

Knights and Knaves Return: Motivation and the Delivery of Public Services

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In 2003 I published a book with Oxford University Press with the rather lengthy title *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens* (Le Grand 2003, 2006). One of the arguments of the book was that the design and implementation of most forms of public policy usually had buried within them untested assumptions about the motivation of the people who implement the policy concerned. At one extreme, the motivational assumption was that the relevant public servants were completely self-interested: knaves, in the terminology of the 18th century philosophers Bernard de Mandeville and David Hume¹. At the other extreme, the assumption was that they were not knaves, but something closer to knights: perfect altruists, public-spirited professionals motivated entirely by the desire to serve. This was a view I attributed, *inter alia*, to Richard Titmuss: my predecessor in the chair I hold and after whom the chair is named. He was one of the post-war welfare state's principal architects, most of whom held similar views².

The book was written over six years ago and much has happened since then, both in terms of scholarly research on public service motivation and in the real world of public policy and the economy. I have also had more experience of working on the development and implementation of public policy in government, including a two year stint in No 10 Downing St. as a senior policy adviser to the then British Prime Minister Tony Blair. This resulted in another book, also with a lengthy title and subtitle: *The Other Invisible Hand: Delivering Public Services through Choice and Competition* (Le Grand 2007). That book examined the delivery of public services

¹ Thus polices should be designed that 'remain unshaken though most men should prove knaves' (Mandeville 1731: 332). And 'in contriving any system of government, every man should be supposed to be a knave and to have no other end, in all his actions, than private interest' (Hume 1875: 117-118). Hume did not actually endorse this view of the world, adding that it 'appears somewhat strange that a maxim should be true in politics which is false in fact'.

² See Le Grand (2006) Ch.1. Titmuss did not use the terminology of knights and knaves. However, he did believe that human beings were innately altruistic, claiming that 'man has a sociological and biological need to help' (1970/1997: 310).

such as government funded health care and education, and set out four ‘models’ for delivering them, termed trust, mistrust, voice and choice, and discussed the relative merits of each.

This brief paper tries to bring aspects of these books’ arguments together. It discusses the motivational assumptions implicit in the incentive structure of each of *The Other Invisible Hand*’s models of public service delivery. Since the Blair Government in fact tried all four of the models from 1997, when it was elected, until 2007, when Tony Blair left office, I have presented the discussion as a kind of narrative, drawing on my understanding and experience of that government in operation. But I believe the basic arguments have a much more general application, one that goes well beyond one government, one period, or, indeed, one country. In particular, I hope they may be of interest to those analysing any public services anywhere, including school education, health care, social care and indeed any other services funded by government – now, of course, including banks and, in the United States at least, car companies.

Trust

The idea that issues of motivation, or associated concepts such as the role of incentives, might matter to public services was alien to many of those I encountered when working in government. This was because, despite an occasional cynical aside, at a fundamental level they believed with Titmuss that those who worked in public services – doctors, nurses, teachers, head-teachers, social workers, civil servants, service managers - were something close to knights: public-spirited, altruistic professionals committed to the welfare of the people they were employed to serve. These knights could be trusted to provide high quality services without any direction from government or from anyone else. If a policy affecting a particular service was going wrong – if it were not achieving its aims, or if it were having perverse consequences – it was only necessary to sit the relevant actors around a table to discuss the problems, and to find a solution that would best serve the public interest. Once that solution was found, it would be implemented without fuss and bother.

This view was particularly prevalent among those professionals who were working in government or in governmental organisations. It was also regularly invoked by the

professional associations, such as the British Medical Association and the National Union of Teachers, and by public sector unions, such as Unison. It appealed to many political activists, especially those on the liberal or left part of the political spectrum. It led to such individuals and groups supporting the ‘trust’ model of public service delivery, about which we need to say a bit more.

The basic idea behind the trust model is this. The government raises the taxes to pay for a public service and sets the overall global budget for the service. However, that is the limit of the government’s role. Those who actually provide the service are trusted to spend the budget. The providers are usually professionals of one kind or another, and, in spending the budget, these professionals are trusted to do so, in a word, professionally. That is, they are presumed to allocate resources in such a way as to achieve what we might consider to be the aims of a good public service: a service that is efficient, responsive, accountable, equitable and of high quality. In doing so, they are not subject to high-level central government directives: they are not told what to do. Nor are they subject to market or quasi-market pressures. Indeed, they are not subject to outside control of any kind: they are autonomous professionals with the discretion to make resource allocation decisions as they will.

Under the idealised trust model, there is no competition, or conflicts of interest, between those working in public services, or between the institutions in which they work. Rather, it is assumed that they do, or should, work in collaboration with one another, either informally or through more formal networks. Hence the trust model is sometimes known as a ‘network’ or collaborative model (Mayer 1995; Tomkins 2001). However, the model is in fact broader than simply one involving networks or collaboration; for it relies upon trusting professionals and others working in public services in all situations, whether they are working collaboratively in networks or not.

Supporters of the trust model tend to oppose performance measurement in public services: why measure something if the relevant actors can be trusted to deliver it to the highest possible quality? For similar reasons, they oppose the setting of targets by government, and any attempt by government to direct or manage performance in an attempt to meet those targets. And they dislike the use of markets or market-type rewards, believing them to be, at best, unnecessary, and, at worst, corrupting.

More generally, they do not believe in incentives (either positive or negative). Pay or other rewards for good performance; 'league tables' whereby public service institutions are rated or ranked, thereby encouraging them to compete with one another; other aspects of competition, such as patient choice of medical provider or parental choice of school; the impositions of sanctions or penalties on individuals and institutions that fail to deliver an appropriate service: none will succeed in ensuring high quality services. The trust model proponents argue this is partly because of the difficulties of measuring performance in public services: if performance cannot be measured accurately, it cannot be used effectively as part of a management or policy tool. But, in addition and indeed more importantly, it is because the introduction of incentives of almost any kind are considered to be actually damaging to professional motivation. For those who are motivated to perform effectively by internal or intrinsic factors, such as their sense of professional duty and their altruistic concern for the welfare of the people they were serving, the use of external rewards or penalties at best leads to discouragement and demoralisation, and at worst actively promotes damaging, self-interested behaviour. Extrinsic motivation drives out intrinsic motivation. The knights become knaves.

Arguably the trust model was that adopted by the post-war founders of the welfare state, and applied by them in its construction and in its subsequent development. The Labour Government of Tony Blair elected in 1997 also subscribed to aspects of the trust model, and partially applied it in public services - in particular, to the National Health Service (NHS), when it rolled back some of the quasi-market mechanisms for health care delivery that had been introduced by the previous Conservative government. But belief in the efficacy of the trust model goes well beyond Britain and British governments. It is prevalent throughout continental Europe, sometimes appearing under the label of solidarity. And it forms part of the political controversies over education and health care in the United States. For instance, Alain Enthoven has noted with respect to the debates over school education in the US that liberal Democrats, opposed to school choice, prefer to rely upon trust and voice. 'The teachers' unions are large supporters of the Democratic Party and teachers, understandably, strongly support the trust model'. He points out with reference to health care that 'Medicare was based on the trust model, but with a fee-for-service

system that includes strong incentives for doctors to do more when less would produce the same outcome' (2007:171).

In the UK, following the election of 1997 it did not take long for problems to emerge with the model, especially in the NHS. From 1997 to 2000, waiting times for simple medical procedures - already over-long by international standards – increased. And there were few indications of any other kind of quality improvement. This led to considerable political frustration, especially since more resources were being pumped into health care and other public services at an ever increasing pace. Labour politicians and political commentators were genuinely puzzled. Why, when all this extra money was going in, were there so little signs of improvements in outcomes - or even of increases in activities?

And there were other puzzles. New policies, seemingly immaculate in conception, failed in implementation. Old policies that were demonstrably failing to achieve their stated ends often continue unchanged and unscarred. Why, when it was obvious what should be done - when it was clear what was the right thing to do - didn't it happen? More generally, why was there so little innovation in the public sector? Why, when innovation did occur and there were 'good practices' within a public service (and evidence that such practices were indeed good and effective), were such practices not adopted throughout the system? There were no obvious answers – at least within the trust model.

Mistrust

However, another of the groups I encountered in government – one that usually comprised seasoned politicians or long-term civil servants - had a ready explanation for the difficulties afflicting policy implementation and reform. This involved exactly the opposite view about the mainsprings of public service motivation. For them, self-interest was all. Everyone, both in and out of government (except perhaps themselves), was a knave. If a policy was failing, that was because it did not serve the self-interest of the people delivering that policy. New policies stalled, and good practice did not spread, because they both involved change: change that was uncomfortable, making them unpopular with everyone. But, even more importantly, such changes were almost always generating losers: people, both in and out of

government, whose self-interest was directly and adversely affected. These out of government shouted at the top of their voices - often very loud ones - and regularly drowned out feeble expressions of support for change from any gainers. Those in government obstructed reform by what might be called the three d's of policy obfuscation: delay, diversion and distraction.

Those who believed in this structure of motivation supported a quite different model of public service delivery from that which relied upon trust: one that we might indeed term 'mistrust'³. The mistrust model – perhaps more familiarly known as command-and-control - can take various forms, but all versions of it have similarities. There is a managerial hierarchy and direction from the top of that hierarchy, coupled with external rewards or penalties for those complying or failing to comply with the central directives. Staff could not be trusted to do their job properly without outside intervention; they had to be incentivised to do it. The reward and penalties included direct appeals to knavish self-interest for staff, such as financial gain, promotion, demotion or ultimately job loss. But there were also more subtle forms of (self-interested) incentives. One was the offering of greater autonomy for the organisation in the event of success - and the withdrawal of autonomy in the event of failure. Another was so-called 'naming and shaming': the publicising of poor performance to peers, and/or to the general public, with the intention of humiliating the staff of the organisation concerned and hence encouraging them – in their own self-interest - to do better.

A version of the mistrust model was tried in England by the Blair Government from 2000 onwards. It was known then as targets and performance management; more recently, it has been described as 'targets and terror' (Propper *et al* 2008). Within the National Health Service (NHS), numerical targets were set for the activities of hospitals and those of other institutions. For instance, 98% of those who attended a hospital accident and emergency department had to be seen, treated or discharged within four hours. 75% of ambulances called out on life-threatening emergencies had to reach the point whence the call emanated within eight minutes. No patient for

³ In *The Other Invisible Hand*, for reasons to become apparent, I termed this model targets; I now think that mistrust is more accurate and of more universal application.

elective surgery should wait longer than a given period: currently eighteen weeks from the date of referral by a general practitioner.

The ‘terror’ – or, less evocatively, the performance management - element of the model was implemented by direct personal contact between the central authority and the institutions concerned. Phone calls, face-to-face meetings, electronic communications: all were used to deliver and reinforce the message that the institution concerned had to meet the target or heads would roll.

As several independent studies have shown, the mistrust model, at least in its targets and terror form, worked - especially within the English NHS (Bevan and Hood, 2006a,b; Bevan and Hamblin 2008; Propper, Whitnall and Windmeijer 2008). In particular, waiting times fell dramatically across the service - and did so within the time frames specified by the performance management regime.

The rest of the UK, which explicitly or implicitly rejected the mistrust model in favour of the trust model, did not fare so well. On receiving its devolved powers over health policy, the Welsh Assembly abolished targets and refused to allow its officials to use top-down performance management, concentrating instead on promoting co-operative working between health, local government and the voluntary sector. Basically, it decided to rely upon the trust model for delivering services, with its leaders explicitly rejecting the English model as not suitable for Wales.

The results for Wales give little support to believers in the effectiveness of the trust model. There was a substantial increase in waiting lists. In 1999 11% of patients waited longer than a year for elective surgery; by 2003 it was up to 16%. In England over the same period it went from 4% to zero (Bevan and Hood 2006a). Ambulance response rates to emergency calls within eight minutes in Wales were around 50% in 2001; they were still 50% in 2004. In England in 2000 only one ambulance service was able to meet 75% of emergency calls within eight minutes; by 2005 more than four fifths were doing so, and even the worst performer was managing over 70% (Bevan and Hamblin 2008). This was despite the fact that Wales had more resources per head than England and a similar rate of growth in those resources (Alvarez-Roseté *et al* 2005). Similar conclusions have been reached for Scotland, again with

more resources per head than England, but with waiting times there falling far slower than in England – apparently as a direct result of the management regime in England (Propper, Whitnall and Windmeijer 2008)

The mistrust model also seemed to work in English education. Targets were set for school performance in English and mathematics, and league tables were published showing each school's performance according to various indicators. Again the results were positive. The percentage of eleven year olds achieving a given level of proficiency in English rose from 57% in 1995-6 to 79% in 2006, and that achieving equivalent in mathematics rose from 54% in 1995-6 to 76%⁴. There were also improvements in GCSE results; national exams taken at the end of compulsory education. The percentage of pupils aged 15 at the beginning of the academic year, who achieved five or more GCSE examination passes at grades A* to C increased from 45 per cent in 1997 to 56 per cent in 2005.⁵

It should be noted that some of these improvements (especially in English and mathematics) seem to have been achieved not so much because of the setting of targets in the area (although targets were indeed set), but rather because of another form of mistrust model was implemented: one involving direct compulsion. Specifically, each school was required to include in the curriculum a 'numeracy and literacy' teaching hour. Again, this seems to have been effective. A systematic study of the imposition of a literacy hour on some English primary schools before it was made compulsory across all schools found large increases in attainment in reading and English in pupils exposed to the literacy hour as compared with pupils who were not. Interestingly boys received a greater benefit than girls (Machin and McNally 2004).

So the mistrust model in its various guises appeared to work, at least in England – in terms of creating improvements in pre-specified indicators, such as hospital waiting times, or numeracy or literacy. But why did it do so? Was it because the mistrust

⁴ Department for Education and Skills, Statistical Bulletin, National Curriculum Assessments for 7, 11 and 14 year olds, various years.

⁵ Department for Education and Skills (2001, 2006b). There has been much discussion as to whether or not the increase reflects a genuine improvement in standards: see, for instance, West and Pennell (2003).

school were right: that everyone working in the public sector was actually a knave, and hence a system of fairly draconian rewards and penalties was necessary to motivate them appropriately? Or did the regime actually turn erstwhile knights into knaves, driving out their intrinsic, more altruistic, motivations, but at least making them responsive to knavish incentives? Or did it simply strengthen knightly motivations, enhancing performance in a direction that the people concerned were keen to move anyway?

Put another way, following the terminology used in the motivational literature (Deci and Ryan 1985, Frey 1999) were the rewards/penalty structure inherent in the performance management regime perceived by those affected as ‘controlling’, and therefore resulted in a ‘crowding-out’ of intrinsic motivation? Or were they considered to be ‘reinforcing’: an acknowledgment, or recognition, by the external world of the quality of the job that the individuals were doing, and thereby ‘crowding-in’ motivation?

We do not have the data to be able properly to answer these questions. All we can observe is that there was movement in the right direction – ‘right’, that is, as interpreted by those in charge. Whether that came about because everyone concerned was actually a knave; or because everyone was actually a knight, but knightly motivations were crowded out by knavish concerns, with the knavish incentives so powerful in their effect on increasing performance that they more than offset any crowding out of knightly motivation; or whether the regime actually involved a crowding in of knightly motivations; all this is impossible to deduce from the evidence of improved performance alone. (For those who find diagrams useful, a diagrammatic exposition of this argument is given in the Annex).

However, we can obtain a clue as to some of the kinds of motivational effect from observation of the behaviour of the institutions concerned: especially that of gaming. Gaming occurs when individuals or institutions change their behaviour in ways that conform to the letter (or number) of the target, but actually do little genuinely to improve the service concerned – and might even harm the people whom it is supposed to benefit. Now, it is indisputable that, under the targets and terror regime, some gaming did occur. Examples included the unnecessary admitting of patients into a

general hospital ward from the accident and emergency department in order to count them as 'seen' within the four hours; ambulances that concentrated on dealing with emergencies a short distance away so as to meet the requirement for a response within eight minutes; and an ophthalmology service that met a target for new outpatient appointments by cancelling and delaying follow-up appointments (which were not targeted). In consequence of this last, at least 25 patients were estimated to have lost their vision over two years (Bevan and Hood 2006b).

The fact that gaming occurred in places suggest that some knavish incentives were at work, and that knightly motivations did not always dominate. For the principal motivation in each case of gaming had to be, not the welfare of the service users concerned, but the need to meet the target and hence to avoid any penalties that might accrue from failing to do so. Of course, the fact that knavery appeared prevalent in some situations does not mean that it dominated throughout. Indeed, there were cases where targets were exceeded, within institutions priding themselves on doing so, suggesting knightliness at work. However, overall, it is hard to escape the impression from gaming that the targets were viewed as controlling in many cases, and hence, in those cases at least, in all probability their imposition resulted in a crowding out of intrinsic motivation.

There were other problems with the target and performance management system. One was that the emphasis on numerical targets was considered to divert management attention from the non-targeted aspects of health care or education. It has to be noted that this did not always happen. Hauck and Street (2007) compared the performance of hospitals on either side of the England-Wales border over a six-year period before and after devolution. Waiting times were targeted in England, but not in Wales. They found that that, unsurprisingly, English patients waited less time and were more likely to be treated within the target waiting period. However, the English hospital also improved in non-targeted areas: it had increased levels of activity, undertook proportionately more day case activity and had declining mortality rates. At the same time activity levels remained constant in Wales, the proportion of day cases fell and mortality rates rose. All this they attributed to the 'stronger performance management regime' in England than in Wales.

Still, overall, during the early years of this century, there was a growing anxiety in the Blair Government that top-down government direction, although apparently effective in obtaining short-term results for simple targets, had had too many problems associated with it to be an effective way of achieving longer term and more complex goals in public service delivery. What was increasingly regarded as preferable was a system for service delivery that had incentives for reform embedded within it. Then providers would endeavour to provide a high quality service without having to be told to do so.

It was also felt that these embedded incentives should include a bottom up element. If greater responsiveness of users' needs and wants was to be achieved, users' own perceptions should not be treated as irrelevant in determining what their needs and wants are – as unfortunately they tended to be in both the trust and mistrust models. Two such 'bottom-up models' were identified: voice and choice.

Voice

Perhaps the best definition of the voice model is that of the man who originated the term in this context, Albert Hirschman. He defined it as 'any attempt at all to change, rather than to escape from, an objectionable state of affairs, whether through individual or collective petition to the management directly in charge, through appeal to a higher authority with the intention of forcing a change in management, or through the various types of actions and protests, including those that are meant to mobilize public opinion' (Hirschman, 1970, p.30).

Put another way, voice is shorthand for all the ways in which users can express their dissatisfaction (or indeed their satisfaction) by some form of direct communication with providers. This could be through informally talking to them face to face – parents talking to teachers about the education of their child, patients chatting to their doctor. It could be more indirect: talking to parent governors of a school, even becoming a parent governor, speaking at patients or public consultative fora, joining the board of a hospital. It could be more formal: invoking a complaints procedure, or complaining to elected representatives. And it could be collective, though the process of voting.

There were tensions within the Blair Government concerning voice and its effectiveness. On the one hand, there was a strong historic commitment to the instruments of voice, one that stemmed from the collectivist roots of the Labour Party. As a result there were some efforts to strengthen the voice model, especially in health care. Foundation trust hospitals were introduced, with membership boards that included patients and other members of the public. And the Government replaced what were perceived to be failing institutions for voicing the concerns of the public (community health councils) with other types of institution (public and patient fora and, now, local area networks or LINKs⁶).

However, there was also a growing awareness of the limitations of voice as a means of ensuring high quality service delivery. The instruments of voice require energy and commitment to activate; they take a good deal of time to operate; and they can create defensiveness and distress. Users who complain are not necessarily those who have the most to complain about; and adversarial relations between professionals and users, especially tied to a threat of lawsuits as they may well be, can lead to expensive and inefficient defensive reactions on the part of providers.

More fundamentally, many individualistic voice mechanisms favour the educated and articulate middle classes. They have louder voices: they also have better contacts and sharper elbows. And they are adept at using their voice to demand access to more extensive services (such as a specialist outpatient consultations, diagnostic tests, inpatient treatments, better teachers and so on). Generally, better off patients and parents are more articulate, more confident, and more persistent than their poorer equivalents. Moreover, the medical practitioners and the school teachers who are taking the relevant decisions are more likely to speak the same language, and thus relate better to middle class patients and parents.

⁶ LINKs appear to have no set institutional structure, but are being set up by each local authority independently. However, they are explicitly instruments of voice. According to the Department of Health website, LINKs 'aim to give citizens a stronger voice in how their health and social care services are delivered. Run by local individuals and groups and independently supported – the role of LINKs is to find out what people want, monitor local services and use their power to hold them to account'.
http://www.dh.gov.uk/en/Managingyourorganisation/PatientAndPublicinvolvement/DH_076366

In addition, many of the middle classes have friends or acquaintances who are in one of the relevant professions, and who can help them navigate the system. Hence they are much better placed than those lower down the social scale to ensure they get quality medical treatment for themselves and their family and better education for their children. Further, they are more likely to participate in the institutions of voice: becoming a parent governor of a school, for instance, or a member of a hospital board.

Moreover, the better off do not always have to rely upon voice to get their way. Even in systems where there is no public system of choice, there are nonetheless two possibilities for exercising a form of choice. First, in most countries, there is always the possibility of opting out (or never entering) the public system: using the individual or the family's own funds to buy private education or private health care (Canada - where private health care is outlawed in some provinces - is a partial exception, although even there is the possibility of crossing the border). And, second, there is the possibility of moving house so as to benefit from good schools or hospitals.

It is not surprising that in these circumstances non-choice systems can favour the better off. For instance, a review of utilization that I and colleagues conducted found that unemployed, and individuals with low income and poor educational qualifications use specialised health services less relative to need than the employed, the rich and the better educated (Dixon et al, 2007).

But even this better-off bias is not the principal difficulty with voice. That lies in the absence of incentives. On their own, voice mechanisms do not provide much by the way of incentives for improvement. If a provider has a monopoly on the supply of a service, it can ignore the complaints of its users with relative impunity.

This can be partly resolved by coupling voice with one of the other models. For instance, voice could be coupled with trust, and rely upon the knightly motivations of providers to rectify any deficiency that is brought to their attention by users. The snag with this is that, as we have seen, not all public service providers are knights, and, even when they are, they are not always sympathetic to pushy users.

Alternatively, voice could be coupled with mistrust or command and control. Providers that ignored complaints could be subject to sanction from above. However this would suffer from the problems of demoralisation and demotivation already mentioned in connection with command and control. Providers being told how to behave are not likely to be the most willing to offer a responsive service.

Or it could be coupled with choice. If providers know that ultimately the dissatisfied can exit - can go elsewhere – they really have an incentive to improve. Choice can give power to voice. But, to understand this properly, we need to examine choice in more detail.

Choice

As noted above, as the post-2000 decade progressed, the Blair Government became increasingly interested in bottom-up models of public service delivery, such as voice and choice. And, aware of the problems with voice, it increasingly turned to user choice, coupled with provider competition, as a means of encouraging service improvement. So, in health care, patient choice of medical provider was developed; a system by which the money followed the choice was introduced (payment-by-results); new kinds of independent providers were introduced (foundation trusts, independent sector treatment centres), and both new and old providers were encouraged to compete for patients. In education, again new, more independent providers were set up (academies, trust schools), and parental choice encouraged.

Choice in public services was regarded by the Blair Government as being intrinsically desirable. But, more importantly, it was viewed as having an instrumental value as well as an intrinsic one, promoting both equity and efficiency. It promoted equity through extending opportunities to the less well off, opportunities that the middle classes already possessed through their ability to go privately or to move house. It also diminished the role of voice, with the latter's intrinsic middle class bias. And it provided incentives for providers to offer a higher quality service efficiently and in a responsive fashion. If providers faced adverse consequences from not being chosen – if, for instance, they will lose resources if they cannot attract users – then they will want to improve the quality of the service they provide.

Of course there are many conditions that have to be fulfilled if choice and competition are actually going to deliver a high quality, equitable public service. Users have to be properly informed; the competition has to be real; opportunities for cherry-picking or cream-skimming have to be limited. I discuss these in some detail elsewhere (Le Grand 2007); here I want to concentrate on the issue of motivation.

So what are the assumptions concerning motivation implicit in the choice model? At first sight it would appear that the model is based on the assumption of knavish self-interest. Certainly one of the reasons why providers might feel impelled to provide a good service in a quasi-market is because it is in their self-interest to do so. If they do not provide an appropriate service they will lose business and perhaps their livelihood; if they do provide a service that users like they will increase the resources available to them and hence will be able to improve their own standard of living.

However, self-interest could be only one of their motivations. In fact, this incentive structure should work whether providers are knaves, knights or a combination of both. Knavish providers will want to attract users because their livelihood and thus self-interest depend on their staying in business. But knightly ones will also want to stay in business so that they can continue to provide a service of benefit to users – an incentive that will be even more powerful if their knightliness takes the form of wanting to do the best for their users as the users themselves perceive it. So knights as well as knaves will want to provide services that benefit users.

It should be emphasised that this argument will only apply if the individual provider concerned is a certain kind of knight: one who wished to fulfil the needs and wants of users as they themselves perceived them. A more paternalistic knight, one who had his or her own perceptions of what would contribute best to a user's well-being and who was not overly concerned with the user's self-perceived concerns, would not be incentivised to behave appropriately in this model. For the incentives in the model are bottom-up: to respond to the signals given by users themselves, driven by their own perceptions of what they need.

Could not this argument – that the incentive structure implicit in the choice model could appeal both to a knave and to (a certain kind of) knight – be also applied to the other models, such as mistrust and voice? We have already seen that the mistrust model could incorporate incentives that appeal to knights as well as knaves – just so long as the incentive structure was perceived as reinforcing, not controlling. However, even if it were so perceived, it would only work as an incentive (or, more accurately, would only be perceived as actually re-inforcing motivation) if the individual concerned had the same top-down perception of what was desirable for users as those at the top. Again, he or she would have to be a specific kind of knight, but on this occasion a paternalistic one whose paternalistic vision of what users wanted or needed coincided with that of those running the system.

The paternalism criticism could not be applied to the voice model, which could appeal to the same kinds of knights as choice and competition: those whose concerns were with the welfare of users as they – the users - express it. The problem with voice is that, as we have seen, it provides no incentive on its own for knaves to improve their service to users. For that it has to be coupled with another model such as command and control, or choice and competition.

Conclusion

The central message of this paper is that any model for public service delivery - including the four discussed here: trust, mistrust, voice and choice - has assumptions concerning the motivation of those who work in public service built into it. If the model is to work – that is, if it is to deliver a high quality public service – a large part of the motivational assumptions have to be fulfilled. So, for the trust model to work, public service professionals and workers have to be knights. For the mistrust model, if the rewards and penalties that are part of the model are perceived as controlling, those subject to them have to be knaves or have to become knaves; only in the (unlikely?) event that they are perceived as reinforcing, are they consistent with knightly motivations. Even then the motivations have to be paternalistic in nature – or at least to incorporate the same motivations as those in charge. The voice model will appeal to non-paternalistic knights, but has to be coupled with other models if it is to be effective for knaves: with mistrust or choice. And choice relies upon both knavish

motivations and non-paternalist knightly motivations if it is to be effective in delivering a high quality service that meets the needs and wants of users.

The choice of one of the four models as the 'best' for delivering public services is often an ideological one. Liberals are attracted by the trust model; impatient social reformers (and dictators) by the mistrust one. Voice appeals to socialists and other collectivists; choice and competition to pro-market conservatives. However, the arguments here suggest that the decision as which is the best model - or the least worst one - will depend in large part on two empirical questions. What is the motivational structure of public service professionals? And how is that structure affected by the context in which those professionals find themselves, including the models themselves? Answering these questions is beyond the scope of this paper; but not, it is hoped, beyond that of the wider research community.

REFERENCES

Alvarez-Rosete, Arturo, Bevan, Gwyn, Mays, Nicholas, and Dixon, Jennifer. 2005. Effect of diverging policy across the NHS. *British Medical Journal* 331: 946-50.

Bevan, Gwyn and Hamblin, Richard (2008) 'Hitting and missing targets by ambulance service for emergency calls: effects of different systems of performance measurement within the UK' *Journal of the Royal Statistical Society Series A* 172(1), 161-190.

Bevan, Gwyn and Hood, Christopher (2006a) 'Have targets improved performance in the English NHS?' *British Medical Journal* 332: 419-422

Bevan, Gwyn and Hood, Christopher (2006b) 'What's measured is what matters: targets and gaming in the English public health care system'. *Public Administration* 84(3) 517-538.

Deci, Edward L. and Ryan, Richard, M. (1985) *Intrinsic Motivation and Self-determination in Human Behaviour* New York: Plenum Press

Department for Education and Skills (2001) Statistics of Education: Public examinations GCSE/GNVQ and GCE/AGNVQ in England (2000) London: Department for Education and Skills.
<http://www.dfes.gov.uk/rsgateway/DB/VOL/v000279/vol02-2001.pdf>

Department for Education and Skills (2006b) GCSE and equivalent results and associated value added measures in England, 2004/05 (Final), London: Department for Education and Skills.
<http://www.dfes.gov.uk/rsgateway/DB/SFR/s000664/index.shtml>

Dixon, Anna, Le Grand, Julian, Henderson, John, Murray, Robert and Poliakoff, Emma (2007) 'Is the British National Health Service equitable? The evidence on socioeconomic differences in utilization' *Journal of Health Services Research and Policy*, 12 (2) 104-109.

Enthoven, Alain (2007) 'An American Perspective' in Le Grand (2007) Afterword.

Frey, Bruno (1999) *Economics as a Science of Human Behaviour* Boston: Kluwer Academic Publishers.

Hauck, K. and Street, Andrew (2007) 'Do targets matter? A comparison of English and Welsh national health priorities' *Health Economics* 16: 1155-1158.

Healthcare Commission (2009) *Investigation into Mid Staffordshire NHS Foundation Trust*
http://www.cqc.org.uk/db/documents/Investigation_into_Mid_Staffordshire_NHS_Foundation_Trust.pdf

Hirschman, Albert. 1970. *Exit, voice and loyalty*. Cambridge, Mass: Harvard University Press.

Hume, David (1875) 'On the independency of Parliament' in *Essays, Moral, Political and Literary* Vol 1 (ed.T.H.Green and T.H.Gross) London: Longmans.

Le Grand, Julian (2003) *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens*, Oxford: Oxford University Press. Revised Paperback Edition (2006).

Le Grand, Julian (2007) *The Other Invisible Hand: Delivering Public Services through Choice and Competition* Oxford: Princeton University Press.

Machin, Stephen and McNally, Sandra. 2004. *The literacy hour*. London: Centre for the Economics of Education.

Mandeville, Bernard (1731) *Free Thoughts on Religion, the Church and National Happiness* (3rd edn) London.

Mayer, R., Davis, J. and Schoorman, F. 1995. 'An integrative model of organizational trust' *Academy of Management Review* 20:709-734.

Propper, Carol, Sutton, Matt, Whitnall, Carolyn, Windmeijer, Frank (2008) 'Did 'targets and terror' reduce waiting times in England for hospital care?' *The B.E. Journal of Economic Analysis and Policy* 8(2) (contributions) Article 5. Available at <http://www.bepress.com/bejeap/vol8/iss2/art5>

Titmuss, Richard (1971/1997). *The Gift Relationship*. London, Allen and Unwin.

Tomkins, C. (2001) 'Interdependencies, trust and information in relationships, alliances and networks'. *Accounting Organisations and Society* 26:161-191.

West, Anne and Pennell, Hazel. (2003) *Underachievement in Schools*. London: RoutledgeFalmer.

ANNEX: Diagrammatic Presentation of Crowding-out and Crowding-in

This annex presents the argument concerning the effects of introducing knavish incentives (rewards/penalties) in diagrammatic form.

Figure 1

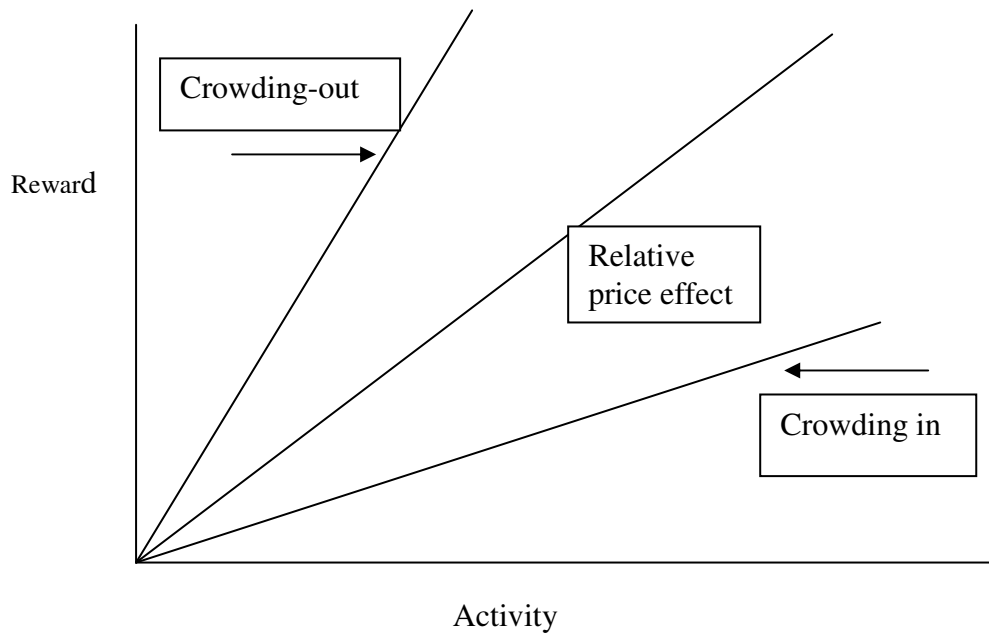
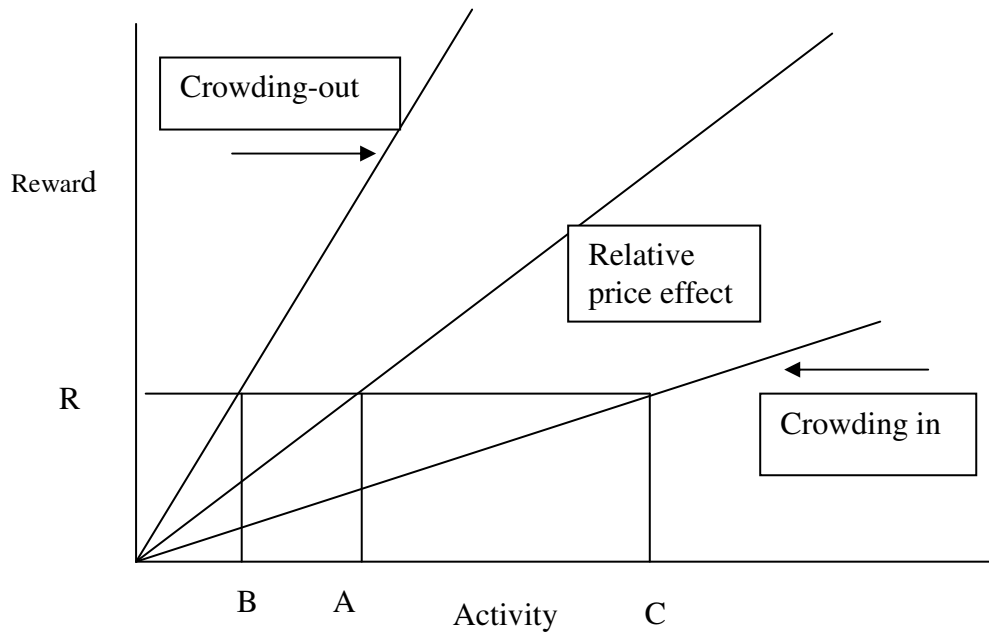


Figure 1 shows the supply curves for an activity for which a reward is offered. (For simplicity we only considered rewards here; a system of negative rewards or penalties or a combined system could be analysed in a similar fashion). The 'relative price effect' curve is what one might think of as the normal one: as the level of reward increases so the amount of the activity supplied increases. The 'crowding-out' curve illustrates what happens if the individuals concerned view the offer of a reward as controlling, and so are partly alienated from it; at every level of reward they offer less of the activity than if they did not feel so alienated. The 'crowding-in' curve illustrates what happens if they view the reward as re-inforcing; here at every level of reward they offer more of the activity.

This is illustrated for a given level of reward in Figure 2

Figure 2



A

With level of reward R , if there is some crowding out, the activity level will be B ; if crowding in; C ; if neither, A . But in each case there is an increase in activity; so it is impossible to tell simply from observing that fact which phenomenon is present or absent.