

**THE DEVELOPMENT OF CONTRACTING  
IN THE CONTEXT OF INFRASTRUCTURE  
INVESTMENT IN THE UK:  
THE CASE OF THE PRIVATE FINANCE INITIATIVE  
IN THE NATIONAL HEALTH SERVICE**

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***ABSTRACT:** Ongoing change in the management of public services has led to development of many initiatives in the control of day-to-day resources as New Public Management<sup>1</sup> (Hood 1991, 1995) continues its reforms. In this context debates about control of capital expenditure have taken a less-visible role despite some earlier and influential comment on the area (Perrin 1978, for example). Perhaps as the flow of ideas for reform in the management of day-to-day activities has waned, attention has turned more systematically to the efficient use of capital resources or infrastructure. This has been accompanied by recognition of the poor state of some public sector infrastructure. This paper is concerned with the implications of the changing approaches to the provision of infrastructure in the UK National Health Service (NHS). Its particular focus is the Private Finance Initiative (PFI) and the contractual implications this brings into infrastructure development.*

The push for efficiency in the NHS has influenced a number of changes in the approach to infrastructure development, initially through the introduction of capital charging. This is an accounting device for recognizing the cost of using capital assets. It moves the public sector toward the adoption of the accounting practices of the private sector, where depreciation and capital costs are taken into account in the context of calculating profits. This move toward private sector accounting approaches is an apparent trend in the rest of

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the English-speaking world. However, efficiencies in the use of capital have not provided sufficient improvement in the state of public infrastructure. There has been recourse, not just to the practices but also to the resources of the private sector, through the introduction of the Private Finance Initiative. In building linkages to the private sector, PFI advances another of the technologies of NPM in that it extends the use of contractual relationships. It is in this aspect that PFI is a novel policy initiative, since it changes the nature of working relationships in the hospital, moving them from a bureaucratic structure (described by many senior officials as the NHS family<sup>2</sup>) to a contractual one. While contracting in the NHS is not new, the novelty of the PFI lies in the length of the contracts that are entered into, which can be as long as sixty years.

In analyzing the provision of capital resources in the UK's NHS, this article will therefore give particular emphasis to the changing contractual relationships that surround the acquisition and use of these resources. Our interest centers on the impact that this different form of provision of capital has on the NHS as an organization. The purpose of the article is to extend the literature considering the introduction of contracting in the public sector (cf. Broadbent, Dietrich, and Laughlin 1996). It is driven by questions and concerns about the ramifications of the changes that are occurring. It is also intended to add to the theoretical understanding of the relationships.

Following this introduction, the paper includes four substantive sections, a final discussion, and conclusion. First, we review the recent history of capital investment in the NHS, where we illustrate the introduction of contractual relationships. The second substantive section provides a framework on which to base our analysis of the relationships. We highlight the use of transaction cost economics alongside a critique of this approach (Campbell 1997) to introduce ideas of relational contracting, which, of necessity, build these contractual relationships in different ways. These issues are illustrated, in the third and fourth sections, in the context of the contractual relationships generally in the NHS and specifically in the Dartford and Gravesham PFI scheme.<sup>3</sup> Finally, in the concluding section, we provide a discussion and draw out some implications of this mode of organizing.

### **THE RECENT HISTORY OF CAPITAL ALLOCATION IN THE NHS: FROM BUREAUCRACY TO CONTRACT**

The changing arrangements for developing and controlling capital investment projects in the NHS from pre-1991 have sought to introduce more control over this area. The motivation for these changes has been well documented and was reflective of and reflected by changes elsewhere in the world (Guthrie, Humphrey, and Olsen 1998). Inherent in those changes was a desire to break down bureaucratic relationships and introduce some level of competition. The assumption was that competition was good for efficiency, and that the introduction of systems of contracting or quasi-contracting was the chosen mode (Broadbent, Dietrich, and Laughlin 1996). In essence, a transition away from bureaucratic to contract type relationships at the operational level was sought, in the context of a strong neoliberalist thrust that retained control over process.

These changes are reflected in the context of the planning of infrastructure development. Before 1991, what limited capital finance that was available was allocated

to the NHS regions.<sup>4</sup> It was then the responsibility of regions to allocate this capital fund to district health authorities. This was done “through a system of bidding together with option appraisal of their schemes” (Appleby 1999, 79). Capital amounts were, therefore, allocated rather like revenue amounts—to be consumed within the year of allocation with no thought to future cost or benefit apart from the time when money was allocated. The allocation from any region to any district health authority was undertaken in the context of the bureaucratic structure that ran from the Department of Health down through the service. Once hospitals were built and operational there was no further formal tie between the two bodies in relation to this transaction. Accountability related to the expenditure in the year in question, not to amounts allocated in previous years (whether of a capital or revenue nature), and there was no formal accounting for the efficiency of capital asset usage.

This system changed with the introduction of the National Health Service and Community Care Act of 1990, which introduced quasi-contractual relationships. The act also introduced capital charging and external financing limits, and introduced the purchaser/provider split in health care provision. District health authorities (renamed health authorities) and some GP practices (those who chose to be fundholders) were the new purchasers of secondary care from hospital providers<sup>5</sup> (which over time all have become NHS trusts). Hence, the notion of a contract or quasi contract was introduced in the context of the provision of day-to-day services.

NHS trusts have a unique legal status. They are quasi-independent bodies that, on establishment, took ownership of their land, buildings, plant, and equipment. At the same time they incurred “an interest bearing debt equal to the value of the initial assets” (United Kingdom Department of Health 1989, paragraph 4.4). Trusts were given their assets but were also liable to an annual 6 percent charge on the assets (or, more accurately, the equivalent debt), to be paid to the NHS executive. This provided an accounting-led means of considering the efficiency of capital asset usage. As many authors have indicated in their analysis of the capital charging system (cf. Mayston 1989, 1990; Perrin 1989; Mellett 1990; Heald and Scott 1995, 1996) the total cost to the NHS as a whole is nil, as the revenues collected recirculate into the NHS purse that is then available for distribution. However, individual NHS trusts incur an additional cost burden of some substance. Individual NHS trusts recoup their increased costs through the charges they make for the provision of services. In the context of the quasi-contractual relationships that existed at that time, the assumption was that those trusts that do not use their capital assets efficiently would face resistance from their customers because their prices would not be competitive.

The strong, centralized bureaucratic control of the capital allocations remained and was reflected in the management of further capital allocations. From 1991, allocation was by the NHS executive instead of being made through regions. This allowed the introduction of external financing limits as a means of controlling overall borrowing (Appleby 1999, 79) provides a full explanation of EFLs). It should be noted that it was difficult to obtain funding for infrastructure projects despite the poor state of the NHS estate.

PFI was introduced in 1992, arguably in the first instance as a means by which to avoid public borrowing controls (see Norman Lamont, House of Commons Hansard (HCH) 12/11/92, (c) 1998). It provided the possibility of obtaining private finance for

public services provision in the context of infrastructure investment (see Broadbent, Haslam, and Laughlin 2000 for more details). Under PFI, private sector contractors provide facility management services for the infrastructure assets they own. It has thereby introduced contractual relationships in infrastructure development to the NHS. These are very different contractual controls to those used in the context of such initiatives as competitive tendering that have been common for many years. We argue below that this new type of contracting affects the internal workings of hospitals that have previously been organized in a tight bureaucratic structure. As noted in the introduction, this structure has led to an often-stated view of the NHS as a ‘family.’

In the context of day-to-day working relationships, in using private financing as a source of developing the infrastructure the NHS has created structures that are governed by contracts. Thus, the day-to-day operation of the PFI scheme creates relationships that are very different from the family relationships that previously existed in the NHS. PFI involves new partners from the private sector who contract to provide services to the NHS. Instead of building new hospitals and running the services themselves, the NHS instead pays a fee for the provision of services in premises provided by the new, private-sector partners. In essence, this provides a substitution of the need for capital expenditure by the payment of increased revenue charges. The nature of the payment for the availability of the asset-based services will be defined in the contract document that governs the PFI scheme. Equally, the nature of the service quality will be specified, as will any penalties for lack of performance.

It should be recognized that while, in the past, contracts have been used to control the provision of facilities management services of various kinds through competitive tendering processes, PFI contracts are very different. The reason for the difference rests in the magnitude and duration of these contracts, typically twenty-five to sixty years. Were the contract simply for the provision of services, the timing could cover a shorter period, as in previous contracting arrangements. As PFI projects are associated with schemes that provide premises in which services are delivered, the length of contract has to be longer to ensure the viability of the scheme for the contractor who cannot use the property for other purposes.

## **CONTRACTS AND CONTROL**

### **Relational Contracts**

Given that the move to contractual relationships is strongly influenced by a view that this is a way to ensure efficiency, we turn to some of the ideas of contracting to provide a framework for our analysis. The underlying assumptions of contracting must be explained in order to understand the implications they have for the relationships in the NHS. In doing so we argue that a particular form of contracting, relational contracting, is likely to be more constructive in the context of a long-term contract. Campbell and Harris state the matter succinctly when they note that “[E]fficient long-term contractual behaviour must be understood as consciously co-operative” (1993, 167).

Campbell (1997) argues that much of the development of classical contract law over the last twenty years has been based on ideas of transaction cost economics. He is critical of this alignment and also of the somewhat crude way in which the two have often been

associated, arguing not for a rejection of economic analysis but for recognition of the limits of economic thinking. His argument is for the adoption of the notion of relational contracting in a manner that does not reject economic thinking but which places transaction costs in the context of their social relations.

Campbell's argument that the neoclassical underpinning of contract law is inappropriate rests on the argument that there has been an inappropriate utilization of transaction cost economics. He turns to the work of Arrow to substantiate his case. Campbell argues that classical contract law relies on the idea of presentation. This means that the goal of a contract is to make the contract reflect all the aspects of the future relationship. This means is that there is an attempt to agree, at the present time, about how any future possibility will be dealt with. It assumes that there is some level of possibility of predicting the future. Campbell points out that this involves an element of risk, and the role of the contract is to allocate this risk.<sup>6</sup> He also points to the difficulty of realistically fulfilling these assumptions, implying that this is a particular problem for classical contract law. In turning to the work of Arrow, Campbell finds a framework that he sees as more relevant to the analysis of contracts. This framework retains the notion of transaction costs. Campbell identifies two elements he sees as particularly important—strategic or opportunistic behavior, and bounded rationality. These are fundamental to transaction cost economics, yet Campbell casts them in ways that are subtly different than their normal uses.

These factors—strategic behavior and transaction cost economics—are particularly relevant in the context of PFI. Consider first the issue of strategic behavior. PFI is one of the complex contracts that Campbell argues have particular possibilities for strategic behavior. He uses the example of asset specificity, arguing that where this exists there is a lock-in effect for the parties which can lead to power plays between them. As argued earlier, in PFI there is considerable asset specificity because hospital buildings cannot easily be used for other purposes. An environment of rapid technological change attenuates the risk that the premises might become inadequate or redundant before the payback on the building has been received. Consideration of the extent to which provision of medical services has changed over the last twenty years gives some indication of the possibilities here. The problem of predicting whether this will happen leads us to consideration of Campbell's second issue: bounded rationality. Campbell (1997, 313) notes: "Bounded Rationality obviously makes presentation an illusory goal."

Campbell argues that the developments of an ethical, rather than an informational, approach to the organizational theory of the firm can help us understand how both these matters can be dealt with. His argument is that the reason firms exist is that they can do things that markets cannot in the context of large-scale, complex projects. They allow the possibility of overcoming the residual risk that remains for those making a commitment to an activity in which risk cannot be eliminated or allocated under a contract (1997, 316). This is necessary because presentation is impossible, particularly so in complex contracts. Campbell argues that this has ethical dimensions, which are reflected in the fact that the managerial authority of a firm relies upon the ongoing cooperation of individuals within them. Campbell's point is that this allows the consideration of norms, trust, and cooperation as part of the debate as to why firms exist. Hence, he recognizes the limit of economic rationality and argues the analysis of contract, even when located in ideas of transaction costs, cannot ignore these limits or the social context in which they

are embedded. If this is the case, we can consider the role of the PFI contract as a constitutive element of social relations and also explore how the contract is constituted by those relationships. Campbell's argument is that the consideration of social relations has often been ignored and a psychology of utility maximization has been substituted. This has limited the usefulness of many analyses.

The bias toward an economic analysis of law has arguably led to an approach to governance that is unduly market driven. Campbell (1997, 325) suggests that "[I]n particular, directly ethical constraints which appeal to (and punish infractions of) norms of mutual self-interest and conscious co-operation must be recognised to be the *foundation* of solutions to strategic behaviour problems." He argues that if monitoring of behavior ignores or undermines the existing social relations, they cannot succeed.

Taking this analysis seriously, we can raise questions about the effect of PFI contracts on the social relations that exist in the NHS. In particular, we can ask whether the resulting contracts will destroy existing social relations or allow the development of new social relations between the NHS and private contractors. In a context where previous relationships have been built through a bureaucratic structure and in the context of strong professional groupings, this has the potential to be a sensitive issue. Health professionals are not necessarily sympathetic to an approach that sees the competitive element of market economics as reflective of the social relationships they value, and this means there is a need to look at the nature of these contracts and their operation with some care. We need to ask the question as to whether PFI contracts have the capacity to become relational contracts; that is, contracts geared toward defining the boundaries of relationships and seeking to clarify frameworks in which changes might be dealt with. It is based on notions of regulatory law (Teubner 1987; Broadbent and Laughlin 1997) and thus seeks to provide a framework in which social relations can develop autonomously rather than be predefined to bring about a particular end.

### **The Role of Contracts**

The discussion above assumes that the contract is important as a descriptor of the relationship. However, we must also question the extent to which contracts actually regulate exchange relations. In essence, even if a contract exists it may not be the actual or only regulator of the relationship. We turn to the critical exploration of the role of trust relations and cooperation in firms provided by Deakin, Lane, and Wilkinson (1997) as a basis on which to develop this issue. Deakin et al. note that both sociolegal scholars and proponents of transaction cost economics have contested the importance of the actual contract in the development of ongoing relationships. Thus, it is argued that the actual details of the contract are little used in controlling the ongoing relationship. Deakin et al. provide an elaboration of this opinion, and suggest that the role of contract is, in fact, relevant to the development of trust rather than simply as a descriptor of the relationship between two parties. This is of interest to us because it is echoed in another study (Seal and Vincent-Jones 1997) that sees accounting processes enabling trust in a similar way.

Thus, a PFI contract that uses accounting-control processes to monitor the day-to-day relationship of the parties may have significant implications for the development of trust relationships. What these studies add to our analysis is an understanding that social relations are important, but they are enabled and interrelate in complex ways by the contracting process.

Deakin et al. are anxious to move discussion of the nature of trust beyond its depiction as either embedded in a rational self-interest, on one hand, or as a nonrational element located in social relationships, on the other. In the context of an empirical analysis of contract relations in three different nations, Deakin et al. demonstrate the importance of the institutional context for contracting relationships. Acknowledging the importance of cooperation for any level of contracting, yet recognizing that this might be problematic as power relationships develop, they note that “[O]nce the performance of the contract has begun and sunk costs have been incurred, each party is at risk of exploitation by the other” (1997, 107). As the agreement to a contract does not preclude the existence of either some element of separate interests or differential power, there has to be some level of trust for any contract to be undertaken and for it to be operable.

Deakin et al. use the work of Sako (1992) to illustrate the complexity of the meaning of trust. Three types of trust are identified. Contractual trust refers to the reliance that the nature of the exchange will be as per expectation and that the contractual terms will be met. For example, if the contractor agrees to wash the windows each week, it is expected that the windows will be washed at the agreed time. Competence trust refers to a belief that the partner has the relevant skill and expertise to fulfill the requirements of the exchange. Developing the previous example, we trust that the contractor will wash the windows and leave them clean. Goodwill trust provides the belief that the partners will move beyond their original promises to ensure ongoing viability of the relationship in circumstances not specified because of the problem of presentation. Thus, if new types of staining on windows occur that compromise the washing process and mean that the windows have to be treated with a solvent rather than simply washed, we expect that some negotiation about these new circumstances will be possible. This latter element of trust is different from the first two elements, the former two acting to limit discretion, the latter providing for its existence. While the first two elements are necessary for any contract they are not in themselves sufficient for a relational contract. Arguably, a relational contract will have to exist in an environment that allows development of all three elements of trust.

In this connection, Deakin et al. introduce the need for a further type of trust that is related to the contractual environment—an institutional or system trust (1997, 110). This can be seen as the institutional structures and the accepted standards of behavior that provide expectations that bound the nature of the items around which agreements are made. In this environment it is more likely that the parties to a contract will feel confident enough to move to implement goodwill trust.

Deakin et al.’s analysis illustrates the importance of the contractual environment or the institutional context within which individual contracts are made. There is likely to be a reflexive relationship between the individual and social contexts of contracts. However, it is important to highlight that the environment engendered by the type of system trust that exists will impact the extent to which other types of trust can develop in the context of the contracting relationship. A consideration of the development of the PFI

environment shows how the state has sought to develop system trust. The rather more difficult question to answer at this stage, given that no contracts have been running for more than two years, is whether the contractual regime will allow the development of goodwill trust.

### Summary

Bringing together these two strands suggests that if the bureaucratic relationships that previously characterized the NHS are to be successfully replaced by a contracting regime, the nature of that regime must be carefully constructed. Our argument is that this will require a relational contract. More than that, a relational contract can only develop in an environment in which trust can develop. This means at an institutional level there must be system trust and at an organizational level the capacity to develop goodwill trust.

The view that, at the organizational level, a relational contracting position must be adopted is in some tension with neoclassical approaches to contracting that have taken the view that contracts will provide efficient, comprehensive means for the provision of services. The implications of this are discussed in the final section of the article. Relational contracting is an approach that in many ways replicates, in a contractual format, some of the elements of the bureaucratic relationship. This is particularly the case given the long-term nature of the contract. The implications of this will also be returned to in the final discussion. In the next section, consideration will be given to the development of trust at both an institutional and organizational level. This will then be amplified in the following section through an examination of one particular contract and the extent to which it has provided the basis for the foundation for a relational approach.

### THE INTRODUCTION OF PFI TO THE NHS: THE INHIBITIONS TO AND CREATION OF SYSTEM TRUST

Some of the events and legislation around the introduction of PFI can be seen as an exercise designed to create an environment of system trust. That this system trust did not exist was evidenced by initial reluctance to undertake PFI schemes in the NHS. An attempt to deal with this was an early instruction, in 1994, that private finance should be sought for all schemes. This led to considerable activity by hospital trusts, with sizeable fees for consultants and accountants hired to assist in the process. Baroness Cumberlege, speaking on 3 June 1997 in the House of Lords, summarized the situation as follows:

... 71 NHS PFI schemes have been approved since the launch of the scheme, bringing in private sector capital amounting to £626 million. Of these, 43, with a capital value of £317 million, have reached contract signature state—32 have been completed and 11 are under way.

Larger schemes are now starting to reach contract signature: the Norfolk and Norwich project, with a capital value of £194 million, was signed in November 1996, although it has yet to reach financial closure.



A further 150 schemes with a total capital value of about £2.1 billion are testing private finance options. They include 22 schemes worth over £10 million each that have got as far as appointing a preferred bidder. Their combined capital value has been some £1.7 billion (Lords Hansard, 3 June 1997, Column 579).

Baroness Jay of Paddington pointed out in the same debate that this frenetic activity cost £30 million on “legal and financial advice and other consultancy fees,” but then added, “. . . without a single *major* contract being secured” (Lords Hansard, 3 June 1997, Column 576) (emphasis added). This suggests that despite this attempt to bolster the scheme, system trust was not, at this stage, developed sufficiently to ensure progress on the major schemes. The Conservative Government had established PFI and there was a feeling it could be abandoned on their removal from power. There was uncertainty about the commitment of the Labour Party to PFI, even though they were committed to exploring working partnership (Brown, Cook, and Prescott 1994).

On taking up government, Labour Party conversion to PFI was rapid. The developments they instigated can be seen as attempts to develop system trust. The new paymaster general (Geoffrey Robinson) was given overall responsibility for PFI in the new government. He appointed Malcolm Bates to undertake a speedy and comprehensive review of PFI. This gave a clear sign of a commitment both to adopt PFI as well as to adapt the approach to provide a solution to the capital shortages in the public sector. Three other immediate actions were taken. First, one week after the general election, on 8 May 1997, Geoffrey Robinson announced that the universal requirement to seek private finance for all capital projects would be abandoned (HM Treasury News Release 41/97). Second was a commitment that clinical services would be exempt from any private finance arrangements. Third was a commitment, made in the Queen’s Speech, to introduce legislation to “free the logjam of privately financed hospital projects” (Independent 9/5/97). The second and third of these major developments in PFI are particularly important as they provide the foundations of system trust.

The retention of clinical services in the public domain sought to provide legitimacy for PFI with the general public of the UK, who value the NHS and the security it provides. Universal care, which is free at the point of delivery, is a fundamental element of the NHS in the UK. PFI brought with it a fear that this might be one stage in a move to privatization, and this in turn brought a fear of undermining the fundamental ethos of free care. Hence, the commitment to retain clinical services in the public sphere sought to relieve this fear. There remained two related elements that clouded the issue: the question as to the nature of clinical services and the perceptions, therefore, of what is ‘PFI-able.’ The health minister, Alan Milburn, acknowledged the problem, promising future attention to this important definitional problem and at the same time demonstrating the extent to which the government had to fight to legitimate the need for PFI:

By the end of the year, once the review is complete, we shall have a categorical statement of what may or may not be included in PFI. I do not propose to anticipate the detail of that review, but am pleased to be able to repeat for the benefit of hon. Members an assurance given to my hon. Friend in the other place that pathology and radiology services will be excluded from PFI. I know that there will be other services about which hon. Member will want similar assurances, but I believe strongly that the review should be conducted before conclusions are drawn. Our commitments on pathology and

radiology are given in response to specific issues that have been raised during the passage of the Bill, and to act as a signpost for the future (Commons Hansard, 14 July 1997, Column 81).

Thus, the first element in building system trust was the move to ensure the support of the general community and to seek to demonstrate that the PFI was not meant to undermine the nature of health care.

However, this work to legitimate the limits of PFI in the public mind did not relieve the logjam of projects where deals could not be closed. There was a need for the resolution of questions about a number of financial and accounting issues, which can be seen as foundational to the development of the legitimacy of PFI as an activity in a contemporary economy.<sup>7</sup> Therefore, to consolidate the foundations of system trust and ensure that the companies involved would have the confidence to undertake the projects, a number of issues had to be addressed. First was an issue related to the risk undertaken by the financial institutions and in which primary legislation was needed. This was to assure the bankers of private sector PFI consortia of the security of their investment in PFI deals. Thus, system trust for the financial institutions was consolidated by legislation to reduce this risk.

This legislation identified ultimate responsibility for long-term leasing costs should the NHS trust become bankrupt. The Conservative Government passed the NHS (Residual Liabilities) Act in 1996 and committed the government to pay the debts of a bankrupt NHS trust to deal with this possibility. However, a loophole was found in the act and lawyers argued it did not provide the watertight commitment the banks wanted. Despite a further comfort letter (Accountancy Age 9/1/97) from the then Secretary of State for Health Stephen Dorrell, the banks were still not prepared to release the money and hence agree to the signing of the contracts. As a result, a further bill and act were deemed required to cover this loophole. The new act, which was to “remove any element of doubt” (Baroness Cumberlege, Lords Hansard, 3 June 1997, column 578), was available before the General Election but was passed by the new Labour administration even though the bill was “word for word [that] drafted by the previous government” (Baroness Cumberlege, Lords Hansard, 3 June 1997, column 578). The act (National Health Service [Private Finance] Act 1997) became law on 14 July 1997, virtually unchanged from its original design by the Conservative Government.

The need for two acts within a year of each other that seemed to address similar concerns rested on the fact that the banks, who are so vital to PFI, were unwilling to put forward money without watertight legal protection. As Alan Milburn, minister of state for health, noted, the bill “is about removing doubt, providing certainty and, above all, getting new hospitals built” (Commons Hansard, 14 July 1997, column 155). More directly, Baroness Jay of Paddington made plain, “the banks concerned have seen and agreed the wording of the Bill and have made clear that it satisfies all their concerns” (Lords Hansard, 3 June 1997, column 577). Thus, the National Health Service [Private Finance] Act of 1997 was passed to allow PFI contracts to be signed and agreed to. It was driven not by health need, but by bankers who “will stump up the cash” (Alan Milburn, Commons Hansard, 14 July 1997, Column 157). The legislation created an

environment in which contractual activity could develop. There are now sixty-four PFI projects, worth a total of £7.4 billion. The commitment to these schemes has provided, first, for a foundation, and then a consolidation of the system trust that emanates from the existence of a favorable contractual environment.

The consolidation of system trust in the contractual environment of PFI was also affected by ambiguity about its accounting treatment, demonstrating the importance of accounting as a building block in developing trust (Seal and Vincent-Jones 1997) and as a legitimator. The outcome of debates between the Accounting Standards Board and the government (including a wide consultation) about the accounting treatment of PFI was rather different to that originally anticipated, and the resolution of how to approach it followed a complex discussion (see Broadbent and Laughlin 2002 for more details). The problem centered upon the question of whether PFI schemes should be on or off the public balance sheet. Arguably, had the schemes been on balance sheet for the public sector, some of the benefit of the scheme for the state would have been reduced, as borrowing limits would have been affected. While this assertion can be contested, conversations with many parties to PFI make it clear, despite official denials, that individuals were concerned that this might have been the case. This also led to concerns about whether the PFI scheme had a long-term future as a government initiative. Had the accounting rules that were agreed upon been problematic in relation to the ability of the NHS to provide an off balance sheet solution, then trusts would have been left with a problem of affordability. In the year that was taken to negotiate a solution to the accounting problem there was, therefore, a delay in the approval of any new schemes. Thus, accounting was fundamental in providing an acceptable account of the nature of PFI, demonstrating the potential for accounting to affect the way in which things are viewed. The underlying process of PFI remains the same, but the way in which it is accounted for changes the attitudes toward its adoption. In this sense the incident demonstrates the constitutive power of accounting (Hines 1988) and its potential to act as a legitimator of action (Sikka and Willmott 1995) as well as a resolver of uncertainty. In the context of this article it acts as a powerful element in the creation of system trust (or in impeding its development).

Another accounting-related element related to the role of the National Audit Office (NAO). We have argued elsewhere that the role of the NAO in relation to the legitimation of PFI has been important (Broadbent and Laughlin 2003). The NAO published a number of value-for-money studies of PFI prior to its investigation of Dartford and Gravesham. Each study reinforced the value for money claims and thus their involvement gave legitimacy to the initiative. The delay in publication of the NAO report on the Dartford and Gravesham PFI project was therefore another factor affecting the building of system trust in relation to the NHS. The contents of this report were seen as important in clarifying concerns about a number of issues, including the value for money of the scheme and the NAO view on the robustness of the accounting treatment. Had either of these been subject to criticism, this could have undermined the legitimacy of PFI in the eyes of the general public and the business community. Arguably, until this uncertainty was resolved system trust was again unsubstantiated. A report published in May 1999 provided the view that the Dartford scheme was flawed, but was still value for money. It was therefore legitimate, and that legitimacy was provided by the NAO's authoritative support.

The publication of the report, followed by the announcement of the new accounting advice (discussed above) at the end of June 1999 and the release of a second Bates report on PFI in July 1999, all provided for ongoing business confidence in the continuation of government commitment to PFI. All these elements acted to dismiss anxieties and provided reassurance that the PFI would be maintained as an approach to the provision of services and premises in the NHS. Alongside the need to reassure the public that their health service was not being undermined was a need to reassure the business community of the commitment to PFI. It should be noted that the technologies of accounting were closely implicated in this process. Thus, institutional and system trust was developed in an active way in the early stages of the New Labour government and many PFI schemes have been launched. Since then, the reflexive relationship between the existence of a contractual environment and the development of schemes has acted to reinforce and extend the possibilities for PFI. In this way system trust has been consolidated and extended, and the use of PFI is an established mode of national procurement in the NHS.

It should be noted that as well as creating a national or societal environment of institutional or system trust there must also be a local environment of system trust. Thus an NHS trust seeking to build a PFI deal will, in addition to dealing with the private sector, have to negotiate with its local health authority and gain the support of the NHS executive to build a successful deal. These local dynamics are clearly affected by the societal environment, but it should be recognized that they may also have their own dynamic. Hence, many of the NHS trusts describe the length of time and the extent of the effort they put into the negotiations with local stakeholders such as their local authorities and the local MPs. Clearly, successful schemes have negotiated these barriers as well as the national ones.

The provision of property through a different mode creates the need for very different relationships in the general environment, as shown above, that in turn have an impact on organizational relationships. The next section explores how the elements of competence and goodwill trust are reflected in the contractual relationship at the organizational level.

## **TRUST AND PFI CONTRACTS AT THE ORGANIZATIONAL LEVEL**

### **Generic Issues of Complexity in Contractual Relationships: The Role of Accounting**

At the organizational level we highlight two initial issues. The first is that the NHS has to demonstrate that the PFI scheme is both value for money and has effected the relevant risk transfer. This means that the NHS trusts have to control their activities to ensure that the promised efficiencies are produced. Thus, contractual and competence trust must be demonstrated, the aim being to use the discipline of the contract to ensure efficiency. This approach fits with the ethos of neoclassical approaches to contracting. Second, the NHS trusts have to manage their relationship with their institutional partners in the context of ensuring the terms of the contract are being met, and at the same time negotiating how to modify them if needed. The need to ensure that modifications can be enabled requires a relational contracting approach so that goodwill trust is created. In

essence, the possibility of a contradiction between the broad demands of achieving efficiency and building goodwill is set up.

The detailed outworking of these demands for value for money and control are framed by the contract and the documents that operationalize the contract, such as the concession agreement. In general, as well as specifically in the Dartford and Gravesham NHS Trust PFI, the contractual documents define the expectations that each party has of the other. Implicit in their signing is an acceptance by each party that they trust the other and can deliver the service required—in the terms used in this article, that contract trust exists. These documents also define the boundaries of competence trust, thus setting out what each party expects and trusts the other has the ability to undertake. Finally, they frame the arena in which there is the possibility for the development of goodwill trust. The relationships between all these elements is complex and intertwined analytically—as is their outworking in practice.

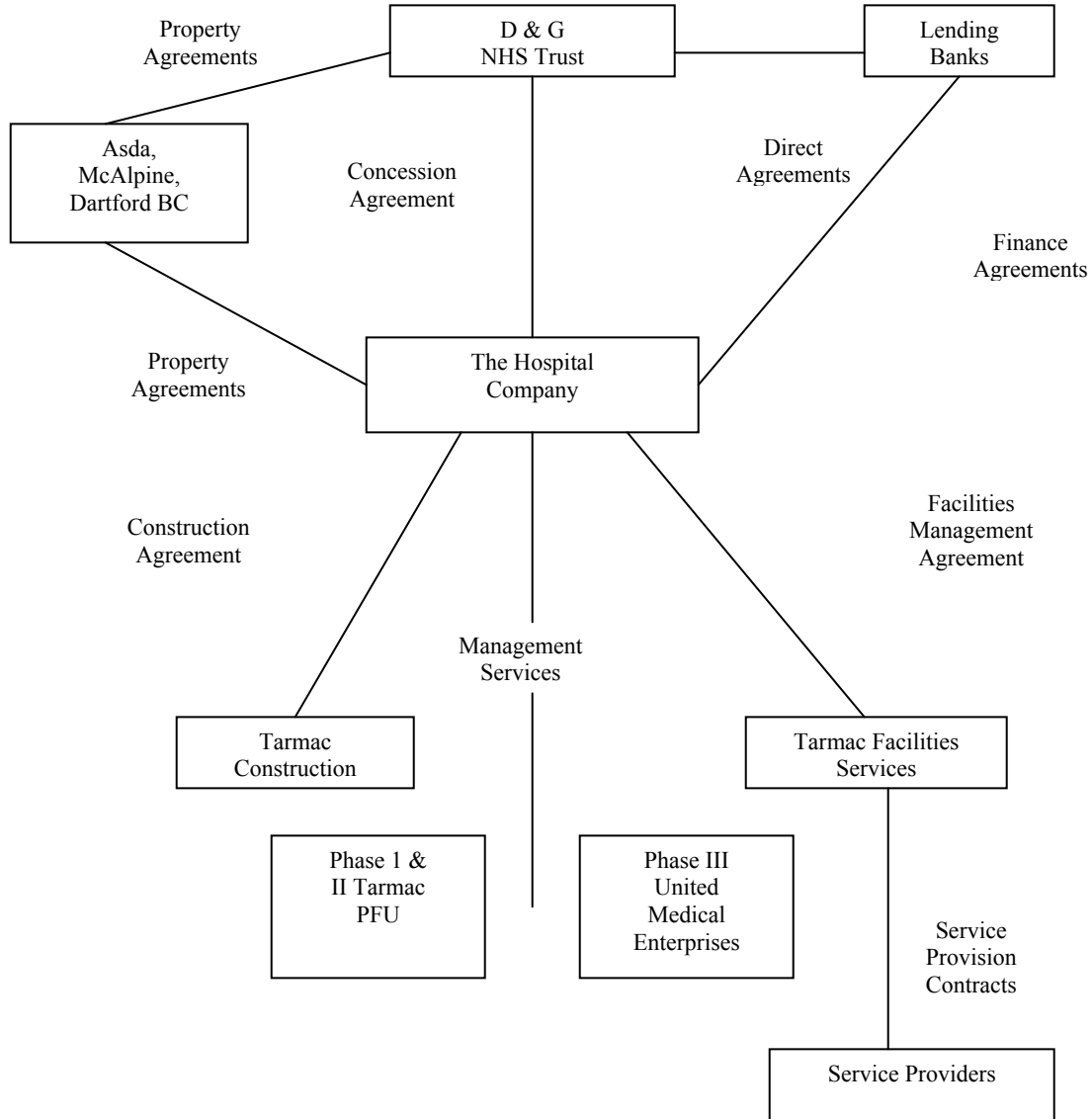
In the context of this complexity, the role of accounting again becomes important as it make visible the relationships between the parties and therefore demonstrates how control is being operationalized. It provides the possibility to demonstrate, through its ability to provide an account to each party, the extent to which the terms of the contract are being maintained. Moreover, because it measures the financial elements, it provides a means by which to evidence and measure the notion of value for money. In providing financial visibility it also provides the foundation upon which goodwill changes can be negotiated. As such, it is an important process that helps in developing the relationship between the parties (Seal and Vincent-Jones 1997). Thus in operationalizing the contract we see a system of monitoring that provides the basis for calculating the payment to contractors, that has within it a series of penalties for nonachievement of any contractual requirements. It is around these that the notions of contract or competence trust are managed. Equally, here is where goodwill trust is developed as performance, and the corresponding payment is judged through negotiation between the contract parties. Thus in Dartford and Gravesham, as detailed later in this section, performance cannot fall below 95 percent without penalty. However, some negotiation may well be possible as it is not always easy to define more subjective output levels. Hence, the possibility of a penalty if improvement is not achieved in the next month provides a means by which to motivate future performance. By being lenient in the first instance, trust managers hoped to build goodwill and mutual commitment to the task.

### **Contract Complexity: The Structure of Relationships at Dartford and Gravesham NHS Trust**

To illustrate how these possibilities are managed operationally at the organizational level, we explore the Dartford and Gravesham NHS Trust (the Trust hereafter) PFI contract that achieved financial closure on 30 July 1997. It was the first PFI contract signed and has been subject to an extensive National Audit Office investigation (NAO 1999) which can be used as illustration of various issues (references in the following will be to NAO, paragraph..., p...). This audit report, coupled with the addendum to the full business case<sup>8</sup> (references in the following will be to ADD, paragraph..., p...) allows considerable public access to material on this PFI contract. In using the Dartford and Gravesham case we shall show some of the key contractual elements, which, at one level,

are very specific to that situation, but at another level have applicability to all PFI projects. The purpose of this detail is to demonstrate the ways in which the contractual framework frames the development of these new relationships and enables contractual and competence trust to be demonstrated and goodwill trust to develop (or not).

One major issue that impinges on these matters is the complexity of the contractual framework and the relationships of the parties involved. Figure 1 depicts these initial re-



**FIGURE 1.** Contract Framework for Dartford and Gravesham NHS Trust’s PFI Project. Taken from the Addendum to the Full Business Case, p. 6.

relationships. The Hospital Company (Hospital Company [Darent] Ltd.) (HC, hereafter) was a separate, created legal entity to manage the PFI project. The HC has entered into two major subcontracts (or agreements, as they are referred to in figure 1) for the provision of construction (by Tarmac Construction), and facilities management (from Tarmac Facilities Management). It has also called on a range of companies to provide management support (from Tarmac PFU initially, and finally from United Medical Enterprises). The two subcontract agreements are largely the responsibility and concern of the HC, although as we will see below the Trust has also been party to their content. The Trust has a direct agreement with the banks who provide finance<sup>9</sup> and a contract of central importance with the HC called a concession agreement. The key issue is the network of contractual and subcontractual relationships, all of which may well be subject to change as parties change their subcontracting arrangements or sell parts of their operations. This complexity and potential for change could make it difficult to build relationships and raise possible problems of fragmentation of responsibility.<sup>10</sup> Thus, the first specific point to highlight in the context of the Dartford and Gravesham contract is the complexity of the contractual relationships.

### **Building on System Trust**

The next issue to highlight in the Dartford and Gravesham NHS Trust is that this contract builds on the system trust discussed earlier. Thus, there is a direct agreement which is the only direct, finance-related contract between the Trust and the lending banks which provides “the banks with step-in-rights exercisable in the event of the Hospital Company’s default and other rights which are specific to the banks’ lending requirements and which need the Trust’s participation or approval” (ADD 3.4, 5). Thus the direct agreement builds on societal attempts to develop system trust and provides another element in the range of protection that banks insisted should be in place before agreeing to lend money to the HC. However, in this way the contract is also dealing with issues of competence—to ensure that there is a competence trust to pay in a last resort.

### **Construction of the Hospital and Trust Relationships**

The concession agreement provides the key vehicle for defining the contractual agreement between the Trust and the HC and is therefore the base for their ongoing relationship. It is a foundation for contractual, competence, and goodwill trust: “The heart of the contract structure for the construction of the hospital and its subsequent availability and services, is the Concession Agreement. This is the agreement (to which the Trust and the Hospital Company are parties) by which the Hospital Company is given the necessary rights and placed under the required obligations to build and make the hospital available and provide non-clinical services. It is the document under which the Trust’s right to use the hospital arises together with the Hospital Company’s entitlement to receive its payments” (ADD 3.1, 4).

The concession agreement specifies the duration of the contractual relationship. Phases 1 and 2 run from the signing of the agreement (on 30 July 1997) to the services commencement date, which is the “first day after the completion of the hospital” (ADD

4, 8). It “is intended that Phase 3 (i.e., the period during which The Hospital Company recoups its capital investment by earning revenue from making the hospital available and the performance of the services) will last for 60 years, subject to the parties’ rights to terminate after 25 years” (ADD 5, 8). Thus, we are dealing with a contract of considerable length.

The concession agreement details the scope of the contractual relationships, which comprise property services and facilities services. In the first instance the contract requires the HC “to design and construct the new hospital to the design agreed by the Trust” (NAO 1.22, 21). This phase of the relationship is complex but relatively short, and there is a capacity to judge competence and contractual adherence in a relatively short time.

In Dartford and Gravesham considerable efforts were put into the successful completion of the building on time. PFI contracts, in general, are awarded with an assumption that the contractor has the competence to complete construction on time as building time overruns were seen as largely responsible for cost overruns. The hospital was completed on time, and although there was the usual snagging<sup>11</sup> the building is functioning and a successful technical evaluation of the building has been completed.

Despite successful completion, there have been problems with the design and build phase of PFI. Given the argument that PFI would provide superior design, public expectation has been that the buildings should work well and a good deal of publicity has attended any failures of the buildings. Press coverage at Dartford and Gravesham (and other PFI schemes) has been very critical of this type of failure. This publicity has undermined PFI as a means of procurement, and the competence of the private sector to deliver has been questioned.<sup>12</sup> In this way it has been a countervailing influence on attempts to build system trust. This has impacted much at the level of the local community.

At the organizational level, good will is needed in the context of building a hospital because of problems of presentation and the possible need to change original designs. Rather than provide tight specification of facilities required through standard building notes, design improvement is sought through contracts based only on output specifications. The explicit lack of detailed input specification thus provides some ambiguity as to how a particular facility or service should be delivered. Interpretation of output specifications opens the possibility that good will may be required to reach agreement about what is seen as good design for purpose.

The boundaries between competence and contractual adherence are blurred, and good will is likely to be needed to deal with this. In the Dartford and Gravesham scheme, for example, a dispute about the finish of workbenches in a laboratory brought all these matters into play. There was a dispute as to the meaning of terms in the contract (raising questions of contract trust) that the contractor claimed were followed and which had led to the installation of a patterned work surface. This interpretation of the terms of the contract were contested by the Trust, who required a plain surface, and, in essence, they questioned the competence of the contractor as they saw the surface provided as not fit for purpose. With some good will in play, the horizontal working surfaces were replaced but the vertical coverings were retained as installed.

It should be noted that the NHS has considerable experience in commissioning the building of hospitals, and the intellectual capital of the individuals in this NHS Trust was



of central importance in managing this phase and this relationship. The intellectual capital of NHS personnel and their consequent skills in working through difficulties with the contractors is based on their detailed understanding of what is required. Without this intellectual capital, the incident noted above would have been a difficult one to be recognized and settled.

### **Facilities Management and Contractual Relationships**

We move next to facilities management and the provision of ongoing services. In Dartford and Gravesham, the HC “are to provide the Trust with seven facilities management services—building management and maintenance; domestic services, window cleaning and pest control; portering, transport and internal security; linen and laundry; catering; switchboard and telecommunications; and external security and car parking” (NAO 1.23, 21).<sup>13</sup> Detailed specification and performance expectations and penalties are contained in the concession agreement in some detail. To provide facilities management services, staff currently employed by the Trust in the seven areas have been transferred to the HC.

The financial elements of the concession agreement detail the agreed monthly payments from the Trust to the HC and arrangements for the penalties resulting from reduced service provision.<sup>14</sup> The NAO report details (1.25, 22) that the monthly payment (in 1996 terms) from the Trust to the HC is £1.32 million (£15.84 million annually), divided into an availability payment (of £879,000 per month) for making the hospital available and a performance related payment (of £441,000) for service provision. These are adjusted in line with the Retail Price Index (ADD 5, 12).

Appendix 5 of the NAO report summarizes the complex rules that apply to deductions for availability and performance.<sup>15</sup> In simple terms, the availability of the hospital is assessed every twenty-four hours, and if selected areas are unavailable the availability payment will be reduced. The performance related payment for each of the seven service areas is calculated using a scale in which full payment is made when performance reaches a 95 percent rating, and reductions apply on a sliding scale below that level.

This does not define how availability and performance can be monitored and measured in precise terms. Thus, because the contract itself has not set out the whole detail of the working relationship, much effort has been needed to operationalize the framework. Inevitably this relied on the exercise of goodwill trust. For example, the contract gave the NHS Trust the right to define 50 percent of the facilities management indicators. It is in working through this detail that the foundation of the relationship between the parties has been developed, as it involved the parties in more detailed consideration of the nature of the tasks than had been possible at the contract stage. The operational managers themselves were able to debate the detailed nature of the service provision. Relevant performance indicators (PIs) were chosen to monitor the service levels, and like all PIs these then become constitutive as well as reflective of performance.

Ongoing monitoring of the contract provides a continuous and reflexive development of contract, competence, and goodwill trust. For example, consider the elements relating to cleaning services. One element that is not specified is any penalty for failure in the

standard of cleaning in the office space. It follows that this might be seen as an area where contractual trust might be compromised. Some failures in this respect have been noted, and offices have sometimes not been cleaned thoroughly. However, this has not caused any problems to NHS managers, as they recognize that the contractors have an interest in remedying failure in this area. Any ongoing failure to perform adequately could be seen by the Trust as providing worries about the competence of the company. The Trust recognizes that this, in itself, provides an incentive to the contractor. The Trust manager concerned indicated he simply calls his counterpart on the telephone and “things are sorted because we have a good relationship” (from notes of a confidential interview by the authors at Trust headquarters, 27 April 2001). Experience has shown deficiencies have been dealt with quickly and without resort to argument or to arbitration processes, which are the fall-back contractual option. This illustrates the complex intertwining of the different streams of trust.

### **Contracts and the Control of Risk**

The allocation of risk between the HC and the Trust was a central concern throughout, and a key element in the contract construction and in the predecision processes. Risks associated with the Trust’s PFI contract and who should bear the costs involved should they occur, have been summarized in Appendix 4 of the NAO report. The risks are divided into ten major areas.<sup>16</sup> Within each of these broad-risk categories a number of possibilities are outlined and a cost allocation is specified (between the HC and the Trust) in relation to the potential outcome. For example, in the design and construction category, if the construction lasts longer than expected or there is a failure to provide the hospital to specification, then the HC must cover the costs involved.

Because of its centrality, the management of risk allocation was a key element in the negotiations for and the formation of wording of the concession agreement. The concern to cover as many eventualities as possible and specify who would cover the costs of each, should they occur, permeates the concession agreement. However, there was a realization of the impossibility to specify all the possible problems and difficulties that might arise in a contract of this length and complexity. This signifies recognition that goodwill trust would have to be implemented in the context of operationalizing the contract. Thus, where possible, risks were specified and the costs involved allocated to either the Trust or the HC, but if the totally unexpected happened there was still a set of arbitrating arrangements to ensure that a resolution could be achieved between the parties to the contract. While these provisions might be seen as a substitute for goodwill trust, the reality might prove otherwise. It is in neither party’s interests to enter expensive arbitration processes when goodwill trust would avoid this. It should be noted that the arbitration process has not been entered into as yet. However, it should be noted that the contracting environment could add a rather adversarial element to the relationship.

A final issue that can be highlighted is that while in predecision the issue of risk assessment was central, postdecision and during the operation of the contract it seems invisible. There has been no attempt on the part of the Trust to seek to evaluate whether the required risk transfer has been achieved. Instead, there is an implicit monitoring of the risk transfer. This has been enacted through the monitoring processes that have been designed to ensure that service quality and availability is as required. The implicit

assumption is that if the contract is adhered to, the risk transfer will be as intended. The postproject evaluation required by the NHS relies only on a technical evaluation of build quality. This is an issue that needs further consideration in the context of a broader evaluation of PFI projects.

### **Concluding Comments**

While these examples of the elements of the Dartford and Gravesham contract are not exhaustive or fully representative, they provide some indication of the way in which the contract sets out the boundaries in which competence trust can be substantiated and in which goodwill trust can be built. They also give some illustration of the way risk definition and allocation occurred in this particular PFI contract.

### **SOME IMPLICATIONS AND A FINAL DISCUSSION**

The recognition of a need to upgrade the capital assets of the NHS has led the UK to develop the notion of PFI in the NHS. This raises a number of issues in the context of contracting relationships. It also brings about a number of contradictions.

The extent to which the attempt to ensure this control is successful relies on the degree to which the contract provides the necessary framework. This highlights a central issue in this article. In changing the way in which capital assets are provided for the NHS, the state has changed not just the source of the bricks and mortar, but also the whole raft of working relationships within the organization. Instead of these being controlled by a bureaucratic web of rule and regulation, they are now controlled by contract.

In essence, instead of the previous bureaucratic relationships, new and extremely complex relationships are being built and predefined in the context of the contracting process. In particular, in the context of these long-term contracts, we have argued that the neoclassical view of discrete utility maximizing transactions is unhelpful, as it sets up a competitive rather than a cooperative relationship. This may be appropriate if the aim is to extract surplus value for shareholders. It may also be appropriate in the context of seeking to discipline the private-sector contractors providing the service, but may be less appropriate for building the relationship needed to make the contract work in the longer term. In particular, if presentation is not possible, there is likely to be a need to adjust expectations and obligations to make the contract work in a changing environment. Instead of adopting an adversarial stance, we have argued that there is a need to build trust in these relationships, in and through the contracting process. We would argue that those involved, at different levels, have accepted this and great efforts have been made to create an environment of trust.

Before trust can be developed at the organizational level it must be built at the societal level, and much work has been undertaken to do this through the creation of system trust. Thus, legislative activity was undertaken to pass two instruments to alleviate the worries of bankers as to the security of their investments. Also, there was agreement to an accounting framework to ensure that there were no worries about the balance sheet status of PFI. It was also promised that clinical services would remain in the public sector. Alongside this has been the work of the NAO to study the value for

money of the schemes, which has given some confidence that value for money was possible.

The outcome of these attempts to build system trust has been a reduction in the overall risk for the private-sector partners. The legislative framework, the agreement to the form of the accounting standards, the commitment to retaining clinical services in the public sector, and the endorsement of the NAO adds to the legitimacy of PFI. This builds its acceptance as a means of procurement and makes it less likely to be discontinued or undermined in the future. The greatest immediate contribution to this reduction of risk is perhaps in the context of the protection offered the private sector in the case of any financial failure of the trust. The two acts passed ensure that if the trust fails the private-sector partner will not be left with an asset that cannot be used for other things. Hence, at the macro level, the government has underwritten the potential problems of asset specificity. It should be recognized that this undermines some of the claims that there is, in PFI, a transfer of risk to the private sector. It may, of course, substantiate the argument that risk needs to be allocated to those who can most effectively carry it. It highlights the importance of both law and accounting in the construction and monitoring of the risk transfer.

While system trust at the societal level is perhaps a prerequisite for successful contracting, at the micro, organizational level there is also a need to build goodwill trust. We argue that at this level, the only way that contracting in the long term might successfully be conceptualized is through the idea of relational contracting, which recognizes the importance of goodwill trust. This recognizes the difficulties of presentation and acknowledges the need to account for the underlying social relationships in the organizations concerned. The latter are complex in the context of PFI in the NHS. Some of these parties to the PFIs are people entering a new relationship, not least the managers of the facilities who are managing staff previously working in the NHS and supplying a service to those remaining in the NHS (clinicians, for example). Other parties were previously employed to provide a service and remain within it, but are now working for different managers, providing services for their previous colleagues. An embedded set of social relationships exists, but these are now being transformed by the imposition of a contract. Clearly, until these relationships become reinstitutionalized there is a possibility of great stress. Even without these tensions there is always a possibility of conflict, and the industrial relations history of the NHS shows this. However, in a situation where there is a need to renegotiate the relationship base this tension is likely to increase. The tension is more likely to be difficult in a situation where the values of different parties are challenged, and in the context of what is seen to be private-sector impingement on the public services this is the case.

Moreover, given that the aim of PFI is to extract efficiencies from the provision of services, there is still a strong neoclassical ideology behind the contracting process. This provides a strong adversarial base to the relationship that is likely to be amplified if any of the participants come under pressure. In the case of the NHS, this is likely to occur in the context of ensuring that there is efficiency, leading to a need to put pressure on the private sector. In the context of the private-sector partner this is likely to be pressure to make returns for shareholders. Contracts have been set in such a way as to seek to ensure that the rights and obligations of the parties are recognized in advance. Nevertheless,

presentation is impossible and for any contract to provide a full framework for relationships is impossible.

Given the fact that contracting provides a mode of operating that exists outside the existing relational structures of the NHS, there has already been a need to provide some relational framework within which PFI can work. Our argument is that the existence of system trust is an important precondition for the development of goodwill trust within a relational contracting mode. System trust at the societal level provides context and the framework for the parties to the contract to recognize the rights and obligations of their own relationship. System trust is important in defining the relationships of both the internal parties to the contract (those who are working together on a day-to-day level) and the external parties (who provide the finance but are not normally working together daily). Our analysis of the Dartford and Gravesham PFI contract shows that beyond general government efforts in providing the institutional or system trust at a macro societal level, the contract has started to develop in such a way as to embed trust organizationally at the micro level. That trust is built not only on contract and competence—elements of goodwill trust are also developing through the relationships being constructed.

We are not yet able to see how, in the longer term, the environment of societal system trust will frame the internal contractual relationships between the different parties working together. Clearly, if we take the argument of Deakin et al. (1997) seriously we should also consider the extent to which the process of contracting has the possibility of developing trust within the system. Once again it is too early in the process of the PFIs to see if this will be the case. Perhaps the whole process of negotiating and closing a deal is about more than formalizing expectations that contractual and competence trust can be met. Put another way, one assumes that if parties were not satisfied that contractual capability and competence could be achieved, then the contract would likely fail. In that respect the negotiation process itself is also likely to be about building goodwill trust; as the parties to the negotiation build a relationship, social relations emerge. These in turn provide the basis for a relational contract and allow the possibility for goodwill trust to emerge. If parties are seen to have been fair in the context of the negotiation, then the expectation of fairness provides some base for goodwill trust to aid the resolution of issues that were not defined in the original contract. The consolidation of goodwill trust will continue and be tested in the ongoing implementation of the contract. Where this may prove to be more difficult is in the context of the situation where those who have negotiated the contract then move on to another post, leaving a new set of people to operationalize their understandings.<sup>17</sup>

As noted above, when the contract is running the expectations of all parties will be tested on an ongoing basis. The complexity of the various relationships will then be important, and the contradictory impetus is inherent. Good will for one set of parties may be bad will for others. Deakin et al. also remind us that once a contract is closed the relative power relationships of the parties become important. For example, a very important question for the future is whether the needs of the private sector to provide financial return to their shareholders prove more powerful than the need to maintain goodwill trust within the PFI partnership. Such a question would have been irrelevant prior to the introduction of PFI.

We might also ask whether a relational contract at an operational level can control better than the previous bureaucratic relationships. We can also question whether the relational contracts will, in the longer term, be different than the bureaucracies they replace. To what extent does a contract that runs from twenty-five to sixty years simply institutionalize the relationships in the way that a bureaucracy does? Is the need to minimize transaction costs in a long-term contract simply going to lead to the formation *de facto*, if not *de jure*, of a set of relationships that are to all intents and purposes bureaucratic? Our ongoing work will seek to assess this. In conclusion, there is much more to learn as the new relationships are operationalized. The political determination to make them work has been demonstrated by the ongoing development of legislation to build societal system trust. How the ongoing goodwill trust that will be needed to ensure the day-to-day working of the organizations in question will develop in the context of the diversity of values and the competing financial demands of the various parties remains to be documented.

Finally, we should reflect upon the extent to which an initiative that changed the mode of the provision of infrastructure resources was thought through in respect to the impact that it might have at the organizational level. This article has argued about the nature of the process that might be necessary to make long-term PFI contracts work. It has shown how the government has set out an environment at the societal level in which trust can be built to make PFI work. It has illustrated how a particular contract is addressing the need to build an environment in which the operations can function. It has also commented on the inherent contradictions that are set up in the context of societal demand for neoclassical efficiency that has driven the approach, and the need for long-term working relationships. However, our article has not directly addressed the issue as to whether it is all worthwhile. The question that remains and can only be answered in the longer term is whether PFI partnerships are, in essence, better than the bureaucratic structures they replace or whether they are instead bureaucracies in the making.

## NOTES

1. We note the recent debates as to whether New Public Management is a sensible term in the context of a set of issues that are over twenty years old; however, we retain the term as it is the one referred to in the literature from which our concerns build.

2. Interviews with successive NHS financial directors and with senior officers at regional and hospital trust levels has often elicited, without any prompting, the view that the NHS is a family-type organization. While this may well be a rhetorical device and less of a reality than a myth, the power of the imagery is important to note and the fact that recourse to this descriptor has been made so frequently is important.

3. The Dartford and Gravesham PFI scheme is the first hospital PFI to be signed. It has had more public exposure than most, having been the subject of a value for money audit by the National Audit Office (NAO 1999).

4. Prior to 1991 three different levels were involved in the management of the secondary (hospital) sector of the NHS. The NHS executive was, in effect, the head office and then the country was divided into a number of major geographic regions. Nested within regions were district health authorities, who handled health care in smaller geographical areas. Each district health authority had, within it, a number of hospitals for whom it had responsibility.

5. Note that there has been a further change with the introduction of primary care groups and trusts in 1999. Our analysis does not seek to address this further change.

6. This is an important point in the context of PFI, which rests on the argument that it allocates risks to those who are best able to carry them.

7. I.e., in a capitalist economy in which there is a need to extract surplus value from ongoing business activity.

8. The business case is available for purchase through the NHS Trust, but is not published as such.

9. A mixture of agreements finances the HC. These are principally from banks (Deutsche Morgan Grenfell, Rabobank International, and the United Bank of Kuwait) but also include external investors (Tarmac, United Medical Enterprises, BZW Equity Fund, and Innisfree). Financing was also obtained from once-off sales of land owned by the Trust (sold to Dartford Borough Council, Alfred McAlpine, and Asda supermarkets).

10. The recent debates about the workings of the UK rail system have raised concerns about the problems of assigning responsibility in a system which is fragmented in terms of ownership, but has to work as a whole.

11. Snagging is the term used in the building industry to refer to matters that need to be dealt with once the building is completed. These are things that have not been finished satisfactorily or that do not work as intended. It is a phase that would occur with any building, be it a large-scale contract or a domestic extension. Clearly, the extent of the problems is relevant and the aim should be to reduce any such difficulties.

12. It should be noted that the private sector has always built hospitals and problems about delivery have always occurred. The point here is not to debate that, but to note that the promise of PFI to deliver better quality and better design has not necessarily been perceived to have been provided.

13. However, the Trust “will provide the clinical services of the new hospital” (NAO 1.23, 21). This institutionalizes the commitment that clinical services would remain in the public sector, following concerns about the extent to which PFI is privatizing the NHS.

14. Other financial matters concerning the overall value of the project are contained in the outline and full business cases and are not considered here.

15. Contained in clauses 29 and 30 in the concession agreement.

16. Design and construction, operation, legislation/regulation, availability, volume, technology/obsolescence, disposal, termination, finance, employment.

17. Our wider research project suggests that this is often the case with a team breaking up once the contracts are finalized and the scheme moves toward operation.

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