

ORIGINAL ARTICLES

Balanced scorecard method for healthcare quality improvement: A critical analysis

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ABSTRACT

Throughout the world there is an on-going effort to determine quality in healthcare settings. The very definition of “quality”, particularly in healthcare, is rather elusive. The aim of this critique is to analyze the Balance Scorecard method to measure quality as it relates to patient safety in healthcare organisations. Analysis of the Balanced Scorecard in this context determined that the objectivity, both in its measurements and its ability to link together the organization’s quality and financial goals, is indeed beneficial. However, this methodology was also found to be unduly focused on systems and administration rather than on the actual health and safety of patients. The result is a tool that measures “quality” in financial and organizational terms, as sought by healthcare management, and this will continue to be the case until there is a fundamental shift towards defining quality of healthcare in terms of the patients that utilize healthcare services.

Key Words: Balance Scorecard method, Patient safety, Healthcare quality, Healthcare organisations

1. INTRODUCTION

In response to a perceived crisis in standards, there has been a vast upsurge in the amount of critical attention paid to quality in healthcare, especially concerning initiatives aimed at improving its quality.^[1] This article aims to critically analyze the Balanced Scorecard method for healthcare quality improvement that can be implemented to improve the quality of care within the secondary healthcare context. For the purpose of perspective, the discussion will seek to concentrate upon secondary healthcare contexts, looking in particular at the aspect of quality as it relates to patient safety. In the health network, secondary care is made up of specialised ambulatory and hospital services, with an intermediate technological density between that of primary and tertiary care, historically interpreted as procedures of medium-level complexity. This

level includes specialised medical services, diagnostic or therapeutic support services, and emergency services.^[2]

This quite clearly represents an especially complex problem to attempt to address, with indistinct boundaries between managerial rhetoric and healthcare practice affecting attempts to analyze the contours of the broader quality debate.^[3] As such, it is prudent to divide the article up into distinctive subsections, to offer a holistic view of what remains an essentially multi-faceted issue. Thus, after considering the complexities of defining quality as it relates to healthcare, an overview of the main issues that health organisations need to address will be considered. Before turning attention towards considering a conclusion, an analysis of the strengths, weaknesses and limitations of the Balanced Scorecard will

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also be undertaken. In this way, the unique challenges of managing healthcare organisations will be emphasised.

2. THE COMPLEXITIES OF DEFINING QUALITY IN HEALTHCARE

The application of quality in healthcare represents one of the most important challenges facing medical professionals and healthcare policy makers. There is no standard, universal, clear or precise definition of the term “quality”, which creates the difficulties faced by most studies of quality. Differences in the meanings make it both a seductive and slippery philosophy of management.^[4]

The term “quality” represents a buzzword in contemporary managerial terminology. As a result, the concept of quality has become synonymous not only with healthcare but, rather, with all of those public services that have been subject to the unprecedented spate of managerial reforms that have been initiated over the course of the past two decades.^[5] Understood in this way, it is apparent that efforts to improve upon the quality of care, commissioning, standards and processes do exist. The efforts can be seen within a broader reformist framework which seeks to instil a free market, private sector mentality into frontline public sector services in a bid to improve efficiency and increase cost effectiveness. Thus, to understand the specific complexities of quality as they relate to healthcare managers it is imperative to consider the political context in which managerialist public health reforms have been conceived.^[6]

In the final analysis, the concept of quality is not value-free. Rather, it is apparent that stakeholder perspectives on quality of care influence definitions of quality.^[3] As Donabedian^[7] attests, the definition of quality shifts depending upon the angle from which one views the concept. Whereas quality technical care (that is, the quality of the care provided by physicians and practitioners) depends upon “the knowledge, judgment and skill of those who offer it”, the amenities of care (that is, access to care and hospitals) “depend on factors generally beyond the direct control of practitioners”.^[7] There is, therefore, a considerable difference between the definitions of quality as it is understood in macro-level, societal terms and the reality of quality as it is experienced in micro-level, individual terms.^[3] As McGlynn observes, “quality may be evaluated from the perspective of individuals or populations”.^[8]

Consequently, it is important to acknowledge the underlying paradox of definitions pertaining to quality whereby, in an ideal scenario, quality would conform to service users’ expectations. However, in reality, quality tends to refer to the managerial definition of standards.^[9] Viewed from this

perspective, quality relates not only to the care afforded to service users but also to budgets, managerial efficiencies and the broader demands of politicians and healthcare professionals.^[10] Attaining a comprehensive definition of quality is, therefore, affected by deep-seated “conflicts and compatibilities between users, potential users and taxpayers”.^[10]

As a result, it is apparent that, in order to consider the problems inherent in constructing a method for quality improvement in healthcare, it is important to consider, in the first instance, two elements. These are: the social construction of quality and the primacy of political interests and stakeholder power in the evaluation of what is considered a high quality and efficient healthcare service.^[3] As Boaden details, the vast majority of quality improvement approaches are dependent upon organisational change.^[4] Thus, the important power differentials that influence the make-up of organisations deeply influence the social construction of quality, as it is understood in healthcare. The underlying “social mission” of both public and private sector healthcare providers can, and often does, “take second place to organizational survival and growth”.^[11] Consequently, it is apparent that only by looking at the situation from a social constructivist viewpoint can an accurate picture of quality be drawn.

It is extremely important to consider the problems regarding the definition of quality, given the existence of the direct causal relationship between the definition of quality and the attempts to measure and subsequently improve it.^[10] For instance, if quality is to be defined in terms of the amenities of care, then attempts to measure and improve it must look to the healthcare organisations that run secondary care institutions. Attention must now be turned, therefore, to the analysis of the main issues that affect these healthcare organisations.

3. MAIN ISSUES THAT HEALTH ORGANISATIONS NEED TO ADDRESS

As the above analysis has demonstrated, quality is peculiarly complex, multi-faceted concept whose definition is, to some degree, located “in the eye of the beholder”.^[8] The lack of consensus regarding the definition necessarily affects approaches to quality improvement, especially concerning the sheer scale of the issues that health organisations need to address. Health organisations need to consider the impact of diagnostic equipment, technology and the broader healthcare system, and the ways in which these affect the quality of service delivery.^[12] In addition, quality improvement programmes must also consider the role of healthcare professionals, as well as “interactions between participants in the system”.^[4]

Yet, arguably, the most important issue that health organisations need to address in order to improve quality is the functioning of the organisation itself. As Berwick has illustrated, the quality improvement strategies that are used in healthcare contexts are derived primarily from quality assurance initiatives that have previously been used in manufacturing contexts.^[13] These represent a “total” approach to quality improvement in which the organisational structure is viewed in terms of a process.^[14] The insights afforded by quality improvement programmes that have evolved from the manufacturing sector have, in a healthcare setting, created a dichotomy between two competing quality paradigms. On the one hand there is the standards/inspection-based approach, while on the other there are the “newer continuous quality process improvement processes”.^[10] It is this second approach, the continuous attempt to improve quality throughout the organisation, which has attained a position of predominance in healthcare.^[8]

Quality improvement programmes that adopt a continuous approach to administering healthcare can serve to address the main issues that affect organisations. These issues can range from external reviews of organisational performance to smaller quality improvement programmes that seek to change the practice within organisations.^[11] This is because continuous quality improvement programmes allow for “learning in cycles”, whereby improvements in quality occur through the process of change management.^[14] Understood in this way, the twin concepts of change and improvement can be seen to be always together with all forms of quality improvement, leading to a process of continuous change.^[15] Thus, the major issues affecting the quality of the services delivered can be addressed through a long-term adherence to the principles of continuous quality programmes.

However, as has been mentioned, quality cannot only be defined, measured and subsequently improved by considering the functioning and the efficiency of healthcare systems. While the technical aspects of quality control are best measured via recourse to those institutions that provide healthcare, the main issues that concern patients are vastly removed from the main issues that concern organisations and their stakeholders.^[8] As Berwick points out, quality cannot be considered to be improved if quality improvement programmes do not take into account the perspectives of service users.^[15] Thus, it is impossible to consider the main issues that health organisations need to address without considering the issues that concern patients.

As far as the secondary care context is concerned, there can be little doubt that the spectre of patient safety constitutes a very important factor for quality improvement experts to

consider. As Boaden acknowledges, safety is not only a key dimension of quality; rather, it is “an essential step in improving the quality of care overall”.^[16] Although there remains an indistinct dividing line separating patient safety from quality of care, it is difficult to conceive of a health organisation that does not consider patient safety to be a prerequisite of quality.

However, while it is apparent that patient safety represents one of the main issues that health organisations need to address, it is less clear how best to devise and implement strategies that are able to forecast the risk associated with patients in secondary care. This, according to James Reason, is because “correct performance and systematic errors are two sides of the same coin”.^[17] When, for instance, a cognitive psychological perspective is employed, it is apparent that the human error that increases the problems relating to patient safety is, in fact, the residue of the “recourse limitations of the conscious workspace”.^[17] With this understanding, human error, and the incumbent sense of risk that this entails, is an inevitable feature of healthcare. This is especially the case in a secondary care context, where complex procedures are reliant upon a combination of human expertise and technological quality. When analysing the effectiveness of particular quality improvement methods it is, consequently, imperative to examine whether patient safety has been considered as one of the main issues that needs to be addressed.

4. THE BALANCED SCORECARD METHOD: STRENGTHS, WEAKNESSES AND LIMITATIONS

The Balanced Scorecard method looks beyond the short-term gains of financial measures as the sole indication of an organisation’s performance to consider the long-term strategic objectives of four inter-related management processes.^[18] These four management processes consist of:

- Translating the vision (incorporating an integrated set of objectives that define the long-term organisational vision for success);
- Communicating and linking (stressing the value of departmental and consumer objectives in order to improve the functioning of the whole of the organisation);
- Business planning (involving the integration of business and financial objectives within the context of the broader long-term organisational goals);
- Feedback and learning (monitoring short-term results from the perspective of customers, internal processes, and systems and growth).

Considering the four management processes that reside at the centre of the Balanced Scorecard method demonstrates both

the strengths and the weaknesses of this approach to quality improvement. In terms of the strengths, it is important to consider the way in which the Balanced Scorecard enables an organisation to link financial goals to underlying strategic objectives.^[18] In a healthcare context, the Balanced Scorecard should be considered beneficial because it “aligns the organisation around a more market-orientated, customer-focused strategy”.^[19] Furthermore, in adopting a “whole systems” approach, the Balanced Scorecard “assigns accountability for performance at all levels of the organization”.^[19] Understood in this way, the Balanced Scorecard can be seen to be synonymous with the multi-faceted goals of quality in healthcare. This could be by seeking to improve long-term financial results, while at the same time considering service user satisfaction.

In addition, in emphasising the importance of feedback and learning on the quality process, the Balanced Scorecard method responds to the continuous quality imperative. According to Berwick, this imperative ought to be understood as an ideal of health service provision.^[13] The Balanced Scorecard consequently provides a template through which managers are able to achieve “consistency of vision and action”.^[18] For these reasons, the Balanced Scorecard method should be understood as a dynamic means of understanding the complex relationship between a continuous, underlying dedication to quality and change and the (often misguided) relationship between short-term financial objectives and long-term organisational goals. In a secondary care context, which is dependent upon the smooth operational functioning of diagnostics, this is an important point to note.

In terms of the weaknesses and limitations of the Balanced Scorecard method, there are three key issues that need to be considered. Firstly, it is apparent that the Balanced Scorecard represents an overly target-based and managerial approach to healthcare management. This does not consider the subtle yet profound psychological factors that influence human error in a professional context.^[17] While it is true that the Balanced Scorecard offers a “whole systems” approach to the functioning of the organisation, this method does not offer a similar approach to employees. Nor does it offer the unique sense of autonomy that is bestowed upon healthcare professionals in a secondary care context.^[4] The Balanced Scorecard method thus ignores the prevalence of rules-based and knowledge-based mistakes. This is where previously unknown situations expose the limits of “pre-packaged problem-solving rules”.^[20] Bypassing the human contribution to quality failures represents a significant shortfall in the Balanced Scorecard method. In a practical secondary care setting, the Balanced Scorecard method needs to be modified “to reflect industrial and organizational realities”.^[21]

Secondly, although consideration is paid to the importance of customers, the Balanced Scorecard is overly concerned with systems, structures and organisations rather than the patients that use the healthcare amenities. As a result, in a secondary care context, the health and safety of patients is rendered secondary to the financial/organisational needs of the healthcare provider. Ultimately, it is apparent that, in an economic climate which is characterised by cutbacks and working under the guidance of a political system that is obsessed with efficiency and performance management, the views of the consumer are not considered the primary directives driving changes to healthcare management in the contemporary era.^[6] As Esmail observes, talk of “‘systems problems’, ‘continuous quality improvement’, or ‘process engineering’ is the dry language of structures, not people”.^[22] In the final analysis, the Balanced Scorecard is unable to address the imbalance between systems/structures and people/patient. To put it another way, those who focus on balance sheets, and who see healthcare simply as a commodity, do consider the experience of being a patient – who is never an active consumer or agent in the marketplace when undergoing medical treatment. Instead, the patient is at the mercy of healthcare providers; there are, as a result, power imbalance, quality of life and safety considerations not addressed by the Balanced Scorecard.^[23]

Thirdly, it is important to acknowledge the difficulties inherent in “moving from concept to practice”.^[24] As previously observed, many of the quality improvement models and theories currently being used in healthcare contexts originated in the manufacturing sectors. However, there is a considerable difference between applying management paradigms in a large private sector organisation and applying them in the public sector. This is especially so in health organisations, where there is an almost constant risk linked to the safety of human lives.^[22] Healthcare professionals work on an autonomous basis, which is in many ways alien to private sector methodologies.^[4] In considering the limitations of the Balanced Scorecard method, it is consequently imperative to bear in mind the considerable distance that needs to be travelled before the theory of a whole systems approach to healthcare management can be translated into the practice of continuous quality improvement.

5. CONCLUSION

This article critically analyzed the Balanced Scorecard as a method for quality improvement that could be implemented within a secondary care context. It also discussed and highlighted several aspects, such as the complexities of defining quality and the weaknesses, limitations and the strengths of the Balanced Scorecard, as well as providing an overview of

the main issues that health organisations need to address.

When examining the changes that have occurred in healthcare management in recent years, especially the changes in the concept of quality improvement, it is important to consider the economic and political context in which those changes have been framed. The pressing need to reduce costs and a pervasive managerial doctrine have ensured that public sector services have been infused with a market-style mentality with regards to both their financial and organisational structure.^[6] This, in turn, has significantly affected the evolution of quality improvement strategies in healthcare organisations. The prerogatives of powerful commercial stakeholders now seem to take precedence over the concerns and views of the service users utilising frontline public healthcare amenities. As a result, healthcare managers have increasingly defined quality in terms of cost efficiency rather than in terms of the two “principal dimensions of quality of care for individual patients; access and effectiveness”.^[3]

The Balanced Scorecard method does attempt to address all of the issues affecting the definition, measurement and

improvement of quality in healthcare. Underlying strategic objectives, which include quality of care for patients, are thus married to broader financial goals that seek to make the organisation more competitive in an increasingly market-driven economy.^[19] The Balanced Scorecard has proven able to address the financial and functional issues affecting healthcare organisations, especially with regards to the imposition of a “whole systems” approach to management. However, there remains a considerable difference between the concept of quality improvement theories and the application of quality improvement at a practical, individual level. More importantly, it is apparent that much of the discourse relating to quality improvement is couched in political rhetoric.^[22] This, in the final analysis, does not bode well for quality relating to patient safety. Viewed from this perspective, it is clear that quality remains vested in the hands of powerful stakeholders who continue to dictate the pattern of healthcare provision at the dawn of the twenty-first century.

CONFLICTS OF INTEREST DISCLOSURE

The author declares that there are no competing or potential conflicts of interest.

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