Thinking backwards about management

Since the 1970s, getting things done – or, to put it in more formal terms, implementation – in pursuit of public policy objectives has been the subject of enormous amounts of sometimes unilluminating literature. Most of this has focused on macro-level policy objectives – implementing government decisions.

In this article I will summarise one outstanding but sometimes misunderstood and often neglected paper from this body of work. I will argue that its insights are just as applicable to implementing management decisions made in the middle of a hierarchy as to policy decisions made by government ministers.

In order to explain the distinctiveness of this paper we must first characterise certain aspects of the literature from which it differs. Much implementation research finds it surprising that anything like policy ever gets implemented at all.

Among the many reasons given for this are the impossibility of specifying from the top of a hierarchy exactly what is to be done at the bottom and the complexity of linkages between agencies, departments and hierarchical levels, each of which provides a potential barrier to implementation.

In a groundbreaking paper, Elmore (1979) argued that the above problems derived from an approach to implementation that he termed “forward mapping”. That is, one in which problems and objectives are defined at the top of the hierarchy, with a consequent passing downwards of solutions and instructions.

According to such logic, the main remedies for implementation failure are a tightening of hierarchical discipline and increased specificity of objectives and instructions for implementation. When such remedies fail, says Elmore, the reaction is often to call for market or quasi-market solutions that aim to bypass the problems of hierarchy.

Elmore asserts that such solutions bring their own problems (of market failure) and proposes instead a logic that he terms backward mapping.

His core assumption is that the closer an actor is to the source of the problem to be addressed, the more likely a person is to be able to influence it, since it is at operational levels that the necessary skill and expertise are typically located. He writes:

“…..backward mapping stresses the dispersal of control and concentrates on factors that can only be indirectly influenced by policymakers: knowledge and problem-solving ability of lower-level administrators; incentive structures that operate on the subjects of policy; bargaining relationships among political actors at various levels of the implementation process; and the strategic use of funds to affect discretionary choices” (Elmore 1979: 605).

Elmore thus inverts the logic of forward mapping. The main consequence of such an approach is that the policymaker – a manager in our case – should begin by specifying the behaviour desired by actors at the lowest hierarchical level. In his words, analysis of a problem and potential solu-

In number four of our Signpost series Steve Harrison dusts off a paper from 1979. It combines an unfamiliar concept, backward mapping, with a much more familiar one, professionalism. Bringing them together challenges us to think about how service improvement can best be delivered – a key issue for today’s NHS.
tions should begin with “the point at which administrative actions intersect [with] private choices” (1979: 604).

Elmore continues by arguing that the policymaker (manager) should work upwards through the hierarchy, considering at each level what ability exists to affect the target of the policy/decision and what resources are necessary to do so.

A further consequence of the above core assumption is that successful policy/decision-making is likely to be best promoted by delegation of discretion to lower-level actors with the particular expertise to affect the problem.

This represents another inversion of the conventional forward mapping model – tightly controlled hierarchy is seen as inimical to successful implementation. In Elmore’s view, this often depends on localised fixing by actors who are capable of galvanising the attention, energy and skills of those closest to the problem, and on the negotiation of appropriate but limited incentives to enable this.

Impact on policy

More than 30 years after the publication of Elmore’s paper, some of his insights seem to have found their way into English health policy, though this is neither to claim a direct influence nor to argue that either example represents a fully-fledged example of backward mapping.

One example is the Quality and Outcomes Framework (QOF) in primary care, three characteristics of which are consonant with Elmore’s prescription:

- The clinical interventions whose usage is measured are largely (not entirely) supported by research evidence generated within the primary care community.

- The scheme is formally voluntary. GPs remain free to adopt or ignore some or all of the targets, though in practice most have responded energetically to the financial incentives that accompany achievement of targets.

- The scheme allows “exception reporting” – removal from target calculations of individual patients for whom a particular incentivised intervention is deemed inappropriate by the clinician.

In implementation terms, QOF has been a spectacular success, with little resistance from GPs, even where private doubts have been expressed about the validity of particular evidence, or about the scheme’s tendency to treat patients rather narrowly as standardised bearers of symptoms rather than more holistically as individuals with social and psychological characteristics.

Another example of the successful application of Elmore-style analysis to English health policy can be found in the employment over the past 20 years of what has been termed “manipulated emergence” to reorganise NHS institutions.

Essentially, this approach consists of establishing a new institutional status and inviting existing institutions to volunteer for the new status. The earliest fully-fledged example of this approach was the creation in 1989-1991 of NHS trust status for hospitals and fundholding status for GPs. Applicants for these were incentivised by the promise of new organisational freedoms and perhaps a feeling of being at the forefront of developments. The resulting bandwagon saw all NHS hospitals gaining trust status and almost two-thirds of GPs gaining fundholding status in the space of some six years. None of this is to suggest that the Elmore

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**STUDY NOTES**

The academic paper under discussion in this article is Elmore RF (1979), Backward mapping: implementation research and policy decisions, *Political Science Quarterly* 94(4): 601-16.

I have chosen to connect aspects of the governance of organisations that are often dealt with by distinct literatures. Hence the paper is to be found in a politics journal and focuses on ‘policy’ implementation. But there is no obvious reason why such ideas cannot be applied elsewhere within the hierarchy, in the domain normally considered to be management. It is important to note that although Elmore is sometimes described as having a bottom-up approach, he is actually advocating a more subtle and thoughtful approach to top-down governance than the approach he characterises as forward mapping. There exists a literature – notable for its wide variety of authors’ backgrounds – on the limitations (in some views, impossibility) of simply giving instructions from the top of the hierarchy. See Dunsire (1978), Gunn (1978), Pressman & Wildavsky (1979), Lipsky (1980), Peters & Waterman (1982).


**References**

- Pressman JL, Wildavsky A (1979), *Implementation: How Great Expectations in Washington are Dashed in Oakland; Or, Why it’s Amazing that Federal Programs Work at All, This being a Saga of the Economic Development Administration as Told by Two Sympathetic Observers Who Seek to Build Morals on a Foundation of Ruined Hopes*, 2nd ed. Berkeley CA: University of California Press
prescription has been either consistently adopted in English health policy or consistently successful.

One example of a largely unsuccessful intervention along these lines was the localised change agents programme (“fixers”, in Elmore’s terms) pursued in the late 1990s.

More recent ostensible programmes of manipulated emergence – such as progression from primary care group to primary care trust status at the turn of the century, and the more recent pathfinder programme for GP commissioning – have transpired to be barely disguised central government diktats rather than truly voluntary.

Back to professionalism

However, there is sufficient evidence of the power of Elmore’s essential insight: the priority consideration in managing hierarchical organisation is how the behaviour of those at the lowest level will be influenced.

An approach to governing organisations that is consistent with backward mapping – though Elmore himself does not make this claim – and which is especially relevant to health services, is professionalism.

This requires some explanation, since over the past few decades professionalism has come to be associated with self-serving monopoly and with autonomy and opposition to hierarchical management.

Such criticisms are no doubt partly valid but also cynically self-serving on the part of governments that prefer not to be opposed. However, it is possible to understand professionalism in a more abstract fashion, as a form of social co-ordination existing alongside markets and hierarchies rather than as a set of concrete medical, nursing and other institutions.

In brief terms, markets achieve co-ordination through the intersection of purchasers’ and providers’ self-interested activities. Hierarchies achieve it through the exercise of authority, while professionalism achieves it through socialisation of workers into shared values and cultures. From this perspective, management could perhaps eventually become a profession.

Ideally, professionalism can provide space for the exercise of expert judgements about complex and uncertain questions regarding the treatment and health of individuals and the organisation of services, along with intrinsic job satisfaction.

It represents an approach to organisation that has the potential to address the shortcomings of markets and of bureaucracy in the context of healthcare.

Classic examples of market failure include the asymmetry of information between provider and user (patient) and the perpetual need for the users and purchasers to be wary of the provider. Professional expertise can operate in the patient’s interest to provide a level of information that matches but does not exceed the patient’s own preferences. Professionalism can also help to create trust that reduces the transaction costs – especially those of surveillance and performance management – associated with markets.

Bureaucracy also has classic areas of failure that professionalism can help to address.

An important example is the goal displacement that can result from incentivised rule-following becoming an end in itself. Professional discretion may help to enable more appropriately individualised treatment and care than is enabled by the standardised protocols and pathways that are now so prevalent in healthcare.

Conclusions

Two points need to be made in conclusion. First, there is no suggestion that professionalism should wholly substitute for markets and bureaucracy. Although these are distinct as abstract types, they co-exist in the real world. Thus, many markets consist of competition between bureaucracies and are regulated by bureaucratic rules. Many bureaucracies have internal markets for the exchange of services. Bureaucracies may have substantial elements of professional autonomy within them – so-called professional bureaucracies – and professions may compete in markets. The governance of organisations should be designed to recognise this real-world situation and to incorporate elements of all three rather than in accordance with simplistic beliefs in the virtues of one or another.

Second, I have sought in this short article to provoke consideration of an approach to organisation that is deeply unfashionable, and to link it to the reasoning deployed in Elmore’s paper. Backward mapping and professionalism are worth a second look.

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