC aims at balancing the financial targets with “softer” measurements. The building and implementation of a BSC is top management’s business, starting from the top in the organization, processing down to mid-management and ending up on the shop floor. The focus in the BSC change program presented by Kaplan and Norton (1996) is the formal structure and systems, representing vision, mission, strategies, objectives and goals. Changing peoples’ attitudes and behavior is of minor consideration in the early writing about the BSC (Kaplan and Norton 1993), although recent literature emphasizes the practical implications of BSC (Kaplan and Norton 2001; Olve et al. 2003). Although the BSC reflects the company from different perspectives, the view of the organization is dominated by an economic value aspiration, which leads the motivation to change. According to Kaplan and Norton (1993) a “BSC facilitator” identified as a top management member or an external consultant should enable the programmatic change of building and implementing a BSC.

Literature from the TQM field originates from the Theory O approach to organizational change. The changes in organizations aim at improving organizational effectiveness in the first place by learning from past experiences through the application of continuous improvement in order to satisfy the demands of the customers (Juran and Gryna 1980; Deming 1993; Dahlgaard et al. 1998; Bergman and Klefsjö 2001). Everyone’s involvement in the change program is an essential principle in the TQM philosophy, which is based on the confidence in bottom-up changes as well as top-down controlled approaches. Dahlgaard et al. (1998) denote TQM as a culture emphasizing customer satisfaction, continuous improvements and participation. A TQM change program is thus focused on changing the existing culture to a TQM culture. Continuous improvement through the PDSA cycle is advocated in implementing change initiatives, which represent an emergent approach to planning. Although planning exists, there are no general programmatic sequences of steps to follow. Financial incentives are of minor consideration in TQM change programs. Human motivation and capabilities are of foremost interest, in which external...
consultants have a minor role. Instead of acting experts, the consultants should motivate people to change the organization from inside and to change the organization in small steps. The emphasis is on organizational effectiveness rather than on economic efficiency.

Grant et al. (1994) make a similar comparison when elucidating the differences between TQM and the conventional economic model of the firm (see Table 2.1). This could also be used as a framework in understanding the different approaches of TQM and BSC.

2.3.2 A model of the organizational work setting

In their article Organizational Development: Theory, Practice, and Research Porras and Robertson (1992) present a model constituting the organizational work setting as a way of understanding changes in organizations. The authors view organizational change as improvements in organizational functioning, which may represent the Theory O approach mentioned above. Their work is based on the analysis of 14 years of empirical evidence from the organizational development field (OD). The model includes four categories of specific factors constituting the work setting, which originate from the internal organization and which shape the job behavior of people. The categories are: (1) Organizing arrangements, (2) Social factors, (3) Physical setting, and (4) Technology. The external environment influences the work setting through the determination of the vision, which represents the guidance of the organization.

![Figure 2.3: Factors constituting the organizational work setting](Source: Porras and Robertson 1992, p. 729)
The factors included in each category are the following.

Organizing arrangements: Goals, Strategies, Structures, Administrative policies and procedures, Administrative systems, Reward systems, Ownership

Social Factors: Culture, Management style, Interaction processes, Informal patterns and networks, Individual attributes

The Physical setting: Space configuration, Physical ambiance, Interior design, Architectural design.

Technology: Tools, equipment, and machinery, Information technology, Job design, Workflow design, Technical expertise, Technical procedures, Technical systems

The basic assumption underlying the model is that organizational change requires change in the behavior of individual organizational members. The work setting constitutes people’s work environment, which plays a central role in determining people’s behavior. Changes in the work environment, that is the work setting, will thus initiate changes in the on-the-job behavior of people. These changes in the behavior of individuals will ultimately effect changes in organizational outcome (Porras and Robertson 1992).

To improve organizational performance the categories need to be designed so as to change work setting conditions that support effective on-the-job behavior of organizational members. In doing so, the factors need to be dealt with simultaneously since they are inevitably interconnected. Changes in one factor influence the functioning of others, which means that there is a need for congruence among the factors in order to achieve effectiveness and efficiency (ibid).

2.3.3 Task alignment approach to change

Porras and Robertson elucidated organizational change by dividing the work environment into categories of specific factors. Beer et al. (1990) take a similar approach to change efforts by dividing the change initiatives into two groups – programmatic changes and task alignment. The authors claim that a task alignment approach to change is the best way of understanding organizational changes.

According to the programmatic change model, problems in behavior depend on people’s knowledge, attitudes and beliefs. This model, they argue, is the most common approach to changes in organizations and the belief is that changes in knowledge and attitudes induce changes in the behavior of organizational individuals.
“Changes in attitudes, the theory goes, lead to changes in individual behavior. And change in individual behavior, repeated by many people, will result in organizational change.” (Beer et al. 1990, p. 159)

According to the task alignment model, organizational changes start in people’s behavior. The knowledge, attitudes, and beliefs are influenced by recurring patterns of behavioral interactions. They argue that the target of changes is at the level of roles, responsibility, and relationships in the organizations instead of beliefs and attitudes.

“Individual behavior is powerfully shaped by the organizational roles that people play. The most effective way to change behavior, therefore, is to put people into a new organizational context, which imposes new roles, responsibilities, and relationships on them” (Beer et al. 1990, p. 159).

Beer et al. (1990) argue that the task alignment model is the best way to handle changes effectively. The authors argue that many change programs fail because of an incomplete view on the organization. Usually change programs are focused on changing one part of the organization, for instance people’s competence, and neglect other parts such as how to internalize the new competence into the organizational context. In order to succeed with change programs, Beer et al. (1990) argue that management needs to consider how to create commitment among people, coordinate the changes, and how to build up competence around the changes made. All these factors need to be considered in order to succeed in change processes.

Both Beer et al.’s and Porras and Robertson’s models present how changes in behavior can be understood. Porras and Robertson present factors influencing on the job behavior. Beer et al. thinks that behavior is affected by considering commitment, coordination and competence of the changes. This view seems very helpful in research into change processes, since it considers a set of contextual factors that influence changes. The models advocate change initiatives as integrated processes in the organizational context, which is formed by social factors, organizing arrangements and so on. However, the models presented may be viewed as static since they focus on the current organizational context and do not consider the influence of historical events and experiences in understanding organizational changes.

2.3.4 Change through Managerial Breakthrough

In his book “Managerial Breakthrough” from 1964 Juran discusses the importance of breakthrough changes in organisations. Breakthrough means “change, a dynamic, decisive movement to new higher levels of performance” (Juran 1964, p. 2). He claims that managers are busy doing both breakthrough and control activities, but that breakthrough activities initiate changes that are necessary in maintaining
organisational competitiveness. Juran refers to ‘control’ as an organized sequence of activities, by which the company prevents changes (Juran 1964, p. 4). He argues that the company is devoted to both preventing change (meeting budgets, maintain schedules, pay its bills, distribute the mails etc) as well as creating change (become involved with new markets, new products, new plants, new ways of organizing, to reduce waste etc.).

Juran suggests that there is an interrelation of breakthrough and control activities because they are parts of one continuing cycle of events. The manager’s role is to create the means by which people can see the need for reaching a new level of performance, that is to make people aware of the need of breakthrough changes, and to take initiatives to get there. Juran further claims that managers’ attitudes need to change in order to make breakthrough changes implemented:

“But managers generally lack awareness that the attitudes, the organisation, and the methodology used to achieve Breakthrough differ remarkably from those used to achieve Control. The differences are so great that the decision of whether, at any one time, to embark on Breakthrough, or to continue on Control, is of cardinal importance. This decision hinges on managerial attitude. Once this decision is made, the respective sequences of steps begin to unfold.” (Juran 1964, p. 8)

Juran illustrates the evolution of breakthrough and control activities in an organization in a diagram presented in Figure 2.4. In order to attain good performance, the organization needs to implement breakthroughs. This is done initially by creating breakthrough in attitudes and in knowledge-diagnosis and thereafter changes in cultural patterns. Then results can occur.
2.3.5 Factors influencing change initiatives

Whereas the Breakthrough model presented by Juran (1964) emphasizes the role of initially changing people’s attitudes, the models presented by Beer et al. (1990) and Porras and Robertson (1992) emphasize the importance of changing the behavior of organizational individuals in order to succeed with change programs. Hence, the authors may be viewed as representing two different fundamental viewpoints in achieving effective change: Juran on one side, who points to the role of changing individual attitude and Beer et al. and Porras and Robertson on the other side, arguing for changing individual behavior.

The following sections discuss important factors influencing the outcome of the changes. Porras and Robertson (1992), Beer et al. (1990) and Juran (1964) are examined.

*Conditions for Effective Change*

Results from the study of Porras and Robertson (1992) show that there are mainly four factors influencing the effectiveness of change initiatives. First, the *degree of participation* and involvement of individuals in the organization is viewed as an
essential issue. External change agents and consultants are given a minor role, since members of the organization are the source of the changes. Another important factor in change initiatives is the recognition of a need for change (Porras and Robertson 1992). Rogers (1974) presents a framework of propositions in research into social change and proposes that changes in a social system occur through a crisis, which is identified as a situation that is perceived as so threatening that its future is at stake.

The third factor presented by Porras and Robertson (1992) is related to the change capability of the organization. In effective changes people have a willingness to change and to risk moving from the present state to the future state. Finally, the role and characteristics of change agents are discussed by many researchers and are a part of building the climate of change. Porras and Robertson (1992) identify several characteristics common in literature of effective change agents. One aspect of the characteristics is the change agent’s interpersonal competence. These are relational skills, ability to support and involve others, facilitate group processes, ability to influence others etc. Furthermore, they state that the change agent has theory-based problem-solving capabilities, such as knowledge of theory and methods of change, ability to link theory to practice etc. Next, the role of the change agent is to be an educator, who can build learning experiences and to motivate people to explore new areas. The final characteristic is presented as having self-awareness.

Six steps to effective change

Beer et al. (1990) propose a model for managing change programs concerning task alignment, which they identify as reorganizing employee roles, responsibilities, and relationships in order to solve specific business problems.

The first step involves defining a clear business problem. People involved by the change should participate in the problem discussion in order to create a shared diagnosis of the improvement potentials. The general manager can then mobilize initial commitment to get the change process started.

The second step includes a development of a shared vision of how to organize and manage the future statement. Not all employees can participate in the initial formulation of the vision, and that is why the vision in the next step needs to be communicated throughout the organization. A consensus is established on the vision and the competences are defined for fulfilling it. According to the authors, management plays a central role in holding the line of the change when resistance occurs. Not all people can agree to changes until they have worked with the new organization.

The fourth step includes the revitalization of all departments, but without the top management pushing it. The authors argue that each department needs to adapt to the
changes and feel that the changes contribute to their situation. Instead of forcing the issue in all parts of the organization at a time, the changes can be initiated in small steps in order to avoid resistance. The fifth step in the model is to institutionalize revitalization through formal systems and structures that is ensuring that the changes continue even after the management has found new responsibilities. The issue in this phase is the time needed and the authors argue that people need to learn their dependence on the new intervention before management can start institutionalizing the changes. The final and sixth step in the model is to monitor and adjust strategies in response to problems in the revitalization process. The purpose of the change is to create a learning organization that can adapt to changes in the environment. This implies that the steps are being processed again with the involvement of all employees.

**Accomplishment of Breakthrough in performance**

Juran (1964) presents a sequence of steps that need to be accomplished to succeed with breakthrough implementations. These steps are presented in Figure 2.4. As discussed previously, the starting point in the change process is people’s attitudes:

“The starting point is the attitude that a breakthrough is both desirable and feasible. In human organizations there is no change unless there is first an advocate of change. If someone does want a change, there is still a long, hard road before change is achieved. But the first step on that road is someone’s belief that a change – a breakthrough – is desirable and feasible.” (Juran 1964, p. 15)

Thus, the management’s role is to clarify the need of a breakthrough in the organization.

The second step in the accomplishment of breakthrough in performance is to evaluate whether a breakthrough is likely to occur if the management mobilize for it. This stage includes an analysis according to the Pareto principle, which identifies the major problem and separates the “vital few” from the “trivial many”.

In the third step the management should organize for knowledge creation based on the pareto analysis. The organization for breakthrough in knowledge involves a Steering Arm and a Diagnostic Arm. The Steering Arm aims to direct the acquisition and use of the new knowledge and focuses on the purpose of the unity, theories that should be affirmed or denied, authority to conduct the factual and analytical studies, and action based on the resulting new knowledge. The Diagnostic Arm consists of a group that collects facts and does the analysis needed to pave the way for action. The Diagnostic Arm supplies the Steering Arm with missing time, skills, and objectivity.

The fourth step includes a diagnosis of the findings from the previous step. These are discussed between the Steering Arm and Diagnostic Arm and further investigations are
conducted. This goes on until the new knowledge needed for actions is acquired and thereby breakthrough in knowledge is achieved.

The achievement of breakthrough in cultural pattern is dealt with in the fifth step. Juran argues that the management needs to discover the effect of the proposed changes on the cultural pattern, and find ways to deal with resistance towards the changes. He claims that this is the most difficult and important step to achieve in order to make the changes sustain in the future. Culture is referred to as a label for the fabric of human habits, beliefs, traditions etc. (Juran 1964, p. 143). Positive training programs and a high level of participation are pointed out as important in this stage of the breakthrough.

The sixth step concerns the achievement of breakthrough in performance by making the change everyone’s responsibility and not only the Steering Arm’s business. Juran advocates that the company gets control over the results by preventing the performance from decreasing.

The previous discussion shows that despite the fundamental difference in views of how changes are achieved, there are similarities between the authors’ views on the factors that influence the change. Juran, Beer et al. and Porras and Robertson argue that it is essential to identify a problem or a need for change in order to succeed with the implementation. Porras and Robertson and Juran argue the need for a high level of participation in change programs. The management is given a major role in all three models in terms of a high level of commitment in the change.

Juran’s strong emphasis on changing management and employees attitudes, compared to Porras and Robertson and Beer et al., may be derived from the development of the Human Relation movement during the 1960s (Axelsson and Bergman 1999). The HR movement advocated an improvement of the organizational structures by focusing on the social relations between the employees and management. Instead of focusing merely on productivity in terms of economic profitability, the HR movement paved the way for focusing on the internal customer and work environment in achieving productivity (ibid). Juran’s model for Breakthrough may be viewed as an input to this evolution of a positive view of the human being in companies of that time.
3 THE RESEARCH PROCESS

This chapter presents the methods used in the research study. The intention is to give the reader a chronological presentation of how the research was conducted, the choices that were made and the thinking behind decisions. A discussion of the author’s reflections on knowledge is presented, followed by how the research strategy was selected. Moreover, the specification of the case and how the data was collected is discussed. The chapter describes how the data was analyzed, and how the structure to present the findings evolved. The chapter discusses the quality of the research and is concluded by presenting the author’s reflections on the research process.

3.1 REFLECTIONS ON KNOWLEDGE

My interest in studying the BSC in practice was triggered off while writing my master thesis. The thesis focused on the implementation of a BSC in a municipality, and I became interested in how the BSC was actually integrated in the organization and used by management and employees at a later stage of the implementation process. I had experience from how to implement a BSC, but how was it actually used in practice?

During my first year as a doctoral student I attended courses and studied literature about the BSC in order to formulate a research topic. I found that empirical studies about the practical use of the BSC were few in number and that the findings were mostly based on results from surveys or multiple case studies. Since there was a need for inside knowledge in how the BSC was used in organizations, and the fact that I had interest in conducting qualitative research, the research focused on the understanding of the use of the BSC in practice.

What does understanding then mean in this thesis? The understanding of human behavior is concerned with the empathic understanding of human action rather with the forces that are deemed to act on it (Bryman 2001). The researcher thereby interprets and understands the world by taking the social participants’ perceptions as a starting point since reality consists of interpretations of the people involved. However, there is a dissonance among social sciences of how to encounter social participants’ descriptions of themselves and their actions (Gilje and Grimen 1992; Denzin and Lincoln 1994, 2001). One tradition argues that the participants’ descriptions should not be included since these are often wrong and they involve concepts that are unscientific. The other tradition argues that social action is created through the participant’s view of human behavior, and therefore individual’s descriptions play a major role in understanding reality.
Understanding the use of the BSC means in this thesis to take peoples’ own descriptions and actions related to the BSC as a starting point. The thesis thus aims to describe and present peoples’ descriptions of the BSC through the terms and concepts used by the participants. However, in order to provide people with another picture of the phenomena that is somewhat different from the participants’ experience I also aim to make use of theoretical concepts and statements stemming from prior research and theory. In addition, using a theoretical framework to describe and reconstruct the stories of the participants also aims to develop new questions for inquiry in future research. This is done by identifying differences between work practice and existing theories and literature.

Based on the aim to increase the understanding about the BSC, two research questions were generated. The first question of interest is of an exploratory nature and originates from a literature review of the BSC: How is the BSC designed, implemented and used in organizations? The second question aims to explain the use through identifying factors that enable and constrain the use of the BSC: What factors enable and constrain the use of the BSC in organizations?

### 3.2 SELECTING A RESEARCH STRATEGY

As the purpose of the thesis was identified, the assigner of the research, the Federation of the Swedish County Councils, was contacted in order to determine the purpose and discuss a suitable research strategy. Due to the interpretive character of the research with focus on understanding as well as my personal interest, a qualitative research strategy was selected. According to Denzin and Lincoln (2001, p. 3) “...qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them”.

Since the thesis aimed to explore and explain a contemporary phenomenon in a real-life setting, which the researcher has no ability to control, the case study strategy was selected as a research strategy (Yin 1994). In addition, the research questions of the thesis at this stage involved several organizations, and therefore a multiple case study strategy was of our foremost interest.

### 3.3 IDENTIFYING A CASE

Together with the assigner of the research, a discussion concerning the identification of suitable cases commenced. Since other health care organizations are intended to learn how to use the BSC in their organization from the findings, we decided to focus on organizations that have already implemented BSC and use them in practice. The organizations that were proposed were the Women’s Health Clinic in Motala, the
Department of Pulmonary Medicine in Linköping, the Department of Internal medicine in Eksjö, and the Heart and Lung Center in Lund.

In order to receive an initial insight in how the BSC was used in a health care context, I visited the Women’s Health Clinic in Motala for two days and the Department of Pulmonary Medicine for one day. Recently after these visits I visited the Heart and Lung Center in Lund for half a day. According to Stake (1994), qualitative case study is characterized by “researchers spending expended time, on site, personally in contact with activities and operations of the case, reflecting, revising meanings of what is going on” (Stake 1994, p. 445). This means that the researcher has to be more or less involved in the case, leading to a certain degree of familiarity. In intervention research the degree of familiarity with the field is of importance in determining the role of the researcher (Westlander 1993). Westlander (1993) differs between two cases of intervention. In the first case the initiative of the intervention comes from within the organization, and hence the role of the research is to study the course of events from the “outside”. In the second case the researcher initiates the intervention and the research is conducted as a part in a prospective research program. The researcher thus studies the intervention from the “inside”.

The present research study may be identified as a Case 1 intervention study since the initiative to implement the BSC came from within the organizations. My initial visits in different health care organizations helped me in the planning and preparation of the study and made me familiar to the health care context. I learned about the health care services in general, its mission, goals and structures. I received insight into the terminology that is used in general and learned about people that have the main responsibility for the BSC.

After my initial visits I started to reflect on the implications of comparing the four cases above. In order to compare the cases we decided that the organizations should have similar medical approaches. Since the Women’s Health Clinic in Motala differed most in its medical approach we therefore decided to focus on the other three organizations.

During the same time, I started to reconsider the choice of a multiple case study strategy with respect to my time schedule and research focus. I planned to conduct the case studies over a period of six months.

In order to fully explore and explain the use of the BSC in all three cases I estimated that this time period was insufficient. Instead of reformulating my research focus, I decided to explore only one of the selected cases in this thesis.
3.3.1 Criteria for selecting a case

According to Stake (1994) the case should be selected with respect to what can be learnt. The researcher should choose cases from which he or she believes they can learn the most. Based on this statement and the following criteria I selected the Department of Pulmonary Medicine as a case for the present research study:

1. The design of the BSC in the organization includes financial and non-financial measures that are derived from a vision and strategy and are categorized into perspectives derived from the original four presented by Kaplan and Norton (1992).
2. According to people familiar with the health care context, the BSC is implemented and used in the organization.
3. The investigator has access to information needed to collect case study data.
4. Geographical vicinity

The first criterion concerns the fact that the organization has really implemented a BSC. According to the advocates, the original framework of the BSC proposed by Kaplan and Norton (1992) contains four perspectives encompassing goals and measures. Since the BSC in practice is being changed and adapted to the organization’s conditions, the original framework has been used in judging if the organization has implemented a BSC or not. According to Malmi (2001), for a measurement system to be a BSC, it should contain financial and non-financial measures, which should be derived from strategy and the measurement framework should contain perspectives derived from the original four. Thus, the number of perspectives does not matter, but should be derived from the original framework.

The second criterion concerns the implementation process. How does one know that the BSC is fully implemented in the organization? Kaplan and Norton (1996a) suggests that it takes about 25-26 months for a company to make the BSC a routine part of the management process. However, the time schedule depends very much on the organization’s background, history and current situation. Therefore, in this case people from the County Council of Linköping and the Federation of the County Councils, who are familiar with the health care context, were questioned about organizations that have implemented the BSC. In addition, before selecting a case, managers in the organization were asked if they made use of the BSC in their work.

According to Yin (1994), there is a potential risk in conducting single-case studies that a case may turn out not to be the case it was ought to be from the beginning. Therefore, the case needs to be carefully investigated beforehand to prevent
misrepresentations and to maximize the access to the field. Thus, the third criterion for selecting a case is that the investigator has access to information.

### 3.3.2 The initial unit of analysis

As I selected a single case study strategy I reformulated my research questions to concern a single organization (see 1.2 Purpose and Research questions, p. 6). The unit of analysis was thereby defined as the department as a whole. Figure 3.1 illustrates the different types of case studies categorized by Yin (1994). Type 1 focuses on a single-case, and has a single unit of analysis. Type 2 is an embedded single-case study, in which the analysis of the case includes the outcome of the sub-units. Type 3 involves multiple cases, which are analyzed from a holistic viewpoint respectively. Type 4 focuses on the analysis of multiple cases through the outcome of sub-units of analysis within each case.

The initial unit of analysis in this thesis was thus defined as a Type 1 referring to the Department of Pulmonary Medicine.

### 3.4 Collecting the data

As the aim of this thesis is to describe and explain protagonists’ perceptions on the use of the BSC, interviews were selected as a main source of data (Kvale 1997). In order to explore how the BSC is designed in the organization, I also collected documents for analysis. My intention was to collect data through observations of forums in which the BSC was used in order to validate the findings from the interviews and to receive knowledge of the activities involved in the use. However, as the interviews proceeded I chose to focus on the material from the interviews and not on conducting observations. Instead I chose to follow two nurses in their work for two days in order to increase my understanding of the organization. The following sections describe the rationale behind my decisions.
3.4.1 Interviews

The case study presented in this thesis is based on fourteen semi-structured interviews with thirteen people (the Quality Coordinator of the department was interviewed twice). The interviews were conducted in autumn 2002 and lasted about 1-1.5 hours. In thirteen interviews a tape recorder was used and the investigator also took notes during the interviews. The interview guide used during the interviews is presented in Appendix 1. The themes dealt with in the interviews were (1) interviewee’s professional background, (2) design of the scorecard, (3) implementation of the scorecard and (4) the practical use of the scorecard. These themes were derived from the first research question, which aims to explore the design, implementation and use of the BSC.

The interviewees were free to describe the BSC with respect to the themes during the interview. In order to make the interviewee focus on the subject, key questions were stressed within each theme. The BSC representation was used during the interviews.

The interviewees were selected on the basis of (1) the person’s position in the organization, and (2) the person’s profession (see Table 3.1). This selection was intended to enhance the ability to analyze the data from different frameworks and to receive different views on the use of the BSC. In addition, the interviewees were selected on the basis that they had been working in the organization since the introduction of the BSC in 1998. Employees were selected with respect to whether they belonged to the in-patient or the out-patient unit.

Table 3.1: Selection of interviewees

<table>
<thead>
<tr>
<th>Employees at the Department</th>
<th>Management of the Department</th>
<th>O-center</th>
<th>County Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>7 Employees</td>
<td>1 Head of Department</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Quality Coordinator</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Head of Care Unit</td>
<td>1 Head of O-center</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1 Quality Coordinator</td>
</tr>
<tr>
<td>Profession</td>
<td>3 Nurses</td>
<td>1 Physician</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Assistant nurses</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Paramedicine</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Physician</td>
<td>1 Physician</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 Nurses</td>
<td>1 Master of Science</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Physician</td>
<td>1 Economist</td>
</tr>
</tbody>
</table>
Employees from the department were selected for interviews after a discussion with the Quality Coordinator in the department. People from the O-center and the County Council were interviewed in order to receive perceptions from outside the department. The interviewees were contacted by e-mail. However, as I did not receive any responses from three employees in the department I decided to send out a written letter about myself, and the purpose of the research project. I received one response through the letter, but as I needed two additional interviewees I contacted the Head of Department, who persuaded them to participate in the study.

3.4.2 Documentation
According to Yin (1994), documents play an important role in data collection in case studies, which can provide the researcher with corroborating information for the evidence selected. The documents can also generate new insights and inferences, which can lead to new lines of inquiry (Yin 1994).

Before the interviews began, I started to collect documents of interest for the study. In the planning of interviews, an introduction folder including a list of employees at the department, the department’s vision and mission statement, and work design was used to select interviewees and to receive an understanding of the department’s work practice.

The most important documentation has been the representations of the scorecard in the organization. These have been used as artifacts in interview situations to focus the discussion and clarify any obscurities. Other documents used in the case study are the annual reports of the County Council of Östergötland, the annual reports of the O-center, a measurement document at the Department of Pulmonary Medicine, a budget plan of O-center, and the Swedish Quality Award’s assessment report of the department.

3.4.3 Planning the observations
I started to plan the observations as the interviews began. The interviews showed that the BSC was used during management meetings at the department among other things, and therefore I chose to observe these meetings. After my first observation of a management meeting I started to reconsider the value of the observations. The observations aimed to validate the results from the interviews by confirming peoples’ perceptions of the BSC. Thus, the observations were not aimed to generate new knowledge concerning the meaning of peoples’ perceptions of the use of the BSC.

In addition, the interviews showed that the management in addition to the management meetings used the BSC in different situations throughout the year, which were hard to
predict and thus observe. Moreover, the interviews showed that the employees used the BSC once a year primarily. This time did not coincide with the time period for the study, which complicated the observations further.

Due to difficulties in conducting observations in practice and the minor role of observations in knowledge creation with respect to the purpose of this study, I chose to focus on the interviews in the analysis. Instead of the observations, I decided to follow two nurses in their work from the in-patient unit and the out-patient unit for two days, in order to gain knowledge about the way people work in the organization and to understand if the BSC was used in the day-to-day work. Thereby, my familiarity with the field increased. During the days, notes were written down and questions were asked in order to have specific activities explained.

### 3.5 Analyzing the Data

In order to make the material accessible to others the interviews were reprinted in full. The reprinted material was also useful in the later stage of the analysis since I could go back to the source of information if any ambiguity arose.

I started to analyze the material by reading through each interview, marking important aspects that the interviewee had emphasized, and writing down my initial thoughts about how the interviewee perceived the BSC. Thereafter, I summarized the interview based on the markings in the interview in order to reduce the text mass. The markings in the source interview were referred to in the summary in order to be able to trace back to the source if necessary. My own initial interpretations were used in a later stage of the analysis. The summaries of all interviews were then documented in the qualitative data program NVIVO.

Every summary was then divided into different units that were denoted with codes derived from the core of the unit. Examples of such coding are depicted in Table 3.2.

As every interview had been coded, I categorized the units in each interview into the themes that I used in the interview guide, namely background, design, implementation and use. Thereafter I categorized the units into sub-themes. The denotation of these sub-themes was derived both from the key questions that I asked during the interviews and my initial interpretations of the interview. Thus, the denotation does not derive from the interviewee’s own choice of vocabulary. A tree structure is constructed for each interview (see Table 3.3).
Table 3.2: An example of the coding of an interview

<table>
<thead>
<tr>
<th>Unit</th>
<th>Summary</th>
<th>Core</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1</td>
<td>The interviewee thinks the scorecard stimulates communication in the organization. According to the interviewee the aim of the scorecard is to create a dialogue that leads to learning. It contributes to perceive what you are doing [793-801]. It creates participation among employees [816-823].</td>
<td>Creates communication and participation.</td>
</tr>
<tr>
<td>A2</td>
<td>The interviewee perceives it both as a management tool and as a tool for other people at the department. The interviewee also thinks it creates equality among people since you know your role in the system.</td>
<td>For management and employees</td>
</tr>
<tr>
<td>A3</td>
<td>The risk with the scorecard can be that you never become satisfied, which can create a frustration that is based on the feeling that you never become good enough. [834-842]. The interviewee tries to keep an eye on this balance.</td>
<td>Can create frustration</td>
</tr>
<tr>
<td>A4</td>
<td>A prerequisite to make it work is to learn the language [878-887]. Critical success factors have not been used, but have been replaced with questions such as, What do we need to be good at? Balanced scorecard has not been used either since it is not popular with three-letter concepts. The interviewee thinks the important is not to make people use the words, but to understand what you will accomplish.</td>
<td>Important to understand the language</td>
</tr>
</tbody>
</table>

Table 3.3: An example of sub-themes in an interview

<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>Core</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of scorecards</td>
<td>How scorecards should be used</td>
<td>Continuous adaptation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Management control instrument</td>
</tr>
<tr>
<td></td>
<td>Effects of the use</td>
<td>Can create frustration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Creates communication and participation</td>
</tr>
<tr>
<td></td>
<td>Areas of application</td>
<td>Evolution of scorecard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Negotiations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tertiary and annual report</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comparisons</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dialogue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Information dissemination</td>
</tr>
</tbody>
</table>
As all interviews were categorized into different sub-themes the interviews were grouped into one common structure. In this stage I took the overall themes as a starting point and integrated all the sub-themes into these themes. Sub-themes that were interpreted as similar were merged together. Thereafter I scanned all the units in order to find patterns and differences in the stories of the interviews. If there was any ambiguity in the stories I could easily go back to the source of information since I could trace every unit back to the summary through NVIVO. In addition, my references in the summary referring back to the actual interview also helped me in returning to the source. Units that I found similar were merged together. A new tree structure emerged that illustrated the whole interview material.

During the coding of the data I noticed differences in how people at the O-center, management of the department and employees in the department described the BSC. As the material was written down according to the tree structure, I therefore read the material on the basis of these groups of interviewees and started to identify similarities and differences in how the BSC was designed, implemented and used between the groups.

![Diagram](image.png)

**Figure 3.2: Units of analysis in the present case study**

### 3.5.1 Reconsidering the unit of analysis

In this stage of the analysis I started to re-evaluate the unit of analysis, which I had identified as a holistic single case, representing the Department of Pulmonary Medicine. Based on my findings in the analysis I found it interesting to consider the O-center’s BSC in the analysis and therefore I chose to expand the unit of analysis to...
include the O-center. The unit of analysis was still a single case, but included embedded sub-units of analysis (see Type 2 in Figure 3.1) representing the center level, department level and unit level (see Figure 3.2).

3.5.2 Evaluation of research questions
In this stage I tried to take a step back from the material and view all the stories at the same time. I could then identify a general pattern and relations between units in the material. I could also identify differences between interviewees’ perceptions, and find lacks in the material that generated new questions.

I started to reflect on how the research questions could evolve from the material. I tried to find relations between sub-themes and units by testing selected theoretical statements on the material. Examples of statements are:

- a need for change should be identified in the organization to make effective changes
- an implementation initiated by the top-management is more likely to succeed than if it is initiated from within the organization.
- change agents play a significant role in change initiatives

Hence, I used my theoretical framework to critically review the findings from the interviews. Thereby, I could draw conclusions about how the BSC is designed, implemented and used in the organization and find factors that influence the use of the BSC in the organization.

3.5.3 Analysis of documents
Since the scorecard documents were used during the interviews, these were reviewed and analyzed as the interviews commenced. The scorecards were firstly analyzed by using the theoretical framework as a starting point. Vision, strategic goals, critical success factors, goals, measures, targets, and action plan were identified as factors included in a BSC in literature, and I used these factors to review the documents. Since the documents were used during the interviews, I complemented my own review with the interviewees’ stories in order to conduct further analysis. I could then critically review the material by emphasizing differences between my own presentation based on theory and literature, and the comments from the interviewees.

Other documents were reviewed to receive information about the organization and the County Council. These were continuously reviewed to receive input for interviews and confirm the interviewees’ stories.
3.6 PRESENTATION OF FINDINGS

During the analysis the structure for presenting the material was constructed. Firstly, I present how the different organizational levels perceive the design, implementation and use of the BSC. The analyses of the scorecard documents are presented in the design section. My description of the document, the comments of the interviewees and my own reflections are presented. The implementation and use section include the analysis of the interviews. After each section I briefly reflect on the descriptions.

Thereafter, I synthesize the information from the three levels to give the reader a picture of the whole organization. This chapter is followed by a critical review of the material by relating to the theoretical framework in order to identify relations between factors and the use of the BSC.

3.7 WHAT ABOUT QUALITY?

How can the reader evaluate how “good” the results in this thesis are? There are different tactics for testing the quality of case study research. Yin (1994) proposes four tests concerning the construct validity, internal validity, external validity, and reliability. Guba and Lincoln (1994) argue the need for an alternative way of assessing the quality of qualitative research since validity and reliability are criteria mainly suitable for quantitative research. They propose that qualitative research should be evaluated through assessing its trustworthiness. Trustworthiness is divided into four criteria: credibility, transferability, dependability and confirmability, which have equivalent criteria in quantitative research (Bryman 2001). The quality in this research with respect to its trustworthiness is discussed below.

**How believable are the results?** I have tried to increase the credibility of this thesis by letting people from the organization that was studied review the case description. Thereby, the first stage of analysis, which is the descriptive representation of the material, was confirmed. The next stage of analysis in which I aggregated conclusions about the over-all case were reviewed and discussed with researchers and colleagues. I have also received input and ideas from a Scientific Reference Group with experts from different fields of research. During data collection I used different sources of information and several interviewees in order to receive different perspectives on the BSC.

**Do the results apply to other contexts?** Since I have focused on the contextual uniqueness and significant aspect of the use of the BSC in a single case I do not have the ability to generalize the results to another context. Instead, I have tried to provide the reader with a “thick description” (Denzin and Lincoln 1994), from which the
reader can make judgments about the possible *transferability* to his/her context or other milieus.

**Are the results likely to apply at other times?** This question concerns the *dependability* of the research conducted. During the research process I documented the research topic, planned time schedule, methodology and preliminary results in a thesis proposal, which was continuously updated. As I entered the field I started to document my thoughts and choices in a “research diary”, which was used in writing this chapter. In order to provide readers with an insight into how I have conducted the research, what choices I made, and the methods I used, I hope to have increased the ability for other researchers to repeat the study in future. However, since the case and reality is not static in time due to changes in the surroundings, it is unlikely that another researcher conducting the same study at a different time will come up with exactly the same results. The new, and somewhat similar results are useful in the sense that they emphasize another perspective of the phenomenon.

**Has the investigator allowed her own values to intrude to a high degree?** Since complete objectivity is impossible in social research, *confirmability* deals with ensuring that the researcher can be shown to have acted in good faith (Bryman 2001). In this thesis, I have tried to put aside my personal values during the investigation and primarily focus on the interviewees’ perceptions on the phenomenon. At one stage of analysis I tried to take a step back from the interviewees’ stories and instead view the findings from a theoretical perspective. I have also tried to take a step back regarding the research process and take a more critical stand to my results. This discussion is presented in Chapter 6. However, it is impossible to prevent my prior experiences and values from influencing my findings since I am the interpreter of peoples’ perceptions on the BSC and my choices, which are partly based on my values and prior experiences, influence all the stages in the research process.

### 3.8 Reflections on the Research Process

Looking back at my research process it has been far from straightforward. Although my first year was devoted to literature about methodology, I soon experienced that a theoretical understanding was far from sufficient to fully understand how to conduct qualitative research in practice. Decisions concerning, for instance, the unit of analysis, methods and analysis were taken as the process proceeded although my initial research design included these issues. New insights experienced during the process triggered off new questions and reflections. Despite the new insights, I do not experience the end product to be different from the view I had on the thesis from the beginning. The purpose of the thesis as well as the research questions have not undergone any remarkable changes during the process, although they have been re-
evaluated several times. While the procedures for achieving the goal have changed, the goal has been the same from the beginning.

The anthropologists Keller and Keller’s (1996) study of the work of a blacksmith can illustrate my experiences from the research process. By combining participant observations and introspection they studied the work of a blacksmith producing a skimmer handle. The blacksmith’s so called “umbrella plan”, representing an internal representation of goal and procedure, is altered and enriched as the work proceeds until the plan meets the objective conditions of the actual work. The initial construction of the “umbrella plan” is influenced by the blacksmith’s prior experiences from blacksmithing among other things and includes a rough idea of the goal for production and procedures to attain the goal. The “umbrella plan” is thereafter reconstructed as the work proceeds. The process is described in three replicable steps: (1) transformation of the object, (2) evaluation of the result, and (3) transition to the next action. When the umbrella plan meets the objective of the process, that is to create a skimmer handle in the spirit of 18th- and early 19th-century, the final product is completed.

Reflecting on my research process and taking Keller and Keller’s study as a starting point, the “umbrella plan” was represented through my initial research design influenced by literature concerning research methodology and BSC, and my prior experiences. In the research design I tried to describe the topic of the research, research questions, methods for collecting and analyzing data. The objective of the thesis was then established together with the assigner, the Federation of the Swedish County Councils. As I entered the field I evaluated the results from each meeting or interview, which triggered new insights about the research. This led to changes in my initial “umbrella plan”. The researcher’s workmanship in this case can be perceived as the tools used for investigation, that is interviews, visits in the organization, documents, the researcher’s own documentation of reflections etc. Thus, as I experienced new insights during the process, I evaluated the value of the insight with respect to my overall objective, and changed my “umbrella plan” so it finally aligned with the objective. Although I did not have a complete plan from the beginning - only my rough “umbrella plan” – the fact that I had an objective in the process supported me in evaluating the knowledge acquired during the process.
4 THE BSC IN A HEALTH CARE ORGANISATION

This chapter describes the empirical case study and has four sections. The first part gives the reader an insight into the County Council of Östergötland, the University Hospital of Linköping and the O-center. In addition, a short background to the introduction of a BSC in the case organization is presented. The following parts describe the BSC at the center level, department level and unit level. The BSC is described with respect to how it is designed, implemented and used on each organizational level.

4.1 BACKGROUND

The health care organization studied belongs to the University Hospital in Linköping in the County Council of Östergötland, which is a democratically governed organization. The task of the County Council is to promote the health of inhabitants of Östergötland. In addition to health care, the County Council works with dental care, education, culture, business and industry questions, and communication. The county council consists of a County Council’s Assembly, which is the highest decision making body in the county council. The delegation includes 101 members elected by the public and decides, among other things, on the resources the County Council receives as a whole.

The County Council’s Assembly appoints the County Council’s Executive Board, which is the board for the County Council’s 90 production units. The production units were founded in the 1980s during the decentralization of the County Council. The board prepares the issues for the agenda of the assembly and is responsible for the economic follow-up and balancing of the accounts. The responsibility for the unit’s development and improvement lies with the executive board. The County Director of Finance is utmost responsible for the production units, and is the head of the administration division.

The task of the Health Care Committee is to identify and analyze the inhabitants’ needs in the health and dental care area. The County Council’s Assembly decides what shall be done, to what extent, at what price and at which level of quality. This is stipulated in agreements with the care providers.

The County Council’s budget for 2002 came to a total of 6.5 billion SEK. The largest revenues are county tax and government subsidies, which together amount to 78 percent of the budget. Hospital care uses 70% of the County Council’s budget for 2002. The County Council employs approximately 12,000 employees.

Hospital care in the County Council of Östergötland includes four hospital organizations, the University Hospital in Linköping, the Vrinnevi Hospital in
Norrköping, the Health Care Services in western Östergötland, and the Local Health Care Services in Finspång.

4.1.1 The University Hospital of Linköping

The University Hospital (UH) is a university and research hospital, which is closely associated with the Faculty of Health Sciences (FHS). The UH works with medical and health care including diagnostics, consultation and treatment within all specialized medical areas except for organ transplants. Together with FHS, the UH carries out experimental research, clinical and applied research and medical care development. They also pursue basic, further and advanced training for most professional groups in the health care organization. The hospital is responsible for providing county medical services within the central district of Östergötland and for cases requiring special resources and skills for people throughout the home county.

Activities at the UH are organized into ten centers functioning as independent production units. Each Head of Center is responsible for the results of the combined operations of the center, which means that the unit is self-controlling on the basis of its own income statement and balance sheet. In order to follow up the production units, every unit submits an annual report to the County Council’s Executive Board.

According to the County Director of Finance, systematic quality development has been an important issue in the County Council since the 1990s when a TQM program was initiated. In the program, training in different quality tools and models was available.

In order to carry out a systematic follow-up of the County Council, a quality assessment tool called QUL⁶ was introduced. All the production units were recommended to write their annual reports according to the QUL model. The County Director of Finance views the QUL model as a management tool, which supports the managerial work by providing managers with a broad framework that is helpful in describing the activity. According to the County Director of Finance, the management of the production unit can see what is prioritized and thus find a balance in controlling the activity.

The County Director of Finance emphasizes the need for following up the unit’s activity. He claims that follow-ups are important in order to see results and thus to make improvements.

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⁶ The QUL (sw. Qvalitet, Utveckling, Ledarskap) concept is the health care and medical service’s equivalent of the Swedish Quality Award (sw. USK - Utmärkelsen Svensk Kvalitet) (SIQ)
"In public services it’s common to talk about future planning, and we are rather bad at following up activities. The basic idea is to facilitate follow-up. Instead of only following up the next level, every level should continuously follow up itself. [...] The key to success is follow-up."

(The County Director of Finance)

Later on the BSC was introduced in order to support follow-up processes. According to the County Director of Finance, the Balanced Scorecard (BSC) is an easier and more comprehensive tool than QUL. He views the BSC and QUL as parts of the systematic quality work being conducted in the County Council. In 2000, the BSC was introduced in the County Council’s Executive Board as a substitute to QUL.

4.1.2 The O-Center and the Department of Pulmonary Medicine

The O-center is one of ten centers in the University Hospital in Linköping. The center is focused on the diagnostics and treatment of tumor diseases according to approved rules and regulations. In addition, the O-center supplies the local inhabitants with health care of oncology diseases in the areas of pulmonary medicine, urology, and hematology. The activity at the O-center is regulated by agreements with the Health Care Committee and by agreements within the region.

The O-center employs 702 people and has a turnover of 686 million SEK. Eleven units and clinical departments belong to the O-center, including the Department of Pulmonary Medicine, which was grounded in 1978 as a part of the UH. Until 1986 the department was focused on institutional care. The department’s main task is diagnostics and treatment of diseases in lungs, mediastinum, pleura and bronchi. The department also offers training and research in these areas. The department’s mission is to be the southeastern district’s competence center in pulmonary medicine.

The Department of Pulmonary Medicine is organized into five out-patient units and one in-patient unit. The in-patient unit has 15 beds for treatment of in-patients and 2 beds for polyclinic patients. The personnel in the in-patient unit work in two care teams, which include physicians, nurses, nurse assistants and physiotherapist. The welfare officer supports the teams if needed.

The out-patient units are specialized in different treatments and diagnoses. The units are focused on cytostatic treatment, oxygen treatment of “KOL” patients among other

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7 Quotation 1, Appendix 2
8 Translation of the Swedish term “vårdlag”
9 KOL is a Swedish shortening of Chronic Obstructive Lung disease
things, treatment of patients with cystic fibrosis, analysis of unclear lung changes, and treatment of patients with bronchial and interstitial diseases.

The department employs 75 people and has a budget set at 65 million SEK. The department is obliged to report its results to the O-center every fourth month and annually. An accountant from the O-center handles the economic follow-ups. Together with the yearend report, the department is responsible for handing in a quality balance sheet. The O-center is responsible for reporting results to the UH.

**Background to the BSC at the O-center and Department of Pulmonary Medicine**

The BSC in the organization studied was introduced in 1998, as the management of the Department of Pulmonary Medicine was invited to join a network organized by the Federation of Swedish County Councils. As the implementation of the BSC proceeded in the department, the head of O-center started paying attention to the new concept. The BSC was introduced at the O-center through the County Council’s Executive Board in 2000, and later on in 2001 the O-center was given instructions to submit an annual report and budget to the University Hospital according to a BSC. The Quality Coordinator at the O-center together with Quality Coordinators from the nine departments started designing a BSC at the center level, which was presented and approved by the management of the O-center. During the same period, all the departments at O-center were given instructions to start reporting their results and plan the activities according to key questions included in the O-center’s BSC.

A more detailed description of the background is given in the following sections, which describe the design, implementation and use of the BSC at the center, department and unit level respectively.

4.2 **THE BSC IN THE O-CENTER**

In 2001 the County Council’s Assembly gave all production units instructions to report their budget according a BSC including five perspectives – the economic perspective, the employee perspective, the customer perspective, the process perspective and the research and development perspective. According to the County Director of Finance, the BSC was aiming at enabling follow-ups of the production units’ results.

As the O-center received the directive to start using the BSC in the follow-ups the Quality Coordinator of the O-center together with the Quality Coordinators from the nine departments at the center started designing a scorecard for the O-center. At the same time, the Head of O-center gave the departments instructions to report the budget for 2001 according to the five perspectives corresponding to the perspectives in the County Council’s directive.
4.2.1 The design of the BSC

The BSC of the O-center is presented in Figure 4.1. The vision of the center is illustrated in the left of the scorecard: “O-center - a learning organization for health and life quality”. The scorecard is divided into five perspectives: (1) the Patient/customer perspective, (2) the Process perspective, (3) the Development/Future perspective, (4) the Employee perspective and (5) the Production/Economic perspective. Strategic goals and key questions are derived from each perspective. Every strategic goal in the O-center’s scorecard contains four key questions. The key questions are formulated as critical success factors, which are the most critical issues for an organization’s competitiveness and are hence aligned with the vision and strategic objectives (Kaplan and Norton 1996b). All the questions are ‘yes/no’ questions and goals are set on each key question. All goals are set to 100%, which represent the proportion of the departments belonging to the O-center answering ‘yes’ on the current question. Thus, the key questions are aimed for the use of departments in following-up their results. Below the strategic goals and key questions are dealt with in more detail. The strategic objectives, together with critical indicators, help the organization to deploy the over-all vision down to strategically important measurements (Kaplan and Norton, 1993). Hence, in order to analyze the scorecard of the O-center the following discussion emphasizes what the O-center focuses on in achieving their vision.

**Strategic objectives and key questions**

In the Patient/customer perspective the strategic objectives are “Right availability with good reception and information. High medical quality.” Hence, the key questions aligned with this objective are “Do we have right availability? Do we have right reception? Do we give good information at the right moment? Do we reach results of high medical quality?” The focus in the patient/customer perspective thus lies on having good availability, good reception and information and achieving medical results with high quality.

In the Process perspective, the strategic objective is defined as “Well-functioning processes”. This indicates that the O-center is striving for a process-oriented organization in reaching the vision. The key questions in the process perspective are: “Do we systematically improve our processes? Are our processes documented? Do we compare and learn from leading organizations? Is the adverse event reporting system working?” Thus, the O-center prioritizes the improvement, documentation and benchmarking of processes in the achievement of a process-oriented organization. In addition, the discrepancy management needs to function well in order to reach effectiveness.
<table>
<thead>
<tr>
<th>Perspektiv</th>
<th>Strategiska mål</th>
<th>Nyckelfrågor</th>
<th>Mål</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/kund</td>
<td>Rätt tillgänglighet</td>
<td>Har vi rätt tillgänglighet?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>med bra bemötande</td>
<td>Har vi bra bemötande?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>och information.</td>
<td>Ger vi besked och bra information vid rätt tidpunkt?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Hög medicinsk kvalitet</td>
<td>Uppnår vi resultat av hög medicinsk kvalitet?</td>
<td>100%</td>
</tr>
<tr>
<td>Vision:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>O-centrum en lärande organisation för hälsa och livskvalitet</td>
<td>Välfungerande processer.</td>
<td>Förbättrar vi systematiskt våra processer?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Är våra processer dokumenterade?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Jämför vi och lär oss av ledande organisationer?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fungerar avvikelsehanteringen?</td>
<td>100%</td>
</tr>
<tr>
<td>Utveckling/</td>
<td>Systematisk verksamhetsutveckling.</td>
<td>Utvecklas och förbättras verksamheten systematiskt mot tydliga mål?</td>
<td>100%</td>
</tr>
<tr>
<td>framtid</td>
<td>Skapa en långsiktigt god kompetens.</td>
<td>Har verksamheten rätt kompetens?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>FoUU enligt HU:s mål och strategplan.</td>
<td>Ger vi rätt utbildning med hög kvalitet till våra studenter?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Har vi rätt forskningsnivå?</td>
<td>100%</td>
</tr>
<tr>
<td>Medarbetare</td>
<td>Nöjda medarbetare i en utvecklande och hälsorfrämjande arbetsmiljö.</td>
<td>Har och följer medarbetarna individuella utvecklingsplaner?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>Bra ledarskap och medarbetarskap.</td>
<td>Deltar medarbetarna i verksamhetsutvecklingen?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Har vi bra ledarskap och medarbetarskap?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Har vi mål och handlingsplan för arbetsmiljöarbetet?</td>
<td>100%</td>
</tr>
<tr>
<td>Produktion/</td>
<td>Följa avtal om produktion med balanserat bokslut och med hög effektivitet.</td>
<td>Har vi rätt produktion i/f med budget senaste 4 resp 12 månads period?</td>
<td>100%</td>
</tr>
<tr>
<td>ekonomiskt</td>
<td></td>
<td>Finns och följs långsiktiga avtal?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Har vi balanserat bokslut?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Har vi hög effektivitet jämfört med ledande organisationer?</td>
<td>100%</td>
</tr>
</tbody>
</table>

Mål 100% motsvarar målet att klinikerna/avdelningarna svarar ja på nyckelfrågorna.
For att nyckelfrågorna ska kunna besvaras gäller att respektive klinik/avdelning definiera egna mål och mättal som kliniken/avdelningen ansvarar för.

Figure 4.1: The design of the BSC at the center level as presented by the O-center
The strategic goals in the Development/Future perspective include “Systematic quality development. Create long-term good competence. Research and development according to goals and strategy plan set by the Faculty of Health Sciences.” The development/future perspective further contains the key questions “Is the business developing and improving systematically towards clear goals? Does the business have the right competence? Do we provide our students with the right education with the right quality? Do we have the right research level?” In order to work systematically with quality development, departments need to have clear goals. Moreover, in order to create long-term, good competence, the department needs to make sure that the right competence is available; to provide students with good education; and to reach a certain level of research aligned with the goals and plans set by the FHS.

The Employee perspective contains the strategic goals “Satisfied employees in a developing and health-promoting work environment. Good leadership and colleague support.” These strategic goals indicate that the O-center prioritizes the work environment in the strategic discussions. The employee perspective includes the key questions “Do the employees have and do they follow individual development plans? Do the employees participate in quality development initiatives? Do we have good leadership and colleague support? Do we have goals and action plan for improving the work environment?” The center thus focuses on individual development plans, participation in quality development, leadership and colleague support, and work environment in their key questions in order to align with the strategic objectives and thus the vision.

The Production/Economic perspective includes the strategic goal “Follow agreements of production with balanced accounts and with high efficiency.” Thus in order to attain the vision, the center needs to follow the agreements with the County Council of Östergötland regarding the productivity and economic requirements. These goals are linked to the key questions “Do we have right production compared to the budget set in the latest 4 month period and 12 month period? Are there any long-term agreements and are they followed? Do we have balanced accounts? Do we have high efficiency compared to other leading organizations?” Thus the emphasis in the key questions is on keeping the economy in balance according to the budget set in the latest four-month period and the annual budget. In addition, the departments should follow agreements if any, and there should be high efficiency, which should be benchmarked with leading organizations. This perspective is dominated by key questions concerned with regulations in the County Council, which reflects the organization being a part of the public sector.
**The interviewees’ comments**

According to the Quality Coordinator the vision is appropriate for the O-center. He thinks that the O-center involves departments from many different areas, and therefore the vision needs to be quite broad in order to suit the activities of all the departments. The management of O-center thinks it is good to work in a learning organization and to continuously improve, as stated in the vision. Before the scorecard the O-center did not have an explicitly stated vision.

The strategies and the key questions are based on the UH’s reporting template to the O-center. The Quality Coordinator explains that the strategies and the key questions are closely connected since terms used in the strategies occur in the key questions. According to the Quality Coordinator the directive from UH concerning the annual report has been designed according to five perspectives since the end of 1990’s. The five perspectives in the scorecard are thus based on the perspectives from the report, although the designation of perspectives is different. For instance, instead of the customer perspective in the report, the O-center uses a patient/customer perspective.

"Previously, [the hospital’s management group] had pointed out a number of questions during the annual review of the organization. Later, they introduced these perspectives that we should take as a starting point when describing our activities. Some questions should then be answered. Then the O-center was told to start working with the Balanced Scorecard. I therefore linked the things the hospital had presented as a scorecard...At the center level we started to work with the vision, mission statement...for the entire center. Then we thought the questions presented at the hospital could be used in the scorecard [at the O-center].”

(The Quality Coordinator, O-center\(^{10}\))

**The author’s reflections on the design**

A central question regarding the design of the BSC is the organization’s strategic focus and direction. The vision provides the direction, focus and motivation that guide the organization, for both the short and long term and represents the values and purpose of the organization (Porras and Robertson 1995). The vision at the O-center involves becoming a learning organization to achieve health and life quality for the patients. The Learning Organization (LO) was introduced in 1990 by Peter Senge in his book “The fifth discipline: the art and practice of the learning organization” (Senge 1990).

In becoming a learning organization five disciplines need to be considered, namely (1) building shared visions, (2) applying systems thinking, (3) expanding mental models, (4) developing a sense of personal mastery, and (4) team learning. Hence, from a Quality Management perspective, becoming a learning organization means dealing

\(^{10}\) Quotation 2, Appendix 2
with a wide range of aspects that involve both learning on an organizational and individual level. According to the quality coordinator at the O-center the vision needs to be broad due to the wide range of departments at the O-center. However, one may question how directed, focused and motivating such a vision is for people working in the organization. The vision is based on the values in the Quality Management field, which primarily aims to develop organizational capabilities (Beer and Nohria 2001, see Table 2.3 this thesis). Economic profitability is thus not the primary aim at the O-center.

Another reflection concerns the influence of the University Hospital on the BSC design. According to the Quality Coordinator, the BSC design is based on the directive from the UH concerning the annual report. This means that the BSC design at the O-center primarily communicates the directives and regulations from the UH to the departments. Hence, one may question the O-center’s ability to control the departments based on the results in the BSC. It seems that the O-center has a minor role in affecting the departments’ strategic focus and that the role of the O-center is to transmit information between departments and the UH. The BSC at the O-center may thus function as an information system rather than as a system to canalize the departments towards a common vision.

Another reflection regarding the BSC design is the use of strategy maps (see Kaplan and Norton 2001). According to Kaplan and Norton (2001) strategy maps are used to describe “the process for transforming intangible assets into tangible customer and financial outcomes” (Kaplan and Norton 2001, p. 69). Strategic outcome measures are identified in the customer and financial perspective. The authors identify the intangible measures in the other perspectives as performance drivers. The O-center does not use a strategy map to present its scorecard, which makes it hard for people that has not been involved in building the BSC to understand the strategies and their inherent logic (see e.g. Olve et al. 2003). There is then a risk that people in the departments choose to report measures that are not strategically aligned with the O-center’s strategic decisions.

Dividing the measures into performance drivers and outcome measures indicate that the O-center’s main strategic focus is on high performance in the Patient/Customer perspective and the Production/Economic perspective (see Table 4.1). The key questions in these perspectives concern strategic outcomes, such as balanced accounts, high efficiency, high medical quality, and right availability. One may also identify strategic outcomes in the Development/Future perspective, such as providing students with the right education, and having the right research level. Together with FHS, the UH carries out experimental research, clinical and applied research and medical care development. They also pursue basic, further and advanced training in the health care
organization. These two goals at the UH provide the basis for identifying strategic outcome measures in the Development/Future perspective. The other key questions may be interpreted as performance drivers because they provide the basis for attaining the strategic outcomes.

Table 4.1: A division of the O-center’s key questions into performance drivers and strategic outcomes.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Performance drivers</th>
<th>Strategic outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Customer perspective</td>
<td>Do we reach results of high medical quality?</td>
<td>Do we provide our students with the right education with the right quality?</td>
</tr>
<tr>
<td></td>
<td>Do we have right availability?</td>
<td>Do we have the right research level?</td>
</tr>
<tr>
<td></td>
<td>Do we have right reception?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do we give good information at the right moment?</td>
<td></td>
</tr>
<tr>
<td>Process perspective</td>
<td>Do we systematically improve our processes?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Are our processes documented?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do we compare and learn from leading organizations?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Is the adverse event reporting system working?</td>
<td></td>
</tr>
<tr>
<td>Development/Future perspective</td>
<td>Is the business developing and improving systematically towards clear goals?</td>
<td>Do we have the right research level?</td>
</tr>
<tr>
<td></td>
<td>Does the business have the right competence?</td>
<td></td>
</tr>
<tr>
<td>Employee perspective</td>
<td>Do the employees have and do they follow individual development plans?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do the employees participate in quality improvement initiatives?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do we have good leadership and colleague support?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Do we have goals and action plan for improving the work environment?</td>
<td></td>
</tr>
<tr>
<td>Production/Economic perspective</td>
<td></td>
<td>Do we have right production compared to the budget set in the latest 4-month period and 12-month period?</td>
</tr>
<tr>
<td></td>
<td>Do we have balanced accounts?</td>
<td>Are there any long-term agreements and are they followed?</td>
</tr>
<tr>
<td></td>
<td>Do we have high efficiency compared to other leading organizations?</td>
<td></td>
</tr>
</tbody>
</table>
4.2.2 The implementation of the BSC

The Head of O-center first became acquainted with the BSC concept in the beginning of the 1990s in the University Hospital’s management group. He then welcomed the new concept due to its logic and similarity to his way of managing the center. Moreover, the emphasis on both financial and non-financial assets made the tool even more attractive later on since the County Council Executive Board had been focusing too much on financial cutbacks during the stringent economic measures in the 1990s. The Head of O-center explained that the aspiration to shift focus was one important aspect when agreeing to implement the BSC in 2001. The Quality Coordinator at the O-center was introduced to the concept during one of CQ’s seminars at the end of the 1990s. The role of the coordinator is to support the departments in the implementation. The responsibility for the implementation of the BSC belongs to the Heads of the departments.

Complement to QUL

In addition to the strengths of the BSC, the Head of O-center explains that the weaknesses of the QUL model enabled the acceptance of the BSC implementation. As a prior assessor of QUL, he claims that QUL was very resource demanding to use and required expert skills. The Quality Coordinator at the O-center explains that the BSC has won greater acceptance in the departments than QUL. The departments think it is more applicable and easy to use. Only a few departments knew about QUL and could see its contributions. According to the Quality Coordinator the departments feel that they control their own activity by setting their own goals and measurements. The coordinator views QUL as a foundation to BSC, but the departments claim the BSC is easier to work with. The coordinator views the two concepts as complements to each other.

Building a BSC on the center level

The Quality Coordinator of the O-center together with the Quality Coordinators from the nine departments started designing a scorecard for the O-center. The design of the scorecard at the O-center started with the formulation of a vision. The management group at the O-center decided upon a common vision for the center and thereafter the UH’s directives for the annual report were used as a basis for designing perspectives, strategies and key questions. The formulation of key questions on the center level aimed at facilitating the implementation of the scorecard on the department level according to the Quality Coordinator. The departments could then focus on measurements, goals and action plans instead of putting effort into strategic goals and key questions.
After a BSC had been designed on the center level, the management at the center level approved the scorecard. At the same time, the Head of O-center decided that all departments should report the budget for 2001 according to the O-center’s BSC design.

**Deployment of the BSC**

According to the Head of O-center the departments are free to deploy the scorecards throughout their organizations. Thus, there are no directives concerning what level the scorecard should be taken down to. He has an open attitude about the department’s own choice of deploying the scorecard model, but he requires that the scorecard should be used as a budget and reporting model at the department level. Although there are no requirements on the degree of deployment, the Quality Coordinator at the O-center strongly believes in taking the scorecard down to the unit level and thinks that the departments are gradually getting used to the concept and are becoming aware of its benefits.

**Resistance to change**

The Head of O-center explains that the BSC was initially received with great skepticism in the departments partly due to its terminology. He brings out the terms ‘process’ and ‘customer’ as difficult to use in the health care organization, and mentions that the terms ‘care-chain’¹¹ and ‘patient’ is more usable. He further argues that the difficulties in getting started with BSC depend on peoples’ focus on their own interests. According to the Head of O-center, autonomous units that do not want to be forced in a certain direction, characterize the health care organization. He thinks that the physicians seem to be more difficult to involve in this work and make them accept the changes. He claims that "the medical profession have a large impact on the organization and there is a great reluctance toward changes if I may say so."¹²

According to the Head of O-center, the center tries to enable and support the implementation of the BSC in the departments as much as they can. The O-center has, for instance, used so-called ‘good examples’ such as the Department of Pulmonary Medicine in order to motivate the other departments to start working with the instrument. In addition, the Head of O-center argues that the Quality Coordinator’s efforts and support are essential in the implementation. He further emphasizes that each clinic needs to learn by their mistakes and adapt the scorecard to their own activities, in order to accept the new concept and not view the scorecard as being

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¹¹ Translation of Swedish term “vårdkedja”

¹² Quotation 3, Appendix 2
forced on the departments. Another important issue for the Head of O-center is to find an appropriate ambition level for the work with the scorecard. He means that the departments are free to develop their own scorecards, but that the clinical activity still needs to be focused on.

"I think it’s good, but for me it is about finding an appropriate ambition level... And I have a very flexible attitude. If a department wants to focus on the details very much I let them to do so, but they still need to manage the clinical activity. [...] It should not become something they have to do, they must feel that it comes naturally and something they can benefit from. I believe we really have come a long way in all departments."

(The Head of O-center\textsuperscript{13})

The Quality Coordinator emphasizes the importance of letting the implementation of the scorecard take time in order to make the departments accept the new concept. The Head of O-center further emphasizes the importance of enthusiastic leaders in order to succeed with the implementation. Regarding the training in the departments, the center primarily recommends the management of the department to attend the seminars arranged by CQ. The departments decide on which people to send to the training sessions.

\textit{The author's reflections on the implementation}

One important factor that influences the effectiveness of change initiatives is the recognition of a need for change (Porras and Robertson 1995). If people in the organization experience a “tension to change”, the change initiative is more likely to be successful than if people experience the current situation as satisfactory (see e.g Olsson 2002). In this case, the Quality Coordinator and the Head of O-center experienced that the existing reporting system, QUL, was very resource demanding to use and required expert skills. Thus, there was a need for change concerning the reporting system, which may have enabled the acceptance of the BSC at the O-center. Based on the fact that the BSC is viewed as a complement to QUL, the main use of the BSC seems to be as a follow-up and reporting system.

Another important aspect in change initiatives is to let the departments adapt to the changes and feel that the changes contribute to their situation in order to make changes effective (Beer et al. 1990). At the O-center, the management has an open and flexible attitude towards departments that develop their own scorecards. The Quality Coordinator emphasizes the need to let the implementation take time and let the departments get used to the concept. In order to enable the implementation in the departments, the O-center has formulated key questions that will make the departments

\textsuperscript{13} Quotation 4, Appendix 2
focus on the measurements and goals. In addition, the Quality Coordinator recommends the management of the department to attend the BSC training in order to gain knowledge about its implications in practice.

Although the O-center seems to create conditions for an effective implementation of the BSC through an open attitude, recommendations, adaptation of terminology and time allocation, one may reflect upon the consequence of letting the departments adapt the BSC to their own conditions. As the departments are free to interpret the key questions in the BSC themselves and to choose their own measurements and set their own goals, the O-center has a minor, or no, ability to evaluate and assure that the targets set at the O-center are achieved since the framework for interpretation differs. This further supports the analysis in the previous section that the O-center has a minor role in controlling the departments’ results.

Another aspect of the O-center’s approach to the implementation is the use of ‘yes/no’ questions in the BSC. According to the Quality Coordinator at the O-center, these are used as a way of making the departments focus on measurements and targets in the BSC. However, as the questions only require the departments to answer ‘yes/no’ to the question, departments with low or no experience with measurements do not have any incentive starting to measure their day-to-day practices. Thus, one may question to what extent the key questions actually influence the measurement behavior in the departments.

4.2.3 The use of the BSC

The Head of O-center perceives the BSC as a natural instrument in management, and argues that it is not a new way of organizing managerial work. He explains that the BSC contributes to documenting managerial work in a structured way, which leads to orderliness in the management.

"I think the structure is similar to how most managers think in their managerial work. I mean... the wheel has not been reinvented. For some managers it is as if the wheel has been invented but I don’t think so. It is well-structured and accessible."

(The Head of O-center\textsuperscript{14})

The Head of O-center views the BSC both as an instrument in following up the departments’ results as well as in the strategic planning process: “So, it’s like a follow-up instrument, but also a platform for discussing strategies”\textsuperscript{15}. The Quality Coordinator at the O-center views the BSC as a dynamic tool, which develops from a

\textsuperscript{14} Quotation 5, Appendix 2

\textsuperscript{15} Quotation 6, Appendix 2
way of describing how to follow up and how to plan the activities in the departments. He believes it takes time to develop the scorecard to become a way of controlling the activities at the department level.

"When you start with the BSC it becomes more like a description of the activities. But if you continuously work with it and become familiar with following up goals, measures and action plan every four months, it becomes more and more a controlling factor. Because the focus is then shifted to planning and follow-up from just watching and seeing what happens. It will take time before all the departments work this way."

(The Quality Coordinator, O-center  

**Planning, annual reports and follow-ups**

Once a year the BSC of the O-center is discussed in the Quality Steering Group including the Quality Coordinator of the O-center and Quality Coordinators from the nine departments. The discussion aims at changing and adapting the key questions according to the directives from the UH. There have been some small changes in the questions, but the Quality Coordinator does not think there will be any radical changes since the questions mainly correspond to the balance sheet regulations at the UH. As the BSC has been discussed in the Quality Steering Group, the BSC is approved and discussed in the management group at the O-center.

Once a year the O-center reports their results according to the five perspectives in the BSC to the steering group of the UH. All the production units then present their results according to the BSC and to the measurements determined by the UH. The Quality Coordinator compiles the departments’ results in a cobweb diagram, which is presented during the meeting. The diagram includes the measurements determined by the UH.

All the departments are obliged to submit a balance sheet to the O-center every four months and yearly. Together with the economic balance sheet a so-called ‘quality balance sheet’ is handed in, in which the department’s goals, measurements and action plans are described according to the five perspectives included in the O-center’s scorecard. The reporting form is standardized and aims at describing the department’s activities according to the key questions presented in the O-center’s scorecard. However, not all departments follow the standardization since some departments have developed their own scorecards. The Quality Coordinator does not see any conflict in having departments developing their own strategy and vision. The standardization is

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16 Quotation 7, Appendix 2  
17 Translation of the Swedish term “spindel diagram”
aiming at helping departments that have not yet started implementing the scorecard, rather than constraining the departments that have developed their own scorecards.

“If they want their own vision they can have it. And it is the same with the strategies [...]. The standardization aims to help those departments that have not yet started. [...] I don’t think it’s a problem. The important thing is to find kinds of measures, goals and action plans.”

(The Quality Coordinator, O-center\(^{18}\))

The Head of O-center uses the tertiary and annual reports to receive information about the departments’ activities. Reporting the results according to the standardized key questions make the work easier for the Head of O-center since it enables him to get an overview of the organization. The Quality Coordinator further explains that the common reports help the Head of O-center to receive an overview of the center. However, the Head of O-center does not tell the departments what they need to focus on and what measurements to improve solely based on the quality report.

**Development of performance measurements**

In order to facilitate the reporting of results from the production units, the UH has decided to develop a limited set of measurements for all departments in the organization. By having a standardized set of measurements at the departments, the O-center can compile some measurements directly in the BSC, which leads to a more effective reporting process. According to the Quality Coordinator at the O-center the new measurement system enables the reporting of the measurements on the department level since the departments do not have to come up with their own measurements. The center can thus support departments in their measurement process by deciding upon a common set of measurements that they should report. According to the Quality Coordinator, the standardization of measurements provides comparisons between departments, which are useful, both for the management of the single department and for the O-center.

The introduction of the new measurement system means that some of the measurements are compiled on different levels in the organization. For instance, instead of having all departments reporting their own economic measures, the O-center may compile the measures after requesting a standardized set of economic results from the departments. Other measurements that are suitable for standardization according to the Quality Coordinator are ‘absence due to sickness’, measurements in the research perspective and some patient and employee surveys. According to the Quality Coordinator the new measurement system means that the departments can focus on the

\(^{18}\) Quotation 8, Appendix 2
action plans and goals instead of finding appropriate measurements for all perspectives. Due to the development of a new measurement system, the departments are today told by the Quality Coordinator not to put too much effort into finding measurements in the economic perspective and for ‘absence due to sickness’ since these are supposed to be reported from the center level in the future.

**The author’s reflections on the use of the BSC**

According to the Quality Coordinator the BSC is a dynamic tool, which develops from a way of merely describing the work at the departments to follow up and planning the activities. He further claims that the BSC is “becoming more and more a controlling factor”. Thus, the Quality Coordinator believes that the BSC is primarily a tool for the departments to use in their strategic management control. By control he means following up and planning the activity in accordance to the BSC at the departments.

The findings from the interviews show that the BSC is used mostly in the O-center for reporting results to the UH steering group once a year and to follow-up and compile the tertiary and annual balance sheets from the departments. The BSC at the O-center is also revised once a year in accordance with the directives from the UH. Thus, whereas the BSC is aimed for use in strategic management control in the departments, the primary use of the BSC at the O-center seems to be in reporting information between the UH and the departments during the tertiary and annual reporting.

The Head of O-center claims that the BSC from the departments according to the key questions provides him with an overview of the departments’ activities. However, it is unclear to what extent the BSC from the departments actually affects O-center planning activities according to the BSC. The empirical findings indicate that the O-center’s annual planning according to the BSC depends largely on the directives from the UH. Thus, the scorecards from the departments do not seem to directly influence how the O-center plans its activities according to the BSC.

The implementation of the BSC in the O-center has initiated a development of performance measurements in the organization. According to Kennerley and Neely (2002) it is important to have an effective process for reviewing measurements in order to enable the evolution of performance measurement systems. In addition, they emphasize the importance of having a flexible system for collecting and reporting data and having the necessary skills and human resources for developing the system. They also argue that the measurements should be accepted in the organization in order to succeed with the evolution of the performance measurement system. In this case, the O-center has an established process for collecting data from the departments and reporting results to the UH. Additionally, the O-center annually reviews the measurements in the BSC in accordance with the directives from the UH. The Quality
Coordinator has the main responsibility of developing the measurements at the O-center with the support from UH. He has attended the BSC training program provided by CQ and has an educational background in Quality Management. In addition, the O-center has long experience with following-up and reporting performance measurements. However, it seems that several departments in the O-center have no or little experience from performance measurements as requested in the BSC, which could be a barrier to effectively developing new measurements in the organization.

Another aspect worth illuminating is the O-center’s open and flexible attitude towards departments that have developed their own scorecards. This may be identified as a barrier to the development of a more effective reporting process, which the O-center aims to do by standardizing some measurements. One may argue that departments, which have already developed their own scorecard, are unwilling to change their measures in accordance with a new standardized set of measures determined by the O-center. Although the Quality Coordinator argues that only a few measures are being standardized and reported from the O-center, the fact that departments are allowed to develop their own scorecards may fuel resistance to future changes regarding the performance measurement system initiated by the O-center.

4.3 THE BSC IN THE DEPARTMENT OF PULMONARY MEDICINE

In 1998 the management of the Department of Pulmonary Medicine was introduced to the BSC during network meetings organized by the Federation of Swedish County Councils. Thereby, the management of the department started viewing the BSC as a useful tool in linking the different parts of the department. Although the terminology used in the BSC was at first hard to understand, the management team later on got used to the terminology and understood its implications. At the time of the BSC introduction, the department had recently experienced a turbulent situation partly due to economic cutbacks and restructuring in the County Council.

4.3.1 The design of the BSC

The department’s over-all scorecard is illustrated in Figure 4.2. The scorecard is presented as an arrow including six steps. These steps are interpreted as an illustration of the building process of the scorecard. The first step concerns the department’s vision, which is followed by the strategic choices in Step 2. The third step includes the identification of critical success factors, and the fourth step illustrates the key measurements and the targets for each measurement. Step 5 includes the establishment of an action plan. The sixth step is denoted ‘measurement and follow-ups’, and is represented in a cobweb diagram. Steps 2-4 are differentiated into five perspectives, namely (1) the Customer perspective, (2) the Process perspective, (3) the Research &
Development perspective, Learning perspective, (4) the Employee perspective, and (5) the Economic perspective.

**Vision, strategic choices and critical success factors**

The department’s vision is presented to the left in the scorecard: “For the patients, Lungs, Air and Life, and for the personnel, Knowledge and Empathy”

Within each perspective strategic choices are depicted. The strategic choices are interpreted as the management’s long-term, strategic decisions on how the department can realize the vision. In the third step in the scorecard, critical success factors are identified. These are interpreted as factors important for the long-term survival of the department, and aligned with the strategic choices (Kaplan and Norton 1992).

In the Customer perspective, the strategic choice contains the statement that “in the right way, at the right time, optimal and professional over-all care”. In addition, “needs should be guiding”. The critical success factors are identified as “availability”, “professionalism”, and “good care”. In order to reach optimal and professional care with a focus on customers’ needs the employees need to be available, act professional, and take good care of the patients.

In the Process perspective the strategic choice is depicted as “doing the right thing from the beginning” and “to follow the relevant legislation and care programs”. The critical success factors in the process perspective are depicted as “good medical results”, “good diagnostics and treatment”, and “availability”. The strategic choice identified as doing the right thing from the beginning and following laws and regulations is achieved through focusing on good medical results, diagnostics and treatments and being available for the patients. One issue worth noting is that the indicator “availability” is also used in the customer perspective. This means that being available for the patients is a prioritized area in the department’s strategic approach.

The strategic choice in the Research & Development, Learning perspective includes the statement ”to follow FHS:s goals and strategy plans” and “continuous development of the activity” concerning these issues. The perspective includes the critical success factors “research, development and learning”. In order to follow the FHS’s goals and strategies and continuously develop the activities, the department has to focus on research, development and learning.
Figure 4.2: The design of the BSC at the department level as presented by the Department of Pulmonary Medicine.
The Employee perspective contains the strategic choice that the department has to be “an attractive and developing workplace” for the employees. In order to achieve the vision the employees need to view the department as an attractive workplace characterized by opportunities to develop their skills and knowledge. The critical success factors aligning with these strategic choices are identified as having “high competence”, “good work environment” and “high level of work satisfaction”.

The strategic choice in the economic perspective is formulated as having an “balanced economy”, “having a production unit that follows agreements” and “Information and cost-conscious employees”. Thus, these strategies are based on the economic framework, which is set and regulated by the County Council’s Executive Board. The economic perspective encompasses the critical success factor “overall thinking regarding costs”. The strategies and critical success factor indicate that both the management and other employees need to have an over-all approach regarding the department’s costs in order to achieve a balanced economy and a production unit that follows agreements.

**Key measurements, goals and action plans**

The key measurements and goals are presented in the fourth step in the scorecard. The key measurements align with the critical success factors in order to indicate how the department stands in respect to the overall vision (Kaplan and Norton 1992). All goals are presented in percentage points, and reflect the goal achievement from the previous four-month period. Every key measurement is related to a goal. For instance, in the customer perspective, the measurement “care-taking in three months” has a goal on 90%, which means that 90% of the patients shall be taken care of within 3 months.

The measurements and goals in the scorecard are also documented in a *measurement document*, which includes all performance measurements reported from year 2000. This document includes 87 measures, which are related to perspectives and critical success factors. 15 measurements of these 87 are presented in the department’s scorecard. Each measurement in the document is described as to how and when the measuring takes place, and who is responsible for the reporting of the results. Goals and results are linked to the measurements in the document. An example of the employee perspective in the measurement document is shown in Figure 4.3.

The action plans of the department are described as ‘Step 5’ in the scorecard. However, these are not presented in the scorecard since each unit at the department specifies its own action plans. Therefore these are found in each unit’s scorecard.
Sammanställning av handlingsplan för verksamhetsuppföljning på Lungmedicinska kliniken, US 2000-2002

**MEDARBETARPERSPEKTIV**

Vår arbetsplats skall vara attraktiv och utvecklande för alla medarbetare. Där ska anställningstrygghet, säkerhet, information och erkännande vara grundläggande och bidra till en god arbetsmiljö.

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<td>Permanent anställning</td>
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|                            |       | AL | Antal reviderade kapitel | 100% | 100% | 100% | 75% |
|                            |       | AL | Antal reviderade kapitel | 100% | 100% | 100% | 75% |

**Figure 4.3:** The employee perspective in the measurement document as presented by the Department of Pulmonary Medicine
Illustration of measures

Step 6 in the BSC contains a cobweb diagram illustrated in Figure 4.4. The diagram presents the results achieved in relation to the annual goals. All the measurements are represented, except for the measurements in the economic perspective.

Figure 4.4: A visual display of the measures in the BSC at the department level as presented by the Department of Pulmonary Medicine

The dark gray area in the diagram illustrates the goal of the year and the light gray area shows the results achieved for one four-month period. When the diagram is totally filled with light gray, the goal has been achieved in all the areas during the previous four-month period. In those areas showing a dark gray color the goal for that area and period was not achieved. The diagram shows that the goals for the measurements ‘care in three months’, ‘participation’, ‘answer to questions’, ‘doctor responsible for the patient’ (PAL), and ‘diagnostic precision bronchoscope’ have been achieved by a great margin during the previous period.

The interviewees’ comments

All the interviewees recognized the department’s BSC as presented in Figure 4.2. In addition to the BSC illustration, all the interviewees recognized the vision. The interviews with employees in the department show that the vision represents the values of the department, while the management of the O-center had become acquainted with the vision primarily through the department’s tertiary and annual report. All interviewees also recognized the cobweb diagram. The interviews show that the
diagram, as a way of visualizing measurements, is a common technique throughout the University Hospital. One interpretation of the extended recognition of the BSC is that the design of the department’s BSC is communicated throughout the organization. Illustrating measurements in a common diagram and by making people identify with parts of its content may be identified as important aspects to make people accept the BSC.

Although most people argue that the department’s BSC represents the values of the department, the interviews show up some shortages in how the BSC is designed, which primarily concerns the choice of measurements. One of the interviewees in the management team thought that measurements usually remain in the BSC due to the measuring tradition in the department. The interviewee points out that ‘sick leave’ is an important measurement, which is not included in the scorecard. This measurement is also brought up as important by another interviewee in the management team. One management team member is surprised by the absence of the measurement ‘symptom alleviation’ in the scorecard.

The interviews further show that some measurements are more difficult to identify than others. One management member thought that the measurements in the research and development, learning perspective are difficult to identify due to the perspective’s ambiguous meaning.

The difficulties regarding the design of the BSC is also reflected in the visual presentation of measurements. According to the Quality Coordinator at the department, the measurements in the economic perspective are not represented in the cobweb diagram, due to difficulties in visually illustrating these measurements. All the economic results exceed the goals set for the measurements, which complicates the presentation of the measures in the diagram.

**The author's reflections on the design**

As mentioned in the previous section, the organization’s vision provides the direction, focus and motivation that guide the organization, for both the short and long term and represents the values and purpose of the organization (Porras and Robertson 1995). The vision of the department is “For the patients, Lungs, Air and Life, and for the personnel, Knowledge and Empathy”. Hence, the vision identifies two stakeholders in the department, namely the patients and the employees. Providing the patients with lungs, air and life is identified as the mission at the department. The mission is achieved through having employees with knowledge and empathy, which is the main focus in the department. The fact that the employees are mentioned in the vision may also contribute to increasing the motivation among the personnel. Although it is difficult to evaluate, based on the interviews, how well the vision represents the values
and core beliefs of the department, the fact that all the interviewees at the department recognize the vision indicates that the vision is a good representation of the department’s values.

Another reflection of the BSC design concerns the visual representation of measures in the cobweb diagram (see Figure 4.4). The diagram shows both the real outcome and the planned goal for each measure presented. Hence, the design makes it possible to compare the annually set goal with the actual outcome after a four-month period. However, the visual display does not enable any comparisons between measures exceeding the planned targets, since the area of the outcomes covers the planned goals.

Another aspect of the visual display is that the diagram does not communicate the measurements’ relation to perspectives, strategic choices, or critical indicators, which makes it hard to relate the measures to the BSC. In addition, the diagram presents data from one four-month period at a time, and thereby it does not present any historical information. This makes it difficult to interpret trends and predict outcomes based on the visual display (Elg 2001).

One may also reflect on the fact that the economic measures are excluded from the cobweb diagram. According to the Quality Coordinator, the measurements in the economic perspective are not represented in the diagram, due to the management’s difficulty to display these measurements. It thus seems that the primary reason for not including the economic measures in the diagram is the problems in the visual display itself. Since the diagram seems to be an important source for communication throughout the County Council, it is essential that those using it for information dissemination understand the technique behind the visual display. According to Kennerley and Neely (2002) an infrastructure for collecting, analyzing, and reporting appropriate data needs to be available in order to trigger the evolution of a performance measurement system. In this case, the technique behind the cobweb diagram may be identified as a barrier for using the BSC as an information system at the department. If the technique is going to be used despite its shortcomings in visualization, it is essential to have skills available to use such a technique (Kennerley and Neely 2002). In this case, the management of the department seems to have insufficient knowledge of how to visually present the economic measures, which constitutes a constraining factor in the use of the BSC as an information system.

In addition to the problems related to the visual presentation, the empirical findings show that the management of the department finds it difficult to select measures in the BSC. Measures seem to remain in the BSC although they are not in use. Having too much data reported in the system is identified as a barrier to the evolution of performance measurement systems in the study by Kennerley and Neely (2002) and is
a result of insufficient management time set aside to reflect on performance measures (Kennerley and Neely 2002). Reviewing and reflecting upon measures is also an important issue in working with quality management.

The change principle of continuous improvement (Hackman and Wageman 1995) contains this self-reflecting process in which the system is being evaluated and changed in accordance to the new conditions. Hence, the empirical findings indicate that the department has the potential to improve the evaluation process of measures in the BSC in order to achieve effective use of the tool.

Like the O-center’s BSC design, the department does not use strategy maps to illustrate its scorecard, which makes it hard for employees to understand the strategic decisions on the departmental level. Dividing the key measures in the BSC into performance drivers and strategic outcomes shows that the strategic focus in the department is on measures in the Customer perspective, the Process perspective and the Economic perspective (see Table 4.2). To be available for the patient seems to be important in the Customer perspective since the department focuses on measures such as answer to the patient’s questions and to provide the patient with care in three months. The Process perspective includes measures that focus on attaining good medical results and on being available for the patient. In the economic perspective, the focus is on the level of production and on costs for medicines in in-patient and out-patient units.

The measures in the other perspectives are identified as performance drivers because they concern process documentation, and employee related measures. They are important to focus on in attaining the strategic outcomes.
Table 4.2: An illustration of how the measures in the department’s scorecard may be divided in performance drivers and strategic outcomes.

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<tr>
<th>Perspectives</th>
<th>Performance drivers</th>
<th>Strategic outcomes</th>
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<tr>
<td>Customer perspective</td>
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<td>Care in three months</td>
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<td>Participation</td>
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<td>Answer to questions</td>
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<td>Doctor responsible for the patient</td>
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<td>Process perspective</td>
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<td>Patients in national O2 register</td>
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<td>Cancer patients that start treatment in one week.</td>
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<td>Diagnostic precision, bronchoscope</td>
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<td>Diagnostic precision, lung puncture</td>
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<tr>
<td>Research &amp; Development, Learning</td>
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<td>perspective</td>
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<td>Employee perspective</td>
<td>Employees that follow development plans</td>
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<td>Employees that participate in developmental work</td>
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<td>Employees ”Level placement”</td>
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<td>Economic perspective</td>
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<td>Production</td>
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<td>Medicine costs out-patient</td>
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<td>Medicine costs in-patient</td>
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4.3.2 The implementation of the BSC

In spring 1998, the Federation of Swedish County Councils invited the management of the department to participate in network meetings about the BSC. The meetings aimed at sharing knowledge about the BSC among five departments that had shown great results in quality improvement activities. At that time, the Quality Coordinator and the Head of Department had heard about the BSC from management journals and other departments. However, it was through the network meeting invitation they learnt about its implications in practice. Four members of the management team decided to attend the network meetings in order to gain more knowledge about the concept. The network meetings provided the department with knowledge and forums for reflections about the design and implementation of the BSC.
The Swedish Quality Award

The Department of Pulmonary Medicine started actively working with quality issues in 1993 as the department was participating in a project concerning the Swedish Quality Award\textsuperscript{19}. At the Department of Pulmonary Medicine the award won great interest, although they at first experienced difficulties in understanding new terms such as ‘customer’ and ‘process’. The first time the department wrote their annual report on the basis of the award description was in 1993. The second time in 1996 they received the Swedish Quality Award for their efforts in quality development. At the same time, the management of the department experienced that following up the activity according to the award description was not dynamic enough. According to the Quality Coordinator it was difficult to identify measurements indicating the department’s future direction. In addition, the QUL model was very resource demanding to use.

The interviews with the management of the department and employees show that the Swedish Quality Award in 1996 led to increased attention from media and other health care organizations. Employees were invited to different forums and seminars to present how the department had worked with quality improvements. Although the reactions from external stakeholders and organizations were mainly positive, the reactions from the hospital were somewhat different.

"[After the award] everyone was out holding presentations and people came to visit the departments. We worked very hard. [...] We received a small rise of 300 SEK, but it disappeared into the big black hole. We received attention from media but not so much from the hospital. Instead, we shouldn’t go round and thinking we are special."

(Employee\textsuperscript{20})

Frustration among employees

Most employees that were interviewed describe the period after the award in 1996 as turbulent. Although the award led to increased pride and commitment in the department, employees express a frustration with the situation.

"It was not so much about the award, but about the cutbacks in the hospital that started. It was totally crazy. Nobody took notice of our improvements and that we had reduced our lead-time and everything we were up to. Instead we were going to make the same cutbacks as everyone else. [...] We were left with only a small part. We were left dejected in the corner with twelve beds and almost no assistant nurses and two nurses. They made major cutbacks in personnel, but the assistant nurses were affected the most."

(Employee\textsuperscript{21})

\textsuperscript{19} sw. Utmärkelsen Svensk Kvalitet, USK
\textsuperscript{20} Quotation 9, Appendix 2
\textsuperscript{21} Quotation 10, Appendix 2
"It was a hard time after the award. We became almost too good. Then a lot of personnel were dismissed. The number of patients decreased. The finances were going to be made more efficient. […] We saved a lot on the personnel. Of course, we were the best.”

(Employee22)

The economic cutbacks in the County Council affected all the departments at the center, and the Head of O-center describes the measures as necessary and expresses an understanding that people at the department experienced not receiving enough attention and appreciation from the hospital.

"[The department] probably thinks they haven’t received enough appreciation. I suppose there has also been some jealousy from a few department that have been expressed through ‘how can they have so many resources to work with that, we don’t have those resources’ […] The department received the award and then got a pat on the back from the County Council. They might think that it has not been enough and, of course, that is true. They have the same tough economic demands as every other department. ”

(The Head of O-center23)

The management of the department started to rethink things and came up with new ideas how to find new energy and get the department back on its feet. According to the Swedish Quality Award assessment report the leadership had improvement potential. Hence leadership became the priority focus of the organizational change. At the same time in 1997, a new Head of Department was employed.

"The question was how we should move on. According to the Swedish Quality Award, the leadership was very indistinct, and thereby this was the first issue to deal with. The Head of Department was a driving force because she needed to know how to lead the department otherwise it would not work. She had to feel that the rest of department supported her leadership. ”

(The Quality Coordinator, Department24)

The new Head of Department started to establish a new management structure including new role descriptions and a new organizational structure. The turning point came in 1998.

22 Quotation 11, Appendix 2
23 Quotation 12, Appendix 2
24 Quotation 13, Appendix 2
"We did many different things. I initiated a project together with the [occupational health service], that aimed to investigate the psychosocial climate at the individual level under complete confidentiality. I believe in funerals and weddings, i.e. you have to bury the old before you can begin something new. We did that. Then I proposed a management structure that was very accessible since it specified who’s in charge and how. [...] Mainly, [it contained] structure since it leads to security and accessibility. Now you don’t need to be concerned about the rules since you know the roles, and who’s responsible. You know how decisions are made and that the informal decision-making process is not valid."

(The Head of Department²⁵)

**Building a BSC on the department level**

As the BSC network meetings commenced, the members of the management team experienced that the BSC approach was a useful tool for linking different parts of the department. The management members started to reflect on an overall vision for the department. They realized that the existing vision did not represent the values of the department. The objective was to establish a vision that everyone could identify with. Different proposals of a vision were discussed together in a group setting, which included employee representatives from the department. The group communicated the proposed vision throughout the organization in personnel meetings and union forums. After several discussions with employees about an appropriate vision, one employee came up with a proposal, which was finally accepted by the whole clinic. The Head of Department describes the responses from the personnel:

"Some [employees] said that it was the worst thing they have ever heard of. And it kept on for a while. Finally one employee came up with a proposal, so it was not us. It was not the management of the department that proposed the final version of the vision, but it was an employee. It feels special in some way, since you have initiated a dialogue and had employee participation from the beginning."

(The Head of Department²⁶)

The formulation of a new vision took approximately one year from the idea of the first proposal to the decision of the final version of the vision.

After the establishment of the vision the management of the department continued making a BSC on the departmental level by determining the present situation and agreeing on the mission of the department. Thereafter, the management team started discussing strategies, critical success factors and objectives. The Head of Department

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²⁵ Quotation 14, Appendix 2
²⁶ Quotation 15, Appendix 2
describes the process as non-linear, in which new and old items were included in the scorecard and the different elements were continuously discussed and questioned.

"We started with the vision, our mission, how the activity is conducted today, our critical success factors and goals. We used already existing documentation to add to the BSC and define the different perspectives and so on. We were learning all the time. We are only ordinary laymen that work in the clinical activity in different ways. It is a great learning experience for us to just understand it before we can communicate it to others."

(The Head of Department)

During the design of an over-all scorecard, the management team started discussions about deploying it within the department. At that time, all the units reported their results in an annual report, which were written in free hand. The management decided to redesign the annual report into operative scorecards including three perspectives, namely a customer perspective, a process perspective and an employee perspective.

The author's reflections on the implementation

When the management of the department introduced the BSC concept, people in the organization had been experiencing a turbulent period after having received the Swedish Quality Award. People experienced some frustration due to the lack of attention from the hospital management combined with economic cutbacks. This situation indicates that there was a need for change as the BSC was introduced. Porras and Robertson (1992) emphasize the importance of identifying a need of change in order to make the organization change effectively. Rogers (1974) proposes that changes in a social system occur through a crisis, which is identified as a situation perceived as threatening for the organization’s future. In this case, people seem to have been strongly affected by the situation, which indicates that people experienced that the department’s future existence was at stake (see quotations p. 81). The management dealt with the situation through improvement initiatives concerning the leadership and the introduction of the BSC was a part of these initiatives for change. Hence, the changes expected from the introduction of the BSC were likely to succeed, as there was a need to change the situation, which was experienced by both management and employees. However, I do not want to over-emphasize the impact of the crisis in the organization on the introduction of the BSC since people tend to re-construct historical events in order to make them reasonable and logically explainable afterwards (see 7.2 A Critical Review of the Research Process, p. 127).

Another reflection concerns the degree of participation in the implementation. The management seems to believe in having a high degree of participation from an early

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27 Quotation 16, Appendix 2
stage of the BSC introduction. All the employees were involved in the formulation of a vision, and the management let the formulation take time. This way of implementing a BSC differs from the way proposed by Kaplan and Norton (1993; 1996b; 2001), who argue that the over-all BSC should be built and constructed by management and thereafter make people accept it through a top-down communication process. However, the participation of employees has a major role in Quality Management initiatives (see e.g. Dahlgaard et al. 1998; Eklund 2000; Olsson 2002) and is emphasized as an essential condition for effective organizational changes (Porras and Robertson 1992).

One may further reflect upon the process of building the BSC. The management describes the building as a learning process, in which strategies, critical success factors, objectives, and measures were discussed backwards and forwards on the basis of old documentation. This is different from the way proposed by Kaplan and Norton (1993, 1996b), who describe the building of a BSC as derived from the vision of establishing new operational measures. If the BSC is built up around old measures that are not derived from the vision and strategies through a coherent strategic discussion, Olve et al. (2003) claim that the organization reduces its potential to experience the benefits from the BSC.

It is also interesting to note the role of external consultants in the building of the BSC. Kaplan and Norton (1993) suggest that a “balanced scorecard facilitator” identified as an external consultant, or an executive should be hired during the building and implementation of the BSC. In this case, the management of the department has handled the building and the implementation of the BSC on their own. Dealing with the implementation themselves instead of hiring external consultants may lead to higher costs and efforts being put on the implementation. However, it may also create conditions for an effective implementation since the facilitators have sufficient knowledge about how to link theory with practice (Porras and Robertson 1992).

4.3.3 The use of the BSC

According to the Head of Department the BSC is a method, which contributes to basing decisions on facts. She claims that the scorecard provides the discussions with a knowledge foundation of the department’s activities, which is useful in meetings and negotiations with superiors.
"I think [the BSC] is good, but regardless of what method you use, it’s important to have facts that you can base your decisions on. If I say something in a meeting or negotiation I have facts to backup my statements since we have a lot of measures within all perspectives. It creates a great feeling of security."

(The Head of Department28)

The interviews with management further show that the emphasis in the use of the BSC is on everyone’s participation. The management strives for a high level of participation and involvement in the use of the scorecard. Participation is achieved through a yearly management meeting with each unit, frequent information dissemination in meetings and by letting the units experiment with the BSC themselves. The communication of information is a central factor in the work with the BSC since the management believes that nothing should be kept secret.

**Developmental activities related to the BSC**

The management of the department discusses the content of the BSC and the measurement document during management meetings. The discussions mainly revolve around the construction of measurements, their validity and reliability. The discussions also deal with what measures to present in the BSC from the measurement document (see Figure 4.3). The Quality Coordinator explains that the measures in the BSC should be representative and controllable, but not too numerous. Every fourth month the measurements are discussed in more detail since the results are then reported to the O-center.

According to the Head of Department the discussions involving the BSC mainly focus on the measurements in the economic perspective due to the emphasis on the economic side at the O-center. However, the department’s strategic approach is to focus on different areas, which are identified in strategy meetings and surveys etc. In 2001 the customer perspective was prioritized since the management perceived that the customer had been ignored in the strategic discussion. In 2002 the employee perspective was focused on.

**Reporting results to the O-center**

In February each year, the management of the department hand in the yearly balance sheet to the O-center. The department’s BSC, with a detailed description of the measurements, is then attached to the balance sheet. The description corresponds to the O-center’s instructions, which were sent out to the departments in 2001, and is based

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28 Quotation 17, Appendix 2
on the O-center’s BSC (see Figure 4.1). According to the management of the
department, the instructions for the descriptive report are adapted to departments,
which have no experience with the BSC or have recently started working with the
model. In addition to the annual balance sheet, the department’s results are reported
every fourth month according the O-center’s instructions.

**Following-up the units’ results**

At the end of each year, the units report their results in their scorecards, which are
documented on the department’s computer network. The Quality Coordinator follows
up the results and compiles the measures in the measurement document. If there are
measures missing, she informs the information source or fills in the measures herself.
Usually, there are measures missing, but according to the Quality Coordinator the units
have improved the reporting of measures over the last year. Today, she thinks the
employees are less dependent on her support during the report periods.

In the beginning of the year, each unit hand in their BSC to the management team,
which includes the actions planned and targets for the upcoming year. The scorecards
are then discussed during a meeting between the management and each unit. The
discussion concerns the achievement of goals and how the measuring takes place.
Through the discussions the management can assess the units against over-all goals
and measures. According to the Head of Department, the meetings contribute to
aligning the units’ results to the goals and measures of the department. In addition they
create involvement in the department’s progress.

"Together with the units the management team discusses the measures; if they are
reasonable, if they are right, if they are too many or too few, and so on. Thereby the
units’ results are aligned with the department’s goals, and measures and it creates
involvement. And, as I have understood it, you appreciate it since you have an
opportunity to show your work and receive feed-back."

(The Head of Department\(^\text{29}\))

The units’ scorecards should be handed in together with project plans attached to each
planned action in the action plan. During the yearly meeting with the unit the project
plans are approved by management. According to the Quality Coordinator many units
miss filling in project plans. Instead, the project plans are handed in to the
management during the year. The management then discusses the plans during
management meetings.

\(^{29}\) Quotation 18, Appendix 2
Dissemination of information

During department meetings the Quality Coordinator and the Head of Department use the over-all scorecard to present the department’s result and future direction. It is used as a tool to communicate the reported measures from the units in order to update how the current situation corresponds to the over-all goal. According to the Quality Coordinator, the scorecard stimulates communication and dialogue within the organization.

The over-all scorecard is also used during forums and seminars aimed at presenting the department’s status to external stakeholders within the hospital. In the beginning of the year the steering group of the UH together with representatives from CQ visit every center in the hospital to gather complementary knowledge for the annual report. During the meeting at the O-center all nine departments are represented. The Head of Department then uses the scorecard as a basis for the presentation of the activities at the Department of Pulmonary Medicine.

In order to further disseminate information throughout the hospital all the departments present their results on the hospital’s intranet according to a standard scorecard in a PowerPoint document designed by CQ. The Quality Coordinator updates the department’s document when the results from the units are submitted.

The author’s reflections on the use

As previously mentioned, management uses the BSC during management team meetings to develop and evaluate measures. The focus of the discussion is firstly and foremost on economic measures due to the O-center’s interest in these measures. However, the department focused, for the time of this study, on measures in the employee perspective. Hence, it seems that the department and center have different interests regarding the focus in the BSC. While the O-center focuses on the economic measures, the department has an interest in focusing on measures in the employee perspective. Having different focuses in the BSC indicates that there are different goal pictures in the organization.

According to the management of the department the instructions from the O-center, which are used as a basis for tertiary and annually reporting of results to the O-center, are first and foremost suitable for departments that have no or little experience with the BSC. This picture is confirmed by the interview with the Quality Coordinator at the O-center and indicates that the Department of Pulmonary Medicine, which has been working with the BSC since 1998, has a little or no use of the instructions from the O-center. Since the instructions are based on the BSC at the O-center, the BSC in the department seems to be weakly connected and aligned with the BSC in the O-center. In the view of the fact that the center and department have different goal pictures and
weakly aligned scorecards, one may question the O-center’s ability to align the department’s results with a common vision for the entire O-center.

Another reflection concerns the management’s focus on measures when discussing the BSC. The interviews show that the developmental activities related to the BSC in the management team are focused on measures and their reliability and validity. According to Kennerley and Neely (2002) a main barrier to the evolution of a performance measurement system is the lack of an effective process to reflect upon the measurements. Their study shows that management needs to take time to reflect upon the measures in order to stimulate the evolution. In this case, the management seems to allocate time for reflection upon measures. Every fourth month the measures are discussed in more detail. However, the findings indicate that the discussions in the management team risk getting caught up in technical issues instead of focusing on the measures’ connection to the long-term approach of the department. Elg (2001) shows that a shift in focus from the organizational activities to the measure itself seem to appear when new performance measures are introduced in the system. In this case most measures are still there from the introduction of the BSC in 1998. However, the documentation of measures from the units started in 2000. This may indicate that the BSC is still being developed according to the conditions of the department and that the management team uses the BSC as a way of receiving appropriate information about the units’ activities. Thus, it seems that the BSC at the department level is used as a managerial information system instead of as a strategic management system, which aims to align the operational measures to the over-all strategies in the organization.

4.4 THE BSC IN THE UNITS OF THE DEPARTMENT

At the unit level, the BSC concept was introduced as a management tool by the management team at the department in 1998. The actual scorecards were introduced in 1999 as a new form of reporting results to the management. According to the employees interviewed, the reactions from the employees were mainly negative due to the new vocabulary and the design of the new report. Despite the resistance to the new concept the BSC gradually gained acceptance from the employees. Several reasons are mentioned. For instance, most of the employees saw the benefits when they started working with the BSC. It is mentioned as an easy way of receiving an understanding and overview of the annual activities. Another aspect mentioned is the department’s prior experience with quality improvements.
4.4.1 The design of the BSC

The department’s BSC is deployed to eight units. In addition to the six units mentioned in 4.1.2 The O-Center and the Department of Pulmonary Medicine the Welfare Officer and Physiotherapists report their results according to the BSC.

Each unit is expected to develop its own scorecard, which includes a yearly action plan, measures and goals. In addition, the employees are obliged to fill in project plans for each action in the scorecard. All the units report their results in three perspectives, namely the customer perspective, process perspective and employee perspective.

In Figure 4.5 a scorecard in the employee perspective for one of the units is presented. This is used as a basis for the following discussion about the units’ scorecard design.

Action plans, measurements and goals

A first observation of the unit’s scorecard is that the document is not called a scorecard, but an action plan. In addition, the strategy at the top of the document is depicted with a question, which describes the meaning of the strategy. This is also the case for the terms ‘critical success factors’, ‘action plan’ and ‘critical key measurements’. For instance the term ‘critical success factor’ is translated to the question “What factors are important for us to reach the goals?”

The critical success factors are presented in the first square of the scorecard. These are the same in all scorecards at the unit level, except from scorecards of two units. These units have instead added their own critical success factors. One unit’s scorecard does not include any critical success factors in the process perspective.

The action plan includes actions that are performed throughout the year. All the units have reported their planned actions in various details. The critical key measurements are reported below the action plan, and illustrate the unit’s most important measurements. The goals and results are reported to the left of the measurements.

Reviewing all the units’ scorecards show that the space in which the measurements and goals should be filled in is either empty or incomplete. This indicates that the employees have difficulties in finding appropriate measurements and goals.

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30 sw. “handlingsplan”
Handlingsplan för verksamhetsuppföljning på Lungmedicinska kliniken, 2002
Oxygen/respiratormottagningen

Medarbetarperspektiv

Strategi: (Vilka är våra huvudresultatstvingar för att nå visionen?) Vår arbetsmiljö skall vara attraktiv och utvecklande för alla medarbetare. Där ska anställningstrygghet, säkerhet, information, delaktighet och erkännande vara grundläggande komponenter och bidraga till en god arbetsmiljö

Kritiska framgångsfaktorer: (Vilka faktorer är avgörande för att vi ska "gå mot" målen?)

Hög kompetens
Hög arbetstillfredsställelse
God arbetsmiljö

Handlingsplan: (Vilka aktiviteter ska vi genomföra för att "gå mot" målen?)

Utbildning i respiratorvård på kliniken.
Delta i nationella registermötet.
Utbildning inom O2 och respiratorvård.
Delta i 1 användarträff/år. (Utbildning i företags regi)
Fungerande IT-stöd.
Eget rum + sång till resp.pat på avd. 62.
PM artärgaser.

Kritiska nyckeltal:

<table>
<thead>
<tr>
<th>mål 2002</th>
<th>Resultat / % måluppfyllelse</th>
</tr>
</thead>
</table>

Figure 4.5: The design of the BSC at the unit level as presented by the Oxygen/Respiratory out-patient unit
The interviewees’ comments

The Quality Coordinator of the department initially designed the BSC at the unit level. The management team decided not to include the economic perspective since the financial reporting is done by the accountant from the O-center. The research and development, learning perspective was also excluded in the BSC due to its ambiguous character. However, in order to increase people’s economic awareness, management communicates measurements in the economy perspective throughout the department. Due to the initial resistance to the vocabulary used in the scorecard, the Quality Coordinator decided to include descriptive sentences in the BSC. According to the management of the department all the units are free to include their own critical success factors in their scorecards.

According to two of the employees interviewed, the measurements in the unit’s scorecard are not new but were constructed during the work with the Swedish Quality Award. One employee thinks that the customer perspective in the scorecard does not describe the actual meeting with the patient, which she views as the most important and critical activity in the department. Another employee brings up “the patient’s weight” as a good measurement to include in the scorecard. One of the employees argues that the work environment is an important factor to follow-up since the work is heavy from time to time. She thinks the work environment is good, due to the unit’s independence and autonomy.

The author’s reflections on the design

The BSC design at the unit level includes strategies, critical success factors, action plan, key performance measures, targets and results. These elements make it possible to connect the operational measures to the over-all strategies of the department, which is a basic idea of the BSC framework (Kaplan and Norton 1992). A closer examination of the BSC shows that some concepts have been translated into sentences or more usable terms. For instance, instead of using ‘scorecard’ the BSC is called ‘action plan’ due to the initial resistance to new concepts among employees. This adaptation of the BSC to the needs of the existing organization is also apparent in the management’s approach to the development of the units’ scorecards. The units are free to develop their own measures and critical success factors. This indicates that each unit is highly autonomous in regard to the rest of the department. One may then question to what extent the BSC at the department level aligns with the results on the unit levels if the units are free to set their own measures and critical success factors.

One may also reflect upon the deployment of the BSC into three perspectives. Since the department’s strategic choice is to increase people’s economic awareness (see Figure 4.2), one may argue that the economic perspective is deployed to the unit level.
Extending the economic perspective to the unit level may lead to increased economic awareness since employees thereby receive knowledge of the economic effect of their improvement efforts in the employee, customer, and process perspective. The management’s argument for not deploying the economic perspective is that the accountant of the O-center is responsible for the economic measures. This indicates that the management does not have sufficient knowledge to disseminate the economic perspective to the unit level, which thereby may be perceived as a barrier to increasing the economic awareness among employees.

Like the center and department levels, the units do not use strategy maps in their BSC design. Reviewing the measures in all the units’ scorecards show that the Customer perspective includes about 30 different kinds of measures, the Process perspective includes about 20 different kinds of measures, and the Employee perspective includes about 15 different kinds of measures. The fact that most measures are derived from the Customer perspective indicates that there is a strong customer focus at the unit level. Dividing the measures in each perspective into performance drivers and operative outcomes show further that the focus at the unit level is on the Customer perspective, since most of these customer related measures may be identified as operative outcomes (Kaplan and Norton 2001). Since strategic outcomes concerns measures at a strategic managerial level, I have chosen to call the outcome measures at the unit level operative outcomes. This may clarify that the units are not dealing with strategic managerial decisions at the department level. See Table 4.3. Note that not all the measures are mentioned in the table. Most measures in the Process and Employees perspectives are identified as performance drivers.
Table 4.3: Examples of measures in the scorecards at the unit level and how they may be derived into performance drivers and operative outcomes.

<table>
<thead>
<tr>
<th>Perspectives</th>
<th>Performance drivers</th>
<th>Operative outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customer perspective</td>
<td>STRUL reports taken care of</td>
<td>Patient satisfaction survey 2 times/year</td>
</tr>
<tr>
<td></td>
<td>The CF team includes two people from different professions</td>
<td>Answer to questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients meeting the same doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Availability</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Symptom alleviation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Time to decision about treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Complaints that have been attended to</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Care in three months</td>
</tr>
<tr>
<td>Process perspective</td>
<td>STRUL reports taken care of</td>
<td>Patients taken care of in three months</td>
</tr>
<tr>
<td></td>
<td>Statistical waiting time</td>
<td>Patients in O2 register</td>
</tr>
<tr>
<td></td>
<td>Employees that have got an introduction to the nutrition</td>
<td>Patients in home respiration register</td>
</tr>
<tr>
<td></td>
<td>folder</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employees that have learnt to make pharmaceutical orders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Updating the care program</td>
<td></td>
</tr>
<tr>
<td>Employee</td>
<td>Report 1-2 times/week</td>
<td></td>
</tr>
<tr>
<td>perspective</td>
<td>Team conferences</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Employees participating in training days</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reviewing the checklist for new employees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documented responsibility areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experienced participation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Experienced work environment</td>
<td></td>
</tr>
</tbody>
</table>

4.4.2 The implementation of the BSC

According to the interviews with management of the department, the BSC concept was gradually introduced throughout the department. The management started introducing the BSC concept during personnel meetings by saying that it is primarily a management tool that the management had started to learn more about. They were very clear on not presenting it as a tool the entire department was going to work with, since that would have increased the resistance to the concepts.
"We told them that the management team were looking at something called the Balanced Scorecard. 'It is a management instrument that we would like to learn more about. When we know more about it we will tell you about it.' We told them when we left for meetings and what we did in order to keep the organization informed all the time. But we didn’t say that we were going to start an implementation since that would have been unwise. Then they would have directly said no due to their prior experience with all three letter concepts."

(The Head of Department\textsuperscript{31})

In 1999, when the management team had designed a BSC for the units, the Quality Coordinator started introducing the new reporting form during department meetings. The Quality Coordinator supported the units in filling out the reports by attending their unit meetings. Later on, several employees have attended training sessions about BSC arranged by CQ in order to learn more about its practical use and application. The Quality Coordinator claims that at least one employee from each unit should attend the BSC education.

\textbf{Resistance to the new concept}

The reactions to the introduction of the new concept varied among the employees. All the employees that were interviewed expressed that at first they thought the new concept was difficult to understand. Two interviewees expressed that the vocabulary and concept took a lot of effort to sort out.

"When we filled out our annual reports we had to reflect on what a process is and what is meant by customer and what is an employee. We had to think about the meaning of the concepts and what they meant to us. Since all the units write their own annual report, everyone needs to think about what should be included."

(\textit{Employee}\textsuperscript{32})

One employee thought the new design was hard to relate to and adapt to.

"At first I thought it was a mess. I thought it was difficult to understand what to include. You couldn’t describe anything since it could only contain a few words. I am used to describing my work in several pages. Therefore it took some time to get a grip on it. But when I had used it a few times it became natural."

(\textit{Employee}\textsuperscript{33})

Three of the seven employees that were interviewed expressed that the initial information from the management was poor. One employee thought that it was mainly

\textsuperscript{31} Quotation 19, Appendix 2
\textsuperscript{32} Quotation 20, Appendix 2
\textsuperscript{33} Quotation 21, Appendix 2
one-way communication, which did not create any deeper understanding. Another employee felt that the management of the department sometimes used the concept too often without explaining its implications. Another employee thought that the lack of a clear explanation of the purpose of the new model led to frustration when filling in the BSC form.

"Sometimes it has been so much that I have felt 'No, not that again', but it has been good. Now I feel I can manage some of it. It was quite trying for a while. [The management] talked about Balanced scorecard without explaining its implications. But when they sat down and explained what it means and how it should be used, it is easier to understand."

(Employee^{34})

**Employees’ perspective: Management’s commitment, ‘learning by doing’, and quality experience**

Although the BSC was at first received with skepticism, the interviews with the employees show that the BSC has gained acceptance in the department. The interviews show that there are several reasons for the increased acceptance of the BSC. According to five of the seven interviews with the employees, management’s commitment during the reporting is viewed as an essential factor.

One employee felt that she learnt how to fill in the new report as the time went by. Two of the three employees that attended BSC education think the training increased their interest in the tool. One of the interviewees describes that the trust in the Quality Coordinator has been a significant factor.

"[The Quality Coordinator] has such an authority. She usually comes with something useful, but we might not see it from the beginning. The department has trust in her, and if the things she says are good, we try it and see if it works."

(Employee^{35})

Two employees that were interviewed think the department’s experience with quality issues have had an impact on the implementation process. According to one of these two employees the resistance to the new concept was overcome since the BSC suits the department’s way of thinking. The other interviewee views TQM and the BSC as complements to each other. She claims that many parts in the scorecard are familiar to the employees through the introduction of TQM in the 1990.

^{34} Quotation 22, Appendix 2
^{35} Quotation 23, Appendix 2
Management's perspective: Quality experience, adaptation of terminology, and long-term thinking

According to the management of the department there are several factors that have enabled the implementation of the BSC. The most important factor, which was mentioned in all interviews with the management of the department, is the department’s prior experience with the Swedish Quality Award. For instance, one management member argues that the experiences from the award have led to increased collaboration between people through team working. This has implied that the scorecard could be accepted since the model is constructed through collaboration and everyone’s agreement on common objectives.

Two management members claim that the department’s experience with the Swedish Quality Award has made people accustomed to a different vocabulary. According to the interviewees this has enabled the implementation of the BSC since people are familiar with the terminology used.

"If you are going to understand the processes and so on, you have to identify your customers and all that. If you haven’t understood the terminology I think it is very difficult. I believe we have had enormous benefit from that. [The BSC] is a continuous development of that work."

(The Head of Department36)

However, in order to enable the adaptation of terminology used in the BSC to the department’s current terminology, the management of the department decided to change terms included in the BSC to descriptive sentences. In addition, the new version of the annual report was not described as a BSC, but rather as a new form of annual report.

"The BSC is logical and easy to understand if you learn the language. For example, critical success factors have not been totally accepted in the department. Instead we call it something else: ‘What do we need to be good at?’ The BSC is a three letter concept that is not very popular. Instead we use ‘annual report’ to make the work easier. I don’t believe people have accepted the concept BSC, but rather the way of describing their activities. It depends on what your aim is, to make people understand or make them know a term."

(The Quality Coordinator, Department37)

The Head of Department further emphasizes the importance of long-term thinking in the implementation process in order to reduce the risk of adopting a new methodology and concept when it turns up. She believes in letting new concepts take time, let

36 Quotation 24, Appendix 2 37 Quotation 25, Appendix 2
people agree and accept the new thinking. She also points to the importance of adapting the BSC to the department’s own conditions.

**The author’s reflections on the implementation**

The management’s approach during the introduction was to keep the organization informed about the BSC during staff meetings. The management started to inform the organization as they started to attend the network training arranged by the Federation of Swedish County Councils. Despite the management’s efforts to inform the employees at an early stage of the implementation, some employees felt the initial information from the management was insufficient. One explanation to the differences in interpretations may be the fact that during the initial introduction management was learning about the BSC and therefore did not fully understand its implications. Thus, as employees started to question the BSC management may not have been able to respond since they did not yet have the understanding themselves.

A central enabling factor in the implementation pointed out by employees is management’s support. The Quality Coordinator is mentioned as having a key role in the implementation. The department has confidence in her since her prior initiatives have been successfully implemented in the organization. According to Porras and Robertson (1992) change agents are ascribed a major role in organizational change literature. In this case the Quality Coordinator may be seen as a change agent in the implementation of the BSC with support from the management of the department.

In order to facilitate the implementation of the BSC, management has adapted the terminology in the BSC to the terminology used in the units. According to Kaplan and Norton (1993, 1996b) the BSC should be adapted to the actual conditions of the organization. However, one may reflect upon how far the adaptation of the concept can go until the expected benefits fail to appear. For instance, in this case the deployment of the over-all BSC into three perspectives at the unit level, which can be seen as an adaptation of the concept to the organization’s conditions, may lead to a reduced economic awareness among employees (see previous section). Since increased economic awareness is a strategic choice at the department (see Figure 4.2), the way the BSC is deployed in the units may rather counteract this strategic aspiration. Thus, it seems important to consider how the implications of the adaptations align with the organization’s direction.

**4.4.3 The use of the BSC**

All the employees interviewed express that they view the BSC as a tool that management of the department can draw benefits from in their strategic work. One interviewee did not think that the management discuss the content of the over-all
scorecard every week, but thinks it is frequently discussed between the Quality Coordinator and the Head of Department. She thinks that if the BSC were to be used correctly it should be discussed in the management team every week.

The interviews show that the commitment to the BSC varies between units. Whereas employees from the out-patient units seem more involved in the work and familiar with the concept, employees at the in-patient unit are not used to the concept and not committed to the work.

Employees from the in-patient unit view the BSC as a directive from the management to receive information about the unit’s annual activities. One employee expresses that the management is working with the BSC because it has become a uniform standard of reporting the results in the County Council.

One employee from the in-patient unit mentions several reasons for the differences in the use between the out-patient units and the in-patient unit. For instance, the in-patient unit finds it more difficult, compared to other units, to allocate time for meetings since their patients need continuous attention. The personnel in the in-patient unit are also divided into day and night personnel, which make it impossible to inform all the employees at a time. In addition, the fact that the in-patient unit employs 30 people, which is considerably more than each out-patient unit, makes it hard to involve all the employees in the unit’s scorecard.

**Reporting results to management**

All the units are obliged to report their results every fourth-month and in time for the annual balance sheet. The measurements in the BSC are then updated for the current period. Although the units have some knowledge of the expected reporting procedures, most units do not report their measurements in time, which leads to the management needing to remind the units to fill in their BSC.

The in-patient unit’s results are reported mostly once a year. The unit leader and the Quality Coordinator then fill in the results in the unit’s scorecard after reminding the staff during unit meetings to submit the project plans. Usually, the project plans have not been filled in continuously during the year, and many employees thus have to fill them in after the activities in the action plan have taken place. According to the unit leader, the employees have become better at handing in the project plans during the year.

Contrary to the in-patient unit’s scorecard, which is reported once a year, the other units review their results more frequently. Usually, the updating of the results is initiated after reminders from management.
Planning of annual activities

At the same time as the annual reporting of results from the previous year, every unit put together their BSC for the following year. The units then define their objectives, measures and action plans. According to the Quality Coordinator the BSC is a dynamic tool, which should continuously be changed and adapted to the organization’s conditions. Therefore, the scorecard needs to be reviewed and changed gradually.

"The idea is that you should think of and reflect on [the BSC] and I don’t believe it should be static. Thus I think it should change and develop as new things arise, otherwise it wouldn’t be a BSC."

(The Quality Coordinator, Department38)

However, the Quality Coordinator claims that a continuous adaptation of goals, measures and action plans may lead to frustration since the employees may feel that they never become good enough as the goals continuously change. Thus the employees may lose their commitment to using the tool.

"But there is a danger that we never become satisfied. Can we ever be good enough? Is it not acceptable that we are this good? We check it sometimes and then it’s ok. It creates frustration. And when should you say enough? You need to keep on striving because if you stop you won’t be good enough anymore. But it is hard to understand the fact that if you have 90% or 80% in results it is good, but you still need to become better. We talk about it every now and then."

(The Quality Coordinator, Department39)

In order to make people review their scorecards on a more continuous basis, all the units have one hour per week during unit meetings to spend on upgrading their scorecards. However, the interviews with the employees show that this time is seldom used for that purpose. One of the units uses the action plans in the BSC during unit meetings as a basis for reviewing the actions taken during the week. While the action plan is followed up every week, the measures are mainly reviewed once a year. Another unit sometimes uses their scorecard at unit meetings to check what actions they have planned to take during the year. However, using the scorecard during the meetings is not standard procedure.

One employee expresses that the planning of the activity according to the scorecard is a way of pushing the work forward. By filling in the BSC, the planned actions become more concrete and definite, which creates a feeling of aspiration to fulfill the goals.

38 Quotation 26, Appendix 2
39 Quotation 27, Appendix 2
"It becomes a small whip on your back having it written down and say ‘we will do this in a year’. You almost have to do it since it is written down on paper. If you only say it, it can be forgotten.”

(Employee 40)

**Increased orderliness**

Planning the annual activities according to the BSC is said to be a way of making the work more accessible. Two of the employees interviewed express that the BSC is used to organize and describe existing tools, methods and procedures in the department. The BSC is said to be a tool, which organizes the project plans and improvement initiatives into one template.

"I regard [the BSC] more as a tool that you use to get on with the things you have been working with before. You get a better overview on things. We have been working with this since 1992, but now it is called Balanced Scorecard and is a good tool for us right now."

(Employee 41)

One interviewee claims that TQM has provided the department with a much greater foundation than the BSC. She thinks that the BSC has not significantly affected the way the employees perform their work. However, the improvement initiatives are compiled and documented through the BSC, which contributes to better order in the department.

**Increased understanding of the unit’s work**

Three of the seven employees that were interviewed claim that the scorecard contributes to an increased understanding of the work in the unit. The scorecard is regarded as a tool, not only for management, but also for the employees to understand how they work and how they should plan their work during the year. Four employees feel that the scorecard provides employees with a comprehensive overview of work. Two of the interviewees claim that the new design of the scorecard, compared to the old report document, is easier to review and to look over. The scorecard enables the prioritizing of the activities since one could see the balance between the initiatives and thus recognize if there is a need for more effort in some direction.

According to the Head of Department, the employees can see how the work proceeds on the unit level and what to improve through the reviewing of the BSC. The Quality Coordinator claims the use of the scorecard contributes to an increased understanding.

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40 Quotation 28, Appendix 2

41 Quotation 29, Appendix 2
for the employees, mainly due to the design of the units’ scorecards. She thinks that the design is simple and gives an overview of the unit’s annual work.

Communication tool

Two employees point out that the unit’s scorecard may function as a basis for discussions with colleagues within the unit. The scorecard may function as a basis for communication between different professions.

“We usually have nurse meetings during which we go through the [BSC] and distribute the jobs since not everyone can focus on the same things. We also have meetings with the physicians. Then we used [the BSC] and that was really good because we discussed what we measure and who’s responsible and then it’s good to have the BSC in front of you.”

(Employee 42)

One employee thinks the scorecard functions as a tool in the conversation with management of the department. During the unit’s meeting with management, the scorecard is used as a basis for making the unit’s initiatives in the following year clear.

All the employees have access to the units’ scorecards on the department’s computer network. However, the network is seldom used to receive knowledge about other units’ scorecards.

Representation of the day-to-day work

The interviews with two of the employees show that the BSC is perceived rather as a way of thinking in the day-to-day work than a paper including different elements, which is reviewed each week. Although the employees do not explicitly work with the scorecard in their day-to-day work, there are similarities in thinking in both the day-to-day work and the annual planning in the scorecard. The scorecard is said to be “in the head” of the two interviewees.

“I think people reflect on it in their daily work, but don’t call it a scorecard. During my daily activities I think of the goal with a certain activity and how we should achieve it.”

(Employee 43)

In addition, the scorecard is viewed as part of the day-to-day work as the scorecard represents the daily activities through the measurements.

42 Quotation 30, Appendix 2

43 Quotation 31, Appendix 2
Not enough time

The interviews show that time is a central factor in the involvement and participation in the BSC. All employees that were interviewed express that they do not have enough time to get involved in the scorecard.

"It is hard to set aside time for it, but I think it’s important. Because I think it is interesting, but the patients need to be prioritized. And they are prioritized since they are dealt with here [in the BSC], but it is more direct when the patient stands there and is sick. He doesn’t care about the BSC. In fact, you are struggling between two sides."

(Employee44)

Due to shortage of time, the weekly-allocated time for work with the scorecard is usually used for clinical-related activities. The Head of Care unit experiences that the in-patient personnel more often prioritizes the daily activities in favor of the scorecard than the rest of the personnel. When she asks the units to review the unit’s scorecard, the reactions are mainly negative.

"The paper maybe tells you to allocate time for the BSC every week, but most people prioritize the clinical activity, especially people at the in-patient unit. It can be difficult to stop thinking about the work during that short time. [...] On Wednesdays we go through the weekly plan and remind people to fill in their BSC if there is time for that. ‘Now it’s time for that again’ people can say when we bring it up."

(The Head of Care unit, Department45)

In addition to lack of time, one of the employees thinks the scorecard is rather boring to work with. She thinks there is too much focus on the technology than on how it is used and integrated in the daily practice.

The author's reflections on the use

The findings show that the BSC is used for reporting results up-wards in the organization to the management of the department and in planning the annual activities. The BSC is also used as a basis for discussions within the units. The contributions from the application of the BSC at the units are experienced as increased orderliness and understanding of the work at the unit. According to Kaplan and Norton (1996) the benefits from the BSC are first and foremost referred to as effectiveness in managerial work. For instance, the BSC helps management to clarify and gain consensus about strategy, communicate strategy, and obtain feedback to learn about and improve strategy. In this case, improvements in the leadership structure were the main purpose for the introduction of the BSC in the department. However, the units

\[44\] Quotation 32, Appendix 2
\[45\] Quotation 33, Appendix 2
also seem to benefit from using the BSC although the BSC is expected to mostly improve managerial work in the management team.

One may also reflect on barriers to the use of the BSC at the unit level. The findings indicate that the BSC has received less attention at the in-patient unit than in other units. This may depend on differences in work design and unit size. In addition, time is mentioned as a central factor in order to stimulate the use of the BSC. However, although management has allocated one hour per week to work with the BSC, this time is seldom used for that purpose. The motivation to work with the BSC seems to be unclear among employees. Employees seem to prioritize the day-to-day activities or do not think the BSC is a part of the day-to-day work. The low motivation indicates that employees do not have enough incentives to use the BSC. This may lead to a decrease in the organization’s willingness to change (see e.g. Porras and Robertson 1992), which will affect BSC use in the long run and also other concepts that may be implemented in future.
5 THE DESIGN, IMPLEMENTATION AND USE OF SCORECARDS

This chapter presents the results from the case study through a discussion of how the scorecards in the organization studied are linked to each other. Firstly, the design of the scorecards is discussed, followed by an examination of the implementation of the scorecards. Finally, the differences and similarities of how the BSC is used on the three levels are discussed.

5.1 DESIGN OF THE SCORECARDS

As described in the previous chapter, the design of the scorecards in the organization differs in many respects. A way to illuminate how the designs of the scorecards used in the organization are linked to each other is to reflect on the long-term aspiration and direction that the scorecards mediate. Below, the fact that the scorecards mediate two separate visions is discussed and how this may influence how the BSC is used in the organization. In addition, the influence of the department’s BSC on the units’ BSC is discussed in order to illuminate the department’s ability to align the units’ results to the over-all vision.

5.1.1 Two visions

As mentioned in the previous chapter, the BSC at the O-center encompasses a vision that expresses an aspiration to develop organizational capabilities in the first place with a focus on becoming a learning organization. The Department of Pulmonary Medicine had developed its own vision before the vision of the O-center was formulated. The department’s vision focuses on the principal stakeholders identified as the patient and the employees. A first examination of the visions shows that they align since they both prioritize internal capabilities such as becoming a learning organization, focusing on the patient’s health, and developing employee skills. However, the fact that the department has its own vision, which is developed with no influence from O-center indicates that the department is autonomous in relation to the O-center. One may then question the O-center’s ability to align the department’s results to a common vision for the whole center.

5.1.2 Different strategic and operative focuses

As mentioned previously, neither organizational level makes use of strategy maps in their BSC designs. This makes it hard for people within and outside the organization to understand the strategies and their inherent logic (see e.g. Olve et al. 2003).
Consequently, there is a risk that people choose to report measures that are not strategically aligned to the over-all vision of the organization.

Reviewing the key questions and measures in the scorecards and dividing them into *performance drivers* and *strategic outcomes* indicates that the strategic focus differs in the organization. At the O-center level measures in the Customer/Patient perspective, the Development/Future perspective and the Production/Economic perspective are strategically focused since the key questions in these perspectives may be identified as strategic outcomes. At the departmental level, the strategic focus in the scorecard design is on measures in the Customer perspective, the Process perspective and the Economic perspective. However, the measures in the Process perspective in the department’s scorecard deals with customer-related aspects such as ‘good medical results’, ‘good diagnoses’ and ‘treatment and availability’, which indicates that the department’s main strategic focus is on the measures regarding the customer the economic. Thus, whereas the O-center’s strategic focus is on customer, research, student’s training and economic issues, the department’s main strategic priority is on customer and economic issues.

The units at the department report mainly patient-related measures in their scorecards. Most measures in the Customer perspective are identified as strategic outcomes, whereas most performance drivers are derived from the Process and Employee perspective. Thus, whereas the department focuses on both customer satisfaction and economic value, the units mainly focus on attaining patient satisfaction in their operative activities.

Figure 5.1 illustrates the different focuses in the organization. The rings represent the focus of measures on each level, and the lines illustrate the connection between similar focuses. The BSC in the O-center is designed to make the management at the O-center focus on patients, finances and research and students’ education in the strategic discussions. The BSC at the department level focuses on the measures regarding patients and finances, while the units primarily focus on the patient measures. Thus, while the measures related to the patient are strategically focused in the whole organization, the measures related to research and students’ education are only prioritized at the center level. The financial measures are focused on at the department and O-center level, but not at the unit level. This shows that the aspirations for improvements differ in the organization, which indicates that the goal picture is not common and shared by all the people in the organization. The risk is that the department and the units strive to fulfill their own goals and targets without consideration of the O-center’s directives. This may lead to a goal conflict implying that different measures regarding for instance research and students’ education are ignored and not improved in future. However, it is worth noting that the measures
regarding the patient are prioritized at all the organizational levels. This indicates that the organization is strongly focused on the patients, which is identified as the primary customer group in the health care and medical services.

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**Figure 5.1: An illustration of the strategic and operational focuses in the organization**

5.1.3 Autonomous units

The BSC at the unit level is designed with respect to the over-all BSC for the department. The interviews show that the vision of the department is communicated to employees and was developed through the involvement of the whole department. This indicates that the units have the same long-term aspiration as the department level. Although the units seem to share the over-all vision of the department, the fact that each unit develops its own critical success factors, measures and set their own goals indicate that each unit is autonomous in relation to the rest of the department. Due to the units’ freedom one may reflect on the department management’s ability to align and control the results of the units towards the over-all vision of the department.

The discussion above indicates that the organization consists of more or less autonomous sections, which have the freedom to develop their own scorecards. Kaplan and Norton assumes that an organization has one, unified aspiration, which is communicated through the vision and strategies to operational activities. In this case there are several aspirations, which are communicated through the BSC. This indicates
that the BSC is not primarily used as a strategic management system proposed by Kaplan and Norton (1996a; 1996b; 2001) but rather as a way to represent the activity of each level.

5.2 IMPLEMENTATION OF THE SCORECARDS

A first reflection of the implementation of the scorecards in the organization studied is that it seems to be more complex than the linear implementation model presented by Kaplan and Norton (1993). In an attempt to illustrate this complexity, the following discussion points out how the initial introduction of the BSC was triggered and how this may have had an effect on the use of the BSC. In addition, the adaptation of the scorecards to the organization’s conditions and the role of change agents are discussed. Finally, the implications of everyone’s participation in the implementation process are illustrated.

5.2.1 Need to change

A reflection concerning the implementation of the BSC is how the need of an implementation was triggered in the organization (see e.g. Porras and Robertson 1992, Rogers 1974). In this case the management and employees of the department experienced a need to improve the situation due to economic measures and improvement potentials emphasized through the Swedish Quality Award assessments. A need of change was also identified at the O-center. The QUL model was viewed as unsatisfactory, which led to the introduction of the BSC. Porras and Robertson (1992) propose that the recognition of a need of change is a central condition for effective change. In this case, the fact that people in the organization experienced a need to change when the BSC was introduced constitutes a central factor for the use of the BSC in the organization. People experienced the situation as unsatisfactory, which enabled the acceptance and use of the BSC throughout the organization.

Further examination of the introduction shows that the BSC implementation was triggered from different parts in the organization and at different times. Whereas the O-center introduced the BSC as a result of a directive from the UH in 2001, the management of the Department of Pulmonary Medicine introduced the concept in 1998 as a response to the improvement potential pointed out in the Swedish Quality Award feed-back report. Thus, the implementation of the BSC at the O-center was triggered from the top in 2001 and the BSC implementation at the department was triggered from within the organization in 1998.

Rogers (1974) proposes that top-down changes, identified and initiated by the top management, are more likely to succeed than bottom-up changes. He further proposes
that bottom-up changes involve a greater degree of conflict than top-down change since most organizations are designed for stability, not for change. In this case, the implementation started as a bottom-up change initiative at the department level and thereafter became a top management directive initiated from the top. Taking Roger’s propositions as a starting point, the department is expected to change their BSC in accordance to the directives from the O-center since the change is initiated from the top. However, the empirical findings indicate that the department continues to develop its BSC with respect to its own conditions without any major influence from the BSC at the O-center. Thus the time factor plays a significant role in how the BSC is used in the organization. The fact that the BSC was developed at the department before the BSC was introduced at the O-center may constrain the O-center’s ability to influence the development of the department’s BSC.

5.2.2 Adaptation of scorecards

Another aspect of the BSC implementation is how the adaptation of the BSC has proceeded. According to Kaplan and Norton (1993; 1996b; 2001) it is important to develop and adapt the BSC to the organization’s conditions. In this case, the O-center management has an open attitude towards the department’s scorecard and emphasizes the importance of letting the BSC be adapted to the departments’ own conditions. The management of the department has a similar attitude towards the units’ scorecards and supports the development of their own measures, critical success factors and targets. Adaptations, that have been made, concern the terminology used in the scorecards, letting the implementation take time, deploying the BSC into three perspectives at the unit level, and illustrating measures in the scorecard through a cobweb diagram, which is commonly used in the organization.

These changes create good conditions for making the BSC an accepted and integrated system in the organization. However, one may also reflect on other consequences of the adaptation. As the BSC is changed to the organization’s conditions and needs, it is important to notice that the framework, which provides the basis for the technology presented by Kaplan and Norton (1993), changes. In this case, for instance, the BSC at the unit level does not include financial measures, which is a basic idea of the framework proposed by Kaplan and Norton. This may lead to that the expected benefits, as proposed by Kaplan and Norton, from using the BSC in practice will not be fulfilled (Olve et al 2003).

5.2.3 Change agents

Another aspect in change initiatives is the role of change agents (see e.g. Porras and Robertson 1992). Kaplan and Norton (1993) propose that a “balanced scorecard
facilitator” identified as an external consultant or a management member should lead the building and implementation of the BSC. In this case, the management of the O-center and the department have handled the building and implementation themselves. Specifically, the Quality Coordinator of the O-center, the Quality Coordinator of the department and the Head of Department were largely committed in the building and implementation of the BSC and have the main responsibility for its integration in the organization. These people may be viewed as change agents in the implementation process due to their ability to support and involve employees, their knowledge of the BSC methodology and their knowledge about the activities in which it is being implemented (Porras and Robertson 1992). The interviews with employees working at the department show that people trust the Quality Coordinator at the department and that the management’s support during the implementation has been important in making people accept and use the BSC in the units. The involvement of change agents thus seems to play a major role in the implementation of the BSC in this case, although they are not externally recruited.

5.2.4 Everyone’s participation

Kaplan and Norton argue that the BSC should be built and developed by management, after which the BSC should be communicated down through the organization (Kaplan and Norton 1993; Kaplan and Norton 1996b; Kaplan and Norton 2001). However, participation of employees has a major role in Quality Management initiatives and is a central condition for effective organizational changes (Porras and Robertson 1992). In this case, the department management emphasizes the need to involve employees at an early stage of the BSC implementation. Efforts for active participation were put into action through involving people in the vision formulation, deploying the scorecard down to the unit level, actively supporting employees in their development of the scorecard and continuous information dissemination of the concept. However, this case also indicates that management’s participative approach triggered off a resistance to the concept. Interviews with employees show that management’s initial information about the concept was interpreted as insufficient and top-down oriented, which made people negative towards the whole concept. Although the initial resistance to the concept was dealt with by promoting participation, the fact that the top-down oriented communication initiated resistance to the concept shows that Kaplan and Norton’s implementation process may be questioned.

5.3 USE OF THE SCORECARDS

The case description in the previous chapter shows that the BSC is used in different ways in the organization. The primary use of the BSC is in reporting, follow-up and
planning processes, which are discussed in more detail below. Other activities in which the BSC is used are also discussed. Several difficulties experienced by people using the BSC in the organization are also highlighted.

5.3.1 Reporting, follow-up and planning

All three organizational levels use the scorecards for reporting results to superiors. The units report their results to the department level according to the scorecard model, the department level reports results to the center level, and the center level reports its results to the UH according to the BSC model. In addition to reporting, the department and the center level use the BSC in following up the units’ and the department’s activities. The management of the department follows up the results during management meetings.

The results from the interviews also show that the BSC is used in planning activities. At the O-center, the Quality Coordinators together with Quality Coordinators from all the departments at the O-center discuss the focus areas in the O-center’s scorecard every year based on the directives from UH. Every year the management team of the department discusses the different strategic areas to focus upon in the forthcoming year. At the unit level the units plan their annual activities through the action plan in the BSC. This plan is discussed with the management of the department in order to make the plan align to the department’s goals and measures.

5.3.2 Developmental activities and information dissemination

The interviews also show that the use of the BSC differs between the organizational levels. Whereas the O-center uses the BSC as a basis to develop a new performance measurement system, the management at the department uses the BSC for disseminating information both within and outside the department. At the units the BSC functions as a communication tool in discussions within the unit. In addition, the BSC is used for creating orderliness at the unit level, and to increase the understanding of the unit’s annual work. The BSC is mentioned as a way of representing the unit’s activities. However, at the in-patient unit the BSC is primarily perceived as a tool for the management of the department.

5.3.3 Difficulties in the use of the BSC

Although the BSC is partly integrated in the work practice in the organization studied, there seem to be difficulties in involving all the employees in the BSC. According to employees interviewed, time is a restricting factor in the use of the BSC. Although the management of the department has decided to allocate time every week for the BSC,
this time is seldom used for that purpose. Employees feel that the clinical activities need to be prioritized. Lack of motivation to work with the BSC is also mentioned as a reason to allocate time in practice. The difficulty in getting people involved in the work is primarily evident in the in-patient unit. The size and work design in the in-patient unit is mentioned as limiting the scale of involvement.

Based on this discussion, the BSC primarily seems to be used for reporting results to superiors, following up results and in planning annual activities in the organization. Although the BSC is viewed as a management tool, employees at the department experience some benefits from using the BSC. This indicates that the BSC in practice is not only improving managerial work in terms of information dissemination, development of strategies and measures, but is also bringing value to other parts of the organization.
6 ENABLING AND CONSTRAINING FACTORS

The following chapter discusses factors that may enable or inhibit the use of the BSC in a health care organization. The chapter presents a framework for identifying possible factors and discusses what is meant by the use of the BSC in this case. Factors that can explain the use in a health care organization are grouped into categories identified as autonomy, employees’ participation, introduction of the BSC, change agents, adaptation, and prior experience.

6.1 A FRAMEWORK FOR IDENTIFYING FACTORS

Exploring the use of the BSC has been the main focus of the present research. The case organization selected was intended to use the BSC as an integrated part in the organization. The BSC was expected to include several perspectives derived from the framework presented by Kaplan and Norton (1993, 1996b) and encompass both non-financial and financial measures. According to people familiar with the health care context, the BSC was implemented and used in several health care organizations. These criteria and the geographical vicinity provided the foundation to select the O-center and Department of Pulmonary Medicine as a case in the investigation of how the BSC is used in a health care organization.

In the previous chapter the design, implementation and use of the BSC has been dealt with. This chapter aims to clarify the second research question: factors that enable and constrain the use of the BSC in the organization. As discussed in the introduction of this thesis, the design and implementation influence how the BSC is used in the organization. In addition, Porras and Robertson’s model of the organizational work setting (see Figure 2.3, p. 31) may be used as a framework in identifying factors that enable and inhibit the use of the BSC. Figure 6.1 illustrates possible categories of factors that influence the use of the BSC.

In order to identify factors that enable and constrain the use of the BSC there is a need for clarifying what is meant by the use of the BSC in this case. A discussion of the use of the BSC and its possible consequences is presented in the next section.
6.1.1 What is the use of the BSC in a health care organization?

How is then the BSC used in the health care organization? The BSC is used foremost in planning, follow-up and reporting activities. It is also used for other purposes. At the unit level, the BSC is used in discussions with colleagues and provides employees with a feeling of orderliness and understanding of the annual work with improvement initiatives. At the department level, the BSC is used as a representation of the department during information dissemination within and outside the confines of the department. At the center level, the BSC is used in the development of new performance measurements. The results further show that the linkages between the scorecard designs are vague. For instance, the O-center has little ability to align the department’s results to the over-all vision partly since the directives from the University Hospital have the main influence over the direction of the departments. The O-center also has a flexible attitude towards departments that develop their own scorecards. In addition, the management of the department emphasizes the importance of letting the employees develop their own scorecards. They discuss the units’ scorecards during an annual meeting with each unit in order to align them with the over-all BSC for the department.

This discussion indicates that the organization consists of autonomous units that have the ability to design and develop their own BSC with little influence from superiors in terms of clear instructions. Thus, the BSC is not used as a strategic management
system to align over-all goals in the O-center to actionable measures on the unit level, which is suggested by Kaplan and Norton (1996a).

**Not a strategic management system – then what?**

If the BSC is not used as a strategic management system, then what is it used for? Is the BSC bringing any value to the organization? These questions may be discussed by taking the initial purpose of introducing the BSC in the organization as a starting point. However, in this case the purpose is not unambiguous. The O-center implemented the BSC as a complement to the QUL in order to enable reporting and follow-up processes. The Department of Pulmonary Medicine introduced the BSC due to improvement potentials in the managerial work identified in the Swedish Quality Award model. Hence, the main purpose is not to use the BSC as a strategic management system, but rather to improve reporting and follow-up processes and managerial work at the department level. The findings indicate that these purposes are being achieved since the BSC is used in follow-up and reporting processes and in discussions and planning at the department level. In addition, the findings show that the BSC is used in other forums as well (discussions, information dissemination, developmental activities). Thus, although the BSC is not mainly intended as a strategic management system, the organization uses the BSC to fulfill its initial purposes and thereby the tool is bringing value to the organization. The BSC may be viewed as an *information system* that provides managers with performance measures that are useful in following-up, planning and developmental activities. Employees use the information system to submit measures and to receive information for discussion within the units.

**What may the consequences be?**

What may the consequences then be from using the BSC in such a way? Of course, there are both negative and positive consequences from using the BSC as an information system described above. The adaptations made in the organization concerning the initial BSC model seems to increase the acceptance of the BSC, which contribute to increased commitment to the BSC in the whole organization. Getting people involved and participate in planning and follow-up activities including the BSC contribute to an increased understanding of one’s own work and creates orderliness in the day-to-day work.

While the adaptations contribute to increased understanding of one’s work, a negative effect of the adaptations may be that people’s understanding of the organization’s vision and strategic direction differs. The scorecards are adapted to the conditions and to people’s needs on each organizational level, which leads to an ambiguous goal picture in the organization. One may argue that there is an essential need of a shared
goal picture in such a decentralized organization as the health care organization studied since the goals provide the only tool for evaluating the units. If the goals then are not shared and based on a common framework it becomes hard or even impossible for the County Council to ensure strategic improvements in future, since the different autonomous units make their own adaptations of the BSC that may not be aligned to the over-all strategic decisions. Hence, there is a need for a discussion between people at the center, department and unit level in order to clarify how to interpret different measures and goals. Thereby the BSC may be developed to become a strategic management system in the health care organization, which was advocated by Kaplan and Norton.

The discussion about possible consequences shows that the use of the BSC is not a static phenomenon, but a dynamic process involving a continuous dialogue between people, development of new measures and reevaluation of strategic decisions. A precondition for making people use the BSC in a health care organization is to involve them in the work and to make adaptations to the existing organization. However, the use is thereafter about developing the BSC to become aligned with the over-all vision of the whole organization in order to ensure that the changes made at the operational level will lead to improvements at the strategic level. Although the primary aim of the BSC was not to become a strategic management system, it is questionable if the BSC is not needed to become a strategic management system in the organization in order to ensure improvements. The fact that the organization is decentralized and consists of autonomous units may further argue for a development of the BSC in the organization.

Is it really a BSC?

Another question that has been raised in literature concerns what a BSC really is. If the BSC is not used as a strategic management system in the organization, can it still be called a BSC? Olve et al. (2003) claim that the companies that actually use scorecards as a way of management control suggested by Kaplan and Norton are much fewer than those companies that claim that they use it or soon will. This indicates that companies make their own interpretations of the concept and thereby adapt and use it for their own purposes. The present case supports this statement and shows that the interpretations and use can even vary within an organization. Although the interpretations and use of the concept among practitioners is different from the initial framework presented by Kaplan and Norton, it is not proposed that people should stop calling it a BSC. The concept is obviously appealing to people, which may be derived from its increased popularity in practice and its expected benefits presented in management literature. The fact that people have the ability to adapt the concept to their own needs and conditions and at the same time call it a BSC seems to be the intrinsic strength of the concept, which may save it from becoming just another “three-
letter” concept. However, these adaptations may also hinder the development of the BSC to become a strategic management system, which is argued above.

In addition, as the theoretical framework in this thesis shows, the BSC concept has been developed over the years due to the original advocates’ increasing experiences from BSC in practice (see Kaplan and Norton 1992, 1993, 1996a, 1996b, 2001; Olve 1997, 2002). Thus how practitioners use the BSC influences how the concept is developed in the management literature. Therefore the question of whether the BSC in the organization studied can be called a BSC or not becomes irrelevant, since the concept evolves through practice and not through theoretical assumptions.

Based on the conclusion that the BSC is used in follow-up, planning and reporting activities, information dissemination and discussions between employees, how can the use of the BSC be explained in a health care organization? What facilitates or constrains the use of the BSC in the organization? The factors identified through this case study are presented and discussed below.

6.1.2 Autonomy

As mentioned in the previous section, autonomy is identified as a central factor in explaining how the BSC is used in a health care organization. The autonomy of the Department of Pulmonary Medicine and the units enables the use of the BSC due to the fact that the management of the department and the units use the BSC for its own purposes in discussions within units, managerial work and information dissemination. Examples of enablers concerning autonomy are:

- The department started developing a BSC before the O-center due to their needs to improve the managerial work at the department, which made them adapt the BSC to their own needs.
- The O-center has a flexible attitude towards departments that develop their own scorecards and means that the BSC should be mainly used as a managerial instrument on the department level.
- The management of the department allows the units to develop their own scorecards regarding critical success factors, measures, goals and action plans. The scorecards are discussed in a yearly meeting with the management.

In this case, the BSC is not used to change the organizational structure in terms of increasing the management control of the departments’ results at the O-center. The management of the O-center rather accepts the existence of autonomous units and adapts the implementation of the BSC to this structure. Thereby, the organizational
structure comprising autonomous units becomes an important condition and enabler for how the BSC is used in the organization.

During discussions with people from the Federation of the County Councils, the autonomy of departments was identified as a characteristic of most health care organizations. Hence, one may question the ability and willingness to change this autonomy and use the BSC as a strategic management system in health care organizations that increases management control of the units’ results. Is it possible to use the BSC as a strategic management system in other health care organizations, and what benefits could then be identified? What is then the impact on autonomy? These questions may be focus for further investigations in the use of the BSC.

6.1.3 Employees’ participation

Another factor that is important in the use of the BSC in a health care organization is the level of participation among employees. In order to make employees in the units accept and start using the BSC, the management of the department made them participate in the BSC implementation at an early stage. Some examples of enablers concerning participation are:

- Employees participated in vision formulation, which made people accept the BSC and identify themselves with the vision.
- The BSC was deployed down to the unit level, which enabled participation and the acceptance of the concept.
- The management in the department continuously disseminated information about the concept throughout the department during implementation.

However, the management of the department has had difficulties in involving all the employees in using the BSC due to differences in work design and size of units:

- Differences between units concerning size and work design make it difficult to involve and motivate all the employees in the BSC.
- Employees viewed the initial information from management as insufficient and top-down oriented, which triggered off resistance to the concept.

Participation is emphasized as a central issue in both Quality Management and Organizational Change literature. In order to use the BSC in a health care organization it seems important to create forums for participation. In this case, people participated in formulating a vision for the department and they experimented with their own devolved BSC in order to create commitment to using the BSC.
Whereas it is important to create forums for participation, it also seems important to consider which people are reached through the forums. In this case, the in-patient unit is difficult to motivate and involve in the BSC partly due to its size and work design. In addition, it seems important to consider how employees may interpret the information about the concept.

6.1.4 Introduction of the BSC

The introduction of the BSC has an impact on how the BSC is used in the organization. Identifying a need to change seems to enable the acceptance and the use of the BSC in the organization. Examples concerning the need of change are:

- Employees at the department experienced the situation as turbulent after the Swedish Quality Award due to economic cutback measures in the County Council.
- The management of the department experienced a need to improve the managerial work due to the emphasis on this area in the Swedish Quality Award.
- The management of the O-center experienced that the QUL model was inadequate and too resource demanding.

The fact that the BSC concept was introduced over different periods of time seems to constrain the use of the BSC. The O-center’s efforts to enable the reporting process through the design of their BSC with ‘yes/no’ questions seems to have no effect on the department’s reporting since the department already has a BSC adapted to its own conditions.

- The BSC was first introduced at the department level, which constrains the O-center’s ability to influence the department’s reporting process.

Identifying a need to change is described as a central condition for effective change in organizations (Porras and Robertson 1992). Beer et al (1990) further claim that it is important to have a shared viewed on the problem when implementing changes. In this case, people in the organization experienced different problems when introducing the BSC. Although there was no analysis of the problems they faced, which resulted in a common front to the problems, the BSC was accepted and implemented in the organization. The fact that people experienced the situation as unsatisfactory seemed sufficient for them to accept the new concept.

This case also illuminates the importance of considering to what extent superiors have the ability to use the BSC to influence the BSC at lower levels. The fact that the BSC was introduced over different time periods seems to constrain the O-center’s ability to
influence the BSC in the department and thereby increase the effectiveness of the reporting process.

6.1.5 Change Agents
An important aspect in the use of the BSC is the involvement of change agents in the implementation. It seems in this case as if several internal change agents have enabled the use of the BSC in the organization. Their knowledge, ability to support and get people involved in the organization, and peoples’ trust in them are identified as important:

- The Quality Coordinator at the department and the Head of Department involve and support employees in using the BSC.
- The Quality Coordinator at the O-center, the Quality Coordinator at the department and the Head of Department have knowledge about the work activities as well as the BSC.
- Employees have trust in the Quality Coordinator at the department due to positive experiences from the Swedish Quality Award.

According to Porras and Robertson (1992), organizational development literature emphasizes the role and positive characteristics of change agents for creating a climate of change. The change agent should have knowledge about the theories and how to implement these in practice. He or she should also have the skill to engage and motivate people and groups. The results from this case support the importance of these characteristics of change agents.

In addition, the case points to the importance of having change agents that people trust and can rely on. This trust was built up during the work with the Swedish Quality Award. Thus, it seems that peoples’ prior experience with the change agents are important in how the agents can succeed in the future. Thereby, the fact that the change agents in this case originated from within the organization and were not recruited as external consultants may have enabled the use of the BSC in the organization.

6.1.6 Adaptation
This case indicates that the adaptations made in the organization may both enable and constrain the use of the BSC. Some adaptations that enable the use are:

- The management in the department adapted a BSC terminology in the units, which enabled the understanding of the terms among employees
The management at the department and the management at the O-center emphasize the importance of letting the implementation take time in order to get people used to the concept.

The department management allocates time each week in order to let the units review and follow-up their BSC.

The department management uses a cobweb diagram, which is a well-known communication tool in the organization, in the over-all scorecard to communicate measures.

Constrainers concerning adaptation are also identified:

- The adaptation of the O-center’s BSC to ‘yes/no’ questions may constrain the departments in the O-center to report measurable results since it does not create incentives to start measuring performance.
- The deployment of the BSC into three perspectives at the unit level may constrain employees’ economic consciousness, which may lead to unrealistic action plans.
- The time allocated each week is not used to review and follow-up the units’ scorecards due to a lack of motivation and prioritization of clinical related activities.
- The department management has difficulties in illustrating economic measures in the cobweb diagram, which constrains management to communicate performance measures in the BSC.

Kaplan and Norton (1993) mention the importance of adapting the BSC to the organization’s own conditions. However, little is said about the practical implications of adaptations. This case shows that the adaptations concern both changes in the BSC design, such as changes in terminology and deployment of BSC into three perspectives, and changes in time allocation, such as letting the implementation take time and allocate time each week for the BSC.

However, adaptations initiated at a managerial level (e.g. time allocation) may not always have an impact on employees’ use of the BSC. In addition, the adaptation to existing communication technologies (e.g. cobweb diagram) in the organization may hinder the use of the BSC as a tool to communicate and discuss performance measures.
6.1.7 Prior experiences

History seems to play a central role in how the BSC is used in the organization. Employees and management at the department experience that their prior experiences with the Swedish Quality Award have enabled the implementation and use of the BSC:

- The experiences with the Swedish Quality Award have made employees used to terminology such as ‘customer’ and ‘process’.

- The department received a lot attention due to the Swedish Quality Award, which led to increased pride in the department. This positive experience has increased the willingness to use similar concepts at the department.

However, the experiences from the award have also seemed to constrain the use of the BSC. For instance:

- Several employees describe the period after the Swedish Quality Award as turbulent, which had a negative effect on so-called “three-letter-concepts” in general.

Radnor and Lovell (2003) identify past experiences as important to consider in the implementation of a BSC in a health care organization. This case shows that the organization’s past experiences from the Swedish Quality Award have both enabled and constrained the use of the BSC. The experiences from the terminology and the positive responses from the award seem to have contributed to an acceptance of the BSC.

The initial resistance to the BSC may be related to peoples’ negative experiences after the award. Although the management in the department and O-center claim that there is no relation between the award and the economic cutback measures in the County Council, the fact that people experience such a relation indicates that people have a negative experience from the Swedish Quality Award. This seems to have a negative influence on the acceptance of other similar “three-letter-concepts”.

Table 6.1 summarizes the enabling and constraining factors identified in the present research study.
Table 6.1: Enabling and constraining factors in the use of the BSC at a health care organization

<table>
<thead>
<tr>
<th>Categories</th>
<th>Enabling factors</th>
<th>Constraining factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Autonomy</td>
<td>The department started developing a BSC before the O-center due to their needs to improve managerial work in the department, which made them adapt the BSC to their own needs.</td>
<td>The O-center has a flexible attitude towards departments that develop their own scorecards and means that the BSC should be used foremost as a managerial instrument on the departmental level.</td>
</tr>
<tr>
<td></td>
<td>The management of the department allows the units to develop their own scorecards with respect to critical success factors, measures, goals and action plans. The scorecards are discussed in a yearly meeting with the management.</td>
<td>Differences between units regarding size and work design make it difficult to involve and motivate all employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employees viewed the initial information from management as insufficient and top-down oriented, which triggered off resistance to the concept.</td>
</tr>
</tbody>
</table>
| Employees’ participation | Employees participated in vision formulation  
The BSC is deployed down to the unit level  
The management in the department continuously disseminated information about the concept throughout the department during implementation |                                                                                                                                                                                                                                                                                                |
| Introduction of the BSC | Employees in the department experienced the situation as turbulent after the Swedish Quality Award due to economic cutback measures in the County Council  
The management of the department experienced a need to improve the managerial work due to the emphasis on this area in the Swedish Quality Award  
The management of the O-center experienced that the QUL model was inadequate and resource-demanding | The BSC was first introduced at the departmental level, which constrains the O-center’s ability to influence the department’s reporting process                                                                                                                                                                                                                                   |
<table>
<thead>
<tr>
<th>Categories</th>
<th>Enabling factors</th>
<th>Constraining factors</th>
</tr>
</thead>
</table>
| Change agents | The Quality Coordinator at the department and Head of Department involve and support employees in using the BSC.  
The Quality Coordinator at the O-center, the Quality Coordinator at the department and the Head of Department have knowledge about the work activities as well as the BSC.  
Employees have trust in the Quality Coordinator at the department due to positive experiences from Swedish Quality Award. | The adaptation of the O-center’s BSC to Yes/No questions may constrain the departments in the O-center to report measurable results  
The deployment of the BSC in three perspectives on the unit level may constrain employees’ economic awareness  
The allocated time each week is not used to review the units’ scorecards, due to lack of motivation and prioritization of clinical activities  
The management in the department has difficulties in illustrating economic measures in the cobweb diagram, which constrains the management in communicating performance measures in the BSC. |
| Adaptation | The management in the department adapted terminology in the BSC in the units  
The management in the department and the management in the O-center emphasize the importance of letting the implementation take time  
The management in the department allocates time each week on the unit level  
The management in the department uses a cobweb diagram in the over-all scorecard, which is a well-known communication tool in the organization | Several employees describe the period after the Swedish Quality Award as turbulent, which has a negative effect on so-called “three-letter-concept” in general. |
| Prior experiences | The experiences with the Swedish Quality Award have made employees used to the terminology  
Positive experiences from the Swedish Quality Award have increased the willingness to use the BSC in the department. |  
|
7 SUMMARY OF FINDINGS, A CRITICAL REVIEW AND FURTHER RESEARCH

This chapter presents a summary of the findings from the research. The research process is critically discussed in order to provide the reader with a foundation to further evaluate the findings in the thesis. Finally, questions for further research are discussed.

7.1 SUMMARY OF FINDINGS

The purpose of this thesis is to increase the understanding of the use of a BSC in a health care organization. Findings from the case study show that the BSC in the organization studied is used primarily in planning, reporting and follow-up activities. In addition, the BSC is used in discussions between employees, to disseminate information throughout and outside the department, to create orderliness and understanding of the annual activities, and developmental activities. Comparing the use of the BSC with the purposes of introducing the BSC in the organization indicates that the BSC is used to fulfill its original purposes. The findings indicate that the BSC is not primarily used as a strategic management system that aims to increase the O-center’s management control of the department and units. The BSC is rather used as an information system from which managers receive measurable information about the operational activities that provide the basis for follow-up, planning and developmental activities. Employees use the information system to report measures and in discussions within the units.

In a decentralized organization such as the health care organization studied it may be argued that the scorecards need to be aligned to the over-all strategies in order to ensure that the changes made at the unit level are actually leading to improvements at the strategic level. The use of the BSC in a health care organization is thus a dynamic process that prerequisites employees’ participation and adaptations to existing terminology and organizational structure, as well as discussions between people to create a common framework for interpreting measures and goals in the BSC. The findings show that the health care organization studied has potential for developing the BSC to become a strategic management system in the future. The organization may need to start the dialogue between people at different organizational levels in order to create this common foundation.

Possible explanations to the use of the BSC in the organization are identified through factors that enable or inhibit the use of the BSC. The factors are grouped into categories described below.
The autonomy of the department and units enables the management of the department and units to develop their own scorecards for their own purposes. The management at the O-center has a flexible attitude towards departments that develop their own scorecards. The department allows the units to develop own scorecards, which are discussed in a yearly meeting between the management and each unit.

In order to make people accept the BSC, the management of the department emphasizes employees’ participation. Employees were involved in the vision formulation, the scorecards were deployed down to the unit level, and the management of the department continuously disseminated information about the concept. However, the case shows that differences in work design and size between units may be a hindrance to involving and motivating all the employees. In addition, people interpreted the information from management of the department as insufficient and top-down oriented, which triggered initial resistance to the BSC.

Due to the identification of a need to change during the time for the introduction of the BSC the BSC was accepted throughout the organization. However, as the BSC was introduced over different periods of time, this decreased the O-center’s ability to influence the reporting process through their BSC.

Change agents play a major role in how the BSC is used in the organization. The agents have the skills to involve and support people in using the BSC and have knowledge about the clinical activities. The facts that the agents work in the organization and that people have trust in them seem to be important in this case.

Several adaptations have been made in the organization. For instance, the management of the department adapted the terminology in the BSC in order to increase the understanding of the BSC in the units. The management of the O-center and of the department emphasize the need of letting the implementation take time in order to get people used to the concept. The department’s scorecard includes a well-known communication tool to communicate performance measures and time is allocated at the units in order to make people use the BSC. However, this time is seldom used for that purpose. Other adaptations that may be questioned are the deployment of the BSC into three perspectives at the unit level, the use of a cobweb diagram in the department’s scorecard and the use of ‘yes/no’ questions in the BSC at the O-center.

The findings also show that the department’s prior experiences with the Swedish Quality Award have influenced the acceptance and use of the BSC. The attention after the award generated a feeling of pride among employees and management that have enabled the acceptance of similar concepts such as the BSC. The terminology used in the Swedish Quality Award was also recognized in the BSC, which enabled the use of
the BSC. However, employees’ negative experiences after the award may have led to initial resistance to the so-called “three-letter-concepts”.

7.2 A CRITICAL REVIEW OF THE RESEARCH PROCESS

As described in Chapter 3 the research process has been far from straightforward. In order to give the reader an additional foundation to evaluate the results from this thesis I would like to point out some critical aspects identified during the process.

The study partly aimed to investigate the implementation of the BSC through a retrospective analysis of peoples’ stories of the implementation. During the interview people were asked to remember their first contact with the BSC, which in some cases were about ten years ago. There is always a problem in conducting retrospective analysis since people tend to reconstruct their memories in order to make them logical or suitable for themselves or to the researcher. This leads to an impending risk that valuable information from the interviewee never reaches the investigator or that the researcher never receives the information of how events actually happened.

Using a tape recorder during the interviews may also be identified as a hindrance in the research. In order to make the interviewee comfortable with the situation, I presented the purpose of the project, myself and asked if the interviewee had any questions before I introduced the tape recorder. Anonymity was also emphasized for those interviewees it concerned (the employees). Thereafter, I asked if the interviewee agreed to me using a tape recorder during the interview. In every case the tape recorder was agreed to. Although there is a risk that the use of the tape recorder has made people withhold valuable information during the interviews I experienced that people were open with their perceptions and thoughts.

The reduction of the data in coding and analysis always leads to a loss of information. Even printing the taped interview afterwards involves a loss of information. In this case, the printed interviews were reduced into summaries, which were used in coding and analyses. In order to ensure that no important information was lost, the source interview was used during most of the time during the analysis. This enabled the interpretation of the interviewees’ opinion of certain statements. In addition, statements in the summary were referred to the lines in the text of the interview, which enabled the linkage between the documents. However, one could not neglect the fact that summarizing the interviews may have been a hindrance in the analysis of the information.

During the analysis of the interviews a qualitative data program, NVIVO, was used. The program supported the analysis by automatically linking the cores to specific interviewees and places in the summary. In addition, the program enabled the
reconstruction and building of units into a tree structure since units could be automatically merged into the same document. Thereby, a lot of time was saved in the analysis stage. However, there are also weaknesses identified in using a data program. When I had identified the units with a code in all the interviews and merged them together I could not see the whole tree structure with the complete unit in the summary since the tree only showed the code. Therefore I needed to print out all the units, read them and thereafter reconstruct them into a complete tree structure. The program thus prevented me from seeing all the material at once within the tree structure. Although the program saves time for the researcher in the coding stage, it may hinder the identification of general patterns and differences between peoples’ stories.

Another critical aspect in the research is the fact that the findings from the interviews have been translated into English. This means that statements from the interviews presented in the thesis can be interpreted in a different way than if the statements were presented in interviewee’s own language, Swedish. Therefore, I have let people in the case organization review the English presentation of the material and give comments on the translation. In addition, a native English speaking person has reviewed the material to correct the language. The Swedish quotations are also presented in Appendix 2 to enable the interpretation of the material. However, the reader should keep in mind that the findings are presented in a language different from the native language of the interviewees’ when evaluating the results.

7.3 SUGGESTIONS FOR FURTHER RESEARCH

As mentioned in the previous section, this thesis partly aims to generate new questions that may provide a foundation for future research. I have not proposed any internal priority of the following suggestions since it largely depend on the researcher’s background and personal interest. However, after conducted this case study I am especially interested in studying how the BSC, and maybe other management concepts, evolve over time and how researchers, society and practitioners influence and form these concepts.

Since this thesis focuses on a single case, it may be valuable to study other health care organizations to receive a profound understanding of the complexity of the implementation and use of the BSC in health care services. How do other health care organizations use the BSC? What differences and similarities can be identified between health care organizations concerning the use of the BSC? Is it possible to use the BSC as a strategic management system in health care organizations, and what benefits could then be identified? What then is the impact of autonomy in these organizations?
In addition, it may be interesting to further investigate the effects of using the BSC. This study focuses on peoples’ interpretations of the benefits of the BSC. In order to complement this picture it may be interesting to investigate the relation between the economic development and/or customer satisfaction and the implementation of the BSC. Is there a positive relation between the implementation of the BSC and economic profitability or customer satisfaction?

The BSC has been commonly used in the private sector over the last decade. In order to learn from private organizations, it may be interesting to conduct comparisons between private and public organizations in how they use the BSC.

The question whether there is something that can be called a BSC in practice or not was raised in Chapter 6. This is an interesting issue that needs further exploration. How will the BSC concept evolve over time? How do practitioners, consultants and researchers influence its evolution? What about the evolution of other concepts? What is the meaning of the concepts? Is it merely a question of terminology or does the concept have a practical value of its own?
REFERENCES


APPENDIX 1 - INTERVIEW GUIDE

Bakgrundsinformation
1. Namn
2. Sektion
3. Befattning
4. Hur länge har du arbetat på X?
5. Kan du beskriva en arbetsdag?
6. Har du hört talas om Balanserade styrkort?
7. Har du någon roll i styrkortsgruppen och vilken isåfall?

Berätta om införandet av balanserade styrkort på centrum/kliniken/sektionen!
8. När hörde du talas om styrkort första gången?
9. Vem/vilka ansvarade för introduktionen?
10. Varför introducerades styrkort framför andra ledningsinstrument?
11. Vilka direktiv gick ut?
12. Hur mycket tid/resurser ska läggas på styrkorten?
13. Hur skedde introduktionen av styrkort?
14. Gavs någon utbildning?
15. Vilka problem och svårigheter upplevde du i införandet?
16. Vad innebär styrkort för dig?

Berätta om hur ni har utformat styrkortet på centrum/kliniken/sektionen!
17. När påbörjades utformningen av ett styrkort?
18. Vem/vilka ansvarade för utformandet?
19. Vilka problem och svårigheter upplevde du i utformandet av styrkort?
21. Hur växte styrkortet fram? Från vision, strategier, perspektiv, kff, mätetal och handlingsplaner!
22. Hur är styrkorten nedbrutna?
23. Hur är styrkorten relaterade till andra mätsystem såsom budget, Värdekompassen, Nolan modellen, QUL, Processkartläggning?

24. Tycker du styrkortet fångar det som är viktigt i organisationen? Om inte, vad saknas?

**Berätta vad ni på centrum/kliniken/sektionen använder styrkortet till!**

25. Hur redovisas resultaten i styrkorten uppåt och nedåt i organisationen?

26. När träffar du på styrkort i ditt arbete?

27. Hur utnyttjar du styrkort i ditt arbete?

28. Vad i styrkortet använder du isåfall?

29. Vad bidrar styrkortet med i organisationen?

30. Är styrkortet till nytta i ditt arbete?

31. Vem har mest nytta av styrkort? Varför?

**Avslutning**

32. Är det något i styrkortet som du tycker fattas?

33. Vad är dina upplevelser från intervjun?

34. Tycker du det är något som saknas?

35. Finns det andra personer som jag bör prata med?

36. Återkomma med ytterligare frågor?
APPENDIX 2 - SWEDISH QUOTATIONS

Quotation 1
"I offentlig verksamhet så pratar man väldigt mycket om tillkommande planering och är rätt dålig på uppföljning. I grunden är att man ska kunna följa upp mycket enklare. Inte bara jag ska följa upp nästa nivå utan man ska följa upp sig själv hela tiden.[…] Nyckeln till framgång är uppföljning."

Quotation 2

Quotation 3:
"läkarkåren har stort inflytande i det mesta och där finns mycket ebenägenhet till förändring om jag säger så."

Quotation 4:
"Jag tycker att det är bra, men för mig gäller det att hitta rätt ambitionsnivå. ….Och jag har mycket tillåtande attityd där. År det någon klinik som vill finlira väldigt mycket så får dom göra det men dom måste ju också sköta kärnverksamheten. […] Det får inte heller bli så att det är någonting som man måste göra av något slag, dom måste känna att det är någonting naturligt som dom har nytta av. Där menar jag att där är vi på G riktigt ordentligt på alla ställena."

Quotation 5:

Quotation 6:
"Så att det är som ett uppföljningsinstrument men också en plattform för att diskutera strategier."
Quotation 7:
”När man börjar med styrkort blir det mer en beskrivning av verksamheten. Men om man jobbar med det här kontinuerligt och kommer in i det här att varje tertial ska man redovisa det här med mål och mätetal och handlingsplan blir det mer och mer styrande. För då förflyttas fokus till att planera och följa upp istället för att se bara vad som händer. Det tar ju tid innan alla arbetar på det här viset.”

Quotation 8:
”Vill de ha en egen vision så får de ha det. Och det är likadant när det gäller verksamhetsstrategier […] Mallarna är till för att hjälpa dem som inte har kommit igång. […] jag tycker inte det är något problem. Det viktiga är att hitta typer av mätetal, mål och handlingsplaner.”

Quotation 9:

Quotation 10:

Quotation 11

Quotation 12
“[Kliniken] tycker nog att dem inte har fått tillräckligt med uppskattning. Det har väl också funnits lite avundsjuka från en del kliniker som har uttryckt sig i ’hur kan Lungmedicin ha så mycket resurser så att dom kan hålla på med det här också, det har ju inte vi’ […] Lungkliniken fick det här priset och så en klapp på axeln från Landstingsledningen. Sen tyckte man kanske att det inte har blivit så mycket mer och så är det naturligtvis också. De har samma tuffa krav på sig när det gäller ekonomi som alla andra kliniker.”
Quotation 13:
"Frågan var hur vi skulle driva vidare. Det som man såg i USK var ju att ledarskapet var väldigt otydligt, så det var det första vi tog tag i. Klinikchefen var väldigt drivande för hon som chef måste ju veta hur hon ska leda kliniken annars fungerar det inte. Hon måste känna att resten av kliniken ställer upp på hennes ledning."

Quotation 14:

Quotation 15:
"En del [medarbetare] sa att det var det sämsta de någonsin har hört. Ja, och så höll vi på ett tag. Till slut var det en medarbetare som kom med förslaget, det var inte vi alltså. Det var inte klinikledningens som kom med den slutgiltiga visionen utan det var en medarbetare. Det känns extra kul på något sätt för då har man ju ändå skapat en dialog och delaktighet från början."

Quotation 16:

Quotation 17:
"Jag tycker [styrkortet] är bra men oavsett vilken metod man använder är det viktigt att man har fakta som man baserar beslut på. Om jag säger någonting i något möte eller förhandling så har jag fakta bakom eftersom vi har så mycket mätetal inom alla perspektiven. Det skapar en jättetrygghet."

Quotation 18:
"Vi i ledningsgruppen diskuterar tillsammans med sektionerna kring mätetalen, om de är vettiga att mäta, är det rätt, ska ni göra så här mycket, men har ni inte glömt bort det här osv. På så sätt får det styrning mot klinikens mål och mätetal och det skapar en
delaktighet. Och man uppskattar det som jag har förstått som en möjlighet att få visa det arbete man gör och få feed-back"

**Quotation 19:**


**Quotation 20:**

"När vi skrev vårt verksamhetsbeskrivning var vi tvungna att tänka efter vad en process är och vad ingår i kund och vad är en medarbetare. Vi var tvungna att tänka på vad begreppen står för och vad de betyder för oss. I och med att alla enheter skriver sina [BSC] så måste alla tänka efter vad som skulle in.”

**Quotation 21:**


**Quotation 22:**

"Ibland har det varit så mycket så att man nästan ’nå, inte det där nu igen’, men det har varit bra. Nu känner man att man behärskar lite av det i alla fall. Det var så mycket ett tag. [Ledningen] pratade BSC utan att förklara vad det innebar. Men när de väl har satt sig ner och förklarat vad det betyder och hur man ska använda det är det lite lättare att förstå.”

**Quotation 23:**


**Quotation 24:**

"Om du ska förstå det här med processer och så vidare måste du har beskrivit i verksamheten vad det finns för kunder, vilka kunder du har och allt det här. Har du inte gått igenom den terminologin tror jag det är jättesvårt. Jag tycker att vi haft en oerhörd nytta av det. [BSC] är en fortsatt vidareutveckling på det jobbet.”
Quotation 25:

Quotation 26:
"Tanken är att man ska fundera och reflektera kring [styrkortet] och jag tror att det här kan inte vara statiskt. Jag tror alltså att man kommer att ändra på det här och det kommer att utvecklas och andra dyker upp annars vore det inget styrkort"

Quotation 27:

Quotation 28:
"Det blir en liten piska på ryggen om man har det nedskrivet och säger att det här ska vi göra inom ett år så måste man ju nästan göra det för att det står ju på papper. Säger man det bara kan det ju försvinna."

Quotation 29:

Quotation 30:
Quotation 31:
"Jag tror man tänker på det mer i vardagen, kanske inte kallar det för styrkort, utan jag tänker vad vi vill ha för mål med det här nu vi gör och hur ska vi uppnå det liksom.”

Quotation 32:
"Det är jättesvärt att hinna få tid till det, men jag tycker det är jätteviktigt om man kan få tid till det. För jag tycker hela grejen är intressant, men det är patienterna som måste komma först. Och de kommer ju först eftersom det handlar om de här [i BSC] men det är mer direkt att patienten den står ju där och är sjuk. Han bryr sig inte om styrkortet. Så man slits faktiskt emellan, det gör man.”

Quotation 33:
"På pappret kanske det står att man ska avsätta tid till styrkortet varje vecka, men många prioriterar verksamheten, framförallt de på avdelningen. Det kan vara svårt att koppla bort arbetet under den korta tiden. […] På onsdagarna går vi igenom vad som sker och tar upp BSC om det är dags att fylla i dem. 'Jaha, då var det dags igen’ kan folk säga när vi tar upp det”
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