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Commercial confidentiality: a cloak for policy failure

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The DoH in England is increasingly putting itself beyond the reach of parliament and public scrutiny when it makes fundamental changes to the NHS. In the most recent example, researchers appointed by the DoH to undertake twin studies of six Commuter Walk-in Centre pilot schemes were denied access to both the contract and patient data .[1,2] The researchers were unable to obtain patient information because the DoH deemed it commercial in confidence in one study and in the other study—despite having agreed to provide the data—withdrew permission on the same grounds. Since 2002 the Government has argued that complete accountability of publicly funded programmes will stifle innovation and should be conditional.[3] So which stakeholder interests are being served by this latest exercise in policy secrecy?

In 2004, the government implemented the UK General Medical Services (GMS) contract, which heralded major market-oriented reforms allowing primary care and GP services to be broken up and put out to tender to large multinational corporations and new alternative providers of care.[4] Among the new providers of care are six Commuter Walk-in Centres, which are paid for by NHS funds but provided by four private sector companies: Atos Healthcare, Netcare UK, Walk in Health, and Care UK. A seventh centre will be soon be opened in London. The centres, located near rail stations, were intended to provide primary care services to both commuters and the local population, improve access, and widen patient choice. The contracts for the six centres are estimated to cost the NHS £50 million over five years.

What is the DoH so keen to conceal from academic scrutiny and public gaze, under the cloak of commercial confidence? Value for money claims about the efficiency, performance and benefits of the market can only be tested by having full access to the contract details, the costs of services, and the numbers of patients treated; but the researchers were denied access to all these data. Faced with these information gaps, the researchers were reduced to using patient surveys, staff interviews and press releases.

The findings show that the Centres were working at around half the rate intended; i.e., an average of 87 patients attended each day compared with the 150-180 patients expected for a contract price of £50 million over 5 years. If this treatment rate continues across the life of the contract, up to £25 million—half the contract—could be overpayment by the NHS to the private sector over the five-year period; but without the patient data and the contract details we shall never know for sure.

As one would expect, patients attending the Commuter Walk-in Centres are younger and fitter: 84% of those surveyed were under 45, while only 1% were 65 and over. In contrast, the highest rates for GP consultations nation-wide are among those aged 65 and over, reflecting higher sickness rates.[5] The skewed demographics raises questions as to the basis of the DoH contracts reimbursement.

What the researchers do show is that, on the basis of patients actually seen, Walk-in Centres are paid two to four times the per capita cost that GP practices receive.

Information is not just the lifeblood of democracy, it is the cornerstone of both public health care and the efficient functioning of markets. In the public health paradigm—within which a universal service such as the NHS operates—data and information are required to ensure that the goals of universal access, equity and comprehensive care are being monitored and met and services adapted accordingly. Data are required to monitor and evaluate the population's access to health care; its use of services; met and unmet need; and any inequities in provision by place, over time or by social class and other factors.

Markets are inherently characterized by information asymmetry, a deficiency which must be overcome by state regulation. In a market the role of regulation is to provide information that allows the consumer to make informed decisions on the basis of quality and cost. In this case, the primary care trust (PCT) is a proxy for the consumer, as the transaction costs of making an informed judgment are too great for the patient. Investors and shareholders also need information to ensure the profitability of services, identify how costs are structured and how efficiencies can be made. However, PCTs do not manage these contracts; they are nationally procured by the DoH, and at least one PCT has consequently found it difficult to assess the performance of these centres due to the poor quality of data they received.[6] That the taxpayer and citizen might be interested in the efficiency of NHS-funded, private for-profit Walk-in Centres appears to have eluded the DoH, so intent is it upon the project of privatization.

And here's the rub: as with the banks and the East coast train line, when the market in health care fails the government takes the services back as provider of last resort. At the time of writing, the NHS Choices website stated that the Department of Health is "taking [the seven centres] over from the independent sector".[7] However, we were unable to obtain further information or confirmation regarding this development.

The question is: what have been and continue to be the opportunity costs for the NHS, patients, staff and citizens of paying too much for these private-sector white elephants? How many chiropody, physiotherapy and speech therapy services have been cut to pay for care? How much care have the frail, elderly or the chronically sick had to forego to satisfy the whims and needs of the walking well? Instant gratification comes at a price—a price that is increasingly difficult to determine in the context of commercial confidentiality clauses and exemptions in the Freedom of Information (FoI) Act. But there are wider consequences for the continuity of care and monitoring of outcomes.

The emphasis is shifting to patient satisfaction or patient safety or patient quality—all laudable goals, but no substitute for cost, equal access for equal need and universal access. As health care is being re-modelled by the needs of the market, the risk is that the universal norms of information will also be lost. This development has grave implications for the ways in which research is undertaken in the future.

Commuter Walk-in Centres are only a small part of the larger picture. As the government pursues its £5 billion ISTC programme, its £60 billion PFI programme and its £13 billion IT programme, the exemptions in the FoI Act are being used as an obstacle to both patient and public interest. Based on one case study of an independent sector treatment centre (ISTC) in Scotland, where contract and patient data were made available under the FoI Act, the NHS may have overpaid the private sector by up to £927 million pounds for services provided in ISTCs in England.[8]

As these studies reveal, NHS patients attending Commuter Walk-in Centre —funded and paid for by the NHS—are being rendered invisible by the market, and so too are the true costs of NHS care and the losses to patients. Commercial confidentially and qualified accountability function as a cloak for DoH policy failings. It is no surprise the approach finds favour in Whitehall.

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[1] O'Cathain A, Coster J, Salisbury C, Pearson T, Maheswaran R. Nicholl J. Do walk-in centres for commuters work? A mixed methods evaluation. *BJGP* 2009; in press.
[2] Coster J. O'Cathain A, Nicholl J, Salisbury C. User satisfaction with commuter walk-in centres. *BJGP* 2009; in press.
[3] HM Government. Audit and Accountability in Central Government The Government's response to Lord Sharman's report "Holding to Account". March 2002. CM5456.
[4] Health and Social Care (Community Health and Standards) Act 2003. London: Stationery Office, 2003.
[5] Trends in Consultation Rates in General Practice 1995 to 2008: Analysis of the QResearch® database. Final report to the NHS Information Centre and the Department of Health. London: NHS Health and Social Care Information Centre, 2009.
[6] Leeds Primary Care Trust. Board Meeting Notes: Thursday, 18 September 2008. pg 33 http://www.leedspct.nhs.uk/attachment/e7b2c3bb40c3f78be49766a9c0e35f6f/7320419af149e755558d171071b8f47b/September+2008+Board+papers.pdf (Accessed 5 November 2009).
[7] NHS Choices website. "NHS Walk-in Centres FAQs". http://www.nhs.uk/NHSEngland/AboutNHSservices/Emergencyandurgentcareservices/pages/Walk-incentresFAQ.aspx#q04 (Accessed 5 November 2009)
[8] Pollock A and Kirkwood G. Independent sector treatment centres: the first independent evaluation, a Scottish case study. J R Soc Med 2009;102: 278-286.