Engaging employees with the BSC

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Abstract

The paper looks into the application of the BSC within a healthcare organization. The BSC has had a significant impact on practice. However, it has had both favorable and unfavorable reviews in the literature, some author arguing the benefits of a more collaborative environment through the adoption of the BSC, other highlighting the limitation of this managerial tool, particularly in its implementation. The present paper traces the progressive implementation of the BSC as theoretical information and compares it to some of the experiences that emerged within the organization. A range of practices developed in the organization. Against these the validity of the implementation theory is tested. The findings indicate a lack of appropriate accounting for the motivational factors in the BSC that impinges on the success of its introduction. This emphasizes that while the BSC design may be promoted as 'standard', its implementation process cannot proceed without taking account of the unique factors, which constitute the situation facing the adopter.

1. Introduction

Twenty years have elapsed since the original paper by Kaplan and Norton (1992) introducing the BSC. The BSC has subsequently had a considerable diffusion and adoption, with research focusing on both its success and failure. This paper contributes additional insights to the implementation of the BSC within a healthcare system. The BSC has been considered an ideal tool to be adopted in public sector as, above all, it allows flexibility suitable for a context where healthcare professionals have to contribute to its operations. The dominance of non-financial measures helps professionals to connect with the financial dimension of this

managerial tool, to appreciate the balance between different non-financial dimension and the financial one as both dimensions relate to organizational achievement. As is well known, healthcare his many professionals who are considered to lack any managerial empathy, as they often associate it simply with managerial interference.

The paper develops a theory for the successful implementation of the BSC. It is grounded in the detailed analysis of the research data collected. The theory is derived from the implementation experiences of the healthcare organization. The study highlights the impact that the BSC has on employees and, in particular, the effects of the adoption process followed on employee acceptance of it. The analysis of the case study, in respect of the theory adds additional insight into the problems that characterizes the organizational implementation of the BSC. While the BSC is a tool that can be modified to fit most organizations a more individualistic consideration has to be made in the way the implementation process accounts for the differing characteristics of the staff affected by the BSC and consequently their involvement in its development and adoption. This is key issue often under valued in the need to take account of human motivational theory associated with the implementation theory identified in this work.

The paper begins by presenting a short review of the literature on BSC, followed by the methodology section that highlights the design of the research study. Implementation theory is outlined and than it is used to show how the experience of the Swedish healthcare units studies gave validity to it. The discussion will highlight not only the appropriateness of the theory but also the need to account for the motivation, culture and experience of the individuals expected to engage with the BSC. A lack of this type of analysis is a major cause of unsuccessful implementation of the BSC. This will be followed by the conclusion.

2. The BSC

The BSC is a management accounting tool widely used (Blundell et al., 2003; Ax and Bjørnenak, 2005; Johanson et al., 2006) and at least known in most organization. Its origins dates back to the 90s when Kaplan and Norton first described it (1992, 1996, 2004). The BSC is derived from a strategic map of an organization and translates the organizational strategies into four dimensions, customer, finance, growth, and internal business process. The BSC is characterized by a flexibility that allows it to be adapted to some specific organizational circumstances in respect of crating measurements for these dimensions (Kaplan and Norton, 2004). Multiple articulating BSCs has a cascade development on BSCs from the top to the bottom of the organisation, and similarly a returning flow in order to optimise the information disclosure feedback that is relevant in developing the organizational strategies.

Although the BSC is considered an instrument helping to steer the adopting orgnisation tosuccess, various findings highlight that a considerable number of business abandon the use of the BSC (Johanson et al., 2006), although most published research refer to successful experiences. Studies analysing the weaknesses of the BSC highlighted the need for employees to feel control over their work (Nørreklit, 2000). This is not fully accounted for within Kaplan and Norton's predominantly top-down cascade flow. There is need for motivated staff and for them to believe in the tool/instrument adopted to steer change (Inamdar and Kaplan, 2002; Nørreklit, 2003). This is seen as achievable if there is broad involvement of organisational personnel in the definition of the new process, which again is lacking in the BSC (Johanson et al., 2006). Additionally, viewing the BSC as a mechanical tool, with the management keeping a distance from the operations they are responsible for, is a reason for failure (Noreklit, Jacobsen and Mitchell, 2008). Others highlight the need to give attention to employees as they could harm the whole change process (Nair, 2009).

Healthcare has seen also an increasing use of the BSC. This has occurred with positive results, as the article by Aidemark (2001) highlights the wide acceptance of the BSC within a Swedish healthcare organization. The BSC has improved communication as well as reinforced professional control. Aidemark views the BSC as a tool of easy acceptance by healthcare professionals, although in a later paper (Aidemark and Funck, 2009) highlights that the BSC induced a cultural change within the organization and acceptance of performance measurement by medical professionals. The paper focused on one clinic within a longitudinal perspective. While this paper focused on one specific experience, other research has tended to use experimental data from students (Cadinaels and van Veen-Dirks, 2010) on the impact of the performance indicators selected in the BSC. The limitations of these studies is that they to do not reflect the reality of the application on experienced individuals or limit the analyses just to a section of an organization that might bias the perception of the development that the BSC might have within a structured organization. This paper aims to reflect on a case study on an extended healthcare organization experience.

3. The context

The healthcare organization we are referring in this study is located in the Östergötland county. Its main city, Linköping is two hundred kilometers south of Stockholm. The county is divided into three districts and each district has a hospital, one in Linköping that is the university hospital with a regional catchments area (i.e. extending over the county boundaries), one in Norköping and one in Motala. Until 2004 these hospitals were independent one from the other. However in that year a major reform took place where the different centres were unified under one single centre chief. Starting in 1996 with the Linköping hospital and later on extended to the other two hospitals, the hospital CEO was

removed and centres were identified (orthopedics, children, etc.). The centre managers became responsible for their budgets and answered directly to the county health director for their management. Therefore 2004 represented a year of considerable change involving service integration and more efficient care provision (as an example, most elective orthopedic care is now provided in Motala). At the same time a new centre in each district was created, the 'near by healthcare' centre (Närsjukvård centrum). This centre includes all primary care centres (that used to be independent from the hospital through out the 90s and early 2000s), and also all hospital units considered to be necessary to be provided in the proximity of the patients residence, as emergency and accident, internal medicine, geriatrics and advance home care. The 'near by' healthcare centres are independent one from the other.

4. Research Method

This article is based on data collected when the researcher went to Linköping in the Östergötland county in Sweden to study a healthcare application of the BSC. The original aim of the visit was to collect data with regard to the successful and diffused implementation of the BSC within the above mentioned healthcare system. However, once the data collection had started, the researcher found a different situation than the one portrayed by the manager she had been in touch with at an earlier stage. The expectation was that the BSC would to be adopted at all levels within the organization. In fact adoption was partial and fragmented. The latter was particularly evident from the existence of only 25 BSCs from the whole organization with many units indicating that their BSC was not yet completed or not providing any information at all about a BSC. While in the field the researcher had therefore to review the core content of the interview questions and the aim of the research, which changed to focus on understanding the difficulties in the implementation of the BSC.

The research had therefore become exploratory in nature. This type of study is not easily subject to building research hypothesis due to its exploratory nature. Consequently, the author has not outlined any hypothesis on the research, except the original interest to understand the BSC 'successful implementation' that translated into 'lack of full implementation'. The research approach became more consistent with grounded theory (Glaser and Strauss, 1967). Glaser and Strauss argue the need to access the research field with no 'prejudice' in order to be able to identify elements that are specific to the investigated environment and possibly develop some new insights in the knowledge and theory. This can be seen as an ambitious project, but as Corbin and Strauss (2008) indicate, it is a fruitful way to conduct qualitative research.

4.1 Data Collection

The present article is based on the findings from twelve semi-structured interviews conducted with different care providers, from head managers, centre managers, hospital unit managers, nurse, primary care centre manager, economists, and unit responsible for the BSC. The interviewees were selected on the basis of information collected once the researcher was in situ. They were the individuals the researcher perceived relevant to obtain information from. Two of the interviews were conducted with respectively two and three interviewees. As semi-structured interviews entail, there were a number of questions that were asked to everyone, i.e. when they started to use the BSC, how they learned the characteristics of the BSC, what were the difficulties encountered with this tool, what was facilitating or hindering the implementation of the BSC, the strengths and weakness they saw in this managerial tool. Around these topics questions developed and created the interviews by following the arguments that the interviewee was providing. All interviews were conducted face to face in English, recorded and transcribed. The average length of the interview was 75 minutes.

Ying (2003) suggests using data triangulation to guarantee the reliability of a research. In this case the BSC documentation was available to the researcher.

4.2 Data analysis

It has been suggested that the analysis of the data, with identification of categories, starts immediately after the first interview takes place (Glaser and Strauss, 1967). However, it is also considered acceptable for this to occur once all data have been collected, as it is not always useful to conduct the analysis on the spot (Corbin and Strauss, 2008), particularly when the data are collected within a short time period. The interviews were analysed using the Nvivo 8 software once all of them were collected. However, the interviews and other information collected, where also helping the researcher to identify additional interviewees that would provide more insightful knowledge, a strategy also suggested by Corbin and Strauss (2008). Each interview was processed through this program (Nvivo 8) and coded. The initial analysis used free-node coding which facilitated the creation of different categories. Once all the interviews where coded the author proceeded to identify nodes and the relevant categories (Saldaña, 2010). This meant the categories used in coding the interview content that emerged to be trivial with the analysis, could be disregarded as 'appendix' information. Once the first cycle was performed the author perceived the need to screen the information again, to gather it in the different categories through a second revision of the interview data. Some memo notes were derived from the interviews from analysis and consideration by the author. All this information provided the foundation for the analysis that

developed into the theory from the evidence gathered and that is presented in the following section.

5 The BSC implementation theory

Through the text analysis the importance of communication in the process of implementation and utilization of the BSC emerged. Although the BSC is considered a rather accessible tool (see section 2) easy to understand and use, its implementation is not as easy as the narratives on it suggest. This study focuses on an implementation of the BSC within an environment characterized by high professionalism, i.e. individual that performs activities under a certain degree of autonomy through being a member of a professional group. The 'BSC application framework' is as follows. First of all, ideally there has to be the [1] perception of <u>need</u> for a new managerial tool within the organization, by the members. The need might usually have been recognized in the desire for improvement, for an increased accountability and transparency. A new managerial tool, of course, would be rejected by individuals preferring the status quo or resisting the existing establishment where there is a view that the change has been imposed and reflects a management's agenda. [2] The BSC needs to be <u>introduced</u> in the system, and above all to the users. [3] The <u>users</u> are central in the implementation process, and often identified with the <u>managers</u>. [4] Managers need to be introduced to the BSC methodology. This <u>requires time</u> as terminologies and procedures can be rather foreign to the user and therefore it cannot be successfully introduced in a very short time period. Following the first exposure to the BSC there are largely two reactions, [4A] acceptance, and [4B] rejection. The level of <u>acceptance and rejection</u> may vary within a range that extends from immediate full acceptance to immediate full rejection. The individual rejecting the BSC may might base her/his decision on the impression that the task is difficult to tackle and so a preference is created to avoid engagement and the possibility of failure. This type of individual should not be marginalised or forced to adopt the BSC. It may be that this lack acquaintance with managerial tools [we are discussing of medical staff usually in managerial position within an healthcare organisation] and/or have a more critical attitude towards the suggested changes. When criticism and distancing happens with a positive critical attitude, it allows the identification of the benefits and costs of the change and an assessment of whether it has an overall beneficial impact. A single individual, over a certain period of time, <u>might change</u> her/his personal <u>view</u> on the BSC through increasing their understanding (or refusing) its purpose and application. It has to be noticed that [5] the learning has to be supported over an <u>extended period</u> of time, as a small number of workshop is not the way to effectively transfer the BSC principles and methodology. There needs to be support during the application period as well, as this is the time when doubts can

emerge following the theoretical introduction to the tool. As mentioned above, the manager is an important user of the BSC. The BSC application is most effective when all the unit members are involved and therefore [6] the manager will be the <u>conveyer</u> of the methodology within his/her unit. This might occur once the manager is [6A] <u>confident</u> in the key elements of the BSC in order to do not engender confusion among the staff, although it will still be a [6B] <u>learning process</u> for the manager when trying to develop the BSC in collaboration with his staff. Staff need to be introduced in a timed manner to the BSC, allowing time for <u>terminology discussion and assimilation</u>. [7] There should be a regular <u>revision of terminology</u> usage; this is very important in the early phase, although this has also to occur later in time, perhaps a couple of years later, to guarantee shared understanding of the terminology and aim of the BSC. The successful BSC implementation has a strong emphasis on the [8] <u>communication</u> that has to flow through the different levels, both top-down and bottom-up. These flows should allow diffusion and integration of the strategy; they allow verifying the alignment of the actions with strategy between the different levels, and if needed adjustments can be adopted. [9] Rules that have been outlined need to be placed into practice with appropriate follow up to verify the implementation. Diagram 1 provides a summative representation of the theory.

The following section will analyse the information that emerged during the data collection in respect to the outlined theory for successful implementation of the BSC.

6. The case study

This section presents the case study findings of the organisastion outlined in section **CCCC.**

Over time, the hospital level had been adopting different performance measurements. At one time, the Total Quality Management was introduced in all hospitals and later substituted by the more flexible and understandable BSC. Indeed, for managers that used TQM the shift to BSC proved easy as the concepts and methodology are more straightforward. In contrast, the primary care centres where never formally required to adopt TQM or BSC. Their performance was mainly assessed through the management of their budget and in respect to the planned activities.

The following sections will look into the implementation of the BSC within different units of the healthcare organization.

6.1 The early adopter

The first exposure to the BSC occurred in the mid 1990s by the member of one hospital unit. The manager of the unit, a nurse, got interested in this new managerial tool and started to engage with its methodology and use. As one of the collaborators outlined, first of all she spent some time playing with the tool to get acquainted with the terminology and use of the BSC. Once she had acquired some confidence with the BSC she introduced it to her staff. After two years there was some opposition by some staff members and the unit management decided it was appropriate to take time to educate them more on the characteristic of the BSC. This helped the staff to appreciate the peculiarities of the BSC and realign their commitment. It is also interesting to notice the advice by one of the interviewee involved in this unit to

> *'never use the terminology first. You call it something else and then you, after two or three years, tell "I mean", yes, "you know we [have] done this, this is a balanced scorecard". Evidently it is not an easy tool to adopt, as 'I can see it is easier for a chief, but not for the people who works [with it]' 'you talk not much about economically [i.e. finance], [as] this is not so interesting for a worker, and the terminology is not so easy to understand, so you have to translate it [making it] easier'.*

This unit managed to overcome the difficulties of the terminology and to have the BSC accepted and used by all workers in the unit. The unit developed the BSC at a level that each member of the unit has its individual BSC discussed with the unit manager, as well as the unit has developed BSC with different details of analysis, from a rather synthetic that satisfies the requirement by the center, to a very detailed one that lists the components of each indicators, becoming almost a full record of the relevant dimension. It exceeded guidance to not exceed the half dozen parameters as suggested by Kaplan and Norton. This unit is still the most successful BSC user and ahead in its implementation, as it strives toward improved performance.

This unit experience is rather aligned with the implementation theory. The manager felt the need to adopt this new methodology and made herself acquaintanced with it (1, 2, 4). She had in mind the relevance of her staff members to which she wanted to transfer the information and ability to use the BSC (5, 6). There is support to the staff as well as the BSC was introduced using alternative terminologies to make it more digestible until a later translation (5, 7). In the unit there is a rather well defined communication flow (8) which also translate at the larger organizational level, as this unit is considered the best user of the BSC. The unanswered aspect from the collected data is where the manager obtained support during difficulties and development phases of her implementation process.

6.2 Reluctance

Another hospital unit had a manager who strongly opposed the BSC. It was seen as an interference. However, after some time, the manager fully embarked on the BSC, recognizing its feasibility and above all its strategic value for the unit. The manager became among the most motivated of BSC supporters and his enthusiasm was strongly visible during the interview. He highlighted that the BSC forced the unit to carefully think of their strengths and weaknesses and plan their development. Having their own goal on paper and indicating the way to achieve it through targets and indicators and success factors, was motivating staff as well as giving direction. However, an unexpected advantage was the power that the BSC provided to the managers, for example, in situations involving the discussion of the development of the unit and financial related issues. In these situations, the BSC became the reference element to support the request of the manager, or to contain his requests. This unit developed the BSC in a way where it functioned as a production plan. The BSC was seen as a valid element supporting the growth aim of the unit and therefore its recruitment policy. A BSC was developed for each employee as well, also becoming a useful tool to plan promotion.

In this example, it is evident that the organization had introduced the BSC (2, 4) but failed to succeed in motivating the manager (4B). However, the change of heart is indicative that a critical reflective period had occurred, which made the manager a stronger believer and supporter in the tool than others afterwards. He was engaged in discussing it with his own group members and other colleagues. He became not only a conveyor but also supporter in his attitude (6, and 7). In the unit emerged a regular communication emerged among the manager and unit members, as the group had also developed in sub groups specialised in some dimension of the BSC (8), this also allows verification of the understanding of the terminology used (7).

6.3 Transferring a successful implementation

The manager of one primary care centre (PCC) had been the first to introduce the BSC in the PCCs, before it became a requirement once the PCCs joined the Närsjukvård centrum. The manager got support in the development by the county level unit dedicated to BSC implementation. The implementation process had been a learning path shared with the members of the PCC. Together they discussed and developed their BSC. It had been a demanding but satisfying period that benefited the performance of the organization and contributed to a general employee satisfaction. The manager was later transferred to a different PCC. In the new centre there was a constant shortage of staff and a need for the newly appointed manager to address some of the existing problems in a period of budget reduction. The immediate decision for the manager was to transfer the BSC developed in the

previous centre to the new one, as the needs, problems, difficulties were rather similar, with the exception of a more elderly population. The BSC was opposed by the staff members who questioning the terminology and the elements in it. However, the manager kept the original BSC.

This example is emblematic of the problem of implementation of the BSC. While in the first PCC most of the 1-8 steps had been followed, in the second PCC a very different implementation process was followed. There was a BSC that was developed ad-hoc for a PCC and consequently it seemed logical that it could also be easily implemented in the new PCC to which the manager had moved. However, a conflict situation emerged where the content was questioned and above all the staff members did not manage to relate to the terminology used in the BSC documentation. While there might have been the need for a tool to formalize the strategy of the unit, the relevance of points 2, 6, 7 and 8 were compromised. Having no feeling of authorship of the BSC made the staff reject the communication based on the BSC itself. This also made it less easy for the manager to become integrated in the new centre as some members had become disaffected following the introduction of the BSC.

6.4 Helping to share values

One hospital unit had been using the BSC since the new manager arrived in the 90s, as she had also used it in her previous job. The introduction of the BSC in this case was done in steps, firstly calling meetings where all group members were in attendance. The meetings were used to discuss the BSC at first in an indirect way. The starting point was recognized in the need to discuss the mission and values of the unit itself. The discussion helped to create a stronger identify among the group members. In particular doctors realized that they shared the same values with nurses, which they had tended to consider as belonging to a different professional group. Creating a shared value system improved communication and collaboration. The unit BSC was developed in a rather natural way, becoming the reference guide for the staff. The BSC was kept within an A4 page to be easily accessible and understandable. The unit managed to have a balanced budget and through the years to achieve the goals indicated in the BSC. However in a period of economic depression the hospital management made cuts to the organization and this unit had been badly affected by this, with wards and staff reductions. The staff members remaining in employment saw the top managers' action as unfair and to have hit their unit in a more severe way than was fair. The staff members distanced themselves from the BSC process and the unit manager found herself becoming the only one having 'ownership' over the BSC as

> *'when you have bad feelings in the clinic, than the scorecard we are working [on] for many years… then it shrinks to be mine of [of] a couple of co-workers. Because I can't communicate it, they don't find it interesting'.*

This experience is of interest, as the BSC as implemented in the unit helped to develop the communication, and above all trust among the different members (8). The development indicated that the manager managed to introduce the feeling of need for this tool by supporting its implementation, and highlighting the employees as central in its development as the main users (1, 2, 3, 5, 6, 7). This was evident by the time spent on introducing the BSC to the group and making sure it was easily access and gave them support. However, a central decision to make resource cuts meant all this trust was lost, with group members distancing themselves from the tool which became seen as an extension of the management control system (or giving only hypothetical leverage to the employees).

6.5. Change arrives, the BSC leaves

One centre with three departments in the three hospitals was struggling with the development of the BSC, although the different departments in it had had their own BSC when they were independent centers. Some difficulties seemed to be taking the toll against the BSC. There was evident pressure for the centre manager that had the precedence to start the development of the BSC. One member of the department was still not wanting to join into the new structure and opposing any further reorganization, (also the public intervened in opposing some of the reorganisation of the services available in their area), and some colleagues left the organization. The centre struggled to find any base for communication. The BSC was sidelined, although there was the awareness that it had to be made available soon as the units within the centre were awaiting the centre's BSC upon which to develop their own one as 'we're thinking that we should have a balanced scorecard for every level, of course'.

In this specific context almost all steps expected to be achieved seems to be missing. There was an awareness of need for the BSC at the lower levels, as this would benefit their strategy and planning. However, the BSC process was corrupted by a different battle the centre was undergoing that took priority over the development and implementation of the BSC. In this case also levels 8 and 9 (to be discussed in more detail in the following section) were compromised.

6.6 The influence from the centre

One interviewee indicated that the BSC was managed in a rather top-down manner in the organization. It lacked any bottom-up process. The central organization develops the county healthcare BSC that is then transferred to the centre manager for them to develop their own BSC based on the strategy outlined in the county one. Regular meetings are scheduled to discuss the development of the centre in light of the agreed BSC. The centre BSC has then

to be ratified by the county healthcare director. There is no reward or punishment linked to the BSC although the aim of the directorate was at some point to be able to link the BSC with the budget allocated to the centers. The centres than are expected to act in the same way as the county level with the expectation that the following managerial level develop their own BSC based on the centre BSC and then agree its content with the centre manager. This process should be cascading down, allowing the BSC to become more specific and detailed as it is designed for the operative units.

The BSC developers, who were health care professionals and politicians, attributed five dimensions to the BSC: patients/citizens, 'renewal'/development, (internal business) process, co-workers, and economics (i.e. finance). It is interesting to notice that co-workers are seen central in the development of the organization and service.

> *'[W]e divided the learning into two different parts, improving [development] and the staff [co-workers], and the staff includes in this [the] learning perspective'.*

When collecting the information, not all units provided their BSC as expected. The directorate seemed rather surprised when the researcher did not find the BSC to be available at all unit levels, as they were expected to have developed their own BSC by that time. Additionally, it was indicated that all had been introduced to the BSC. Some interviewees highlighted the lack of their own BSC due to the fact that the centre BSC was not available for the sub units to refer to. These was also failure by the centre level to verifying the development and implementation of the BSC.

From the central management point of view it was noticeable that the county highlighted and introduced the need for a BSC and they provided some training, starting with managers (1, 2). They considered the worker to be a relevant player in the system and indeed there was a dimension in the BSC dedicate to them (3). Managers had been introduced to the BSC supporting their development through regular communication as well as the support of the dedicated unit for BSC development (5, 8). Managers were expected to introduce the BSC at the next level to them. While the county was expecting a regular follow up of the BSC developed at this different level, this did not occur, and the directorate failed to have a system in place to monitor this omission. It simply relied on the rule being applied without verifying the applications. Consequently step 9 was also failed to be achieved by the county level.

7. Discussion

The above section looked into the implementation of the BSC in different units within the Östergötland health care organization. The account presents a rather varying exposure and

adoption to the BSC within the organization, as portrayed through the identified experiences. The aim of the paper has been to verify the application of BSC and through this exploratory work the application of the implementation theory outlined in section 5. As from the previous section there is considerable discrepancies of successes within the organisation.

7.1 Variation in use

Although the study is based in one organization there is evidence of a considerable number of different factors affecting the life in the different units. The BSC found fertile ground in part of the organization while in other units it seems to have almost no space for existence. From the above, it can immediately be noticed that the two most successful experiences were based on the manager perceiving the need for a new managerial tool, being or becoming the BSC. In the first case (5.1) the unit manager became aware of the BSC methodology and decided, first of all, that she/he needed to understand the operational characteristics of this tool before disclosing it to the group members of her team. There was a search for understanding the BSC's strengths and possible weakness; it was perceived the risk of mismanagement if the tool was introduced in a rushed way into unit. The example labeled 'reluctance' (5.2) is again an experience that evidences a successful adoption of the BSC. In contrast to the 'innovator', the manager was initially skeptical of the tool, and opposed to its introduction. This can be seen as symptomatic of defending the status quo, and rejecting the additional interference of top management with another tool which is possibly perceived as introduced to extend control over the unit and not beneficial to the unit itself. However, as suggested by the theory, opposition should not be opposed; opposition should be left space of action as long as it is not destructive. Discussion is indeed allowing to deepen the understanding and risks of, in the specific, a new tool (Baron, 2000). The manager (5.2) was given time for her/his views to mature, while other colleagues where adopting the BSC. There was a growth in understanding of the peculiarities of the BSC and also a vision of benefits that the tool portrayed. Its easy concept was appealing, but in particular the possibility for the manager to link the BSC to the strategic growth of the unit. This manager adopted the BSC by making it a tool to steer progression of all unit. Both managers, 'innovator' and 'reluctant', have been enthusiastic for the BSC and have been leading examples of its development with each member of their unit developing their own BSC in accordance to the overall unit one. A strong internal communication and involvement of tall staff members in the achievement of the gorals through a full use of the BSC has emerged. The BSC is used as a plan tool as well as a controlling tool as it develops to be used to plan and assess the development of staff as well.

It is an important stage to achieve all members developing their own BSC (Nørreklit, 2000), step by step over the time that requires the assimilation of a new working methodology,

characterized by a specific language. These important should not to be missed, as demonstrated by the third experience (5.3). At first, one might be tempted to consider two primary practices to be rather similar. Consequently, with just some adjustments to some key indicators and targets, there should be no issue about transferring inter-organisationally a tool developed by peers (GPs and nurses). However, although in this case we have medical professionals that have a strong consensus view, the relocated BSC does not obtain an acceptance level by the recipients. This is not a mechanical process (Nørreklit et al., 2008), as well as Wisniewski and Olafsson (2004) consider when discussing the problems of unifying toward one single BSC within the local authorities in the Icelandic capital. The technical language is not accepted: it becomes a barrier into understanding and possibility to explore further the different BSC dimensions. The manager, by skipping the steps of the development of the BSC in house, has compromised its understanding and acceptance by the colleagues. To create a functional BSC means the development of a communal language and as highlighted in 'sharing the values' (5.4), the BSC's implementation can induce a group to mature a knowledge of its members' characteristics and principles, and so create a stronger group identity (and therefore shared values). Working with the BSC seems to develop a better group culture. Of considerable relevance become time. The time factor is a potential indicator of success or failure of the BSC implementation. Speeding the implementation of the BSC, due to lack of time to invest on the tool makes an unsuccessful implementation of it more likely. This would also be in contradiction with its peculiarity as leading to performance improvement through collaboration and employees' commitment.

The leading team demonstrates that having every team member engaged with the BSC facilitate the continuous revision of the tool itself through the regular assessment of its achievements and its use in planning the future direction, as discussed individually and in team meetings. This supports the views of Nørreklit (2000) view. When looking back at the application model, it is noticeable that the problems with the application of the BSC occurr when communication is not fully implemented, or the relevance of the BSC for the unit is not recognized. The latter point created tension in one unit (5.4): they achieved a balanced 'economical dimension' but underwent cuts that made them feel the organisational scapegoat.

As Mårtensson (2009) suggests in an organization it is not the measure in itself that is important but the communication that it generates. Through out the implementation of the BSC the dialogue seems to be easily forgotten, at least when we refer back to the above examples. As a consequence, the BSC cannot facilitate change when communication is neglected. More dangerously, when the need for the BSC is not understood, its implementation, and consequently forced one, may be interpreted by recipients as management wanting to reinforce their strategy through pretentious involvement of employees by suggesting an 'ideal' communication and collaboration philosophy. **Trust** is the

key element in any managerial change and BSC is no exception. Frandale et al. (2011) highlight the importance of trust toward managers for employees to fully participate: managers' fairness is assessed, particularly in light of unfavorable circumstances. This had been lost in 6.4 and 6.5 when the unit underwent cuts although achieving their BSC targets and merger occurred. The latter in particular is symptomatic of lack of clear communication and feedback by senior manager, which has implication on the motivation (Camilleri, 2007). Indeed, Along with trust motivation has considerable implications upon the performances of individuals. Emmanuel et al. (1990) consider the performance of an individual affected by its ability (given from training and aptitude) and motivation. However, accounting literature seems to have not given much attention in recent years to this issue with regard to implications it has in change. However, there have been academic studies looking into the impact of financial targets and managerial behavior toward achievements (as for example Merchant, 1981; Mia, 1989), particularly in the 80s and 90s. These studies, however, fail to account the lower level of employees, which as we have seen can be key role players in the implementation and performance achievement of the BSC, focusing their attention to the managerial level (although for example Johansen, 2008, looks into the employees accountability toward social accounting). There have been studies of performance management in public sector (Johnsen et al. 2006) also with regard to the BSC (Johnsen, 2001; Wisniewski and Olafsson, 2004) but with limited insight into the relevance to account for the employee's motivation. The 'bottom line' is, as seen above, a key player in the implementation and performance achievement of the BSC and disregarding its involvement and impact that change has may be potential for missed goals. There is a clear need to better understand how this group of workers can be more appropriately motivated. Although we might need to account first of all the characteristics of motivation and distinguish between intrinsic and extrinsic motivation, which however link together, as the extrinsic motivation still affects the intrinsic one (see Kunz and Pfaff, 2002, reflecting on the relevance of internal motivation and agency theory) However, there should be a reward system in place, and the application model clearly identifies communication as potential a non-financial way to reward the positive and successful actions. But the experience in the present paper indicates that this dimension has been neglected by top managers. Managers had rules in place, but no system to verify it had been followed. The lax attitude, while allowing for autonomy, had given a wrong signal to units that were week in the BSC implementation.

7.3 Dangers in implementing the BSC

One might argue that in this context the BSC was introduced in a peculiar environment, dominated by health professionals, lacking managerial background. Definitely this is something that we might need to account for. However, some of the health professionals showed an incredible ability in managing and handling the BSC and therefore the argument

is not really holding. It all depends on the interest that the tool captures on the professional. If it is not considered to be relevant, no effort will be put into it. Health care professionals, when required on them and they agree are good managers, as Thorne (2002) demonstrates in her work, as well as we would need to consider that there might be a cultural specificity in Sweden.

The BSC is not a tool to be used as driver for reform, as the unit experience 5.5 demonstrate. Employees disregard any collaborative tool that they feel is compromising the quality of their professional work, changes that they do not agree with. Evidently there is no motivation toward the transition, and we can consider this in having being a lack of involvement of this professional in planning and discussing the change in earlier stages. Implementing a change when not wanted, for example introducing the BSC as a ready made product (5.3) introduced long term problems, as the core issues need to tackled first, as the need of the tool and its terminology. The language, as the ideals and values need to be share toward an effective team work. This is particularly important in settings characterized by high professionalism, and relative lack of financial leverage at the lower organization levels (particularly in time of economical difficulties

8. Conclusion

The paper aimed to investigate the implementation process of this managerial tool within a healthcare organization. The research was carried out using grounded theory that allowed the development of the implementation theory against which the experience of selected units from the healthcare organization had been analysed. As highlighted in section 6, the implementation path followed by the units was very different, with variation in its success as well. The application has been compared against the implementation model that made evident that less successful developments did not aligned with some stages outlined in the theory.

The paper clearly demonstrates that the BSC is not a straight forward tool that can be implemented in a mechanical way. A key weakness in the implementation of the BSC, as from the above discussion, emerges to be the lack of consideration for the particular unit's culture and feelings. Lacking to consider that each unit has a different history is to neglect the fact that the BSC needs to different account how to motivate individuals. Organizations, and more specifically the acting managers, forget to identify the knowledge and understanding that individuals already have with regard to the BSC or do not have with the consequent need to invest in exposing each employee to this managerial tool. When time pressure induces to take shortcuts in effort and time committed in implementing the BSC, there is inevitably some potential negative consequences in the near or far future. The BSC

is not a tool that can be implemented without accounting the motivation of the recipient and, consequently, the sociological and psychological characteristic the individuals, as well as group(s), need to be assessed and addressed. The paper demonstrates how managers lack understanding of the implications that their actions have on the motivation of their organization members. There is further need to understand how an organization distributes its knowledge and shares information as these are major reasons for the failed implementations. There is need to understand if appropriate training is considered for organization to support individuals that may not ask for support in the progression of their BSC experience. We need more understanding of the dynamics toward managerial tools to understand if the lack of collaboration is indeed as argued in the present paper a distancing from a tool that is perceived extension of top management or if there is a total mis-trust toward managerial innovations. More insight into these aspects will help to understand the impact that new managerial tools have on the work force and not just the managers. Adoption of grounded theory in future researches management accounting should be considered, as it allows to investigate into practices that might be undetected.

REFERENCES:

Aidemark, L.-G. (2001), The meaning of balanced scorecards in the health care organisation, *Financial Accountability & Management*, 17, 23-40.

Aidemark, L.-G. and Funck, E.K. (2009) Measurement and health care management, *Financial Accountability & Management*, 25, 253-276.

Ax, C. and Bjørnenak, T. (2005) Bundling and diffusion of management accounting innovations - the case of the balanced scorecard in Sweden, *Management Accounting Research,* 16, 1-20.

Baron, R.A., 2000, Positive effect of conflict. In: *Using Conflict in Organizations*, in De Dreu, C.K.W. and Van de Vliert, E. (Eds), SAGE Publication, London, 177-191.

Blundell, B., Sayers, H. and Shanahan, Y. (2003) The Adoption and Use of the Balanced Scorecard in New Zealand: A Survey of the Top 40 Companies, *PacificAccountingReview*, 15, 49-74.

Camilleri, E. (2007) Antecedents affecting public service motivation, *Personnel Review,* 36, 356-377.

Cardinaels, E. and van Veen-Dirks, P.M.G. (2010) Financial versus non-financial information: the impact of information organization and presentation in a balanced scorecard, *Accounting, Organizations and Society,* 35, 565-578.

Corbin, J. and Strauss, A. (2008) *Basic of qualitative research,3e,* SAGE.

Emmanuel, C., Otley, D. and Merchant, K. (1990) *Accounting for management control*, Chapman and Hall, London.

Frandale, E., Van Ruiten, J., Kelliher, C. and Hope-Hailey, V. (2011) The influence of perceived employee voice on organizational commitment: an exchange perspective, *Human Resource Management*, 50, 113-129.

Glaser, B.G. and Strauss, A.L. (1967), *The discovery of grounded theory: strategies for qualitative research*, Aldine Publishing Company, New York.

Inamdar, N. and Kaplan, R.S. (2002) Applying the balanced scorecard in healthcare provider organizations, *Journal of Healthcare Management*, 47, 179-195.

Johansen, T.R. (2007) 'Blaming oneself': Examining the dual accountability role of employees, *Critical Perspectives on Accounting,* 19, 544-571.

Johanson, U., Skoog, M., Backlund, A. and Almqvist, R. (2006), Balancing dilemmas of the balanced scorecard, *Accounting, Auditing & Accountability Journal*, 19 (6), 842-857.

Johnsen, Å. (2001), Balanced scorecard: theoretical perspectives and public management implications, *Managerial Auditing Journal,* 16, 319-330.

Johnsen, Å., Nørreklit, H. and Vakkuri, J. (2006), Introducing a Nordic perspective on public sector performance measurement, *Financial Accountability & Management*, 22, 207-212.

Kaplan, R.S. and Norton, D.P. (1992), The balanced scorecard: measures that drie performance, *Harvard Business Review,* 70 (January/February), 71-79.

Kaplan, R.S. and Norton, D.P. (1996), Using the balanced scorecard as a strategic management system, *Harvard Business Review,* 74 (January/February), 75-85.

Kaplan, R.S. and Norton, D.P. (2004), *Strategy maps: converting intangible assets into tangible outcomes*, Harvard Business School Press, Boston.

Kunz, A.H. and Pfaff, D. (2002) Agency theory, performance evaluation, and the hypothetical construct of intrinsic motivation, *Accounting, Organizations and Society,* 27, 275-295.

Mårtensson, M. (2009) Recounting counting and accounting: from political arithmetic to measuring intangibles and back, *Critical Perspectives on Accounting,* 20, 835-846

Merchant, K.A. (1981) The design of the corporate budgeting system: influences on managerial behavior and performance, *The Accounting Review*, 4*,* 813-829.

Mia, L. (1989) The impact of participation in budgeting and job difficulty on managerial performance and work motivation: a research note, *Accounting, Organizations and Society*, 14, 347-357.

Nair, M. (2009) Overcoming the 9 deadly sins of balanced scorecards, *The Journal of Corporate Accounting & Finance*, 83-90.

Nørreklit, H. (2000), The balance on the balanced scorecard a critical analysis of some of its assumptions, *Management Accounting Research*, 11, 65-88.

Nørreklit, H. (2003), The balanced scorecard: what is the score? A rhetorical analysis of the balanced scorecard, *Accounting, Organizations and Society*, 28, 591-619.

Nørreklit, H., Jacobsen, M. and Falconer, M. (2008) Pitfalls in using the balanced scorecard, *The Journal of Corporate Accounting & Finance*, 65-68.

Saldaña, J. (2010) *The coding manual for qualitative research*, SAGE.

Thorne, ML. (2002). Colonizing the new world of NHS management: the shifting power of professionals, Health Services Management Research.,15, 14-26.

Yin, R.K. (2003) *Case study research: design and methods, 3e,* SAGE.

Wisniewski, M. and Olafsson, S. (2004), Developing balanced scorecards in local authorities: a comparison of experience, *International Journal of Productivity and Performance Management*, 53, 602-610.

Diagram 1: The implementation theory, in summary

1. Perception of NEED

2. BSC introduced

3. Identify USERs, i.e. managers

4. Introduce USER accounting for TIME
    a. ACCEPT
    b. REJECT

8. COMMUNICATION

9. RULE

5. Support the learner over EXTENDED PERIOD

6. Manager CONVEYOR
    a. Once CONFIDENT
    b. LEARNING while conveying, with time for TERMINOLOGY discussion and assiliation

7. REVISION of TERMINIOLOGY