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Public Access to NHS Financial Information: from a freedom of information regime to full open-book governance?

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Abstract

This paper investigates the access that health professionals, researchers, journalists and, ultimately, the public have to review spending in the English National Health Service (NHS). The ability of news organisations to inform debate and decision-making, particularly when hospitals face financial constraints, relies on accessible data. Theorists such as Patrick Dunleavy have suggested that developments in information communications technology induce a dialectical movement, involving changing governance and increasing transparency. Drawing on this premise, the article reviews the extent to which the NHS has moved from a 'freedom of information regime' to one of 'full open-book governance'. Its methodology includes a combination of documentary and freedom of information data analysis, as well as in-depth interviews with directors of commissioning and provider services and national agencies. It argues that, while increased dissemination of information might be consistent with the government's digital agenda, the NHS's quasi-market operation and its relationship to the Freedom of Information Act mean that significant data remains inaccessible or costly to obtain.

Keywords: freedom of information, digital-era governance, open-book governance, NHS finance, data journalism

Introduction

UK government policy has a potentially far-reaching goal. It seeks to open up the budgets and practices of public services – utilising semantic Web technology to combine and share information accessibly with the public (Cabinet Office, 2012; Berners-Lee, 2009). 'Open data' have been lauded as 'possibly the most powerful lever of 21st century public policy' (Cabinet Office, 2011). While the 2010 administration described the release of *financial* data as just one element, it is an important aspect, which this article focuses on in relation to the English NHS.

The post-war Labour administration formed the British NHS in 1948. Since then it has gone through a number of significant structural changes. But it remains a service funded from general taxation and mainly free at the point of delivery. In 1991 the Conservative government split the UK's district health authorities in two. These authorities had previously both planned and provided health services. In their place, the government created a quasi-market, with commissioners purchasing health services from NHS hospital trust providers.

One might assume, given the existence of NHS policy documents calling for *An Information Revolution* (DH, 2010), that there are no longer barriers to journalists and the public obtaining financial data. However, we aim in this article to consider whether this is the case. We review whether there are institutional blocks to openness, making comparisons on spending between trusts more difficult than might be technically possible. The importance of this is that financial data provision can be used to inform debate and pinpoint both failures and successes in healthcare management and public policy. It can highlight options to control costs at a time when around 40 per cent of NHS hospital trusts are deemed to be in deficit (Murray, Imison, and Jabbal, 2014; Hazell, 2014).

We focus on two separate and potentially conflicting sets of initiatives overseen by the UK Coalition government formed in 2010. This administration continued to promote digitisation, e-transparency and freedom of information, on the one hand. And, on the other, it further strengthened competition between service providers, both encouraging more private providers to deliver services and making NHS trusts more independent (Cabinet Office, 2012).

This topic can be assessed from a number of academic perspectives that are referred to later in this introductory review: for instance, those that consider accountancy (Broadbent and Guthrie, 2008), transaction costs (Marini and Street, 2007), contract relationships (Hughes et al., 2011), 'new public management' (Dunleavy, 2010; Clarke and Newman, 1997), freedom of information (McClellan,

2010), quasi-markets (Williamson, 1983; Le Grand and Bartlett, 1993; Greener and Powell, 2009), commercial confidentiality (Gallini and Scotchmer, 2002) and data journalism (Gray et al., 2012). ‘New institutional economics’ has also been used as a framework to consider NHS purchaser–provider relations (Williamson, 1983). Taking this literature into account, our analysis is primarily organised around Patrick Dunleavy’s conception of a move from a freedom of information regime, which he associates with new public management, to one of digital-era, full open-book, governance (Dunleavy, 2010). Dunleavy, who has also written on this issue with academics such as Helen Margetts, provides a theoretical framework to analyse the potential conflicts we highlight between transparency and NHS market policy (Dunleavy and Margetts, 2010).

The article is structured as follows. First comes an introduction to the literature on digital-era governance and the relevant features of the NHS quasi-market. Next, we set out our methodology. Then we present the research findings, informed by interviews with staff from national agencies and local directors, as well as freedom of information-requested data information. Finally, the paper offers further perspectives on information asymmetry (Williamson, 1983) and the extent to which the NHS is moving along the trajectory Dunleavy and his collaborators describe.

1.1 Digital-era governance

The notion of digital-era governance is helpful in structuring this article’s multi-disciplinary topic. Digital-era governance is where public services – both in management and delivery – become more integrated and electronically accessible. There is a focus on digital oversight and communications, with data becoming increasingly open. Dunleavy and his colleagues see shifts in governance and transparency resulting from technological developments in information and communications as part of a dynamic ‘dialectical’ development. Often, such a movement has come to be signify, in summary, one where contending processes are happening at the same time and both interpenetrating

and clashing with each other, resulting in a form of transcendence (Bhaskar, 2008, p.3).¹ Dunleavy uses the term dialectical to highlight the complex, paradoxical and dynamic impact of information technology on governance. Our starting point is a focus on two potentially conflicting initiatives; firstly, encouraging transparency and secondly, increasing competition. However, Dunleavy and his colleagues have provided a theoretical framing that aims to be more predictive. They consider information and communications technology will transform a freedom of information regime and public sector governance arrangements that have previously prioritised quasi-market mechanisms.

Thus, they plot a general direction of travel towards more openness and digital-era governance. Information technology also makes both centralisation and decentralisation within organisations easier, they suggest. We will consider if the element of centralisation here is potentially at odds with government policy in relation to NHS financial data (Dunleavy, 2010; Cabinet Office, 2012).

Dunleavy and Margetts recognise that institutional barriers between services can impact on the use made of information technology. The policies associated with new public management – disaggregation (e.g., the purchaser–provider separation), competition (e.g., the development of a quasi-market created between those purchasers and providers (Le Grand and Bartlett, 1993) and incentivisation (e.g., privatising asset ownership) – are also challenged by this technological revolution, they believe. Broadly, they see a shift away from new public management, although they do not deny that it is still being implemented in some instances (Dunleavy and Margetts 2010). The features of new public management described here, and which Dunleavy and Margetts use, are themselves contested. But they are consistent with the definitions provided by the key theorists who developed the term, Clarke and Newman (1997).

¹ Bhaskar debates whether this is the case (2008).

So, Dunleavy and Margetts contrast freedom of information regimes with the possibility of ‘full open-book governance’, where authorities release information when produced and used, instead of when requested (Dunleavy and Margetts, 2010). By full open-book financial governance within the NHS, we mean open provision of detailed, comparable information on budgeting and spending across healthcare providers. This paper covers a more specific issue than the broader interests of Dunleavy et al.. The concern here is the extent to which, specifically, NHS financial information is open, or whether institutional barriers curtail the full exploitation of information communication technology to increase access to financial data. When it comes to financial information in the NHS, our question is: to what extent has there been ‘a transition to full open-book governance instead of [a] ... partial “freedom of information” regime[s]’ (Dunleavy, 2010, p. 26)?

The freedom of information regime was relatively late coming to the UK; the law came into effect in 2005. The arguments for government transparency and access to data – with freedom of information often seen as an indicator of this – can be simply put. Transparency is a precondition for deliberation and accountability. It supports government agencies in becoming more responsive and efficient in formulating and executing policy (McClean, 2010). To that end, the World Wide Web’s inventor, Sir Tim Berners-Lee, was involved in expanding e-government transparency beyond freedom of information policy during Gordon Brown’s Labour government of 2007–10. Treasury spending then became more open under the Coalition government, with the launch of the COINS database, aimed at making spending more transparent (Rogers and Arthur, 2011). And the Secretary of State for Communities and Local Government, Eric Pickles, called for an ‘army of armchair auditors’ to scrutinise local authority data (Gov.uk, 2010). Two years later the government strengthened freedom of information legislation as part of the Protection of Freedoms Act (2012), which obliges public bodies to make their datasets available in re-usable formats.

Some writers, however, have questioned the rationale for such moves to e-government transparency and whether electronic dissemination of information is indeed synonymous with such transparency (Yu and Robinson, 2012). The policy of 'armchair auditing' has also been criticised for encouraging an unbalanced and unsophisticated analysis (Curtis, 2011; Maguire, 2011). Bannister and Connolly (2011) suggest that costly indiscriminate release can lead to confidential data being inadvertently unveiled or, from a more elitist standpoint, that information can go to the 'wrong' people and be misinterpreted. Yet they accept that this depends on how thoroughly data are contextualised. The concerns regarding journalists having the opportunity to access corporate financial data are typically legal and similar to those governing freedom of information legislation on commercial confidentiality, which we will consider in a moment. If a journalist publishes commercially sensitive information about an organisation that might be of use to a rival, (s)he can be sued for breach of confidence. Analogous to freedom of information law, media organisations can employ a public interest defence in publishing: for instance, if they are bringing a faulty good to the public's attention (Hanna and Dodd, 2012, pp. 295–306). Aside from this, the Information Commission, (the statutory organisation that oversees the Freedom of Information Act), adheres to the principle that it does not matter what the data are going to be used for. Thus the use and impact of transparency policies are 'fundamentally unpredictable' (Michener and Worthy, 2013). Nevertheless, Roberts (2001) argues that public services' 'monopoly control' of raw data should be challenged. Although laws to ensure competition in media markets have been eroded under pressure from oligopolistic corporations (Freedman, 2008), Roberts draws an analogy with the restraints that governments have still maintained on news media monopolisation, with the aim of promoting a level of diversity of expression and informed opinion. Control of public-sector raw data should be similarly diversified, Roberts suggests.

However, the public-sector NHS also commissions healthcare from private providers. Researchers have contrasted public- with private-sector financial

accountability when analysing private–public partnerships. Broadbent and Guthrie (2008) review this literature, and a key difference between the private sector and the public, for the purposes of this paper, is that private contractors and providers to the NHS are not subject to freedom of information requests (Broadbent and Guthrie, 2008; HoC, 2000). This means that the NHS commissions swathes of health provision where the transparency rules do not apply. This issue, while important, is not, however, the focus of our research. Instead, even for public NHS organisations, as with all such freedom of information legislation globally, there are significant exemptions concerning ‘commercial confidentiality’, which come under Section 43 of the UK act (Roberts, 2001). The act exempts information when it constitutes a trade secret (such as organisational methods used in providing services and goods). Also exempt is information that would prejudice the commercial interests of any person, subject to a public interest test (HoC, 2000). This test considers whether there is a widespread interest and significant benefit in data being available, including to journalists. As with news media privacy regulation, the adage applies that ‘the public interest is not necessarily what the public are interested in’ (Frost, 2011).

The public interest test weighs more in favour of information disclosure than against it. However, it also regards the commercial concerns of third-party private contractors and NHS bodies as of public interest. Nevertheless, Llewellyn et al. (2013) found that restricting the flow of financial information has undermined value for money in the NHS because it constrains national bodies in understanding costs across the service. By this token, rulings by the Information Commissioner would have to take into account complex evidence about the economic impact of financial data disclosure. We describe the views of respondents on disseminating such information below.

One objection voiced to extending NHS financial data release is that the service should be governed by the same rules as private firms. The UK government has already rejected this, in effect, by subjecting publicly provided healthcare to

freedom of information legislation, with some seeking to broaden the application of that law to private providers (HoC, 2012a). A further assumption behind restricting public-sector data is that journalists have sufficient access to private-sector information to enable proper scrutiny. Yet, along with the concerns voiced regarding public–private partnerships, recent economic history also suggests that this may not be so. Nobel Prize-winning economist Joseph Stiglitz puts journalists’ failure to cover the financial crisis adequately down to insufficient openness, as well as media shortcomings. Even if financial journalism had been more probing, he considers that ‘the complexity and nontransparency of the banks made an accurate depiction of the situation ... difficult if not impossible’ (2011, p.55).

Conversely, the public provision of ‘big data’ has become a potential news source, and is leading to the development of ‘data journalism’ (Hayes, 2009; Gray et al., 2012). Moreover, data journalism and, in particular, financial data journalism provide the possibility of enhancing the public sphere – the area of society where participation in debate, and formation of public opinion, can occur (Habermas, 1991). This is a construct that has come under fire from, among others, those who see it as universalist and homogenising, and as not sufficiently historically grounded. Its proponents, meanwhile, have focused on its modern-day critical application, viewing it as a theory with which to consider the inadequacies of present democratic discourse, and one that is capable of accommodating difference and disagreement (Gimmler, 2001).

While not a panacea, the reporting of British MPs’ mis-claiming of expenses illustrates the opportunities for enhancing the public sphere by opening up financial information. Journalist Heather Brooke’s repeated freedom of information challenges yielded only limited results. It was only when the *Daily Telegraph* obtained an unedited release of the expenses’ files that the scale of the story emerged. This increased both the visibility and the ‘inferability’ of the data (Michener and Bersch, 2011), making possible a comparison between the more scrupulous MPs and those less so (Brooke, 2011). That the *Telegraph* was now

the data's gate-keeper – paying an intermediary approximately £150,000 for the lifted files (Gayle, 2012) – does nothing to undermine the idea that above-the-board open-book governance could help inform and enhance public debate. Subsequent release of further expenses data also provided the opportunity for data journalist crowdsourcing: that is, outsourcing tasks to a wider network in an open call. In this case, *Guardian* journalists made the call to readers and contributors (Muthukumaraswamy, 2010, pp.48–9). Yet it also showed some of the limits of a process that is still in its relative infancy. One issue it highlighted was that public auditing itself needs quality checks (Daniel and Flew, 2010).

In general, the political implications of transparency initiatives are likely to be complex. Bates and others (2013) consider that the open data agenda is being used to fuel cuts to public services and the privatisation and monetising of public assets and data. The fact that UK ministers have cited as a role-model the low-tax campaigners the TaxPayers' Alliance is instructive in this regard (Open Public Services, 2012). However, many open financial data activists have 'positioned their agenda as a challenge to neoliberal hegemony' (Bates, 2013). More specifically, as referred to earlier, Dunleavy and Margetts (2010) argue that digitisation challenges the fragmentation of public services.

Thus there are divergent pressures for, and outcomes of, open financial data. Nevertheless, it can be argued that a broader range of citizen-based groups than solely those sharing new public management goals have an interest in using such data to offer alternative perspectives on controlling natural and labour resources and, more specifically, the allocation of resources in the English NHS.

1.2 The NHS quasi-market and information asymmetry

Studies have highlighted the fact that, by separating purchasers from providers, as the government did with its NHS reforms of 1991, the levels of financial information available on the two sides can become asymmetric. Those providing a service may know far more than those buying it in (Allen, 2013; Marini and Street,

2007; Croxson, 1999). Theorists of new institutional economics have analysed financial information asymmetry when companies in traditional markets venture outside their own organisations to the market-place to buy rather than make. Williamson considers that market relations make it possible for producers to operate in an opportunistic way – what he terms ‘self-interest seeking with guile’. Yet operating in a single organisation instead ‘promotes convergent expectations’ between all staff (Coase, 1937; Williamson, 1983; Health Select Committee, 2010). The NHS retains some of the centralised features of a single organisation: for example, national pay scales and pay bargaining. The academic literature reports NHS policy confusion on the merits of NHS centralisation, for example (Exworthy and Frosini, 2008; Saltman, Dubois, and Durán, 2011). This confusion is also perhaps reflected when senior health figures variously regard the NHS as a business or as an industry (HoC, 2011; DH/NHSE, 2013). For new institutional economics, the singularity or plurality of the NHS has consequences for open data. Reflecting on our interview data, we later consider the extent to which information asymmetry is indeed a particular issue for the NHS quasi-market.

The Labour governments of 2001–10 further developed the quasi-market, reinforcing the purchaser–provider split. They introduced ‘payment by results’ – meaning that, wherever a patient goes for treatment, the receiving hospital will be paid the same tariff rate for the same procedures (Marini and Street, 2007). This nationally agreed tariff is based on a calculation of the average cost of the procedure in hospitals across the country. Imposing a nationally agreed price adds to the view that this is a quasi-market, as opposed to a ‘real’ market, a distinction that has been debated (Lewis et al., 2009). The Coalition government’s Health and Social Care Act introduced further wide-ranging changes. As well as aiming to make all NHS hospitals independent ‘foundation trusts’, operating under more commercial financial regulations, the government has extended the private sector’s reach in contracting and providing services. The act also made general practitioner-led clinical commissioning groups the purchasers of hospital services (Greener et al., 2014).

Various commentators suggest that having nationally agreed tariffs has increased transparency between hospitals and also for purchasers, thus reducing the problems of information asymmetry (Ashton, 1998; Edwards, 2012). However, this is only partly true. As tariffs are based on centralised average costs, they do not help different hospitals, or wider parties, compare how resources are deployed because they do not show in themselves what is spent on items contributing to the tariff; items such as consumables or staffing. Foundation trusts can go to benchmarking clubs, which enable providers to compare their spending with other trusts. Our research explores how effective this approach is. Moreover, there are other limits on the effectiveness of tariffs as a means of transmitting financial information. The extent to which providers receive funding via the tariff system is variable, partly because many specialist treatments are not costed using tariffs (HoC, 2012b), while there is also evidence that the tariff is based on inaccurate financial information, which is not extracted automatically from hospital costing systems, but is reproduced, thus increasing collection costs (Monitor, 2012).

Furthermore, freedom of information law does not fully overcome the difficulty of public access to benchmarked NHS-wide data. It regards NHS trusts as separate public authorities. So freedom of information requests have to be made to all trusts separately. Under these circumstances, armchair auditors and campaign groups, as well as academics, would not be able to collate and compare data easily or accurately, and then make them available to journalists and the public. And in a world of 'churnalism' (Davies, 2009; Leveson, 2012), it is more likely that news organisations' time constraints would prohibit reporters from performing the task of collating such data from hundreds of organisations. Indeed, the chronic underfunding of investigative journalism has been particularly pronounced in local reporting (Franklin, 2006a, p.4; Franklin, 2006b, p.158). Yet national titles such as *The Guardian* and multinational magazine publishers such as Haymarket have invested in big data journalism (Gray, Chambers, and Bounegru, 2012; Payton, 2014). Media companies have done this to provide data reports for niche buyers.

But they have also used the data to inform readers, providing extra scope and insights that were hitherto unfeasible (Payton, 2014), for instance via data visualisation. If the goal is to enable journalists and the public to utilise financial data to expand debate and enhance the public sphere, then going beyond a freedom of information regime to extending NHS-wide benchmarked open data release is a potential tool, which we intend to explore. Moreover, as journalists become increasingly accustomed to receiving electronic nationally benchmarked information on health service issues other than NHS finances, sometimes through charitable intermediaries, and using these data to highlight local statistical outliers, so expectations on financial data keeping apace could increase (eg. Health and Social Care Information Centre, 2014).

Elsewhere the hitherto piecemeal NHS freedom of information regime has also come under pressure. In 2011 the National Audit Office published a significant report, which concluded that the amounts that different NHS trusts paid for goods and services varied significantly. But it also described the difficulty in obtaining the financial data required to compile the review, particularly from foundation trusts. The Public Accounts Committee (HoC, 2011) took this up. And the Department of Health and NHS England responded by announcing plans for procurement that, would, in effect, curb NHS provider autonomy and increase centralised and thus comparable data analysis (DH/NHSE, 2013, pp.3, 24). This significant development is discussed alongside the findings below, with reference to Dunleavy (2010).

2. Methods

To investigate the levels of access there are to NHS financial data and what ability there is to use freedom of information requests and publication schemes to compare data, we used a mixed method. This included documentary analysis, in-depth interviews, freedom of information requests and financial dataset retrieval. Given that the UK government is developing potentially contending policies in a conflicted NHS, how policy is implemented on the ground will help determine

moves to full open book governance in the NHS. Thus staff opinion and the culture of NHS organisations are important to provide insights into the accessibility of financial data (Laffin and Ormston, 2013). However, given that we are considering Dunleavy's analysis of the potential centralising and decentralising impact of information communication technology – and the need to understand NHS costs in different localities by comparing with other areas – it is also important to gain insights into policy and opinion from national bodies.

The authors conducted a first round of anonymous semi-structured interviews with local directors from both sides of the purchaser–provider divide to elucidate practices and attitudes. The anonymous respondents were located in five cities selected as a sample of the major conurbations spread across England. From the provider side, they represented foundation and non-foundation NHS acute trusts responsible for a wide range of procedures, while interviewees on the purchasing side were employed by NHS commissioning organisations. The directors served populations ranging from 320,000 to 670,000, in organisations with budgets extending from £69 million to just over £1,000 million. Ten audio-recorded interviews took place in the three months prior to the publication of the Health and Social Care Bill in 2010.

In addition, to get an indication of what changes had occurred, if any, since the introduction in 2012 of the new purchasers – the clinical commissioning groups – and to test in practice what data were accessible by freedom of information request, we undertook freedom of information data collection from five additional commissioning groups and five trusts from a similar spread of conurbations. This was designed to provide factual evidence from the groups, not attitudinal data. The results not only triangulate with those previously obtained but also provide information, described later, on whether trusts would interpret the Freedom of Information Act as requiring them to reveal particular financial information. Although we have chosen not to identify the authorities, freedom of information rules mean that these authorities and their responses can be made public. The

question of the impact of anonymity concerning interviews and surveys is highlighted therefore. Evidence on whether it increases the accuracy of responses is mixed, however (Mühlenfeld, 2005; Lelkes et al., 2012).

Given, as discussed, the relevance of centralising features for data comparability, we needed to consider views from the NHS co-ordinating centre (or centres). We therefore conducted five in-depth interviews with senior respondents from national organisations, and further respondents provided us with written evidence. These agencies included strategic health authorities, NHS England, the Department of Health, the Audit Commission, Monitor (the English health service regulator), the National Audit Office and the Information Commission's office. Aside from the Information Commission, where our respondent was happy to be quoted, the anonymity of staff in other national organisations has been protected by referring to those organisations as national bodies. Given the rapidly changing health service landscape and the focus of the research, this ascription is not an issue that will detract from the relevance of the findings. To consider national co-ordination further, our research also involved an extensive analysis of documents and policy statements from government departments and agencies, as well as an analysis of the records of the parliamentary Public Accounts Committee and Health Select Committee.

While the number of interviews is comparatively small, it is in line with previous research, and our results build on aspects of other related studies (e.g., Allen, 2002; Llewellyn et al., 2013; Monitor, 2012; NAO, 2010). The authors transcribed the results, then coded and analysed them using the QSR NVivo package. The article provides qualitative data to illustrate views that relate to the policy of financial transparency, as well as evidence of the current practical interpretation of the Freedom of Information Act. (The terms 'purchasing' and 'commissioning' are used here interchangeably.) Readers should note that it is not our intention to prove or disprove Dunleavy's theory conclusively, as the insights on unfolding

processes do not encourage refutability. Our aim is only to describe NHS developments and relate them to his schema.

3. Findings and analysis

The results of the data collection and documentary analysis are ordered to discuss three interlocking aspects relevant to acquiring NHS financial information. We outline real and perceived barriers to data access, the impact of the quasi-market and, finally, respondents' views on transparency both internally to the NHS and externally. These are all issues related to moving to full open-book governance, as set out by Dunleavy.

3.1 Barriers and access to financial information

News organisations may not appreciate that purchasers do not have complete and clear access to information on providers' spending, given the NHS internal market. Yet, as the number of NHS trusts in financial difficulty increases (Hazell, 2014), both their spending and their cost-cutting measures become more newsworthy (Galtung and Ruge 1965; Harcup and O'Neill, 2001). These important decisions require explanation using accurate financial information, as highlighted by MPs with different political outlooks, with one arguing: 'We need to know if more can be done to stop nurses being made redundant' (HoC, 2011).

Nevertheless, our research suggests that, because of incentives originally designed to promote efficiency, barriers exist to the increased collation and dissemination of information described in the Dunleavy's schema. Providers across the country have regularly attempted to obscure detailed financial information both from the public and from purchasers. They have explicitly exploited organisational barriers in order to behave opportunistically and hide information from commissioners (Greener and Powell, 2009), who feared this was masking financial problems. Providers anonymously admitted reallocating money to pay for other services – to cross-subsidise. So one divulged having 'overrated the costs [of services], and that subsidised our district general hospital services

quite substantially'. Another confided that 'what one is not so keen to reveal are those services which are providing the subsidy', because funding would then be clawed back in future commissioning rounds.

Both local commissioners and providers agreed that the power to control information tended to rest with those supplying services. One commissioner explained that he didn't 'get a fraction of the data that they [providers] have available'. However, commissioners were unclear about what entitlements they had regarding access to financial information from providers. All commissioners and provider trusts indicated that they had received no guidance on this, and, as one commissioner put it: 'If I am honest, I'm not sure exactly what our right is.'

Commissioners saw freedom of information requests as a legal obligation to the public, journalists and private competitors, not as a tool for their own use to counter data access difficulties. One considered that there was no contractual obligation on foundation trusts to reveal spending details to purchasers. And from the opposite perspective, one provider was equally blunt, saying that, as his trust had foundation status, 'it is none of the health authority's business; if they asked to look at [the budgets and spending], we would tell them to go away ... I think it would be ... just people being nosy parkers.' Meanwhile, the piecemeal nature of the freedom of information regime nationally is illustrated by MPs resorting to the use of freedom of information requests to obtain data on NHS trust finances (e.g., Kendall, 2012).

Trusts, when responding anonymously, said commissioners rarely requested financial information. In addition, trusts replying to freedom of information requests stated that they and commissioners exchanged the information that both sides needed. Yet, when it came to trusts under the Freedom of Information Act revealing information on the level of cross-subsidising between tariff areas, some said they were not analysing this. And one said that they considered that Section 43 of the Freedom of Information Act, which exempts information judged likely to

prejudice commercial interests, applied to this information. Internally to the NHS, the openness of information was qualified, as this quote from one provider indicates: 'We will always seek to share [financial] information with [commissioners] unless it is commercially in confidence.' For the Information Commission respondent the issue of commercial confidentiality meant: 'The taxpayer would expect that freedom of information wouldn't undermine contracting to the extent that it would cost the taxpayer more money, for example.' Yet, as we have seen, there is research questioning the extent to which releasing financial data would cost more (Llewellyn et al., 2013).

Therefore, we can see that organisational barriers meant that not only was information not fully open and transparent, but the barriers themselves are to some extent determined by staff discretion. Requests for information may be subject to quasi-legal challenge, and some questions of access will therefore reflect case law. Table 1 (Appendix 1) summarises the current picture of national and local financial openness. The overall picture is one of apparent increased data accessibility since the creation of the NHS quasi-market, which, recalling its new public management credentials, would seem to conflict with Dunleavy's theory. However, while the financial data that are available are more accessible, restrictions created by marketisation and the purchaser-provider divide remain.

3.2 The role of the quasi-market and commercial confidentiality

Given this opacity, here we look at the impact of the quasi-market and the autonomy of providers on the blocking of data collation. Firstly, NHS trusts considered that they were independently responsible for their productivity, in the context of tightening finances – and commissioners concurred. Based on Dunleavy's linking of information and communication technology to issues of centralisation and decentralisation, and on Williamson's earlier new institutional economics work, the commissioners were asked if the NHS should be seen as one organisation, in order to achieve economies of scale, or as an industry, in order to make savings through competition. One director thought that the

foundation trust philosophy of ‘earned autonomy’ created practical difficulties in achieving a ‘one organisation’ approach to savings across the NHS. Another felt that it was a question for ‘our political masters’. Another thought that, because of the tariff, the NHS was, in effect, one organisation. And another considered, conversely, that it was too big and complicated a business to be managed as one organisation. Some directors also expressed concerns about the fractured nature of the system: ‘[Although] you are in a single health economy, you are still judged as individual organisations.’ As we have indicated, there was a similarly mixed picture at a national level. Here some staff viewed trusts effectively as private companies and others suggested the potential for efficiencies through economies of scale and data aggregation. In addition, Margaret Hodge MP, as chair of the Public Accounts Committee, noted a lack of leadership on NHS efficiency and bemoaned the array of national agencies that needed to be questioned on the state of NHS finances (Public Accounts Committee, 2013). We can highlight from Dunleavy and Margetts’ perspective the advantages of the NHS being treated as one organisation. They refer to the efficient exchange of data within the retail multinational Walmart – a larger employer than the NHS (BBC, 2012) – as an example.²

Secondly, we found that, certain tools of the internal market – tariff and payment by results – have aided aspects of transparency, by providing a price per designated procedure, but the tariff has also obscured comparisons on spending. While local commissioners oversee healthcare purchasing based on tariff prices, they confirmed that they have become less responsible for actively comparing trust spending in areas such as staffing and equipment – such as, for example, gloves.

² This is a finding echoed by the businessman Sir Philip Green in his 2010 Efficiency Review conducted for the UK’s Coalition Government. He found that: ‘The government is failing to leverage both its credit rating and its scale’ (Green, 2010).

Some welcomed investment in data collection – which ‘used to be rubbish’ because there was ‘never an incentive to check and correct it. ... Before the purchaser–provider split there was lots of transparency, but crap data.’ One commissioner suggested that tariffs made knowing providers’ costs irrelevant, ‘because I have to pay them the tariff whether they are making a loss on it or whether they are making a profit’.

The principle of decentralised ‘local trust autonomy’ also guided this view that providers’ costs were not of wider concern. One national respondent said that: ‘You can’t turn around and say to any business: “You have got to be prescriptive on how you are going to procure that one glove.”’ He thought that a ‘centralised dictatorship’ needed to be curtailed in order to ‘devolve management down to the local level to deliver public services’. This view contrasts with the theory of Dunleavy and his colleagues that progress towards transparency and full open-book governance involves centralisation, harnessing the potential of information technology. They do not consider this needs to be counterposed to increasing decentralised information at local sites.

However, while the Freedom of Information Act (HoC, 2000) does regard trusts as discrete public bodies, the Information Commissioner has ruled that accessing the financial information of one trust is less useful if it is not possible to compare it with other trusts’ data (ICO, 2006). Nevertheless, the implications of this have not been fully resolved. Trusts employ their own ‘benchmarking clubs’ to help them compare their own data with those of other trusts. We were told of at least nine such clubs (see Table 1). But their analysis is not designed for public consumption. Some trusts stated that they were benchmarking costs in areas such as security, accident and emergency staffing by grade, supplies, interpreting, settlement of legal disputes and spending on clinical coders, whereas others said they were not doing this. Thus, foundation trusts seem to have only an *ad hoc* ability to compare spending.

Thirdly, some provider directors felt that competing with other NHS and private providers limited the amount of financial information they could disclose, as commercial confidentiality was a factor. Internally, as we previously noted, this dictated limits: 'We will always seek to share [financial] information with [commissioners] unless it is commercially in confidence.' Indeed, providers withheld information in order to operate an effective market, one purchaser suggested: 'You create a commercial nexus and it encourages certain types of behaviour. Tesco [supermarkets] don't go shouting from the rooftops that actually they are making a lot of money out of you.' What was important here was a feature of the NHS market system – that commissioners and competitors should not be in the know: 'We have a market which is there to drive efficiency ... So I think having too much data could undermine that. Efficiency will eventually drive its own way through.'

Meanwhile, another commissioner also backed market motivation: 'You don't want to rob providers of an incentive to become more efficient and make a profit ... Most providers are not making super-profits and so, if they are making a profit in one area, it is subsidising another service. Ultimately, as a commissioner, it is my responsibility to ensure continuity of services.' There were indications that staff in national co-ordinating organisations saw themselves as bounded by commercial autonomy. One view was that 'with competition rules, there is no way to force a commercial organisation ... to divulge how they cost their services'. To do this would be 'against the agreement of foundation trust licensing conditions'.

For the Information Commission respondent, nevertheless, aside from competition rules, there are public interest concerns with this data release. What is considered is 'the importance of the public being able to participate in decision-making' and to hold those in power to account (ICO respondent).

However, fourthly, despite some respondents' assessment that the NHS is overly fragmented by competition, as Table 1 indicates, there are also examples of

centralisation, which are relevant to Dunleavy's theory. Thus, centralised data collection does take place in order to calculate tariffs. On this, as referred to in the introduction, Monitor commissioned an important report that recommended the cost information trusts use internally should be collated nationally to calculate the centralised tariff. This was in order to iron out duplication of work in trusts; the current system requires separate collection of trust costing information for central tariff calculation (Monitor, 2012). However, there is clearly scope in the future for harnessing and centralising trusts' own cost information. This, the report maintained, would also be more accurate.

As we referred to in the introduction, the government has also now opted for centralisation to 'de-clutter' the organisations providing procurement support – aimed at encouraging transparency and benchmarking, and creating a single 'data warehouse' for NHS procurement (DH/NHSE, 2013). However, this does not provide the whole picture, since it only relates to external purchasing by NHS trusts. As such, there is not centralised transparent benchmarking between trusts of all spending. This both demonstrates a selective approach to data release and at the same time is a significant development linking information and communications technology, transparency and centralisation, as predicted by Dunleavy's theory.

Given these responses, we can see that, whatever their individual views on the quasi-market, respondents perceived that it often led to opacity, counteracting the government's drive towards open budgets and transparency and perhaps challenging Dunleavy's observations. But some new centralisation of comparative data is evident, which provides opportunities for increased transparency, and which accords more with Dunleavy's schema.

In addition, the Information Commission respondent echoed the perspective of Dunleavy on a move from freedom of information requests to what he called 'transparency by design', or planned publication schemes. The Monitor-

commissioned report (2012), referred to above, also highlights the scope for built-in features that would further facilitate data-sharing across the NHS.

3.3 A culture of financial transparency?

As we have seen, staff have felt they have been given little guidance on financial transparency. The Information Commissioner highlighted the fact that different NHS organisations display varying cultures of secrecy and transparency. And some trusts were more open than others, for various reasons; it ‘may be down to the fact that they are not a very well-trained member of staff, it may be cautious lawyers, there might be a far more secretive culture within the organisation’. The additional workload that freedom of information requests generate meant that staff tended to see freedom of information as a nuisance. But this does not necessarily indicate their opinion on increasing open-book governance, where datasets can be available automatically once the initial work is done to make them accessible.

Our research shows that some staff wanted greater transparency, both within the NHS and also to aid public scrutiny. This view was not universally shared, though. One commissioner thought that ‘open [financial] information would make my job easier, but you don’t set up regimes to make life easier’. Another was worried that people might misunderstand the data, echoing the view of Bannister and Connolly (2011). Nevertheless, other purchasers wanted to see far more openness, so they could jointly plan to improve the financial state of the local ‘health economy’. So one such purchaser wanted more transparency ‘to work out why this service is now more expensive than that service’. He viewed the present system as ‘not a partnership relationship [but] an adversarial relationship. It is not helping in delivering ultimate benefit to the public.’ A provider director concurred. He felt that confidentiality over-protected commercial suppliers. Opening up all providers’ budgets to public and journalistic scrutiny, he thought, ‘would be incredibly radical. Public bodies should put all of their spend in public. I think it would reduce spending.’ As for any negative impact of this, he was much more concerned about

the commissioners having the information than reporters and the general public. While the Information Commission respondent considered that the concern expressed about misunderstanding data was not enough to halt release. Furthermore, he suggested, 'The policy does not assume that the public or journalists will not have an interest in the type of financial data considered here. Its usefulness might only emerge ex-post, when they have play[ed] around with the data over a long time' (ICO respondent).

Internally to the NHS, where information has been forthcoming it has often been because commissioners have relied on relationships of trust. One thought that his organisation 'has good collaborative working relationships with all its providers, and there is sufficient trust for information to be routinely shared between [us], where there is a business requirement'. And another felt: 'We are clear that we must work hard on relationships to obtain full financial data.'

Whether the creation of foundation trusts played a part in instigating a culture of opaque financial activity was disputed. One clinical commissioning group suggested that neither of the trusts it commissioned from shared financial reporting: 'Foundation trusts have additional rights beyond those of [other] NHS trusts to retain surpluses, which don't automatically apply to others, and they only report very high-level financial performance data via the regulator to commissioners.' But one such trust itself considered that 'we publish more information, as an FT [foundation trust], than non-FTs'.

The reliance on non-formal structures for the sharing of financial information and the lack of guidance reflect Pauline Allen's work in which she finds relationships between parties in NHS contract negotiation have an important impact on service developments (Allen, 2013; Hughes et al., 2011). Nevertheless, NHS England could use the standard NHS contract to obtain and publish more comparable data (DH NHSE, 2013, p. 22). But there was mixed opinion from central NHS bodies

on the value of this. Some central staff felt that it was better to let trusts 'operate freely' than to force them to share more data.

Staff also said that financial data were available, but that there was 'no one to analyse it'. This observation has contradictory implications. From the respondents' immediate perspective, it meant there was no point in prioritising open financial data further. However, a culture of increased openness could mitigate the problem that trusts and the commissioners highlight here. The possibility of any opening up to what Yochai Benkler has notably described as *The Wealth of Networks* (2006) – in this case crowdsourcing 'armchair auditors' to analyse financial data – is still relatively untapped. There remain concerns about these sofa scrutineers' accuracy, ability to interpret the data and representativeness, on the one hand, and, on the other, the capacity of news providers, when interested in utilising crowdsourcing, to process contributions on the occasions when there has been a flood of responses. Nevertheless, as we saw in the introduction, there are examples in other areas where journalistic crowdsourcing has corralled both general audiences and experts to analyse general and specialist public issues (Muthukumaraswamy, 2010). It is far from clear whether the existing 'vanguard' will ever become 'a citizen audit army' of the Coalition government's imagination (Worthy, 2013). And it is not clear so far how much use has been made of the rights to access datasets under the Protection of Freedoms Act, for instance (ICO respondent). Yet the commissioner also suggested that the 'old mindset of ... a lot of public sector authorities ... has been to say "What is the reason for this person to have it?" as opposed to [the new mindset of] "What is the reason to keep it secret?"'. From the Information Commission's perspective it cannot be assumed that no citizen or, indeed, journalist wants to analyse NHS financial data. Thus a process of change is under way and the direction of increasing openness referred to by the Information Commissioner at least concords with Dunleavy's theory of a dynamic movement towards a more digital-era governance.

Thus, our overall findings suggest that the NHS structure of separate and competing organisations was reflected in the availability of comparative information and in staff attitudes to data release. Although there was more information available than staff tended to be aware of, both they and the public were restricted in accessing it. Staff were unsure of their rights and responsibilities to review the financial data of other NHS bodies and, to a degree, used informal and *ad hoc* mechanisms. However, some moves were under way to increase national standardisation and comparability of trust financial data, using information technology.

4. Discussion and conclusion

Theorists using insights garnered from new institutional economics have highlighted the high transaction costs in acquiring data when there are barriers between organisations and an asymmetry of information (Williamson, 1983; Marini and Street, 2007). Evidence has been given here of how the quasi-market provides incentives to encourage the opportunistic exploitation of information asymmetry internally within the NHS, hampering external dissemination. However, while Dunleavy and his colleagues have recognised that the power of information communications technology will be curtailed by these ‘new public management’ structures, they have also asserted that the technology will impact on governance, breaking down barriers and allowing for data centralisation, and decentralised data access, along with open-book governance.

In an apparent contrast to the perspective offered by Dunleavy et al., some commentators have championed greater use of the market in the NHS and have suggested that private-sector open-book methods could help disseminate information (Brereton and Gubb, 2010). But research finds that commercial confidentiality is a block to firms employing these too (Meira et al., 2010). The role of confidentiality in market competition has been explored in the analysis of intellectual property rights and the protection of commercial secrets, as justified

by freedom of information legislation. There is a trade-off. On the one hand, there is the welfare goal of disseminating information, to avoid augmenting the monopoly control of one market player. On the other, those asserting private rights argue that information needs to be confidential to provide an incentive for profitable innovation and to exclude ‘free riders’ (Gallini and Scotchmer, 2002).

The NHS directors and national leaders interviewed described an analogous trade-off operating in the quasi-market. To improve efficiency, there was the threat of financial failure and the incentive of a surplus. And to protect the possibility of the latter, it was felt that information again needed to be withheld – this time from NHS commissioners, fellow NHS providers and private concerns, and therefore also from the public. While the staff we interviewed disagreed as to the quasi-market’s merit, they were all obliged to succumb to the logic of a competitive market. Yet this process impedes the broader dissemination of financial information internally – and also its dispersal for public scrutiny.

Notwithstanding internal concerns, NHS financial deficits are newsworthy and of public concern. It may also be of public interest that NHS providers, backed up by freedom of information exemptions, do not always share data, the analysis of which can aid NHS-wide implementation of best practice. In a service funded by national taxation, there is a potential for public anxiety that such system-wide NHS information as is available is not always accessible in a clear, compatible and comprehensive format.

The findings of our study have implications for journalists’ access to NHS financial information and their role in informing public debate. The research has observed changes that can be interpreted as a move from a freedom of information regime to full open-book governance (Dunleavy and Margetts, 2010). However, there are clearly evident blocks to this development. Policy-makers are grappling with digital-era governance. The UK government aims to use information and communication technology to increase transparency. This paper suggests that the

new public management mechanisms of the quasi-market (such as the purchaser–provider split, independent foundation trusts and duplicate data collection systems), coupled with freedom of information exemptions, organisational cultures and a lack of clear guidance, still militate against full open-book governance of the type Dunleavy describes.

Our research shows that local staff on both sides of the purchaser–provider divide believed that providers at times obscured financial information. And national players were not always motivated to address this. While factors such as local relationships between trading partners may also impact on this, the effect of the quasi-market and commercial confidentiality have been shown to be significant here. Local and national staff disagreed over who was allowed to know and hide what. Their conceptions of the NHS market and of wider market mechanisms also diverged. Some felt that a competitive culture undermined joint work to benefit overall financial health. Others saw themselves and trusts as competing with each other and with the private sector. And the Information Commission was obliged to make assumptions about the public interest in financial data release in this contested context.

Given the role of the Freedom of Information Act, the Information Commission’s rulings and guidance are significant in moving to greater open-book governance. Future interpretation as to whether open budgets or open markets serve the public interest is key. On the one hand, current NHS policy in England is attempting to devolve and decentralise power to trusts and provide incentives for clinicians to induce them to improve productivity, contrary to what Dunleavy and Margetts suggest. On the other, the NHS wants to control its £100bn annual budget. As the chair of the government Public Accounts Committee put it in 2011: ‘We need to know how to square the circle of more prescription around [for example] procurement and the more decentralised decision-making structure that comes from the NHS reforms’ (HoC, 2011). These conundrums are not new (Klein, 2010). But the NHS reforms of the past two decades appear to have created further real

and imagined organisational barriers to staff, journalists and the public analysing resource deployment. Yet these barriers and their impact on open data, as we have seen, are the subject of Dunleavy's theory, which predicts that they will wane.

Further extending *An Information Revolution* (DH, 2010) – in contrast to piecemeal local insertion of open-book contractual clauses (Cabinet Office, 2011) – could help counteract asymmetries of information in the NHS quasi-market, providing more thoroughgoing transparency, both internally and externally of the sort Dunleavy and Margetts envisioned. To deliver this would not just illuminate NHS decision-making internally but would also offer the potential to enhance participation in the public sphere. Whether or not they took it up, it would aid journalists' ability to act as watchdogs and the public's capacity to become the armchair scrutineers that the government has claimed would be possible with data release. We have offered some indication – but not conclusive proof – that this NHS financial information revolution is under way. It will be interesting to follow the process and see which wins through: making this public sector financial information increasingly public, or keeping more of it private.

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Table 1

PUBLIC AVAILABILITY OF NHS FINANCIAL INFORMATION

Level of Data Availability

1. Live streamed open-book data
2. Routinely published
3. By freedom of information request
4. Not available by freedom of information request, research finding/tribunal tested
5. No longer collected

National and Local Datasets	Level
DH/NHS England/Monitor/ Health and Social Care Information Centre (HSCIC)/National Trust Development Agency/Other	
HSCIC Review of Central Returns www.hscic.gov.uk/rocr lists 20 financial datasets within a schedule of 155 collections. Data sources are normally NHS provider services. Examples include: estates (R00049); foundation trust accounts (R00104); pensions (R00111); reference costs (R00289); programme budgeting (R00114); education and training (R00415). Also, workforce numbers (e.g., R00433).	2
NHS Business Services www.nhsbsa.nhs.uk/PrescriptionServices/3164.aspx prescription data	2

NHS pay-bands http://www.nhscareers.nhs.uk/working-in-the-nhs/pay-and-benefits/agenda-for-change-pay-rates/ and tariff rates www.monitor.gov.uk	2
Adjustments made to average reference costs in order to incentivise NHS trusts	2/4
Freedom of information requests: the Department of Health website lists freedom of information responses, but not the content, which is available on request. Freedom of information requests to NHS trusts are not collated nationally. Requests via www.whatdotheyknow.com are available	3
Information tested in case law: tribunals regarding Section 43 of the Freedom of Information Act (eg ICO, 2006)	4
Trust Financial Returns; submitted by non-foundation trusts up to 2012	5
NHS Foundation Trusts and Trusts	
Spending to outside organisations amounts of over £25K (over £500 for local authorities)	2
NHS trust departments' spending against their agreed budgets on items: e.g., staffing by grade; travel; consumables. Spending against budgets is reported within the trust. To obtain comprehensive information, requests to each trust would be required	3

Cost apportionment for tariff returns are not routinely published, but may be available by freedom of information request.	3
Benchmarking clubs work for trusts; more than nine clubs were cited by respondents. One was contacted to indicate whether it considered itself to be subject to the Freedom of Information Act. It stated that trusts would need to consent individually to the sharing of collated data	3/4
Cross-subsiding between tariff areas restricted under article 43 of The Freedom of Information Act	4
Patient level information and costing systems data from individual NHS trusts and pilot tools; 85% of hospitals cite commercially sensitivity (Llewellyn et al., 2013)	4
Private companies supplying services to the NHS	4
Personal Social Services Research Unit costs series (secondary analysis) www.pssru.ac.uk	2

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