How strategy map works for Ontario’s health system

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Abstract

Purpose – The purpose of this paper is to exemplify the evolving applications of balanced scorecard and strategy map in the healthcare sector. This paper seeks to describe a number of innovative approaches adopted by healthcare organizations and health systems in their implementation of Kaplan and Norton’s strategy map and balanced scorecard. Although strategy map and balanced scorecard are useful strategic management tools, policy makers and decision makers should be well-informed about implementation issues and challenges of their adoption in healthcare organizations and health systems.

Design/methodology/approach – The paper is based on a literature review of the applications of strategy map and balanced scorecard in healthcare organizations and health systems. Also publications of the Ministry of Health and Long-Term Care and its agencies are examined to assess the strategic priorities and plans for Ontario’s health system.

Findings – From the literature review and case studies cited, an increasing use of strategy map and balanced scorecard was found in the healthcare sector. The implementation is both unique and innovative. Moreover, strategy map and balanced scorecard are effective communication and strategic management tools in aligning and integrating the strategic goals of various levels within the health system.

Practical implications – The paper gives an account of the different implementation approaches of strategy map and balanced scorecard in the healthcare sector; thereby providing policy makers and decision makers with choices on how to implement the strategic management tool in their organizations.

Originality/value – The literature review and case studies described here highlight the value and applications of strategy map and balanced scorecard in the healthcare sector.

Keywords Balanced scorecard, Management strategy, Health services, Canada, Decision making, Strategic planning

Paper type Case study

The health system in Ontario, Canada, has undergone structural changes over the last few years as part of the government’s strategic initiatives to develop “a patient-focused, results-driven, integrated and sustainable health system” (The Ministry of Health and Long-Term Care, 2006, p. 14). Apart from structural changes, there is a focus on providing results information to demonstrate accountability. The Health Research Team for Information Management (HRT-IM), a task force established by the Ministry of Health and Long-Term Care, is given the mandates to lead the development of Ontario’s health information capacity; and to improve the quality and accessibility of data for planning, funding, and performance measurement. The task force not only provides local health networks with a suite of scorecards of health indicators for performance assessment but also formulates the first scorecard for Ontario’s health system.

Kaplan and Norton’s (1992, 2001a, b) balanced scorecard and strategy map are complimentary management tools which have been widely adopted in for-profits...
organizations. Their applications in the not-for-profit sector, especially healthcare organizations, have grown steadily over the last decade. In this paper, we will look at how HRT-IM modified Kaplan and Norton’s strategy map in developing the first model health system scorecard and local network scorecards. We will provide a brief description of strategy map first, followed by a review of the applications of balanced scorecard and strategy map in the healthcare sector. We will examine the use of strategy map in developing Ontario’s first model health system scorecard and assess the value of strategy map in rolling out the government’s strategy to different levels in Ontario’s health system. The concluding section looks at the contribution and limitation of implementing strategy map and balanced scorecard in the healthcare sector.

Strategy map
Kaplan and Norton (2001a, b) advocate the use of strategy map as an organization’s strategic management system. This is a major milestone since their inaugural paper on balanced scorecard in 1992 (Kaplan and Norton, 1992). Kaplan and Norton (2001a, p. 90) state that strategy map is a “logical and comprehensive architecture for describing strategy”, and it “specifies the critical elements and their linkages for an organization’s strategy”. Armitage and Scholey (2007) suggest that the first and most critical step in constructing a strategy map for a for-profit organization is to define its overriding objective, which usually contains a financial target and a time dimension to guide its strategies. The organization then decides on its value proposition to compete in the market and carries on with its strategy mapping process by choosing the financial strategies; choosing the customer strategies; executing through the internal perspective strategies; and planning the learning and growth strategies. Although there is little empirical evidence which proves or disproves the hypothesis that adoption of strategy map and balanced scorecard is positively associated with improved financial performance of for-profit organizations, there are numerous anecdotal reports on the value of strategy map and balanced scorecard to the adopters. A number of organizations claim that they have achieved significant market share gains, operating and financial improvements from the adoption of strategy map and balanced scorecard (Balanced Scorecard Collaborative, 2007).

From his experience working with not-for-profit and government organizations, Kaplan (2001) recognizes that management of these organizations has difficulty in placing the financial perspective at the top of the hierarchy in the strategy map. He recommends that an overarching objective, such as enhancing environmental sustainability, which is significant to achieving the long-term goals and vision of not-for-profit and government organizations, has to be placed at the top of the hierarchy. This results in a modified architecture in the strategy map for not-for-profit and government organizations. Nonetheless, a growing number of not-for-profit and government organizations have adopted balanced scorecard as their organization’s performance management system while others have implemented a strategic management system using strategy maps.

Balanced scorecard in the healthcare sector
Implementation of balanced scorecard in healthcare organizations for performance measurement and strategic management has grown steadily during the 1990s. The Women’s College Hospital in Toronto (Baker and Pink, 1995), the University of Alberta
Hospitals (Baker and Pink, 1995), and Peel Memorial Hospital (Harber, 1998) are the first adopters of balanced scorecard in Canada during the mid-1990s. Despite challenges in implementing balanced scorecard and selecting performance indicators, the initiative was quite successful in these organizations, especially at Peel Memorial Hospital when there were increases in both patient and staff satisfaction levels. The balanced scorecard also provided Peel Memorial Hospital the ability to translate the hospital’s strategic objectives into a coherent set of performance measures and to align the seemingly disparate elements with organizational objectives.

Applications of balanced scorecard in the healthcare sector over the last decade have diverged from evaluating organizational performance to developing clinical pathways. Hospitals, hospital systems, long-term care facilities, psychiatric centres, and university academic departments (Zelman et al., 2003) have all adopted balanced scorecard. Administrators of these healthcare organizations, in general, noted that the balanced scorecard framework was essential to connecting clinical and organizational practices, outcomes, quality, value and cost; aligning performance measurement with meeting organization’s vision, primary value, core principles, and operational strategies; and achieving a balance between productivity and quality (Curtright et al., 2000; Gumbus et al., 2003; Jones and Filip, 2000; Kershaw and Kershaw, 2001; Meliones, 2000; Kershaw and Kershaw, 2001). Health systems have also adopted balanced scorecard. Henry Ford Health System (Sahney, 1998) constructed its scorecard in the mid-1990s while Ontario Hospital Association published its first Hospital Report for acute-care hospitals in 1998.

The early adopters of balanced scorecard, by and large, placed their emphasis on improving quality/process while sustaining their organization’s financial performance. They often ignored the cause-and-effect relationship among performance indicators in the scorecard and the linkage of performance indicators to their organization’s strategic objectives. These healthcare organizations and health systems have not been able to capture the value and benefits which balanced scorecard can contribute to strategic management.

The latest applications of balanced scorecard and strategy map in the healthcare sector, as driven by Kaplan and Norton’s publications in 2001, have been innovative. Some healthcare organizations continue to use Kaplan and Norton’s original performance perspectives of financial, customer, internal process, and learning and growth; while others modify Kaplan and Norton’s strategy map to reflect their organization’s unique mission, vision, and strategic objectives.

**Strategy map in the healthcare sector**

As described in Zelman et al.’s (2003) study, the adoption of balanced scorecard, and recently, strategy map, is now in the growth phase in the healthcare sector. Healthcare organizations, including hospitals, health systems, and academic institutions, use different approaches to create their strategy map.

SMDC Health System (Poisson, 2007) was incorporated in 1997 with the merger of St Mary Medical Centre and Duluth Clinic, Minnesota. In 1997, as a newly merged organization, SMDC engaged a national consulting firm to develop the organization’s first strategic plan. The result was a plan with over 350 initiatives, and there was a lack of strategic focus. The board of directors, management, and employees were confused about the organization’s direction, and the organization’s financial performance deteriorated.
In early 2000s, senior management decided to adopt a different approach for strategic planning. They applied a strategy mapping process to define the organization’s strategy in a cohesive, integrated, and systematic manner. The outcome of the exercise is a strategy map (Figure 1) which incorporated the organization’s mission and vision. This strategy map helps the entire organization understand which strategic drivers are critical to achieving service excellence, clinical excellence, and management excellence while satisfying various stakeholders’ needs. SMDC’s strategy map consists of the conventional performance perspectives: customer, internal business process, learning and growth, and financial.

SMDC’s overarching objective is to achieve focus on safety, quality, and value, which is contrary to that of a for-profit organization, which emphasizes financial success. The strategy map becomes SMCD’s blueprint in defining its strategic objectives, selecting performance indicators, and monitoring progress towards organizational goals. By focusing on strategy and performance with balanced scorecard and strategy map, SMDC has grown over the last few years. The health system now includes four hospitals, 17 clinics, and over 7,000 physicians and employees serving the communities in northeast Minnesota and northwest Wisconsin. The strategy map and balanced scorecard at SMDC not only simplifies communication and facilitates change management but also directs the entire organization’s attention towards implementation of strategy, alignment of initiatives, and execution with accountability.

The Faculty of Health (the Faculty) of the University of Newcastle implemented an “energetic and comprehensive strategic planning process” (Faculty of Health, The University of Newcastle, 2007) in 2002 and the balanced scorecard framework in 2003; both of which are independent of the university’s strategic plan. A unique characteristic of the Faculty’s strategic planning system is a strategy map with a pyramidal structure and five perspectives (Figure 2):

1. our students and communities;
2. our financial sustainability and accountability;
3. our internal processes;
4. our partners; and
5. our people: learning, innovation and growth.

Since the Faculty is a not-for-profit organization with a vision to lead health improvement in its communities and a mission to deliver world-class education to its students, its overarching objective is to serve “Our students and communities”, the apex of the strategy map. “Our people: learning, innovation and growth”, the intellectual capital which defines the capabilities and capacity of the Faculty to serve its students and communities, forms the foundation of the pyramid. At the centre of the pyramid are the other three perspectives which define what the Faculty needs to do to achieve financial sustainability, what the Faculty has to excel in its internal processes, and what partnerships the Faculty must build to achieve the desired outcomes for their students and communities. The pyramidal structure of the Faculty’s strategy map provides a clear picture on how the five perspectives are linked to the Faculty’s vision and mission. It also specifies that financial performance takes a backseat to the organization’s overarching objective in serving its students and communities.
Figure 1. Strategy Map – SMDC

Mission: SMDC brings the soul and science of healing to the people we serve.

Vision: SMDC will be the best place to work and the best place to receive care.

We will pursue our mission and vision through a focus on Quality, Safety, and Value

Customer
To achieve our focus on Quality, Safety & Value, how should we appear to our internal & external customers?

Internal Processes
To satisfy our customers, at which operational & quality processes must we excel?

Learning & Growth
How will we sustain our ability to change and improve as a system?

Financial
To financially sustain our Mission, on what must we focus?

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Notes: Printed with permission from SMDC Health System. *Cancer, Cardiovascular, Digestive, Surgery, Children Specialty Services
Figure 2.
Strategy map – Faculty of Health, the University of Newcastle

Note: Printed with permission from the Faculty of Health of the University of Newcastle
The Faculty has also established strategic objectives for each perspective in the pyramidal strategy map and selected performance indicators for the strategy report to measure and monitor performance towards achieving these objectives. Moreover, the Faculty has rolled out the pyramidal strategy map to its academic units, including the School of Nursing and Midwifery, the School of Health Sciences, and the University Department of Public Health. Now, in its fifth year of implementation, the Faculty is continuing with its successful applications of strategy map and balanced scorecard as their organization’s strategic management system.

Besides health system and academic health unit, the Cancer Quality Council of Ontario, in collaboration with Cancer Care Ontario, is a pioneer which uses strategy map to develop a scorecard of indicators to monitor, report publicly, and guide improvements in Ontario’s cancer system performance (Greenberg et al., 2005). A working group at Cancer Quality Council of Ontario led the development. The process involved a systematic literature review and a modified Delphi panel method, with multiple rounds of structured feedback from experts in cancer care. This resulted in a set of quality indicators spanning from cancer prevention through to end-of-life care. The working group tried to map the core set of indicators to a typical Kaplan and Norton’s balanced scorecard. The attempt failed because cancer system’s strategic objectives were quite different from those implicit in Kaplan and Norton’s framework. Moreover, the scorecard was unbalanced because there were few financial indicators and certain aspects of the continuum of cancer care delivery, from prevention to palliative, were underrepresented.

The working group decided to take a different route to develop the strategy map. It created a strategy map (Figure 3) by highlighting the interrelationships among the five strategic objectives of Ontario’s cancer system. The working group assigned indicators to each of the five strategic objectives by hypothesizing the influence of each strategic objective on others and the cause-and-effect relationships among the leading and lagging indicators. At present, Ontario’s cancer system scorecard includes 30 quality and performance indicators. Cancer Quality Council of Ontario’s plan is to distribute the scorecard to cancer care providers to identify opportunities for improvement and then to the public for accountability.

**Figure 3.** Strategy map – Ontario’s cancer system

*Note: Printed with permission from Cancer Quality Council of Ontario*

*Source: Cancer Quality Council of Ontario*
It is premature to judge the efficacy of the cancer system scorecard to policy makers, decision makers, managers, clinicians, patients, and other stakeholders. It is also too early to assess the scorecard’s contribution towards achieving the cancer system’s strategic objectives of improving access, delivery, and quality of service. Nonetheless, the strategy map has at least provided an effective framework in rolling out and integrating strategies of Ontario’s cancer system to other components, such as palliative care, in the organization.

Applications of strategy map and balanced scorecard in the healthcare sector take various forms. They range from a typical Kaplan and Norton’s strategy map in a private managed-care organization in the USA, to a pyramidal strategy map in a university faculty and department in Australia, and to an atypical strategy map for a publicly-funded cancer care system in Canada. A number of regional health authorities in Canada have also implemented strategy map and/or balanced scorecard as part of their organization’s performance measurement and accountability framework (see, e.g. Provincial Health Services Authority, 2006; Chinook Health Region, 2005; David Thompson Health Region, 2005).

Moreover, the balanced scorecard framework has been adopted for public reporting for almost a decade in Ontario’s hospital sector (see, e.g. Ontario Hospital Association, 1998, 1999). The Hospital Report series provides information on the performance of Ontario acute care hospitals at the provincial, regional, and individual organizational levels in four areas:

1. system integration and change;
2. patient satisfaction;
3. clinical utilization and outcomes; and
4. financial performance and condition.

Its coverage has expanded from acute care to complex continuing care, emergency department care, rehabilitation, and mental health. More recently, the Health Research Team for Information Management (HRT-IM), following the lead of the Cancer Quality Council of Ontario, adopted strategy map in its first model health system scorecard. Strategy maps and scorecards have also been developed for Ontario’s Local Health Integration Networks (LHINs) and hospital sector.

**Strategy maps for Ontario’s health system, local health integration networks, and hospital sector**

“To provide results information to demonstrate accountability” is one of the three strategic directions identified for Ontario’s health system. The Ministry of Health and Long-Term Care (the Ministry) established the Ontario Health Quality Council (the Council) in September 2005 (Ontario Health Quality Council, 2005). The Council’s mandates are to monitor and report to the people of Ontario on access to and effectiveness of publicly funded health services as well as to support continuous quality improvement. It has developed a reporting framework with attributes descriptive of a high-performing health system on accessibility, effectiveness, safety, patient-centredness, equity, resource appropriateness, integration, and focus on public health. The Council published its first report on Ontario’s health system in 2006, and a second has followed. These reports describe what is working and identify what needs improvement in Ontario’s health system. The performance indicators in the report, however, are not linked to the mission
and strategic goals of Ontario’s health system. This gap has been fixed by another initiative of the Ministry on information management.

The HRT-IM was established with a mandate to improve the quality and accessibility of data for planning, funding, and performance measurement. One of its key strategies and responsibilities is to develop a performance management system, linking to the strategic goals of Ontario’s health system and the priorities of the government. From the strategy mapping process of the Cancer Quality Council of Ontario, HRT-IM abandoned Kaplan and Norton’s typical strategy map. It conducted a detailed review of the government’s and the Ministry’s plans and documents to identify the strategic goals of Ontario’s health system. The review resulted in nine strategic themes.

Using Cancer Quality Council of Ontario’s approach, HRT-IM hypothesized relationships among the strategic themes and described how the health system would create value for Ontarians. These nine strategic themes (Figure 4) form the four quadrants of a health system scorecard:

1. evidence availability and use;
2. provision of care;
3. health status and outcomes; and
4. health system sustainability and equity.

They also facilitate selection of performance indicators for the scorecard.

Through a systematic literature review and a modified Delphi panel process, HRT-IM was able to reduce the original list of 2,000 plus performance indicators to a final list of 27. These performance indicators were mapped into the four quadrants of the health system scorecard based on their importance, relevance, understandability,
availability, feasibility, objectivity, reliability, and validity of each strategic theme. These performance indicators have other qualities as well. They can be acted on by policy makers, management, and clinicians; reported at multiple levels of the health system; and have acceptable boundaries of performance values. All these attributes are important to cascading the health system scorecard to other levels, including LHIN-level, sector-level, and provider-level, as well as to sustaining continuous improvement efforts. The first health system scorecard was published in September 2005. It included a five-year data analysis of Ontario’s health system as compared to other jurisdictions. The comparative data help policy makers to identify areas for improvement and to allocate resources for continuous quality improvement efforts.

The first Ontario health system strategy map and scorecard form the foundation for developing strategy maps and scorecards for other levels of the health system. This ensures that the strategic goals of a hospital program or unit, an individual hospital, the hospital sector, the local health system (LHIN), and the provincial health system are aligned.

As shown in Figure 5, the local health system strategy map (Hospital Research Collaborative, 2006), as cascaded from the provincial health system strategy map, consists of 11 strategic themes in four quadrants: knowledge utilization and dissemination; integrated care; health status and outcome; and health system sustainability and equity; two of which are different from the provincial health system strategy map. While the provincial health system strategy map focuses on evidence availability and use as well as provision of care, the local health system strategy map stresses on how knowledge will be utilized and disseminated throughout the LHIN as well as how health services will be

**Figure 5.** Ontario’s local health system (LHIN) strategy map

_Note: Printed with permission from the Ministry of Health and Long-Term Care, Government of Ontario_  
_Source: Ministry of Health and Long-Term Care, Hospital Report Research Collaborative_
integrated among various service providers within the LHIN. The LHIN strategy map is also based on hypothesized cause-and-effect relationships among the strategic goals, and indicators in the LHIN scorecard are a subset of the 27 indicators in the provincial health system scorecard. This makes sure that LHINs’ performance measurement is in compliance with the health system’s performance standards, and that comparative analysis on LHINs’ performance provides for more effective resource allocation decision to be made within the health system.

Likewise, the hospital sector strategy map (Figure 6) (Hospital Research Collaborative, 2006) consists of ten strategic themes which are derived from the LHIN strategy map. It has five performance perspectives:

1. evidence basis;
2. knowledge transfer;
3. resource development and allocation;
4. intermediate outcomes; and
5. long-term outcomes.

Individual hospital can now develop its organizational strategy map based on the hospital sector strategy map and then select performance indicators to monitor its progress in achieving organizational strategic goals and identify opportunities for improvement.

In the processes of developing the provincial and local health system scorecards, performance indicators are selected using a modified Delphi panel process. They are then mapped into the four quadrants of the scorecard. The process of selecting performance indicators for the hospital sector, on the other hand, is quite unique, and somehow disjointed with two initiatives implemented independently and concurrently.

**Figure 6.**
Ontario’s hospital sector strategy map

*Note: Printed with permission from the Ministry of Health and Long-Term Care, Government of Ontario*
*Source: Ministry of Health and Long-Term Care, Hospital Report Research Collaborative*
The *Hospital Report* series, undertaken by Ontario Hospital Association, attempts to assist Ontarians to have a better understanding and assessment of the performance of their local hospitals and of the province’s hospitals as a whole. It also supports efforts by hospitals to improve the quality of their services. When the first *Hospital Report* was published in 1998, the performance indicators in the scorecard were not linked to the health system’s strategic goals whatsoever. Moreover, the performance indicators in the first *Hospital Report* were not aligned with individual hospital's strategy. Yap et al. (2005) report that the 22 acute-care hospitals with organizational balanced scorecards all have a fairly high average number of indicators which are different from those in the *Hospital Report*. Individual hospital would develop its own balanced scorecard with different indicators to reflect their unique organizational strategies. Thus, performance indicators in the *Hospital Report* series are not appropriate for the hospital sector strategy map and scorecard.

The HAA Indicator and Volumes Subcommittee of the Joint Policy and Planning Committee has also been working on performance indicators for hospital annual planning submission (HAPS) and hospital accountability agreement (HAA). The objective of selecting specific indicators for the HAA accountability framework is to facilitate hospital planning for service type and volume, commitment per HAA, measurement and report, and remediation and negotiation. The HAA accountability framework also uses the balanced scorecard approach. There are four quadrants in the HAA scorecard:

1. financial health;
2. organizational health;
3. patient access and outcome; and
4. integration.

The performance indicators and the targets set for individual hospitals in the HAA scorecard change from year to year, depending on the health system’s strategic goals and the hospital’s performance.

With two parallel but disconnected processes and initiatives, it is still practicable to assign performance indicators from the *Hospital Report* and HAA accountability framework to the specific goals of the hospital sector strategy map using a modified Delphi panel process. Thus, when individual hospital works on its strategy map, performance indicators can be identified and assigned according to the organization’s strategic goals.

At present, only the hospital sector strategy map has been developed for Ontario’s health system. Other sector-level strategy maps and scorecards, e.g. long-term care, community health, community support services, and mental health and addictions, have yet to be developed. These sector-level strategy maps and scorecards are critical to aligning the strategic goals of all components, including service providers, of the health system.

Note that neither the strategic goals in the strategy map nor the performance indicators in the scorecard for any levels within Ontario’s health system are static. To be an effective strategic management tool, both the strategy map and balanced scorecard should be reviewed regularly to account for challenges and changes in the health system.
Contribution and implementation issues of strategy map in the healthcare sector

Applications of balanced scorecard in the healthcare sector have changed considerably over the last five years, switching from performance measurement to strategic management of healthcare organizations and health systems. The move towards this strategic focus provides great opportunities for policy makers and decision makers to fully capture the value of strategy map and balanced scorecard in health service management. Although many not-for-profit organizations, including healthcare organizations, manage a diverse set of programs and initiatives, they may not have a well-defined strategy. Kaplan (2001) argues that strategy map and balanced scorecard is invaluable as a strategic management tool by bridging the gap from the organization’s vague mission and strategy statements to day-to-day operational measures; facilitating a process by which not-for-profit organizations can achieve strategic focus; and shifting the focus of a not-for-profit organization from programs and initiatives to the outcomes that the programs and initiatives are supposed to accomplish.

Aside from strategic management, strategy maps and balanced scorecards enable not-for-profit organizations to align initiatives, operating units, and individuals in their drive for performance improvement. The use of strategy map in Ontario’s health system is an exemplary demonstration of how strategic goals of different levels within a system can be aligned. The selection of performance indicators for the scorecard for different levels within the system uses similar methodology and pathway. The systematic approach used to roll out the health system’s strategy map and scorecard from top to bottom is very effective in communicating the provincial government’s strategic goals on health care. It also ensures that the objectives of different components, both institutions and individuals, of the health system are aligned with the government’s goals and priorities. The strategy maps and balanced scorecards bring together different initiatives and programs to achieve the health system’s overall strategic goals.

Applications of strategy map and balanced scorecard in the healthcare sector are subject to specific challenges because of its unique operating environment. First, unlike for-profit organizations, the financial perspective of a health system or a healthcare organization usually takes the backseat when compared to other overarching objectives such as improving accessibility and outcome of health care services. Thus, at times, it can be challenging and difficult to define the cause-and-effect relationships among the different strategic goals in the strategy map and the performance perspectives of the balanced scorecard. For instance, the strategy maps developed for Ontario’s cancer and health systems are based on hypothesized relationships among the strategic goals, which have yet to be tested and validated. Thus, it is important to know that the hypothesized relationships are not precise, and they may change as the strategic foci and goals of the systems change over time.

Second, the selection of performance indicators for the scorecard in the healthcare sector is extremely complex because of the diverse set and vast amount of health indicators that are available. For instance, Cancer Quality Council of Ontario reduced the initial set of 650 cancer-specific quality indicators to 30 while HRT-IM began with 2,000 plus indicators to develop a final set of 27 indicators for the scorecards of Ontario’s cancer and health systems, respectively.

Third, different types of indicators, such as outcome indicator, quality indicator, population status indicator, etc., are being used in the healthcare sector. It is difficult to
identify the cause-and-effect relationships between leading (driving) and lagging (outcome) indicators precisely. Moreover, some scorecard indicators at the health system level may not be appropriate for other levels. Nonetheless, the number of performance indicators in both Ontario’s cancer system and health system scorecards is not extensive. This allows policy makers and decision makers to focus on areas that are critical to achieving the health system’s strategic goals.

The implementation of strategy map and balanced scorecard in Ontario’s health system thus far has been effective. Support and commitment from the provincial government and the Ministry are important to its achievement to date. Moreover, standardization in reporting clinical and financial data from health service providers to the Ministry and other agencies makes the measurement of performance indicators more manageable. Finally, buy-in and collaboration from different institutions within the health system are critical to capturing the full benefits of implementing strategy map and balanced scorecard in the healthcare sector.

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Further reading


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